DOCTORAL PORTFOLIO IN COUNSELLING PSYCHOLOGY

Written by

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

Practitioner Doctorate in Counselling Psychology
D. Couns. Psych.

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

July 2015.
Declaration

The research dossier of any part thereof has not previously been presented 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). With the exception of any express acknowledgments, references and/or bibliographies cited in the work, I confirm that the intellectual content of the work is the result of my own efforts and of no other person, beyond the role expected of my research supervisors Dr Darren Chadwick and Prof. Coral Dando

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Signed.....Jill Mack............................................................

Date........04/05/2016.....................................................
Abstract

There is growing evidence investigating the aftermath of homicide on those families bereaved. The literature suggests a potentially devastating emotional and psychological impact on family members and loved ones. Despite this, the research focused on developing and empirically evaluating service provision and clinical interventions for this population is sparse and lends its focus to support groups (Blakley & Mehr, 2008) and family therapy (Hatton, 2003). The aim of the current thesis is to conduct an evaluation of a service that provides therapeutic interventions with those bereaved by homicide. It will present a mixed methods approach, utilising thematic analysis of interviews with staff members and quantitative analysis of service user’s psychological distress outcomes. Finally, based on key findings presented, implications for future research, policy development and practice are included.
Word count summary

The word count summary is including in-text references, but excluding of titles, tables and diagrams.

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I wish to thank all of those I have had the privilege of working with during your time of need. I am truly humbled by the capacity of human resilience since my encounters with you.

Finally, I pay sincere tribute to my loving family. To my Mum and Dad, you have always believed in my ability to succeed and have allowed me, through your continual, unwavering support, to follow my dreams. I know I could not have managed without your support in every aspect. I hope I have made you proud. To my wonderful children, I have sometimes been a mother to a set of books more than I have to you. I want to thank you both for understanding my wish to succeed in something I believe in, and your support when I felt in over my head. Your ability to support the (eyewatering) reduction in finances has been heart-warming. I love you all tremendously and am extremely grateful every day to have you all as my family.
All work throughout this portfolio has been appropriately anonymised and all identifiable information removed so that no participant can be identified.
Exploring process and outcomes of a therapeutic homicide bereavement service.
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Preface – An Introduction to the Portfolio

The intention of the preface is to provide the reader with an insight into the motivation behind the selected pieces of work which contribute to this doctorate portfolio. Consideration of my beliefs relating to their importance will be presented with specific reflection on the contribution to my identity, growth and competence as a practicing counselling psychologist.

This doctorate portfolio is comprised of a selection of completed work for the Practitioner Doctorate in Counselling Psychology for The University of Wolverhampton. The portfolio contains three distinct dossiers, namely academic, therapeutic and research. A separate document is attached to the portfolio due to the confidential information that is contained and relevant to the research conducted.

1 - Firstly, an academic dossier will present essays that were completed specifically for modules and chosen accordingly as they related to my area of interest. A ‘Life-span’ essay exploring issues of ADHD and a ‘Working with Couples’ essay are submitted as they each contribute in their own way to my interest in the field of trauma.

2 - Secondly, a therapeutic dossier will contain essays produced during the final stages of my three year doctoral training with the specific purpose of illuminating my personal growth in the skill of academic writing and additionally in my professional development as a counselling psychologist. This growth will be reflected in the ‘Professional Issues’ essay and in a ‘Supervised Practice’ portfolio. In order to elucidate this growth and development, all essays are presented without amendment.
Finally, a research dossier will present a literature review, an empirical study and a critical appraisal of the research process.

Confidentiality has been at the heart of decision making and ethical consideration throughout this portfolio, where a conscious decision has been made to protect clients and professionals involved in any way with the research. The decision to use staff members rather than service users was central to the ethical dimensions of working with this population of bereaved individuals and families. Data used that is extracted from service users are anonymised in order that their identities could not be ascertained from this document. A Confidential Attachment has been submitted separately, this attachment will not be available to the public. It contains a process report, personal development summary essays and raw data from this doctoral portfolio (e.g. transcripts from the research dossier's participants).

I have always been drawn and interested in the field of trauma within the counselling psychology domain and have tried to examine multiple areas of enquiry to broaden my knowledge into this fascinating area. This has driven the majority of decision making regarding essay choices including the first essay included titled ‘Issues of identity, gender and treatment in adolescents with ADHD: A Lifespan Approach’. This essay was written during the first semester of my second year and was relevant in terms of my attraction to understanding ADHD behaviours in connection with trauma, a focus of a great deal of research and controversy (Littman, 2009; Weinstein, Staffelbach, Biaggio, 2000). The life-span approach deepened my understanding and reflection of how trauma can impact over the life-span. At the time, I was concerned that my focus of enquiry
into those bereaved by homicide was too narrow and wanted to broaden my understanding of trauma and its impact. As the duration of my doctoral placement has been in a trauma service, I always felt restricted in terms of my professional development and identity. I now see this as the development of a specialism and understand I am still at the beginning in terms of my learning and professional identity. The life-span approach also enabled the development of understanding into children, another area of research interest and psychological enquiry, and how early experiences serve to inform adult relationship patterns and behaviours. This essay was chosen to enhance my understanding of a topic that continues to be of interest and one which I will explore further in the future.

My research proposal into those bereaved by homicide had gained approval at this point and was keen to do justice to those I encounter though my work setting and develop questions that would be pertinent to the development of the service and policy development. The topic of homicide was one that I did not set out to work in, rather through service decisions and the attainment of a contract with Victim Support, I found myself working therapeutically with this population. As I delved into the research, worked within the service with those bereaved and simultaneously conducting a separate service evaluation, I found I was engulfed with homicide and found the essay on ADHD a refreshing shift of focus and at times a respite. The essay on ADHD and exploration of this area enabled me to consider previous reflections of ‘labels’, to consider and question what the label is for and where it originated. This concept of constant curiosity has been central to my professional identity as a counselling psychologist and continues to drive my ambition and passion for the work I do and the individuals I work with. It led me to challenge my
own perceptions and that of others and how these may impact of the therapeutic encounter (Rogers, 1957).

This particular module also enabled my consideration into the life-span approach into my research topic and how specifically traumatic bereavement such as homicide may have, and frequently does, a life-long impact. As I had not had the same experience in that I had not been bereaved in this way, I felt I was a novice in this area and had limited knowledge into the lived experience. The knowledge I had was observing and witnessing the impacts from a therapeutic stance and this gave me the drive and commitment to the importance of my research. This feeling of providing sufficient and relevant knowledge in this area was at times overwhelming and the lifespan assignment provided grounding and at the same time different lens with which to view my research project.

The second piece of work included is an essay for the Working with Couples module of the practitioner doctorate. I was heavily involved with my research at this point and was clear about the direction of the essay entitled ‘Psychodynamic and Cognitive Behavioural Approaches to couples therapy following traumatic bereavement’. This was an important piece of work as it aided my learning in an area that I felt was particularly challenging, working with couples, however it felt was critical to my current work placement. I frequently witnessed and observed the corrosive impact of traumatic bereavement on relationships, particularly couples, as they struggled to integrate the knowledge of the death of a loved one under horrific circumstances. As a service we offer individual therapy to those bereaved however,
I recognised through my work which sometimes involved working with whole families individually, the need for systemic work to explore the family dynamics that played out following such an experience. The couple’s relationship appeared crucial in family dynamics as each member of the family tried to cope in various ways. At a clinical level, counselling psychologists are trained to conduct therapy from a number of psychotherapeutic orientations, with a current UK trend and service decision to favour Cognitive Behavioural Therapies (CBT) and more specifically, Trauma-focussed CBT (TF-CBT). This is due to guidelines indicated by the National Institute for Clinical Excellence (NICE) and the increased use of Improving Access to Psychological Therapies (IAPT) programmes (Department of Health, 2007). I wanted to address this issue in this area as I recognised the importance of utilising various models of intervention and particularly the psychodynamic orientation, in order to understand specific coping strategies influenced from early childhood experiences, as well as how these impact on resilience to traumatic experiences. This had become a main focus of interest for as I struggled to conceptualise purist approaches and how to utilise these with varying client difficulties particularly in my work setting. There was a distinct awareness within the service that although evidence-based models were used and effective in their own right, these were not sufficient in managing the range of difficulties experienced by those bereaved by homicide. My interest became focussed on how to implement various techniques. Additionally, it was evident that to work solely with individual members may be deemed reductionist as an intervention technique (Horne, 2013). I felt that as my training progressed, I was better equipped to assess, formulate and integrate varying models to achieve the best outcome for the client. This I feel was
evidenced in my couple’s essay which addressed traumatic bereavement within a TF-CBT and psychodynamic framework.

The professional issues essay was a mandatory part of the doctoral portfolio, and were written towards the end of year three. This provided a reflective element to my progress as I examined experiences and challenges over the course of the training. This again enabled me to address previous concerns that my placement setting had restricted my development and identity as I had not being able to experience varying placement setting and more specifically NHS settings. I felt that this would be a disadvantage as those who had this experience would be preferential for a job in this arena. This essay enabled a reflection of my endeavours and I feel I have gained experiences and challenges and it is how I choose to utilise the skills and knowledge attained that will make the difference. I still retain the passion I had at the beginning of the training, in fact, this passion has intensified. I am confident in both my personal and professional growth and identity development with the knowledge that there are continual areas of growth and development for which I assume full responsibility.

Finally, the research dossier presented towards the end of the portfolio has played a significant role in my identity development as a counselling psychologist. It has presented me with the most challenges in terms of the time and commitment needed to undertake such an empirical project but also meandering my way through a process that felt unfamiliar. I was weighed down with a sense of ‘doing justice’ to the research, the service and those who use it. It felt imperative that I added to knowledge in this arena which may assist researchers design models of loss that incorporate the totality of their experiences as well as support investigative practices
that will meaningfully contribute to the literature. Above all, I felt it was crucial that
debate and interest in this field of psychological enquiry was stimulated.

The whole process of professional and personal development has been all-consuming
and life-changing. I feel proud to be affiliated with such a profession and will
continue to be driven in my own development and that of the profession as a whole.
I have embraced various theoretical models, practices and methods of enquiry,
gaining invaluable academic and clinical experience that has facilitated my
awareness of the therapeutic encounter. I have explored myself in relation to others,
more specifically, keeping in mind the impact of my own personal and professional
development on the therapeutic relationship and those I have the pleasure of working
with.

I feel privileged to be in this position of learning and I view this development as
ongoing. I feel this doctoral portfolio has significantly aided this development and
given me a sound basis and grounding for my role and career as a practitioner
doctorate in counselling psychology.
References


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Academic Dossier
Lifespan Approach PS5004

Issues of identity, gender and treatment in adolescents with ADHD:
A Lifespan Approach
December 2013
(Word count: 3,020)

Module Leader: Dr. Abigail Taiwo

Introduction

Attention Deficit Hyperactivity Disorder (ADHD) is the most prevalent developmental psychiatric disorder in childhood and adolescence (Merikangas, Nakamura, & Kessler, 2009). Recent literature focus recognises its persistence across the lifespan however there is limited research into adolescents with ADHD. Common characteristics in adolescence include diminished hyperactivity, inattention and academic underachievement which serve to influence an individual’s integration into society (Hirsch & Hack, 1999). The current paper will address current issues of attitude towards ADHD in adolescence, with a particular focus on gender and the impact on an individual’s identity. Theoretical models of identity will be explored and critiqued based on their compatibility with current lifespan stages and a diagnosis of ADHD. Its aim is to address negative appraisals within society’s recognition of ADHD. It will suggest a positive reframing in practice that will serve to focus on adolescents as they endeavour to discover their sense of self within society, rather than on the diagnosis of ADHD.
Research into ADHD primarily focusses on children (Steensel, Bögels, & Bruin, 2013; Milea, & Cozman, 2012) and more recently adults (Quintero et al. 2013; McCarthy et al. 2013), with pharmacological, behavioural and psychosocial interventions recommended as treatment options (National Institute of Clinical Excellence, 2013). Results from research into children with ADHD are often extrapolated for use in clinical practice with adolescence, which fails to recognise important and significant developmental issues that occur throughout the lifespan. There is limited research into the ways in which adolescents develop psychosocially and in turn, cultivate an identity alongside a diagnosis of ADHD. Persistent negative attributions appear inherent with a diagnosis of ADHD, based on a Western society’s lack of accommodation and the individual’s concluding sense of who they are. The acknowledgement that symptoms of ADHD are considered along a spectrum of what Western humans experience at varying times in their life, including impulsivity, distraction and task incompletion are avoided and the disorder is regarded as a significant medical problem (Rafalovich, 2004). This medical model focusses on impairment and ignores the interactionist model that steers attention towards the amalgamation of society and the individual (Prior, 1997). It is not within the scope of this paper to address issues of identity, ADHD aetiology and gender in detail, rather its focus is aimed at suggestions that societal forces underpin and foster the demise of ADHD diagnosis, the individual’s self-concept and development of identity, particularly during the stage of adolescence.

**Adolescence and Identity**

During adolescence, the exploration of different behaviours, roles and identities, social relationships are an important factor at this stage of development. Identity formation is a major developmental task and as the formulation process occurs, they naturally turn to families, friends and society to evaluate and develop their sense of themselves in
relation to others (Grotevant & Cooper, 1985). Bowlby (1979) suggests this transition is supported through secure attachments which enable identity to be established without turmoil. Psychoanalytic traditions have held the view that the successful transition from adolescence to young adulthood is achieved in a ‘rejection of parental definitions of identity’ (Erikson, 1950). Erikson’s (1980) widely used traditional theories of psychological development suggests the adolescent struggles to gain a sense of ego identity and sense of self, which is considered separate from childhood experiences, in order to emerge as an adult. Identity versus confusion is the fifth stage of psychosocial development and relative to the adolescence period. Through this phase of critical development, successful maturation is deemed relative to a facilitative family setting, however there is growing critique whether this viewpoint is appropriate with western traditional family structures that are ever changing and shifting (Summerfield & Babb, 2004). The adolescent who is experiencing the developmental stage of an identity crisis alternates between the experiences of ego identity and identity confusion. According to Kohut (1971), the development of a healthy self occurs along three axes: a) the grandiosity axis; b) the idealization axis, and c) the alter-ego-connectedness axis. This means that caregivers are required to celebrate and admire them and be admired by one or both parents, and to identify with them to the point of feeling that through these special relationships, they are associated with these admirable qualities. The latter demanding that the child’s environment should be such that he feels invited to be part of the group; to feel similar to and included in relationships with them. The outcome is that the individual experiences himself as understood and accepted by others (Banai, Mikulincer & Shaver, 2005).
The theories discussed present a staged approach to lifespan development which fails to recognise the impeding nature of an ADHD diagnosis. This view opposes a more linear process which is indicated perhaps in the explanation of why both identity and adolescence are terms that are difficult to delimit. Both adolescence and identity are not necessarily static processes that occur at the same time, with this development being dependent on varying factors. Research indicates that a pivotal part of identity formation is the focus on self in relation to others. This is of particular importance when considering the period of adolescence with a diagnosis of ADHD. Pisecco, Wristers, Swank, Silva, & Baker, (2001) found that academic self-concept directly leads to the development of antisocial behaviours is consistent with the results of Leung and Lau (1989) and with the widely accepted idea that an individual's self-referent cognitions directly affect that person's actions (Bandura, 1986). With this in mind, Krueger and Kendall (2001) present findings to suggest adolescents with ADHD convey a distorted sense of self, defining themselves in terms of their traits and symptoms of ADHD rather than distinct from ADHD. The experience of ADHD for the adolescent is inherently related to identity and was found to be antagonistic and negative. This appears to be of paramount importance which is frequently overlooked by interventions aimed at adolescence with ADHD. If the adolescent has a poor, negative view of self and thus forms negative appraisals based on those around him, the consequences lean towards negative behaviour expression or internalization.

**Attention Deficit Hyperactivity Disorder**

Attention Deficit Hyperactivity Disorder, formerly regarded as a childhood disorder, is now known as a developmental disorder that may persist over the lifespan. The definition of ADHD has been updated in *The Diagnostic and Statistical Manual of*
Mental Disorders (5th ed.; DSM–5; Association, 2013), to more accurately characterize the lifespan experience. Core symptoms that characterize ADHD include inattention and impulsivity/hyperactivity which are suggested to directly interfere with developmental tasks, academic achievement and social relationships (Cantwell, 1996). Typically adolescents with ADHD present with several comorbid psychiatric disorders such as conduct disorder, depression and anxiety (Jensen, Martin & Cantwell, 1997). Although not considered in this paper, interventions that accommodate comorbidities are important in the efficacy of treatment and therapeutic process, as evidence suggests greater difficulties socially, emotionally and psychologically when comorbidities occur.

There are conflicting reports of incidence rates worldwide, with up to 9% of American children being diagnosed as ADHD in certain regions of the USA compared to only 1 in 1500 in the UK (Hinshaw, 1994; Prendergast, Taylor, Rapoport, Bartko, Donnelly, Zametkin, Ahearn, Dunn, & Wieselburg, 1988). More recently, in the UK, a survey of 10,438 children between the ages of 5 and 15 years found that 3.62% of boys and 0.85% of girls had ADHD (Ford, Goodman & Meltzer, 2003). Aetilogies are unclear, however focus is positioned around genetic, environmental and biologic aspects with varying theoretical models emphasising a primary focus on each in turn. For example, the psychodynamic etiological emphasis is on an individual’s healthy psychosocial reciprocity with their environment, rather than a focus on neurological dysfunction.

During adolescence, ADHD can negatively impact on varying aspects of life (Burke et al, 2007; Elkins et al. 2007) and the consideration of developmental issues interacting with ADHD has received little elaboration. Research has indicated both protective and aggravating factors that serve to diminish or increase symptoms of ADHD across the
lifespan. A high sense of coherence in adolescence is a suggested inhibitor of long-term development of ADHD (Edbom et al. 2010). Barkley (1997) writes that these children often receive more harsh judgments and punishments, moral denigration, and social rejection than other children. This leads to curiosity regarding the individual’s development of identity in a society that labels and attributes negative bias towards them. Treatment models vary in terms of presentation with psychostimulant medications such as Ritalin prescribed predominantly, and although necessary in some cases, there is critique regarding its overuse, side-effects (Thompson, 1996), and short-term impact (Jensen et al. 2007). Medication alone has been found to be insufficient and therefore a variety of cognitive, behavioural, and psychoeducational interventions are necessary adjuncts to medication. Family, school and dietary interventions are amalgamated with behavioural treatments and group therapy, which focus on the external attributions of the individual’s behaviour. This ignores the phenomenological experience of an ADHD diagnosis whereby attitudes and beliefs of society are adhered to and meandered during treatment. These treatment models are often demanding and rarely achievable. Furthermore, there are findings that suggests neither medication, a behavioural focus, or early diagnosis adjusts the negative self-concept that is evident in different forms between males and females (Schubiner et al. 1995). This indicates a need for novel interventions that recognise developmental barriers and facilitators in both diagnosis and treatment options.

**Gender comparisons**

Research comparing the effects of ADHD and impaired functioning present conflicting results, with findings suggesting both similarities and differences between males and females. In a paper which explored social competence in girls with ADHD, Ohan &
Johnston (2011) indicated there was an attempt to present themselves in an unduly positive, self-protective light. Sciberras et al. (2012) found that adolescent girls with ADHD experienced more social problems and more relational and overt victimisation than adolescent girls without ADHD, with victimisation appearing more strongly related to ADHD. Studies have suggested girls, at least as adolescents, may have more internalizing symptoms, such as depression, anxiety, and stress, greater problems with teacher relationships, and poorer verbal abilities in comparison to ADHD with boys (Rucklidge & Tannock, 2001). Research indicates that boys with ADHD have poor social functioning, are less popular and are rejected more by peers than those without ADHD (Campbell & Paulauskas, 1979; Milich & Landau, 1982). Sharp, Walter, Marsh, Ritchie, Hamburger, & Castellanos, (1999) suggests that girls and boys with ADHD are very similar in presentation, while others have found that girls with ADHD are less symptomatic than boys, more specifically, with regard to activity level and aggression (Carlson, Tamm, & Gaub, 1997; Newcorn et al. 2001). These inconsistent findings relating to gender that are not apparent in childhood yet inherent with the adolescent period serve to indicate the need for its consideration, particularly regarding treatment options.

Krueger and Kendall (2001) found in their qualitative study that gender played a part in responses and outcomes to ADHD although caution must be used as the participants in the ‘girls’ category were a small sample size and therefore could not be generalized. Girls were found to adopt inadequate descriptors of self, with boys purporting anger and defiance. In view of Kohut’s (1971) theory of self-development, there was a difference between girls and boys in their perception of temporal continuity; the girls sense of remaining the same over time with the ability to adopt knowledge of the world and self
through past experiences. Boys presented a view of self in the immediate with no associations made between the past and future. Although the girls in the study appeared to have a more consolidated temporal continuity, it was based on negative experiences and had little hope for the future. These findings have implications for the attitudes that have been projected from society regarding the treatment of those with ADHD. Should adolescents find no sense of how they have generated such negative attributions of self, then no change will occur. The gender specific considerations noted, although not exhaustive, provide recognition that this should be a factor when considering psychosocial treatment choice in adolescence. Future research is necessary and should endeavour to diminish inconsistencies in findings relating to gender and ADHD.

**The role of counselling psychology and implications for practice**

It appears that there is no consensus regarding the aetiology, maintenance and treatment for adolescence, despite increasing diagnosis of and popular media attention to ADHD. Society and, more specifically, clinicians, often deemed as experts, remain poorly informed about the efficacy of treatment in practice. (Furnham & Sarwar, 2011). This brings to question whether focus is too far removed from the idiosyncratic perspective of the individual with ADHD to inform practice, attitudes and application to this phenomena. As Barkley (1997) claims, ADHD is not a “disorder of knowing what to do, but a disorder of doing what one knows” (pg.48). There is a justification for effective management of ADHD from a health economic perspective (Bernfort, Nordfeldt & Person, 2008) where treatment considerations are valuable for a considerable population. Currently, the most predominant intervention for ADHD is medication, however there is a growing focus on non-pharmacological treatments with
multimodal interventions which are viewed as suitable for the adolescent (Barkley et al. 1992; Robin 1998; Young & Amarasinghe 2010). This integrates school, home and individual treatment packages however it is debatable whether in practice this intervention is feasible and financially viable with ever increasing diagnosis patterns of those with ADHD. Group therapies have been suggested as a valuable mode of intervention (National Institute for Health and Care Excellence, 2009) however this assumption is based on the generalisability of ADHD and fails to recognise the importance of identity and transition within the adolescent. It also fails to recognise that it is during mid to late adolescence that those using services are likely to disengage (McCarthy et al. 2009). This has implications for ensuring the mode of treatment is specific to the individual in order to facilitate engagement.

Recognition of the language that depicts ADHD as a negative attribute such as ‘disorder’, ‘disease’ and ‘condition’ continue to add to the deficient identity construct. It is no wonder that the process of those who are burdened with the trajectory of such attributions from childhood, go on to develop what could be considered harmful concepts of self. Recognition of the point at which diagnosis was given and how this has impacted on their developing vs immediate self is an important consideration. It appears that more needs to be done in the development of cognitive restructuring that focusses on the formation of such self-defeating concepts, into new models of identity and reconfiguration of interpersonal and cognitive strengths. Increased awareness of ADHD presentation is also required to meet the challenge of correct diagnosis with developmental differences imperative for treatment choices by adjusting to needs and symptoms (Young & Amarasinghe, 2010). The treatment literature available is predominantly focussed on children aged 6-12 years and as such, treatment models for
adolescents are based around this age group. Future research requires exploration into not only the adolescent life stage but over the lifespan of ADHD to enable linear transition of treatment models.

Whilst deliberating the developmental concept of identity formation, individual therapies would appear to bridge the gap in treatment by a facilitative therapeutic alliance and development of autonomous decision making. Wexler (1991) writes that the most important goal of therapy is to help adolescents learn to identify and label internal states. He describes how the ego-impoverished adolescent turns to action to externalise their inner turmoil.

Art therapy is a creative, externalising mode of intervention that facilitates autonomy and enables exploration and integration of unique life experiences into identity formation. Kramer (1971) coined the term ‘sublimination’ whereby inner conflicts, socially unacceptable impulses, feelings and thoughts are expressed through art therapy noting:

“art therapy is conceived primarily as a means of supporting the ego, fostering the development of a sense of identity, and promoting maturation in general”.

This mode of intervention shifts the agenda away from what society can change about those diagnosed with ADHD and lends a focus to what the individual would like to change, cultivating strengths and abilities in order to facilitate autonomous change. This is not to suggest that this treatment option should be used in isolation and an
integrative perspective using techniques such as self-monitoring (Stewart & McLaughlin, 1992) would lend focus to specific, individual difficulties. This focus on autonomous formulation of self and identity through the process of creativity is different from that of childhood as it provides a sense of treatment ownership, opposing the medical model that is imposing. This process would serve to capitalise on the strengths of the individual and provide a novel means of intervention for this unique population.

There are some clear lifespan development issues that underlie the onset, exhibition, and treatment of ADHD. By adopting a developmental perspective, this paper has provided a consideration into the adolescent life stage whilst reflecting on the manifestations of identity from childhood. It appears that the societal model strongly influences adolescent identity and concept of self. Future research requires more robust qualitative methodologies that serves to evidence the effectiveness of non-pharmacological interventions. Recognition of positive interventions that steer focus away from the medicalisation of ADHD in society is of paramount importance. It appears grandiose to assume societies will adjust long-standing views of such diagnosis and as such, it is more fitting that interventions begin with a biopsychosocial model that focusses on the individual and the subjective experience of the adolescent.

The author suggests integrative art therapy to be a client directed, autonomy producing mode of intervention that delves into identity exploration. Gender related considerations have been considered that need acknowledgement in both the presentation and treatment of ADHD, however more research is needed to facilitate efficacy of treatment models that incorporate differences in gender. As practitioners within the counselling
psychology domain, consideration of the person needs to be of paramount importance, rather than a focus on diagnosis and external factors that serve to exacerbate difficulty within the adolescent with ADHD. It is hoped the individual can develop a sense of autonomous identity distinct from the identity accrued by society over the lifespan in order to shift cognitive appraisals and form a more idiosyncratic, positive identity, distinct from the diagnosis of ADHD.
References


PS5009 Working with Couples & Families

Psychodynamic and Cognitive Behavioural approaches
to couples therapy following traumatic bereavement.
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Introduction
Research into couples and family therapy has grown significantly in recent years, however there is a paucity of literature comparing specific approaches. The present paper examines two distinct theoretical approaches to couples therapy, namely Object Relations Couples Therapy (ORCT) and Cognitive Behavioural Couples Therapy (CBCT), to understand dysfunctional patterns of interaction within a couple relationship following a traumatic bereavement. Theoretical underpinnings of each model will be critically examined to identify key differences in their approaches as well as an overview of the impact of trauma on a couple’s relationship. Finally, an evaluation and comparison of each model will be examined in order to determine appropriate interventions and implications for counselling psychologists working with trauma within the couple’s dyadic framework.

Couples are influenced by external and environmental stressors, as well as by environmental resources that are available, to help them meet their personal and relationship needs (Epstein & Baucom, 2002). The purpose of couple’s therapy is to
restore a better level of functioning in couples who experience relationship distress. A “healthy relationship” is defined as one that contributes to the growth and well-being of both partners, in which the partners function well together as a team and relate to their physical and social environment in an adaptive fashion (Baucom, Epstein, & Sullivan, 2004). In contrast to what may be deemed a healthy relationship, chronic stressors such as traumatic bereavement are likely to assault the couple’s resources and increase negative perceptions of each other and their relationship, increasing the couple’s conflictual interactions (LaTaillade, 2006). Various theoretical models have been suggested as effective within the dyadic therapeutic endeavor, including cognitive behavioural and psychodynamic models which have elaborated on their efficacy whilst working with trauma symptomology (Scharff & Scharff, 1997). Whilst it is beyond the scope of this essay to fully detail each theoretical application and orientation, its aim is to provide a brief overview in relation to trauma and couples therapy, to increase understanding and stimulate debate within this field.

**Cognitive Behavioural Couples Therapy (CBCT)**

Although Cognitive Behavioural Therapy is the individual treatment of choice for trauma symptoms (National Institute for Health and Care Excellence, 2009), CBCT is a relatively new development in couple therapy, emerging in the early 1980s. It is developed from the confluence of three major influences, namely behavioural couple therapy (BCT); cognitive therapy (CT), and information processing in the field of cognitive psychology. In contrast with traditional cognitive behavioural approaches which focused on the couple as the unit of analysis, more recent CBCT employs a broader contextual perspective in defining a healthy relationship, taking into account the individual partners, the couple, and the couple’s environment (Baucom, Epstein, &
This model attempts to discover the negative types of thinking that drive negative behaviours and cause relationship distress as it is recognised that a couple’s behavioural, emotional and cognitive interactions significantly impact the quality of their intimate relationships (Dattilio, 1998). When bereavement occurs, and more specifically under traumatic circumstances, these conflicts may be further complicated and involve problems in daily functioning related to distorted cognitions and attributions connected with traumatic bereavement (Appendix I). Studies have consistently documented an association between PTSD and intimate relationship problems (Monson & Taft, 2005) and due to the corrosive nature of trauma on intimate relationships, CBCT for PTSD has been a central focus in couple therapy (Johnson, 2002; Monson et al. 2012). CBCT for PTSD has the simultaneous goals of improving trauma-related symptomatology in one or both individuals of the couple, whilst improving their intimate relationship functioning. It is within this complex facet of interaction that negative patterns of thinking, feeling, and behaving can become habitual and lead to unhappiness. This can be resolved by identifying negative patterns of interacting, and learning how to challenge and adjust them back into more helpful and cooperative ways. Different aspects of CBCT such as psycho-education about PTSD, communication training, anger control and problem solving can improve the relationship of those experiencing traumatic grief reactions within themselves and their partners. The therapist’s role is to facilitate the couple’s identification of automatic thoughts, underlying schemas, maladaptive assumptions, and cognitive distortions. Relational schemas can be significantly challenged following traumatic bereavement with belief systems based on assumptions and standards within a relationship that can lead to conflict if these are unrealistic or rigid (Epstein & Baucom, 2002). Cognitive work aimed at reasonable attribution of responsibility within a couple
and acknowledging the importance of external causal factors is likely to be helpful in promoting forgiveness and post-traumatic growth. Behavioural activation strategies enable alteration of couple-level interactional patterns that maintain avoidance, which is a primary response to trauma. Monson, Fredman and Adair (2008), indicate a staged RESUME approach to couples treatment of PTSD in which psycho-education enables couples to primarily identify and recognise symptoms of PTSD and the impact this has on interpersonal cognitions and behaviours and on their relationship. Secondly, enhancing a sense of safety in the relationship is explored as couples jointly recognise destructive and negative relationship behaviour. Simultaneously, communication skills are practiced and reinforced whilst the final stage of therapy develops a collaborative meaning making about the traumatic death. Depending on the length of time elapsed since the traumatic bereavement and onset of therapy may add to the severity and rigid coping strategies to manage symptoms of PTSD. Use of this therapy with couples with significant levels of physical aggression, substance dependence, or severe individual psychopathology is contraindicated.

**Object Relations Couples Therapy (ORCT)**

ORCT was developed from psychoanalytic object relations theory, which relates to the couple as a small group of two and as two individuals, moving easily between their shared external and internal reality (Scharff & Scharff, 1987). A central construct in ORCT is the creation of an environment of neutrality and impartiality to understand the distortions and intrapsychic conflicts that each partner contributes to the relationship in the form of dysfunctional behaviours. Fairburn (1952) presented a view of personality that consists of a self and object in dynamic relation, which are formed in early object relations and reignited and replayed during intimate adult relationships. ORCT is
concerned with development of the infant-mother relationship during which the child desires infantile, all-consuming closeness with the mother, yet wants to avoid being engulfed by the mother (Dutton, 1995). Within ORCT, insight into the defensive, communicative and structure-building functions of unconscious processes, resistance, and working in the transference are utilised by the therapist to inform the couple’s dysfunctional patterns of behaviour. It is hypothesised that the infant develops split components of personality comprising the central self, the craving self and the rejecting self, based on the relational attachment to the mother. This is due to the infant’s inability to manage both rejecting and exciting aspects of response to the mother’s untimely responses, in comparison to the womb’s immediate environment. In order to transfer understanding of object relations theory of individual development to couples, Melanie Klein coined the term ‘projective identification’ (Appendix II) to describe how unconscious communication permeates interactions based on the need of an individual to evacuate their mind of excessive anger or unwanted elements onto another. Lost parts of the self are found in the partner, where they may flourish and be reintegrated into the self or they may be held hostage. This mainly unconscious communication following trauma can be supported within an ORCT framework by facilitating the conscious awareness of these relational patterns and how they derive from early relational attachments and previous traumas. This then enabling new choices about how they relate to each other to emerge.

Scharff & Scharff (1997) note that following trauma, ‘couples may dissociate from the trauma, splitting off and sequestering it in the relationship, or project it onto the spouse and dissociate from it by seeking divorce’ (1997, pg. 167). These processes are also characterized by complex defences, so that every couple-relationship presents with
unique transference and a corresponding countertransference, each simultaneously occurring at the same time occur between each member and the couple therapist. The role of the object relations therapist is to become the psychological holding object for the couple to utilise and deflect anxieties. The therapist, when appropriate, may reveal the nature of their defences and anxieties whilst remaining in a neutral position, hovering between the intra-psychic and interpersonal dimensions of each partner and with the therapist. By working with intra-couple coping style differences, therapists can support couples in understanding and sharing their experience and recovering from the trauma together. Object relations therapy can heighten this understanding by gaining a fuller awareness of representational structures integrated from past experiences which form the basis of current coping strategies. This beginning phase of treatment is key in the treatment of interpersonal difficulties in the context of trauma-focused therapy.

Differences in partners’ coping styles in relation to a traumatic bereavement can present as challenging such as where one partner is primarily highly avoidant of emotions and the loss and the other is repeatedly discussing trauma-oriented narratives.

**Couples and traumatic bereavement**

Grief is an unavoidable and normal reaction to loss which is experienced by most individuals at some point in their life. Following the death of a loved one, typical reactions follow such as sadness, despair, yearning, anger and guilt. These symptoms tend to reduce over time as individuals accommodate their loss and integrate the knowledge of their loss into their future endeavours. More complicated and perhaps one of the most significant life stressors that any couple may experience is a traumatic bereavement (Lohan & Murphy, 2005). A traumatic bereavement is one that is sudden, unexpected, and often results from horrific or frightening circumstances such as a
natural disaster, terrorist attack, suicide or homicide. Trauma responses may impact on normal grief trajectory, as it involves a lack of ability to move on from loss, an inability to develop or maintain interpersonal relationships and is unresolved (Prigerson, 2005). It has been established in the literature that a traumatic bereavement can lead to the development of PTSD and depression (Dowdney, 2000) with anger, intense guilt, and fear reported as common, additional responses. It is therefore suggested that the trauma responses need to be responded to within the therapeutic framework before any grief work can be completed. Generally, a diagnosis of PTSD is made based on the client’s exhibition of symptoms from three primary symptom categories: (1) persistent experiencing of the stressor, (2) persistent avoidance of reminders of the event and numbing of general responsiveness, and (3) persistent symptoms of arousal (American Psychiatric Association, 2000). These trauma responses can significantly impact and damage interpersonal intimacy if they are not managed well (Mills, 2001). A primary shortcoming in working with trauma has been the continued focus on the individual and attending to the primary trauma victim. Although an individual shows evidence of PTSD, the maintenance of these symptoms are a systemic process that results from the interactions between the primary victim and those who interact with him or her on a daily basis. Within couples work, it may be that only one partner experiences trauma symptoms following a traumatic bereavement however it is suggested that both the primary and secondary trauma becomes a focus of attention (Figley, 1995).

Many couples have difficulty communicating the overwhelming feelings of grief that can accompany trauma and oscillate between wanting to connect with and support their partner and avoiding communication for fear of overwhelming the other or the self. In response to traumatic bereavement, individuals will tend to use avoidant, disorganised
or ambivalent response to stress regulation (Lyons-Ruth, 2001), during a time that bi-directional regulation of affect including self and mutual regulation is required in order to sustain effective relational coping strategies. Research has indicated that attachment issues are salient in the development of PTSD and complicated grief (Silverman, Johnson & Prigerson, 2001; Van Doorn et al. 1998). Epidemiological data suggest that posttraumatic stress disorder (PTSD) is one of the disorders most strongly associated with intimate relationship distress and divorce (Chung & Hunt, 2014) with PTSD and major depression associated with difficulties in family role adjustment (Boehnlein, 1987). In particular, McFarlane and Bookless (2001) found that PTSD has serious effects on core elements of successful relationships, including intimacy and communication. The impact of traumatic bereavement on relationships is overwhelming as couples manage their own grief and the additional grief of their partner and other family members (Wijngaards-de Meij et al., 2008). Gender differences in grief work has been the focus of much research with suggestions that men and women may cope in different ways following traumatic bereavement. One study indicates that mothers use more emotion-focused coping strategies than men, with the majority of fathers using problem-focused coping when grieving following a child’s traumatic death (Murphy, Johnson and Weber, 2002).

**Similarities and differences of approaches**

It is clear that working with couples following a traumatic bereavement is complicated by various factors that require thorough assessment, formulation and understanding of these multi-faceted issues. It is therefore essential that therapists working with families and trauma consider the parallel processes of both individual and systemic stress reactions that may occur and become resistant to change without specialist
interventions. Whilst it is evident that trauma can prevail through couples and families, it is also evident that families and other interpersonal networks are powerful systems for promoting recovery following traumatic experiences (Figley, 1989). In addition, perhaps the most promising conceptualizations of couples’ treatment following traumatic bereavement are cognitive behavioural theory and object relations theory.

Whilst it is evident that there are overlapping constructs of CBCT and ORCT (Gurman 1978), there are also distinct features inherent with each model. Both CBCT and ORCT focus on individual in-depth dynamics embedded within systematic understanding of couples and families. Additionally, CBCT and ORCT models suggest facilitating increased awareness as a goal of therapy (Cashdan, 1988; Datillo et al., 1998) with, for example, exploration of cognitive distortions (Beck, 1976) or unconscious defenses and splitting. Within each framework, advances towards viewing the couple dynamics as intrapsychic and interpersonal as opposed to purely interpersonal have been developed to enhance and establish a deeper level of this relational awareness and understanding.

Although CBCT and ORCP view behaviour and cognition as having histories learned largely in past relationships, the extent to which these inform each model varies. While ORCP heavily locates intrapsychic and interpersonal past experiences to inform current dysfunction, CBCT models focus primarily on current symptom reduction rather than underlying and causal factors. This indicates a potential void in CBCT where understanding an individual’s past in relation to their current relational dilemmas as well as systemic components can enhance and broaden the understanding of current difficulties. In addition, within CBCT, the use of the therapist is not utilised as a central
construct to understanding the couple’s interactions and difficulties. In ORCT, unconscious processes are viewed as playing an important role in human behaviour and it is the therapist’s self that facilitates the engine of therapeutic change. CBCT advocates an active, collaborative stance of the therapist leads to directive and goal orientated lens further distinguished from ORCT which enables the couple to primarily lead the therapeutic change. There is also a large emphasis on homework within CBCT with a focus on implementation of skills outside of therapy which is not evident in ORCT. These differences lead to CBCT viewing the process of change as being a relatively short-term process whereas ORCT is a more long term process of change.

In a study of traumatically bereaved parents, Murphy et al. (1999) described those experiencing many changes involving all domains of functioning including affective, cognitive, behavioural, and social (Applebaum & Burns, 1991; Murphy et al. 1999). Due to the holistic nature of the impact of traumatic bereavement on couples, CBCT although useful in its approach to current difficulties is reductionist as a model as it does not grasp the robustness of ORCT which provides an extensive account of assessment, formulation and historical development of maladaptive behaviours. It may therefore be argued that to acknowledge the unconscious processes inherent with ORCT would provide a sound basis and preparatory phase for CBCT, creating a safe holding environment for intense grief and trauma responses and the potentially resultant relational responses. This may lead to a more helpful way of conceptualising and creating a space for interpersonal and intrapsychic communication as Baxter and Montgomery (1996) propose: to ‘‘rethink communication’’ and argue for the ‘‘both/and’’ interplay of openness and closedness in personal relationships. Furthermore, the aspect of CBCT that lays heavy focus on exploring and
communicating cognitions emotions and behaviours during trauma work is challenged by Hooghe, Neimeyer and Rober, (2011) and indicates that the expression of emotions can intensify distress and interfere with one’s active coping strategies and regulation (Kennedy-Moore & Watson, 1999).

Conclusions

Whilst it is evident that object relations and cognitive behavioural approaches to couples therapy have common features, each offer alternative and valuable theoretical frameworks to couples work with those experiencing traumatic bereavement. By utilising integrative object relations and cognitive behavioural strategies, couples are facilitated in increased empathic response to the others coping mechanisms and through psycho-education of post trauma responses, the development of tolerance and new possibilities for relating to emerge. In conceptualising the role and identity of counselling psychologists who place significant importance on understanding the lived experience and subjective account of a traumatic event, the ORCP model appears a more advantageous and fitting approach to trauma work with couples. Irrespective of model, the couple therapist can promote a shared understanding of the meaning of traumatic grief and differences in coping style as a means of psychological adjustment and dual integration that will facilitate growth within each individual and the relationship.
References


APPENDICES

Appendix I: Examples of cognitive distortions that may serve to increase maladaptive patterns of thinking and behaviour in a couple traumatically bereaved:

- Arbitrary Inferences are conclusions drawn in the absence of supporting substantiating evidence. For example, a woman who chooses not to talk about her deceased child and the husband thinks, “She must think I did something wrong”.
- Selective Abstractions describe how information is taken out of context and certain details are highlighted while other important information is ignored. For example, a man whose wife fails to remember an important anniversary concludes, “She must not care about me anymore”.
- Overgeneralization. An isolated incident or two is allowed to serve as a representation of similar situations everywhere, related or unrelated. For example, when a friend does not contact a mother thinking she needs time to grieve, she thinks “no one cares about me or no one understands me.”
- Magnification and Minimization. A case or circumstance is perceived in greater or lesser light than is appropriate. For example, following the bereavement each individual may state “my life is over, our family is broken, the marriage is over”.
- Personalization. External events are attributed to oneself when insufficient evidence exists to render a conclusion. For example, each partner may carry significant guilt relating to the death assuming some sense of responsibility “This happened because I have done something wrong” or “My husband thinks it is my fault”.

Appendix II: Cycle of Projective and Introjective Identification that can manifest in couple relationships.

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The Action of Projective and Introjective Identification. The mechanism here is the interaction of the child’s projective and introjective identifications with the parent as the child meets frustration, unrequited yearning, or trauma. (The same situation could apply to two adult partners.) The diagram depicts the child longing to have his needs met and identifying with similar trends in the parent via projective identification. The child meeting with rejection identifies with the frustration of the parent’s own anti-libidinal system via introjective identification. In an internal reaction to this frustration, the libidinal system is further repressed by the renewed force of the child’s anti-libidinal system. © 1982 David Scharff.
Therapeutic dossier
The professional development of novice to practitioner is one that is influenced by numerous intra-psychic and interpersonal factors. The current essay will attend to and explore these factors in relation to my own development as a practitioner in counselling psychology and explore issues inherent with the process. In doing so, exploration of past and more recent experiences alongside personal shifts in behavioural patterns provide evidence of professional development. My identity as a counselling psychologist will be explored within context, considering theoretical underpinnings and ethical dimensions. As a result, an indication of future development and learning needs will be examined as well as a continuous reflexive stance that maintains standards and ethical framework, integral to the role and competence of counselling psychologist as outlined in varying professional guidelines (British Psychological Society, 2009, Health and Care Professions Council, 2012).

The beginning
The task of examining my professional development left me wondering where to begin. I had the subjective knowledge that I had achieved a great deal professionally since my
commencement on the doctoral programme, however this at first did not appear tangible
and I struggled to gather my thoughts on how to describe this change that had occurred.
This was stifled by an aspect of my training experience that I initially felt had
potentially hindered my development. This was due to spending my three year training
in the same paid placement due to the need to have a stable income in order to
financially sustain my family life and professional development. I feared this may
thwart my development somewhat and I did not regard my longevity in the same service
as complementary to my development. As I progressed through the course I observed
others learning alongside my own and found at times I was both curious to work in
other fields and at the same time grateful that the service I worked in enabled personal
growth and development through drive and commitment to a service and field that I
originally began this journey for – trauma.

My journey and desire to immerse myself into the world of psychology had been
submerged for many years as I maintained a job at an airline in order to raise my
children as a single parent. I had planned the time that I would need to study, alongside
my job in order to develop my journey towards my ultimate goal of becoming a
psychologist. This drive to be a psychologist had derived from a single hour encounter
as a 14 year old with a psychologist who taught me very quickly how to ensure your
client does not engage. This perhaps unconscious process developed into an internal
desire to direct my initial research and reading into children who had experienced less
fortunate circumstances than my own, those who were traumatised. I was fascinated by
a child’s capacity to survive and develop resilience following circumstances of neglect,
abuse and emotional disturbance. I was also saddened that as adults, they struggled to
manage the effects of such care, or lack of.
I maintained my role with the airline whilst I completed my undergraduate degree in psychology, as well as a part-time job in a school supporting learning difficulties. It was then I came across my ideal job as a specialist children’s trauma therapist. Although I knew I was not qualified for role, I applied and to this day remain grateful that they somehow observed my internal passion and drive, offering me an unpaid placement which I did alongside my airline job. Here my learning began as I was sent on various training courses as a novice and blank slate in terms of my professional identity.

I began to develop my understanding of service provision, client issues and working within multi-disciplinary teams. I felt lacking and incompetent and decided it was time to embark on my next endeavour and a colleague introduced me to the doctorate course in Wolverhampton suggesting I would be ‘perfect’ for counselling psychology. At this point, even after my psychology degree, I couldn’t effectively distinguish between counselling psychology and any other form of psychology so this comment left me intrigued.

When I decided to undertake the Professional Doctorate in Counselling, I knew it would be difficult and challenging, however I was resolute in my plan to become a qualified psychologist. As I had started quite late in life, I didn’t feel I had the luxury of time to ponder. I perhaps underestimated the enormity of this academic, financial and personal endeavour. A protective factor throughout my training has been the knowledge that the challenges and difficulties I have faced have been equally weighed with rewards of learning and experience. My only expectation of the course was enhanced learning of
theories and practice and above all knowledge. A priceless additional gain for me has been learning about myself and in relation to others and the world. I can explicitly say I see and experience things through a different lens, one that is clearer and sees further than it ever did before. I have developed a self-care regime that is not only crucial to my professional role and the therapeutic use of self within the therapeutic frame, it is complementary to my personal and family life. There were challenges along the way, the most significant being my sense of being a ‘fraud’ and not knowing what I was doing. This unknown felt very uncomfortable for me for a long time and perhaps until I began the practice of reflexivity within the doctoral programme. This, alongside personal therapy and supervision, enabled a comfortable acceptance of the unknown with the knowledge that it would always be around, as I can never fully know. This led me to respectfully challenge and critique what other’s knew with an excitement that was underpinned by the potential of new learning for me and maybe for others. I find that the action of receiving critique is easier than providing however as I personally view it as potential learning, as it opens the possibilities for wider observations and thinking. It is clear that how critique is delivered is crucial in its effectiveness and I am mindful of this during any relational encounter. This development of continual curiosity and critique has been the most rewarding and significant for me professionally as it feeds my enthusiasm and commitment to the development of myself and new knowledge within the counselling psychology domain.

Professional Identity development

A significant factor lending weight to my professional development is my own personal development. Supervision, journaling, maintaining a reflexive self and personal therapy have all contributed to extensive development of self-awareness, self-knowledge and
self-care, which are deemed as crucial ingredients in both effective therapeutic practice and ethical frameworks (Rubin, 2000). I was unaware of this aspect of development as I began training however, I now understand and endorse as a central construct to professional development within the field of counselling psychology. Woolfe (2006) suggests that personal therapy is an important ingredient to the professional development of counselling psychologists. This is further specified by The British Psychological Society that distinguishes between the profession of counselling psychology and other psychological domains as the therapist’s use of themselves, and their interpersonal skills, are seen as fundamental aspects of the process of therapy. It is, therefore, crucial that counselling psychologists take a lead in increasing their levels of self-awareness on an ongoing basis. Personal therapy and supervision have enabled experience of the client role (Norcross, 2005) and gathering of information relating to the dynamics of interpersonal and intrapsychic interactions within the therapeutic framework. Additionally it has increased my opportunity to experience clinical techniques, first-hand.

**Development within context**

My identity within the framework of counselling psychology at times has led me to question my understanding of where I belong in relation to other professionals. This appears across varying disciplines within work settings with managerial, peer and client beliefs about your ‘level of professionalism’. There appear to be considerable discrepancies on the understandings and practices within varying professions. This is both complementary and conflicting as I witness *defences of competency* within the workplace. Early in my development I encountered various restrictive statements from others professionals who suggest ‘you shouldn’t’ or ‘you can’t’, which were not
supported by what they thought I should be doing. This fuelled my fear regarding competency as a novice practitioner and my ability to work effectively with clients and other professionals. Through supervision I learnt that these views can be the ones that pose most risk as they are driven by static and unreflective thinking. It appeared early on that I would need to source my own identity in relation to others which I propose is ever-evolving. I can provide a succinct or detailed account of my professional identity as I currently write, with the understanding that this will continue to unfold and develop as time passes and experiences evolve. It has been proposed in the literature that counselling psychologists have identity confusion (Lewis & Bor, 1998) and whilst important to consider, I would argue this identity confusion is productive and marries well with the profession, as it continually drives for updated and new learning about the static or fluid nature of professional identity and development. It may appear that the identity crisis has presented itself in the profession as a whole (Whitely, 1984) and continues to filter into the developing trainees and potentially workplace settings. As a practitioner, what is important, is that my identity is that of a competent, professional and developing individual and not someone who needs to be pigeon holed. It does not strive to develop distinct and static viewpoints but endeavours to construct and reconstruct identity that is ever changing and developing. To challenge the status quo and delineate curiosity of what is known. As a developing practitioner this reflexive stance was challenging initially. After a decision to change my career in my late 30s, I felt inferior to other professionals in terms of knowledge and understanding. I knew I had the drive and tenacity to succeed, however I always felt lacking compared to my ideas of what experience others had.
After working with children I felt I needed to gain more knowledge of working with adults. This was challenging as I found new ways of working and questioned my competency again. The notion of competency, considered as a professional standard, was considered as my level of competency in a particular area shifted (McGarrah, 2009). This poses questions about what competency is. Although training can provide significant learning on how to provide effective interventions, there will always be a reduced level of competency at the onset of working within a new field or with a different client base. There have been occasions where I have felt my competency levels have been challenged and I have initiated further support in referring the client to the appropriate interventions. After working with a child for a period of time following the traumatic death of her mother and other traumatizing circumstances, the family requested that they would like me to conduct family therapy to support the impact this has had on their new family. This meant two adults, and four children requested individual and group therapy which I felt was outside my level of competence, and workload. This was confirmed in supervision as we explored the complexity of court proceedings and other professionals involved. I proposed to my clinical lead and responded to other professionals and the courts with an intervention plan that would involve more than one therapist in order to effectively support the family. This including a projected life-span approach to interventions for the children and the family for the future, indicating developmental needs of the children and family. This plan was adhered to and I feel I made appropriate decisions regarding safe, professional practice for my client and her extended family.

Working within a trauma service has been both challenging and rewarding. I have gained alternative training in areas that are specific to the service such as legal
proceedings and writing court reports. I have expanded my knowledge and experience of working within multi-disciplinary teams, abiding by legal, professional and systemic frameworks that at times prove fragmented and lacking in their support of interventions. I have developed my autonomy and accountability through experiencing difficulties in the initial stages of my practice where I felt a heavy reliance on others to support me in my role. At times there was a conflict between what I felt was appropriate for the client and decisions made within the service. Through a deeper understanding of others behaviours and my own, I have gradually learnt when I need to voice my professional opinion and how to manage conflict, which will inevitably be part of my professional role. This has led to a more robust and grounded professional within me and I am confident in my abilities and my capacity to drive my learning further and maintain my professional role.

I have been fortunate to work with a range of individuals within the nationwide service, including children, adults and families. It has been crucial for me to examine my personal cultural, religious and societal values, for example, relating to trauma and bereavement and to potentially challenge Western constructs of grieving as I witness the grief of those from varying cultural, religious and socio-economic backgrounds. This has at times been facilitated by interpreters which has added further learning to the potential dimensions of the therapeutic and professional frame. Working within the homes of clients has led to a significant acknowledgement and respect for the importance of boundaries and safety within any therapeutic frame and peer supervision has enabled a greater reciprocal understanding of these issues. Supervision has again been key in understanding and gaining greater insight into potential ethical risks posed by this type of work.
The role of a counselling psychologist extends beyond client work as services strive to utilise each employee and their skills. For this reason, I have taken a role within the research and development team within the service. This means I have, and continue to gain, extensive knowledge about applying for tenders within a third sector organisation, as well as attending various events to raise the profile of the service we offer. I have also gained an understanding about the social and political agendas assigned to any service provision and feel more able to consider and reflect on these issues. I have delivered training within the service and am proud of and passionate about the work we undertake with individuals with both singular and complex traumatic needs. I am humbled by an increased level of contact between myself and other professionals as they request my advice and offerings of experience with this population. Most rewarding is the development of my research with those bereaved by homicide as part of the doctoral training programme. I feel honoured to be able to voice difficulties and potentially improve service provision for this population as I endeavour to disseminate findings from the research. This is an daunting process as I strive to do the research and those bereaved justice. This is indeed a heavy burden personally and professionally, however one which will hopefully be rewarding for the service and those that use it.

Attending training and conferences has further enhanced my development. Whitcombe (2013) presents an obligation to disseminate her positive experience of attending a counselling psychology conference. Delivering a poster presentation at the Division of Counselling Psychology conference in 2014, opened up possibilities for myself as a practitioner and further added to the research I was conducting. It enabled a greater
scope of potential to my occupational endeavour and opened my mind to possibilities and the network of individuals as passionate as myself in the quest to be an effective practitioner. This particular sense was embedded within the field of counselling psychology as a whole and so enabled a comforting element that as professionals, we are striving to adapt, shift and change the status quo and develop novel and innovative approaches to the helping profession. Through gaining confidence in attending conferences, I went on to disseminate my own service evaluation which offers therapeutic interventions to those bereaved by homicide which I presented at Scotland Yard in London. Again, this repertoire of experience gave the motivation to continue in my research endeavours as others provided confirmation of its importance. I am thus looking forward to the process of developing an oral presentation at the European Conference for Traumatic Stress Studies on my accepted abstract relating to murders abroad. In my quest for professionalism I have already planned my continual professional development for the next year and continue to direct my development in wider areas of practice. I consider this an ongoing aspect of development concurrent with ethical guidelines. There have also been significant shifts in the service since I began my unpaid placement. This has led to my expectations of my work and role shifting significantly. It has also changed my perception of what it is to be a counselling psychologist. I have adapted to service provisions as funding opportunities became less frequent and realised how the ebbs and flows of funding cuts impacts greatly on those at service level. One thing I have learnt is that you need a relentless determination and continual evaluation of yourself as a practitioner.

Theoretical stance
Throughout the course I have developed an understanding of multiple models of intervention and theoretical models. This has been pivotal in the development of my identity as a practitioner. Concurrent with previous research into counselling psychologists training, I experienced significant difficulty understanding the ‘dilemma of plurality’ (Rizq, 2006; p.617). At first I was struck by the different approaches and struggled with conflicting theoretical underpinnings, preferring to take the ‘best bits’ of a model and utilise whatever fits to a particular client. Although my understanding of each model was strengthened, I remain indifferent about a purist position. Fundamentally, and perhaps the clichéd term of “being person centred at the core”, I believe that the basic structures of the person centred approach lies within each model. It is evident across literature that irrespective of the tools or theories used by the therapists, the therapeutic relationship is paramount. Psychodynamic principles have informed my capacity to use myself, the intra-psychic and interpersonal interactions as an engine of change within therapy. Although cognitive behavioural therapy holds a strong influence on the current service provision, the service maintains a fluidity that enables practitioner freedom in utilising other models, if relevant. This has been paramount in my development of working integratively. It must be noted that there are times that a purist approach is useful and necessary, however the skills I have gained through thorough assessment and formulation enable collaborative decisions to be made for what will best fit the client.

**Ethical Dimensions**

Ethical issues are inherent within any therapeutic encounter and must be considered and reflected on within a professional role. The ethical dimension to work with clients has
developed from a daunting one initially as I struggled to connect and make sense of conflicting professional guidelines and contrasting theoretical viewpoints (BPS, 2009, HCPC, 2012, DCoP, 2009). This was furthermore complicated by where my own ethical stance should be placed. Whilst it is clear that personal experiences can influence my assessment of legal and professional issues, maintaining a reflexive sense of self-awareness ensures that personal experience does not distort or supersede ethical guidelines. Instead I consider a thorough evaluation of ethical dilemmas that derive from my own personal ethical compass, guidelines provided in BPS and HCPC which incorporates legal dimensions and finally, my professional network including colleagues and supervision. Most significant in my work with survivors of trauma is the element of self-care and hypervigilance into the potential risks to the self and to the client whilst embarking in this work. Training and awareness into vicarious traumatisation (Pearlman, 2012) has been fundamental to my role and effectiveness as a counselling psychologist. In addition, frequent supervision and personal therapy has enabled reflection on factors including highly emotional content and issues of transference and countertransference. I feel that as a counselling psychologist in training, I am potentially more equipped to work with survivors of trauma due to the requirement and ability to reflect on practice and myself. I recognise my own strengths and limitations within this work, however, there may be significant implications to those who work alongside and not within such a service. Whilst I adhere to autonomous and accountable decision-making and am comfortable in my own ethical perspective in relation to my work, I do not consider that I have all the answers and by acknowledging and gaining insight from many sources, reduces the risk of ineffective or harmful ethical decisions being made. This ethical dimension of identity is further elaborated on with consideration of my own cultural, religious and other belief systems
and schemas as these will naturally inform how I deal with such issues in practice (Fisher, 2009). This ethical dimension to development has facilitated my professional philosophy that the application of sound ethical decision-making is paramount to the professional practitioner.

**Therapeutic relationship**

Above all, my professional development has enabled a greater understanding of what I consider to be the most significant – the therapeutic relationship. Within counselling psychology this factor is deemed most important and perhaps supersedes other psychology disciplines. I have gained a substantial respect and understanding of relating to another, of truly being beside another on their journey and of using myself as a vehicle for facilitating their development as well as my own. I feel privileged and extremely grateful to be in the position of supporting others in a time of need. I feel respectful and hold responsibility within this position and feel that my ethical ethos and identity as a counselling psychologist is one that I will continue to hold firmly and loyally.

**Future learning**

This essay has reflected on and summarised my identity as a counselling psychologist. I consider my growth and development as a counselling psychologist to be organic. Although driven by my commitment and curiosity for new knowledge, I have been
guided somewhat by the experiences I have had along the way. I am excited about the future and the potential it holds as well as daunted by the unknown. Each feeling resides within me and I hope that the passion I have to be an effective and competent practitioner for those I am privileged enough to work with continues. Further stretching my knowledge by working within different fields and NHS settings will be next on the agenda. I have goals that I want to achieve professionally in the short term and long term. For now, I look forward to reading literature that is not determined by my research. To spend more time reflecting on my current practice, increase my utilisation of self-care skills and to enjoy the other aspects of my life that contribute significantly to my professional drive, for example my children. My ultimate goal in time, is to develop my own specialist therapeutic service that will utilise the knowledge and expertise I have gained and will continue to gain throughout my professional career. I feel if anything, towards the end of this doctoral training course, that it has ignited new questions, new passions and curiosities about what it is to be a counselling psychologist. Above all, training on the practitioner doctorate in counselling psychology has exceeded my expectations of what it was I would gain or be able to provide for others. I am both grateful and confident that this learning and development can be disseminated to all those I come into contact with both personally and professionally.
References


Division of Counselling Psychology (2009). Professional practice guidelines. Leicester: BPS.


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INTRODUCTION

This portfolio offers a description of the development towards becoming a counselling psychologist. The experiences I have had to date have significantly shaped my professional identity and personal qualities. I am a highly motivated, resilient, and a determined practitioner, which I hope this portfolio demonstrates. In addition to this, I continue to strive to work within ethical frameworks, my scope of knowledge and core competencies: as determined by my professional affiliation with the British Psychological Society (BPS), Health Care Professions Council (HCPC), and Division of Counselling Psychology (DCoP).

Profile Qualifications

- BSc. (Hons) Psychology
- Ad. Dip. Child Development
- Dip. CBT
- Cert. Counselling Skills with Children
- Cert. Psychotraumatology
- Cert. Supporting Learning in Primary Schools

Professional Affiliation

- British Psychological Society (BPS): Graduate Member
- Division of Counselling Psychology (DCoP)
- Working towards HCPC accreditation

Publications


Mack, J., Chadwick, D. The effectiveness of a Homicide Bereavement Service presented at: Division of Counselling Psychology Annual Conference, 2014 July 11-12; London, Victoria
**Personal Qualities**

- Efficient and well organised;
- Effective within a team setting with the ability to work autonomously;
- Flexible and adaptive to systemic challenges;
- Able to maintain professionalism in highly emotive environments;
- Able to initiate development and influence positive change.

**ORGANISATIONAL CONTEXT**

Homicide Service

**Configuration**

- Ministry of Justice (MoJ)
- Victim Support
- Code of Practice for Victims of Crime

**Transformation**

- Clinical Commissioning Groups (CCG): Now responsible for the commissioning of services based on local needs.
- Commissioning of health care to private groups and local communities.
- Research development.

**Mental Health**

- Reduction in trauma symptomology following bereavement by homicide
- Reduction in co-morbidities associated with post traumatic events
- Systemic approaches to traumatic events
- Multidisciplinary models to provide seamless care and service delivery
- Criminal justice setting
IN TRAINING PLACEMENTS

ASSIST Trauma Care

Homicide Service September 2011 to May 2015

Context Description

This placement is a clinical and counselling psychology department, which operated within the Homicide Bereavement Service. Working closely with Multi-Disciplinary Teams (MDT) including Victim Support and other referring agencies, General Practitioners and Police Investigation units meant that client care could be focused around multiple features of need, such as: Medication, financial support, criminal investigation and media support, social aspects of mental health (housing and benefits) and psychological aspects of mental health (group and individual therapy).

- Therapy was determined through National Institute of Health and Clinical Excellence best practice guidelines, was limited to 15 sessions and reviewed every six sessions.
- The client group were adults and children with no age restrictions.
- Clients were considered to be suffering from traumatic bereavement symptomatology.
- Clients came from a range of ethnic backgrounds and diverse life, social, and cultural experiences.

The service itself had undergone several transformations in its configuration of referral pathways, re-deployment of staff, and changes to the scope of services.

Client Issues

When clients were referred it would often be the case that they would have both a Victim Support caseworker and therapist or psychologist involved in their care. Clients were also referred from other specialist homicide services, such as Support after Murder or Manslaughter (SAMM), National Victims Association (NVA) and Mothers against Murder and Aggression (MAMAA).
Client issues were often complex, multiple and systemic.

Mental health difficulties, such as: depression, anxiety, obsessive compulsive disorder, psychosis and schizophrenia, bipolar affective disorder, post-traumatic stress disorder, atypical eating disorder, personality disorder, abuse and trauma.

Mental health difficulties were often maintained or exacerbated by prior or current social circumstances and potentially judicial processes.

Moderate to high risk of deliberate self-harm, suicidal ideation and behaviour.

**Supervision**

My supervisor in this area of practice was a counselling psychologist with an extensive background in managing, operating, and delivering psychological therapy within secondary care mental health and the homicide bereavement service. Supervision was offered informally through peer supervision and formally in both a group and individual format.

Supervision occurred within the following domains:

- Personal reflection;
- Case management;
- Client issues, formulation, and therapy;
- Service transformation updates and management;
- Risk assessment and management.

**Roles and Experiences**

**Psychological Assessment**

Impact of Events Scale (Revised); Patient health questionnaire (PHQ-9); Generalised anxiety disorder (GAD-7);

Work and Social Adjustment Scale; Complicated Grief Scale; Dissociative scale. Employed semi-structured idiographic assessments.
**Formulation**
Used formulations derived from evidence-based practice, treatment plans, and transdiagnostic methods.

**Provision of Therapy**
Used integrative therapeutic approach relying on a number of modalities, including: Trauma focussed-cognitive behavioural therapy, Humanistic, existential, narrative, psychodynamic, and cognitive-behavioural.

**Screening and Assessment**
Responsible for managing a case-load of referrals to determine suitability for the service, to offer psychological assessment and recommendation of needs, to refer to suitable professionals and services, allocate clients to members of the psychology team, and manage waiting-list. Court reports administered.

**Multidisciplinary Team Working**
Liaised with other health care professionals to share vital information, to coordinate support, and to further facilitate engagement and progress within therapy.

**Risk assessment and Management**

Concerns surrounding the welfare of clients or third parties were coordinated alongside other health care professions, Victim Support, GP’s, single point of access service, or Crisis Intervention.

**ASSIST Trauma Care**
Context Description

This placement was a clinical psychology department, which operated in an independent charitable organisation. Community services were offered for those experiencing singular or complex trauma and attachment issues.

Therapy was determined through NICE best practice guidelines, was open ended depending on referral route and reviewed every six sessions.

- The client group were children aged 3 and adults aged 18 years and over.
- Clients were considered to have mental health difficulties necessitating specialist trauma interventions.
- Clients came from a range of ethnic backgrounds and diverse life, social, and cultural experiences.

Client Issues

Clients were referred through a range of sources including self-referral, general practitioner, schools, and police forces.

- The issues worked with in this placement were bereavement, social anxiety, depression, personality disorder, attachment difficulties, family difficulties, domestic abuse and sexual abuse.
- Low to Moderate risk of deliberate self-harm, suicidal ideation and behaviour, and risk to others.

Supervision

My supervisor in this area of practice was a clinical psychologist with an extensive background in cognitive-behavioural therapy research and practice.

Supervision occurred within the following domains:

- Personal reflection;
- Service development;
- Client issues, formulation, and therapy;
- Criminal
- Risk assessment and management.
**Roles and Experiences**

**Psychological Assessment**
Impact of Events Scale (Revised); PHQ-9; GAD-7; Work and Social Adjustment Scale; Complicated Grief Scale; Dissociative scale. Employed semi structured idiographic assessments.

**Formulation**
The use of formulations derived from evidence based practice and treatment plans.

**Provision of Therapy**
The use of humanistic, psychodynamic and trauma-focussed cognitive behavioural therapy treatment plans.

**Endorsing Counselling Psychology**
Discussions between clinical and forensic psychologists as to the scope and role of counselling psychology and training requirements.

**Multidisciplinary Team Working**
Liaising with other health care professionals to share vital information, to coordinate support, and to further facilitate engagement and progress within therapy.

**Risk Assessment and Management**

Concerns surrounding the welfare of clients or third parties were coordinated alongside other health care professions, GP’s, single point of access service, or Crisis Intervention.

**CORE COMPETENCIES**

**Knowledge**

**Assessment**
Experience using structured, semi-structured, and unstructured psychological assessment for a range of client presentations.
**Formulation**

Able to apply evidence-based, transdiagnostic, and idiographic formulations to understand a range of presentations.

**Therapy**

Able to apply psychological therapy using a range of approaches, including: CBT, humanistic-existential, psychodynamic, and systemic therapy (narrative and solution-focused).

**Research**

Able to use a range of research methodologies and designs, including both qualitative and quantitative methods.

Able to analyse, interpret, and disseminate research outcomes.

Competent at using a range of statistical software packages, including: SPSS and Nvivo.

**Contextual Awareness**

Experience of interacting with clients and participants in a range of settings including: community, outpatient and forensic.

Able to apply counselling psychology in a range of cultural contexts.

Awareness of organisation policy and legislation within psychology, mental health, and criminal justice settings.

Able to identify and employ clinical governance, as appropriate, to support and maintain clinical practice.

**Ethical Practice**

Able to work within the scope of ethical practice as determined by the HCPC (2012), BPS (2009) and DCoP (2005).

Able to apply ethical awareness and decision making to research and clinical practice.
Skills

- Able to communicate effectively both orally and in writing, with clients and a range of professionals and non-professionals;
- Able to provide consultation to professionals and non-professionals;
- Experience of multidisciplinary team working;
- Knowledge of different professional roles in the criminal justice and mental health setting;
- Development of research, service protocols and operational systems;
- Experience of presenting workshops and presentations; and
- Ability to maintain a critically reflexive stance.

Learning Framework

<table>
<thead>
<tr>
<th>Reflective Practice</th>
<th>Co-facilitated and established a research group</th>
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<tbody>
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<td>Personal development groups in training</td>
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<td>Supervision</td>
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<td>Personal therapy</td>
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<td>Skills Development</td>
<td>Role-play</td>
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<td>In-training placement experience</td>
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<td>Video (audio) assessment</td>
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<td>Observation</td>
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<td>Presentation and workshop delivery</td>
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<td>Knowledge Development</td>
<td>Dyadic and dialectical learning</td>
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<td>Lectures, seminars, and tutorials</td>
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CONTINUED PROFESSIONAL DEVELOPMENT

Training and Workshops

- **Psychometric Level A & B:** Assistant Test User and Test User Ability & Personality – University of Wolverhampton – 2014
- **Leadership and Managing Change** – University of Wolverhampton – 2014
- **Working with Lesbian Gay Bisexual Transgender and Questioning (LGBTQ) Clients** – University of Wolverhampton – 2014
Religion: Debates & Treading on Eggshells – University of Wolverhampton – 2014

Considering Diversity: Working with Interpreters and Developing Accessible Practice – University of Wolverhampton – 2014

Assessment and Working with Sex Offenders – University of Wolverhampton – 2014

Acceptance and Commitment Therapy – University of Wolverhampton – 2014

Working with Clients in a Forensic Setting – University of Wolverhampton – 2014

Dialectical Behaviour Therapy and Working with Suicidal Clients – University of Wolverhampton – 2014

Expert Witness training – BPS -2014

CBT for Depression & Suicide – Padesky Cognitive Workshops - 2013

Certificate in Trauma-focussed CBT – MUSC -2012

Exploring Attachment – ACC - 2012

Supporting Families Bereaved by Murder and Manslaughter – Child Bereavement Charity - 2011

Understanding Traumatic Bereavement – Child Bereavement Charity - 2011

Attachment: From Theory to Practice – The Bowlby Centre - 2011

Child Protection and Awareness Training –
This report discusses the management of responses and reactions to stressful events specifically, trauma, bereavement and acute stress.
Department for Education (2013)
Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children.

This document provides guidance on the legislative requirements and expectations on services to safeguard and promote the welfare of children, covering: assessing need and providing help; organisational responsibilities; and, the statutory objectives and functions of Local Safeguarding Children Boards (LSCBs).

Department of Health (2004)
Organising and Delivering Psychological Therapies

This report highlights the need for access to timely, appropriate and effective psychological therapy without barriers to service use.

Department of Health (2001)
Treatment
Choice in Psychological Therapies and Counselling

This report discusses the need to include service users in choice of service and highlights the key evidence-based treatment approaches.


Outlines difficulties faced, judicial, financial issues and review of support services. Offers recommendations and future needs.


REFERENCES


Casey, L. (2011) Review into the Needs of Families Bereaved by Homicide


APPENDICES

Summary Curriculum Vitae

Jill Mack MBPsS
Phone number 07970 079938
Email address jillmack1@btinternet.com

Main Roles and Responsibilities
Main roles include screening client referrals, conducting psychological assessments, and offering individual counselling and psychotherapy to clients based in the local community and for the nationwide Homicide Bereavement Service. Responsibilities include co-ordinating client care, risk assessment and management in the community, and liaising with healthcare professionals, Victim Support Caseworkers and Family Liaison Officers. Additional responsibilities have included providing psychological court reports for clients and therapeutic reports prepared for criminal proceedings.

Research Interests
Research interests include evaluating services that offer psychological interventions to those bereaved by homicide and developing an awareness into to the impact that homicide has and the need for relevant and appropriate therapeutic interventions. An evaluation of the homicide service has been undertaken and published.

Current Experience
February 2007 to Present  Trauma Therapist – ASSIST Trauma Care
                          Singular and Complex Trauma - Children

March 2010 to Present  Specialist Trauma Therapist – ASSIST
                    Homicide Bereavement Service – Adults &
Children

September 2004 to January 2007

Learning Support Worker – Learning difficulties

Bosworth School

Qualifications

Doctorate in Counselling Psychology. University of Wolverhampton, Wolverhampton.
(Completion July 2015)

Certificate in Psychotraumatology. ESTSS (2011)

BSc (Hons) Psychology. The Open University, Milton Keynes. (2009)

Dip CBT.

Professional Membership

Graduate Member of the British Psychological Society (BPS)
Division of Counselling Psychology (DCoP).

Publications


Mack, J., Chadwick, D. The effectiveness of a Homicide Bereavement Service presented at: Division of Counselling Psychology Annual Conference, 2014 July 11-12; London, Victoria

References

Available on request.

EVIDENCE
Integrative Framework

Service Development

Areas explored and discussed during service development:

- Research development
- Staff communications network
- Confidentiality and criminal justice framework
- Multidisciplinary approaches to assessment and risk
- Staffing and training
- Supervision
- Contract
- Website development and marketing strategy

Once these were identified it included writing any relevant literature (such as the therapy contact or information sheets / leaflets), and liaising with key stakeholders to discuss in greater depth the above mentioned areas.
Court Statement Template

Remove all information in italics on completion of report and prior to submission

______________________________

STATEMENT OF (name of worker)

______________________________

1. My name is .........................My professional address is...........................

   Qualification and Experience

   Give details of professional qualifications, when they were obtained, a brief relevant
   employment history and when you /service first became involved with the family

   (In subsequent statements you need not repeat your qualifications etc but should refer the Court
to your previous statements and entitle subsequent statements second/third as appropriate.)

   I make this statement from the reading of (identify the source of your information has come
   from) and my own personal knowledge.

   I have been requested by (put in details of who requested the statement i.e. court, solicitor,
council etc) to provide a statement in relation to care proceedings for (child name and date of
birth).

2. Family Composition

   This statement concerns the (family name) family which comprises:

   Child/subject (name, DOB, address)

   Children within the family/Siblings (name, DOB, address)

   Parents/Carers/Significant Adults (names, DOB, address)

   (Attach a genogram for complex families)

   Home address

3. Contact with the Family
During my/service involvement with the (family name) my records confirm the following contacts:

Eg (number) home visits, clinic contacts, attempts to make contact by telephone or letter, missed appointments, prearranged visits at home when access was allowed, attendances at case conferences, seen in school or clinic setting

Initial Contact

My records confirm that I took over as (professional status) for this family from (name of previous health visitor) on (date). I first met the family on (date) at (address).

4. Child’s Health and Development Needs (see Guidance notes)
5. Parenting Capacity (see Guidance notes)
6. Family History and functioning (see Guidance notes)
7. Analysis and Conclusion
   Summary of risk and protective factors
   Opinion based on professional knowledge and information about child and parent

Declaration

I declare that the contents of this statement are true to the best of my knowledge and belief and understand that it will be placed before the Court and used as evidence in care proceedings. I am able to provide additional specific information on request in relation to this statement if required.

Signed
Printed name
Date

For quality assurance purposes

Name of manager
Signed

Date
Formulation and Treatment Plan

Based on Wells (1997) Cognitive Therapy for Anxiety Disorders.

**Formulation: Social Anxiety**

Formulation:

- Social anxiety situations
- Safety behaviours
- Social phobia questionnaire
- H/W thought records / social anxiety situations / safety behaviours

Treatment Plan: Social Anxiety

Psycho-education and discussion of treatment plan

Social anxiety situations

Safety behaviours

Social phobia questionnaire

H/W thought records / social anxiety situations / safety behaviours

Cognitive Restructuring and verbal reattribution

- Review H/W
- Verbal reattribution
- Thinking errors

H/W thought records with verbal reattribution / social balance log

Social Skills Training and In-Session Practice

- Review H/W
- Positive data log
- Introductions / conversations / observing counter-evidence

H/W practice a skill learnt / positive data log

Behavioural Reattribution

- Review H/W
  - Decrease safety behaviours and external attention manipulation (focus)
  - Review social anxiety situation – graded hierarchy of exposure

H/W exposure lowest anxiety – dropping safety behaviours and shifting focus

Graded Hierarchy of Exposure
Research Dossier
Chapter 1

Homicide Bereavement: The Process and Outcomes of Therapeutic Input

Introduction

1.1 Background

The thesis presents a process and outcome evaluation of a UK-based Homicide Bereavement Therapeutic Service. It will pay particular attention to the process implications of delivering such a service whilst also focussing on outcomes following therapeutic interventions. Whilst there is growing evidence indicating the impacts of homicide on the bereaved (Amick-McMullan, Kilpatrick, Smith and Veronen, 1989; Casey, 2011; Malone, 2007), theories of underlying processes and intervention paradigms are sparse within the UK, with many of those that exist relying mainly on anecdotal accounts.

Vulnerable groups are rarely in a position of power within society and it was whilst working within ASSIST Trauma Care’s Homicide Bereavement Service that I began to consider how to enhance my understanding of the impact of homicide on family members, and loved ones. I also began to develop awareness that this type of experience was largely hidden from society, and as a result appeared all too often overlooked. There was an unspoken avoidance of the horrors that can unfold for
individuals and family systems that experience the death of a relative or loved one by homicide, and the corrosive devastation often associated with this experience.

In searching and reviewing the literature on homicide and surviving family members, I was struck by the lack of research into appropriate interventions and service provision for this population within the counselling psychology domain. Those that exist originate primarily from the United States of America (USA). For this reason, I felt there was a need for UK based research to address this area, believing it to be a worthwhile area of study. Given the existing gaps, investigation was warranted of both the impact of therapeutic interventions within the homicide service and staff perceptions of the processes underpinning therapeutic intervention, with the ‘ideal’ model of service and intervention delivery measured against the reality of working with bereaved individuals. Others have explored the subjective experience of the death of a loved one by homicide (Quinsberry, 2009). However, there is limited research investigating the effectiveness of clinical therapeutic provision for individuals who choose to engage in therapeutic interventions following the homicide of a family member.

In April 2010, the Victims Minister Damien Green announced a grant towards a homicide bereavement service which was given to the Victim Support organisation to deliver. The homicide bereavement service was specifically designed to help families cope with the loss of a loved one through murder or manslaughter by offering a range of emotional, practical and specialist support. ASSIST Trauma Care is a third sector organisation committed to supporting those who have experienced a traumatic event that became one of the contracted organisations that would provide specialist therapeutic interventions to those traumatically-bereaved.
Bereavement is a complex process that is largely considered and understood as a normal and expected life experience, which may be accompanied by a variety of emotional reactions, behavioural responses, and cognitions (Boelen, van den Bout & van den Hout, 2006). Bereavement responses can be experienced following the death of a loved one, the end of a marriage, or following a significant shift or rupture to an important relationship. Whilst many go on to manage and overcome these initial and natural responses to bereavement, others will experience prolonged intense emotions (Bryant, 2013). These have been described in the literature as ‘complicated grief’, identified as a form of suffering distinct from normal bereavement (Horowitz, Siegel, Holen, Bonanno, Milbrath and Stinson, 1997). Bereavement is a highly individual as well as a complex experience. It is increasingly recognized that no two people respond the same way to losses associated with the death of a loved one. People's reactions to a death are influenced by such factors as ethnic or religious traditions, (Royce, 2003), personal beliefs about life after death, the type of relationship ended by death (relative, friend, colleague) (Cleiren, Diekstra, Kerkhof, & van der Wal, 1994), the cause of death, the person's age at death, and whether the death was sudden or expected (Purves & Edwards, 2005). Other factors include the extent of social support from family members, friends and the wider community (See Casey, 2011 for a review).

Many factors contribute to whether an individual may go on to develop complicated grief responses to homicide bereavement, one of which is the nature of the violent nature of the death. Facilitating recovery from this type of loss has been a specific focus of psychological enquiry with varying interventions developed to help conceptualise such a phenomenon (Nicholls, 2014).
1.2 Key definition of phenomena addressed in the study

Various terms relating to homicide bereavement are used throughout the literature and though not exhaustive, those used in the current study are defined below and used interchangeably throughout. Each term derives from social constructions that are inherent within various conceptualisations and associated meanings, based on geography, cultures and beliefs (Hruschka, Christiansen, Blythe, Croft, Heggarty, Mufwene, & Poplack, 2009). For the purpose of this study the following definitions are employed based on my understanding and that of the service being evaluated.

Homicide - The term homicide is frequently associated with the American language, however services in the UK such as Victim Support and ASSIST Trauma Care have employed this term, as both murder and manslaughter are two of the offences that constitute homicide and are deemed appropriate for service referral.

Murder is the unlawful premeditated killing of one human being by another.

Manslaughter can be committed in one of three ways: 1. killing with the intent for murder but where a partial defence applies, namely loss of control, diminished responsibility or killing pursuant to a suicide pact. 2. conduct that was grossly negligent given the risk of death, and did kill, is manslaughter ("gross negligence manslaughter"); and 3. conduct taking the form of an unlawful act involving a danger of some harm, that resulted in death, is manslaughter ("unlawful and dangerous act manslaughter") (Crown Prosecution service, 2012).

Bereavement - the circumstance of having suffered the death of a loved one (Elders, 1995; Rando, 1988). Bereavement refers to the period of mourning and grief following for example the death of a beloved person or animal.
Trauma – Psychological trauma is the unique individual experience of an event or enduring conditions, in which: the individual’s ability to integrate his/her emotional experience is overwhelmed, or the individual experiences (subjectively) a threat to life, bodily integrity, or sanity (Pearlman & Saakvitne, 1995, p. 60).

Grief - refers to the emotional, social, and somatic reaction to loss which will gradually incorporate the loss into the griever’s gestalt (Rando, 1988). Previous research has suggested that the expression of grief during the bereavement process has immeasurable health benefits (Bowlby, 1980).

Mourning is - the social or cultural process of expressing grief about the loss of their loved one (Rando, 1993). Mourning is the word that is used to describe the public rituals or symbols of bereavement, such as holding funeral services, wearing black clothing, closing a place of business temporarily, or lowering a flag to half-mast.

Complicated Mourning is - the process whereby the normal grief process is either absent, delayed, inhibited, distorted, or chronic. Previous research has determined that specific incidents, including a sudden and unexpected death during the course of a random and violent event – such as homicide – is more likely to complicate the bereavement process (Armour, 2002; Rando, 1993).

Secondary Victimization has been usefully defined by Orth (2002) as “(The) negative social or societal reaction in consequence of the primary victimization and is experienced as further violation of legitimate rights or entitlements of the victim” (p. 314).
Homicide Survivor is defined as an immediate family member (i.e. parent, child, sibling, or spouse) who has mourned the loss of a victim of homicide (Amick-McMullan et al., 1989; Armour, 2002).

The following criteria for Prolonged Grief Disorder and Post-traumatic Stress Disorder are used in the service to establish levels of distress and subsequent interventions.

1.2.1 DSM V Prolonged Grief Disorder Criteria

A. Event criterion
   o Bereavement (loss of a significant other)

B. Separation distress. The bereaved person experiences at least one of the following symptoms, which must be experienced daily or to a distressing or disruptive degree:
   o Intrusive thoughts related to the lost relationship
   o Intense feelings or emotional pain, sorrow, or pangs or grief related to the lost relationship
   o Yearning for the lost person

C. Cognitive, emotional, and behavioural symptoms. The bereaved person must experience five (or more) of the following symptoms daily or to a distressing or disruptive degree:
   o Confusion about one's identity (e.g., role in life, diminished sense of self, feeling that a part of oneself has died)
   o Difficulty accepting the loss
   o Avoidance of reminders of the reality of the loss
   o Inability to trust others since the loss
   o Bitterness or anger related to the loss
o Difficulty moving on with life (e.g., making new friends, pursuing interests)

o Numbness (absence of emotion) since the loss

o Feeling that life is unfulfilling, empty, and meaningless since the loss

o Feeling stunned, dazed, or shocked by the loss

D. Duration. Duration at least six months from the onset of separation distress

E. Impairment. The disturbance causes clinically significant distress or impairment in
social, occupational, or other important areas of functioning (e.g., domestic
responsibilities).

F. Relation to other mental disorders. Should not be better accounted for by major
depressive disorder, generalized anxiety disorder, or post-traumatic stress disorder

1.2.2 DSM V Post-Traumatic Stress Disorder Criteria

A1 Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of
the following ways:

1. Directly experiencing the traumatic event(s).

2. Witnessing, in person, the event(s) as it occurred to others.

3. Learning that the traumatic event(s) occurred to a close family member or close
friend. In cases of actual or threatened death of a family member or friend, the event(s)
must have been violent or accidental.

4. Experiencing repeated or extreme exposure to aversive details of the traumatic
event(s) (e.g., first responders collecting human remains; police officers repeatedly
exposed to details of child abuse).
Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

Relatively few interventions have targeted provisions specifically aimed at those bereaved by homicide with management of symptoms often bracketed heavily into either bereavement-related distress or trauma related distress symptoms (Ogata, Ishikawa, Michiue, Nishi, & Maeda, 2011; Rynearson, 2012), ignoring bereavement-related distress. For the purpose of this research, bereavement will be taken to mean the sudden and traumatic loss of an individual through homicide and a critical framework will inform previous loss paradigms to investigate the specific needs of this population.

1.3 Structure of the Thesis

This thesis will be structured in the following way. In Chapter 2, a critical review will address the literature relevant to the current research area, providing a rationale for the research methods and evaluation undertaken. It will investigate historical theories of grief and trauma and how they impact on current understandings of clinical practice with this population. An exploration of the service context will be presented whilst considering the implications of its development with an exploration of its effectiveness. The review will examine psychological, emotional and physical effects of bereavement by homicide and will also present secondary factors pertinent to this experience, which previous literature has indicated can impact on outcomes for service users. Approaches to the treatment of homicide bereavement will then be examined with concluding comments that signal future directions and recommendations for research. This review provides the rationale for the empirical studies presented in later chapters within the thesis.
Chapter 3 presents the epistemology, ontology and encountered methodology employed within the study. Common characteristics of mixed-methods approaches will be discussed followed by an introduction to the specific methods chosen for data collection and analysis.

The first empirical phase of the study is introduced in chapter 4, which details the qualitative element of the mixed-methods approach, exploring the processes inherent within the delivery of homicide bereavement therapeutic services within the chosen organisation. Staff members were interviewed with the purpose of extracting information relating to aspects of service delivery and experiences working with those bereaved, including barriers and facilitators to service-use and the types of interventions used. Conclusions will be drawn based on the findings and barriers and facilitators to service delivery will be identified.

Chapter 5 presents the second phase of the research, the outcome evaluation study that addresses key issues relating to the efficacy of the service in reducing psychological distress. A pre-experimental pre-and post-design is presented which used the retrospective data routinely collected as part of the service delivery design. Through this study changes in symptoms relevant to this type of bereavement, namely trauma, depression, anxiety and complicated grief symptoms are investigated. Scores on the psychometric measures relating to these symptoms of trauma, anxiety, depression and complicated grief for service users, gathered prior to and following therapeutic input are compared.
A discussion will be presented in Chapter 6 detailing the main findings from the studies and the implications for homicide bereavement counselling psychology practice and policy. Recommendations for future research work are also presented. Chapter 6 will discuss and contrast the findings from both the qualitative and quantitative findings.

Finally, Chapter 7 will conclude the thesis with a critical appraisal of the research process. This will include my reflections on contributions to research within the counselling psychology domain, the process and progression of the research and my reflections on the research process undertaken and my influence as a researcher.
Chapter 2

The Impact & Treatment of Homicide Bereavement:
A critical review of the literature.

2.1 Introduction

Defined as the killing of one human being by another, homicide can leave a corrosive trail of devastation for those left behind (Morrall, Hazelton, & Shackleton, 2011). The Home Office Index reports that there were 526 homicides reported in 2013/14 in England and Wales, with murder, manslaughter and infanticide constituting homicide (The Home Office). Stigma is often associated with death by homicide (Kalucy, Rodway, Finn, Pearson, Flynn, Swinson, & Shaw, 2011), relating to perceptions that the victim of homicide may have been deserved in some way due to mental health issues or the association with drug abuse or violent gangs. This act occurs however in varied situations, with numerous motives, including domestic quarrels, skilfully calculated crimes as a method of personal or gang-related revenge, and those carried out for financial or personal gain or retaliation for a previous injustice (Douglas, Burgess, Burgess, & Ressler, 1992). There is considerable research evidence detailing the emotional, psychological, physical and financial impact on those bereaved (Amick-McMullan, Kilpatrick, Smith and Veronen, 1989; Malone, 2007; Casey, 2011). Trauma-related symptomatology are particularly prevalent with an elevated risk of Post-Traumatic Stress responses (Zinzow et al., 2011; Mezey et al., 2002; Amick-McMullan et al., 1991), including anxiety and depression (Parkes, 1993). The corrosive impact, which is harmful and destructive, surges not only through individuals but family
systems and the wider community with an estimated 6-10 family members bereaved by the homicide of a loved one (Gross, 2007).

Therapeutic interventions with those bereaved should take account of the multi-faceted impact and social construction of this type of bereavement. Corwin (1995) examines the relevance of theoretical assumptions about grief and the bereavement process in culturally diverse populations. This includes the ways in which cultural dimensions can shape the expression of grief, mourning practices, and the resolution of grief (Schonfeld, Quackenbush & Demaria, 2015). There is debate over how to term this population with secondary victims (Morall, 2011), co-victims (Spungen, 1997; Connolly & Gordon, 2014) and survivors (Hatton, 2003) used interchangeably to describe those bereaved. For the purpose of this review, the term “those bereaved by homicide” will be used due to lack of consistent evidence for a general consensus of appropriate terminology. This study considers “those bereaved” to be immediate family members who are mourning the loss of a victim of homicide (Amick-McMullan et al., 1989; Armour, 2002) in line with the majority of proposals suggesting that family units must be the primary focus of intervention (Miller, 2009; Mezey, Evans & Hobdell, 2002).

Asaro & Clements (2005) highlight apparent changes in family stability, communication and role functioning within family dynamics, indicating issues that professionals need to be aware of for effective family functioning to be addressed. There is a possibility however, when considering interventions, of omitting individuals that were linked to the homicide victim and not considered to be directly associated
with the family such as colleagues, friends and unmarried partners and those unmarried in same-sex relationships. This also raises questions relating to the apparent distinction of who is affected by the violent death of a loved one with a potential for secondary victimization of those not considered (Gekoski, Adler, & Gray, 2013).

Given the current research base indicating the impact of homicide which will be explored further in section 2.4 of this chapter, it is perplexing that there is a paucity of resources and evaluation of specialist support following this typically harrowing experience. Furthermore, there appears to be relatively little literature or practice based examples available that indicates empirically based interventions developed for those who have been bereaved (Casey, 2011; Morrall, 2011).

2.1.1 International service provision for those bereaved by homicide

Although increasing attention is being directed to the problem of homicide worldwide, literature indicating the type of service provision is a relatively new field of enquiry, with little published information on the experiences of surviving family members (these include the United States, Ewing, 1997, and in the UK, Harris-Hendriks, Black, & Kaplan, 1993). Interventions and service provisions are potentially lacking cultural transferability and are not adequate to use across different cultures due to varying grieving behaviours. Stroebe (1992) suggests that the validity of a dominating, Western grief work hypothesis has not been demonstrated empirically and that several cultures avoid accepting death (e.g., through ancestor worship) or demand that grief be suppressed, without apparent negative results. Internationally, various intervention strategies are utilised including those presented by The Centre for Homicide
Bereavement (CHB), based in Massachusetts, in the United States of America who are a component of the Victims of Violence Program. It offers crisis interventions, ongoing counselling, bereavement support groups, consultation and advocacy for adults and children. Additionally, a Homicide Bereavement Early Stage Support Group is available which is a six-week psycho-educational group offering a framework for understanding the impact of profound loss due to homicide. The CHB also provide a Homicide Bereavement Ongoing Support Group offering a safe and communal context for those who have lost a family member to homicide to engage in the active work of mourning.

The Queensland Homicide Victims’ Support Group (QHVSG) in Australia provides confidential peer support, help, and understanding to the surviving victims of homicide and aims to create an awareness into the unique needs of those bereaved whilst also promoting education and reform. Whilst the majority offer advocate support to the families, government facilitated services historically have focussed on the grief issues, emanating from grief models, ignoring the impact of the trauma of grief trajectory.

2.1.2 UK based service provision for those bereaved by homicide

Due to the early focus of bereavement research, much is known today about the typical manifestations of grief and the efficacy of interventions (Hansson & Stroebe, 2007). It has been documented that bereavement services are useful in lowering the level of stress and psychosomatic symptoms, especially in a sudden and unanticipated mode of grief (Mian, 1990). Specific trauma focussed interventions following bereavement by homicide are designated solely to ASSIST Trauma care who operate across the UK with additional advocacy services offering support (Support after Murder or Manslaughter...
and Mothers against murder and aggression). Guidelines published by the National Institute for Health and Care Excellence (NICE, 2005) recommend that family members of victims of homicide should be assessed for PTSD, with treatment approaches focused primarily on the reduction of post-traumatic symptoms, which are likely to impede the natural grieving process. Guidelines for professionals suggest that trauma-focused cognitive-behavioural therapy (TF-CBT), (Ehlers & Clark, 2005) and exposure therapy such as eye movement desensitization and reprocessing (EMDR) (Shapiro, 1995) should be considered as an effective first line intervention for PTSD (Nijdam, Gersons, Reitsma, de Jongh, & Olff, 2012; Jonas, Cusack, Forneris, Wilkins, Sonis, Middleton, & Gaynes, 2013; Watts, Schnurr, Mayo, Young-Xu, Weeks, & Friedman, 2013; Schoorl, Putman & van Der Does, 2013). This guidance, although useful, fails to combine and integrate the dynamics of grief and trauma that typically pervade this experience, which is further explored in section 2.4 of this chapter.

The purpose of the current chapter is to explore both the theory and research that underpin therapeutic interventions and service provision. It will first provide a historical and theoretical investigation of traditional grief and trauma models, which have more recently been streamlined towards a theoretical underpinning of traumatic bereavement. It will then go on to offer an overview into the impacts of bereavement by homicide in order to facilitate intervention understanding. Third, it will identify gaps in the extant literature, following a review of existing empirical studies of interventions and their efficacy specific to those bereaved by homicide. Finally, it will provide guidance for clinical practice and draw conclusions into recommendations for future research in order to stimulate and inform a more dedicated effort within this discipline and will provide a rationale for the subsequent empirical work presented in chapters 4 and 5.
2.2 Search strategy

Searches of several electronic databases including PsychINFO database, Social sciences Abstracts and Violence and Abuse Abstracts, were carried out using the following search terms: ‘homicide bereavement’, ‘co-victims’, ‘interventions’, ‘traumatic bereavement’, ‘murder’ and ‘manslaughter’, ‘secondary victimisation’. These terms were based on the terminology found during initial reading around this area. Relevant references were identified from the articles retrieved by the searches. Once these papers had been assimilated and read their reference sections were reviewed to identify other relevant articles. A realist synthesis (Rycroft-Malone, McCormack, Hutchinson, DeCorby, Bucknall, Kent, & Wilson, 2012) approach was utilised, which is an increasingly popular approach to the review and synthesis of evidence, which focuses on understanding the mechanisms by which an intervention works, or not. This approach was chosen due to the specific contexts of service delivery being complex, multi-faceted and dynamic, which may indicate that rarely would the same intervention work in the same way in different contexts. Realist reviews have emerged as a strategy for synthesising evidence and focuses on providing explanations for why interventions may or may not work, in what contexts, how and under what circumstances (Greenhalgh, Wong, Westhorp & Pawson, 2011).

2.3 Historical and theoretical investigation of grief and trauma

In order to facilitate practitioner understanding of intervention efficacy, it is beneficial to outline how violent loss is understood. This section is not an exhaustive, historical account of grief and trauma, rather it involves the selection of key literature and authors
who provided pertinent and seminal early writings and studies around traumatic bereavement.

Thanatology, the study of death, includes the wider social aspects of understanding death and the grief process. A key theme in the bereavement literature is the recognition that every grief experience is unique and dependent on many variables, such as the circumstances of the death, characteristics of the bereaved individual, their relationship with the deceased, the provision and availability of support, and numerous sociocultural factors.

Historically, theoretical models of grief and mourning have included the staged or phased model of bereavement, which is argued to be a useful model in explaining the process of grief as a normal part of the life cycle (Kubler-Ross, 1969; Pollock, 1987). Stages include an initial period of shock, disbelief and denial, a mourning phase of somatic and emotional discomfort, social withdrawal and a culminating period of restitution (DeVaul, Zisook & Faschingbauer, 1979). However, despite their utility, these models have met significant criticism due to their lack of focus on the idiosyncratic experience of bereavement and rigid conceptualization (Doyle, 1980), which is often taken too literally (Worden, 1982). When applied to bereavement by homicide, this purist approach to bereavement ignores the traumatic nature of the death and resultant traumatic symptoms that interrupt, exacerbate, and complicate the grieving process (Armour, 2002).
In contrast to the focus on grief and mourning, traumatology is the study, development and application of psychological enquiry specific to individuals who have experienced an extremely distressing event that results in damage to the psyche. Van der Kolk (1989) specifies the complicated nature of trauma suggesting “traumatization occurs when both internal and external resources are inadequate to cope with external threat” (1989, p. 393) which can contribute to the development of Post-Traumatic Stress Disorder (PTSD). PTSD is defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) as a trauma and stressor related disorder results in two seemingly contradictory responses; individuals are overwhelmed by recurrent intrusive memories related to the trauma such as nightmares and continual rumination with negative somatic affect and extreme avoidance of affective involvement.

This biphasic response of trauma and grief has been noted in the literature repeatedly (Horowitz, 1976; Lindemann, 1944) and more specifically in relation to those bereaved by homicide, as these responses appear to be particularly enduring and prolonged (Rando, 1996). ‘The symptomology and management of acute grief’ (Lindemann, 1944) published in the American Journal of Psychiatry is regarded as a classic in the field of bereavement. It was prompted and published following the Coconut Grove disaster, a deadly nightclub fire which occurred in November 1942, killing 492 people and injuring hundreds more. This inaugurated research on traumatic death and recognized the overwhelming, intense grief reactions experienced by survivors (Lindeman, 1944).
The Coconut Grove disaster led to a reform of safety standards and codes across the USA with major changes in the treatment and rehabilitation of traumatized victims. Lindemann laid the foundation for the study of grief and dysfunctional grieving, with Adler, (1943) who worked with more than 500 survivors of the fire, conducting some of the earliest research on grief responses. Adler studied survivors and found that they experienced unresolved grief with personality changes involving guilt, rage and demoralisation, with findings a year after the disaster suggesting that 50 per cent of survivors still experienced sleep disturbances, increased nervousness and anxiety, guilt over survival, and fears related to the fire. Whilst it is acknowledged that specific focus should lean towards the assimilated approach to trauma and grief due to the resulting psychological distress, it is possible that the theoretical underpinnings of such understanding do not translate to clinical practice, which may lack a full understanding of the impacts of homicide. Future research should therefore lay focus on understanding how services and interventions utilise theoretical knowledge to inform practice.

2.4 The impacts of homicide

Existing literature, largely developed in the 1990s, has been concerned primarily with the psychological impact of homicide in relation to traumatic grief, which often leads more specifically to the recognition of PTSD symptomatology (Amick-McMullan, Kilpatrick, & Resnick, 1991; Burgess, 1975; Parkes, 1993; Rynearson & McCreery, 1993). Rynearson (1987) proposed the responses of PTSD were directly associated with the violence, violation, and volition which the loved one will identify. This means
the dying is injurious and often mutilating, is transgressive, and is an act of human intention.

2.4.1 Psychological effects of homicide

The majority of existing research makes a distinction between bereavement reactions following natural death and homicidal death (Rynearson & McCreery, 1993). Although typical grief reactions are different for everyone, phases of grief typically involve emotional and psychological reactions that include affective, cognitive, physiological, and behavioural symptoms (Worden, 2002). Feelings include chronic and disruptive yearning, pining, longing for the deceased, trouble accepting the death, inability to trust others, excessive bitterness related to the death, uneasiness to move on, numbness and detachment, feeling that life is empty, bleak future, and agitation (Jacobs, Mazure, & Prigerson, 2000; Prigerson & Jacobs, 2001; Prigerson & Maciejewski, 2005; Prigerson, et al., 1999).

It is suggested that these responses usually dissipate within 6 months, which is achieved through internal resources and external support from family and friends (Northern Health and Social Care Trust (NHSCT, 2009). Following homicide, additional responses distinct from typical grief may include feelings of rage, revenge, stigmatisation, extreme guilt and fear and justice seeking (Burgess, 1975; Parkes, 1993). Emotional constriction (Sprang & McNeil, 1995) and a prolonged sense of meaninglessness (Janoff-Bulman, 1992) can persist with the desire for retribution and justice bringing additional disturbance to those bereaved as well as to their accompanying support systems (Redmond, 1989; Spungen, 1998). Compulsive enquiry
and rumination about the death scene are specifically associated with this type of traumatic death (Rynearson, 1993).

Current literature indicates an investigation into the impact of trauma on the psyche and reveals that the impact can be profound, with evidence at the neurological level suggesting that psychological trauma can result in biological changes in both the dysregulation of neurochemical systems and alteration of brain function and structure (Blair, 2009). These multi-faceted psychological effects can significantly affect daily functioning with academic, social, familial, financial and occupational functioning potentially being grossly impaired (Connolly & Gordon, 2014).

The distinction between normal and prolonged or complicated grief is supported by surveys of psychologists (Ogden & Simmonds, 2013) and the wider community (Penman, Breen, Hewitt & Prigerson, 2014). There are increasing efforts to define ‘normal’ grief and delineate it from ‘complicated’ grief experiences (Dillen, Fontaine, & Verhofstadt-Denève, 2008). The parallel discourses concerning the recognition of grief as unique and dependent on a number of variables and the differentiation between ‘normal’ and ‘complicated’ grief reactions and their treatments, remains a fundamental paradox in the thanatological literature. Importantly, the current discussion regarding the differentiation between ‘normal’ and ‘complicated’ grief reactions fails largely to recognise the complex factors that impact on the experience of grief (Breen & O’Connor, 2007). This paradoxical phenomenon may contribute to feelings of secondary victimisation experienced by those bereaved due to the lack of consistent
2.4.2 Secondary victimisation

The ability to cope with the likely initial horror and unpredictable nature of homicide is further burdened by criminal justice proceedings and the resultant media attention that often pervades their experience (Orth, 2002; Gekoski, Adler, & Gray, 2013). Depending on the nature of the criminal investigation, family members may be regarded as suspects for a period of time, with additional complications relating to release of the body resulting in a further loss of control for those bereaved (Casey, 2011).

Furthermore, difficulties accessing information about the case, insensitive treatment, unfairness of the criminal justice system and negative reporting of the case by the media can add to the confusion and distress experienced (Connolly & Gordon, 2014). Unsurprisingly, it has been suggested that increased general psychiatric impairment, such as depression and anxiety, is significantly related to criminal justice proceedings including how details of the case are shared with the family, and satisfaction with police investigation and conviction (Jenkins, 2013; Amick-McMullan, Kilpatrick, Veronen, L. & Smith, 1989).

Additionally, deaths that have occurred in stigmatising circumstances, such as drug use or domestic violence may result in isolation from communities and existing support networks (Spungen, 1998). The impacts of homicide can be felt and experienced within an individual, family and community, which encompasses the emotional shockwave
This uncovers questions into the often undefined boundary between individual and family and indeed, whole system interventions. It is apparent that the literature into the unique impact of homicide is complex and multi-faceted, in part, due to the traumatic nature of the bereavement.

### 2.5 Homicide and traumatic bereavement

In relation to bereavement, the DSM 5 (2013) proposes a Bereavement-Related Disorder that includes a Traumatic Death Specifier. The DSM 5 criteria for Bereavement-Related Disorder and PTSD (detailed in sections 1.2.1 and 1.2.2) have been criticised as limited in scope and more specifically in relation to bereavement by homicide (Jordan & Litz, 2014). This is due to the use of singular theoretical constructs of both grief and trauma which present a reductionist account into the understanding of experiences such as violent loss, ignoring the multidimensional assessment of bi-directional traumatic grief symptomatology.

The development within this field of scientific knowledge has yielded models of bereavement and trauma that have been interwoven to recognise how traumatic bereavement, characterised as a ‘unique synergy of loss and trauma’ (Armour, 2002, pg.114), affects individuals such as those bereaved by homicide. Recommended treatment models have emphasised focus on the grief work hypothesis, in that suppressed emotion engenders psychopathology, suggesting healthy mourning involves cathartic emotional expression (Rando, 1993). Traumatic bereavement is viewed as a descendent of the concept of pathological grief, with associations to attachment behaviour towards the deceased, separation distress from the deceased, and traumatic distress due to the sudden and traumatic nature of the death. Raphael (1997) further
distinguished the phenomena of grief and trauma suggesting a dichotomy between a bereaved person who is preoccupied with the deceased seeking reminders of them and the traumatised person, who is avoidant of thoughts of how the person was killed and the trauma scene. The process of grieving a loss through homicide is distinguished by the traumatic nature of violent death, which has driven the primary focus of theoretical constructs. This distinction between grief and trauma laid the foundations for specific assessment needs and therapeutic interventions within those suffering traumatic bereavements with suggestions for treatment models and services based on this assumption which the next section will explore.

2.6 Approaches to the assessment and treatment of homicide bereavement

2.6.1 Assessment methods

Based on an extensive search of the existing literature, there are currently only two bereavement service evaluations (Jackson, 1996; Reid, Field, Payne & Relf, 2006) focussing on staff users’ perceptions of bereavement care which have been conducted thus far in the UK. There are, to the author’s knowledge, currently no evaluations of services of traumatic bereavement services following homicide. There are contrasting views regarding the purpose of assessment with those bereaved by homicide with both a crisis intervention model to assessment that advises services to be non-directive and avoid diagnostic categorisation and opposing recommendations for screening for specific problems or thorough pre-treatment trauma survivors (Redmond, 1989; Rynearson, 1994). This has implications into the model of intervention, which may focus primarily on reduction of current symptoms as in cognitive behavioural methods, which may ignore previous traumas and coping strategy histories. The efficacy of such
models of intervention are detailed in section 2.6.7. Assessment should also take into account the impact of PTSD on families and comorbid symptomatology (Horne, 2003).

Current interventions and literature based on historical grief work hypothesis suggest suppressed emotion engenders psychopathology and that healthy mourning must include cathartic emotional expression (Hurd, 2004; Stroebe, 1992; Rando, 1993). NICE Guidelines indicate cognitive behavioural and exposure based techniques for the treatment of PTSD. There has been criticism and caution towards these guidelines regarding the heterogeneity of PTSD, raising unaddressed empirical questions about the generalisability of treatments to all PTSD presentations (Dorahy, 2006). These include ethno cultural and socio-political factors, which though potentially significant, have not been addressed in randomised outcome studies of treatment efficacy. There are numerous intervention choices with associated empirical support for example, the use of psychodynamic methods in treating PTSD (Gerrity & Solomon, 1996), trauma focused interventions that include exposure based therapies (Foa & Rothbaum, 1998), cognitive behavioural therapies (CBT) (Beck, 1976), Eye Movement Desensitization Reprocessing (EMDR) and Stress Innoculation Training (Meichenbaum, 1985). Each intervention choice additionally explores and considers the efficacy of individual verses group treatment.

2.6.2 Exposure based therapies

Exposure based therapies include treatment manuals developed for various aspects of symptomatology. Prolonged exposure is characterised by re-experiencing the traumatic event through remembering it and engaging with, rather than avoiding, reminders of the
trauma (Foa & Rothbaum, 1998). Imaginal exposure, during which a client is asked to imagine feared images or situations and in-vivo exposure which refers to the direct confrontation of feared objects, activities, or situations by an individual (Tarrier, Sommerfield, Pilgrim, & Humphreys, 1999). These techniques are underpinned by the rationale that exposure enables recognition that the feared memory or situation is no longer a current threat. Individuals with PTSD therefore confront their trauma memories and specific situations, people or objects that have become associated with the traumatic stressor and evoke what is now an unrealistically intense emotional or physical response. It is proposed that this enables the individual to eventually regain mastery of their thoughts and feelings around the incident.

Although this method of intervention focuses on the post-traumatic sequelae and trauma reduction, it fails to acknowledge issues of thanatology and specific circumstances that the individual may be addressing, such as criminal proceedings (Jenkins, 2013). There is also critique surrounding the re-traumatisation of an individual following exposure based therapies which may be heightened during vulnerable stages of their traumatic loss (Prochaska & Norcross, 1999). Early assessment and formulation measures, as well as appropriate timings of interventions are necessary to enhance the efficacy of exposure-based therapies. This would facilitate a thorough understanding of the idiosyncratic nature of the bereavement, including external factors that may impinge on the therapeutic treatment and potentially cause them further distress such as complications with criminal justice proceedings or release of the body.
EMDR is an exposure-based therapy that centres on the recall of traumatic memories in the presence of “bilateral stimulation,” typically eye movements, directed by the therapist (Bryant 2001; Robertson 2004; Shapiro, 1995, 2001). It is an integrative, comprehensive treatment approach that contains many elements of effective psychodynamic, cognitive-behavioural, experiential, interpersonal, and physiological therapies. This treatment although evidenced as effective (Maxfield, & Hyer, 2002; Sprang, 2001) in the treatment of PTSD is somewhat controversial due to the lack of descriptive evidence on exactly how EMDR works and its underlying mechanisms (May, 2005).

2.6.3 Cognitive behavioural therapy

This treatment places greater emphasis on cognitive strategies to help people alter erroneous thinking that has emerged because of the event (Beck, 1976). Practitioners may work with individuals on beliefs that the world is no longer safe, for example. Trauma-Focused Cognitive behavioural therapy (TF-CBT) challenges the distorted, negative thinking patterns associated with the trauma in order to help the development of more adaptive cognitions and behaviours.

There is evidence for the efficacy of trauma focused cognitive behavioural psychological interventions (Jonas, Cusack, Forneris, Wilkins, Sonis, Middleton, & Gaynes, 2013) and it has therefore been argued that a standard response following a traumatic event should be to detect individuals who develop PTSD and offer them trauma-focused psychological interventions (e.g., Bisson, Roberts & Macho, 2003). PTSD sufferers may feel strong guilt or shame related to the trauma with ruminations
relating to what happened, self-recrimination and prevention of the death (Aldrich & Kallivayalil, 2013). Intervention approaches focus on a generalised account of PTSD following homicide and rarely accommodate specific factors of this type of traumatic bereavement (Connolly & Gordon, 2014).

2.6.4 Homicide specific treatment approaches

Additional methods of intervention are offered through an anecdotal focus on bereavement by homicide with psychodynamic and existential components (Armour, 2003). Miller suggests a basic element of effective trauma psychotherapy is the provision of safety and support (Miller, 1998, 2008) while other treatment models lay particular focus on the mastery of traumatic responses of avoidance and intrusion (Rynearson, 1996, 2012) and meaning making (Miller, 2009). Management of PTSD symptomatology including compulsive enquiry and secondary victimisation of which is associated with prolonged recovery, has prompted treatment models to accommodate these issues. For example, Rynearson (1987) proposed the responses of posttraumatic stress disorder were directly associated with the violence, violation and volition of traumatic dying with which the loved one will identify. Components of other therapies are utilised, such as narrative therapy, which is focused on reconstructing a consistent narrative about the trauma (Neuner, Schauer, Klaschik, Karunakara & Elbert, 2004). Furthermore, in psychodynamic psychotherapy an individual works with a therapist to develop a better understanding of their responses to the trauma and how it impacts on their feelings, behaviour and relationships (Foa, 1997).
2.6.5 Timing of interventions

There is debate around the most effective time to intervene with people bereaved by homicide (Aldrich & Kallivayalil, 2013; Gartlehner, Forneris, Brownley, Gaynes, Sonis, Coker-Schwimmer & Lohr, 2013), with debate over interventions for the prevention of posttraumatic stress disorder (PTSD) in adults after exposure to psychological trauma (Rothbaum, Kearns, Price, Malcoun, Davis, Ressler, Lang, & Houry, 2012). The National Institute for Health and Care Excellence (NICE, 2005) suggested that immediately post trauma incident, the bereaved should be offered practical, social and emotional support (National Child Traumatic Stress Network and National Center for PTSD, 2006). Little evidence exists to support the use of early psychological intervention such as debriefing following traumatic events, with evidence suggesting it may have an adverse effect on some individuals (Rose, 2002; Tuckey, & Scott, 2014). Furthermore, it is suggested that the time that had passed since the trauma was not related to treatment effectiveness (Ehlers 2005; Gillespie, Duffy, Hackmann, & Clark, 2002; Resick 2002).

Due to the current political climate which involves heavy financial cuts to funding and service provision, evidence-based models such as TF-CBT that ensure time-limited and speedy interventions are deemed more appropriate than those offering interventions based on the idiosyncratic nature of the clients difficulties (Rizq, 2013). Arguably the sole focus on PTSD does not adequately focus upon the case of bereavement by homicide. This is a considerable oversight given the evidence indicating that numerous comorbidities and social difficulties ensue following such an event and that intervention
models are required which encompass the longitudinal and holistic nature of this experience. The adjustment to bereavement by homicide is reported to be life-long in the literature (Aldrich & Kallivayalil, 2013; Litz 2004) as opposed to brief and time limited, as families struggle to face anniversaries, release dates and various other legal proceedings in the future. The criminal justice system also prevents exposure-based therapy during criminal proceedings with this type of intervention being postponed until after a verdict has been given, due to the potential danger of contaminating evidence.

2.6.6 Group versus individual psychological interventions

There is much debate surrounding the efficacy of interventions with group and family support, (Hatton, 2003; Horne, 2003). Suggestions indicate that some individuals find the sharing of such experiences in a group setting helpful, however such groups can be overwhelming and actually exacerbate symptoms of trauma (Alexander, Neimeyer, Follette, Moore & Harter, 1989). Individual therapy is the treatment of choice initially (Van der Kolk, 1988), as it allows the bereaved a private, anonymous, and safe environment in which to explore and process his or her reactions to trauma and loss and the establishment of a trusting relationship. This trusting relationship facilitates clients in the development of trust necessary for establishing healthier, more satisfying and hopeful relationships (Heineman, 2016). Whilst approaches to the assessment and model of intervention with those bereaved is explored in the literature, the efficacy of such psychological approaches requires further exploration.

2.6.7 Efficacy of psychological approaches
Interventions based on reducing traumatic imagery have been reported as an effective and important first step in treatment (Grigsby, 1987) however only when encouraged as an active, ongoing mastery of imagery (Rynearson, 1994). Interventions aimed at reducing posttraumatic symptoms have been evidenced as effective (Foa, 2008) with trauma focused cognitive behavioural therapy (Bisson 2007; Bradley 2005) and eye movement desensitization and reprocessing (EMDR) (NCCMH 2005) currently having the strongest empirical evidence base (Bradley, Greene, Russ, Dutra, & Westen, 2005) compared to non-trauma-focused interventions such as relaxation or non-directive therapy.

Evidenced-based studies evaluating the results of CBT have noted apparently efficacious strategies such as exposure, cognitive reconstruction and writing (Boelen & deKaiser, 2007; Reynolds, Miller, Paternak, Frank, Perel, Cornels, 1999). Ehlers and Clark (2005) present similar findings which suggests cognitive processing and prolonged exposure to specific or non-specific cues or memories related to the traumatic memories significantly reduces the symptoms of PTSD. This includes modifying excessively negative appraisals of the trauma and its sequelae, reducing re-experiencing by elaboration of the trauma memories and discrimination of triggers and dropping dysfunctional behaviours and cognitive strategies. It is proposed that the exposure to trauma memory is for the purpose of identifying ‘hotspots’, the parts of trauma memories that cause high levels of emotional distress which are often re-experienced. These are addressed with cognitive restructuring, rather than as a method of habituation during which a decrease or ceasing of distress response to a stimulus is found after repeated presentations. Criticism surrounds this mode of reliving therapy with both retraumatisation and ethical concerns, stating much depends on the effectiveness of the
therapist when using this type of treatment due to barriers of its use (Deacon & Farrell, 2013; Olatunji, Deacon, & Abramowitz, 2009).

Murphy (1996) highlights the efficacy of imaginative exposure with only highly distressed mothers showing significant improvement without imaginative exposure. Pilot data from these interventions indicate a decrease in trauma distress and provide the opportunity to develop methodologically sound investigations into the overall efficacy of a more pro-active, robust approach. Further studies indicate the positive outcomes following reliving, with experiences of fear and difficulty being an inherent part of PTSD and trauma recovery (Ehlers and Clark, 2000).

In terms of reducing PTSD symptoms Kutz, Resnick & Dekel (2008) have collated systematic outcome data indicating early EMDR intervention produces very positive immediate effects in the majority of those treated, especially for intrusive symptoms. This evidence is contradictory to most in the field which suggests immediate intervention does not enable assessment of whether symptoms will become problematic or simply resolve themselves (Pollock, 2000). Although EMDR studies have indicated positive outcome measures (Silver, Rogers, Knipe & Colelli, 2005), most studies fail to indicate the specifics of EMDR intervention, or use of specialized protocols (Nijdam et al., 2012). This has consequences for the validity of the studies and indeed their replication as these results may not be generalisable.

It appears the dichotomy between trauma and bereavement although integrated in the theoretical literature, has not yet reached clinical efficacy. This means that services and interventions lay their focus either on bereavement or trauma independently rather than
a combination. This leads to a fragmented application of interventions and service delivery. There are contrasting opinions surrounding the effectiveness of cognitive and exposure-based therapies and much of this literature indicates the competency of the professional providing the intervention and their ability to be flexible with the approach are fundamental (Parpottas, 2012). It appears that the role of training and the therapeutic relationship in the effectiveness of treatment with homicide bereavement is also not well understood (Casey, 2011). This highlights the need for increased empirical evidence to investigate these aspects of therapeutic intervention for homicide bereavement in order to explore the factors that contribute to effective interventions.

Whilst there is recognition that a relatively specific pattern of dysfunctional responses is common following this type of bereavement, treatment approaches that are directed towards a singular response fail to offer a holistic and thorough intervention model to integrate and acknowledge the full range of experience.

Evidence exists supporting many of the treatment approaches, however, these studies have, to some extent, focused upon symptoms of trauma solely as the variable to indicate effectiveness. This ignores more complex approaches, which may be important to adjustment and wellbeing in this population, including grief and mourning processes, the relationship to the deceased and secondary victimization. The use of coping strategies such as avoidance, alcohol and drug use and the pre-existence of mental health problems (Rynearson, 1994: Casey, 2011) need further evidence regarding their impact on treatment efficacy. Currently, within the UK, The National Institute for Health and Care Excellence recommends various evidence-based treatments models (see NICE guidelines, CG26). These interventions are time limited and structured which can mean that they may not be able to accommodate the idiosyncratic needs of
individuals within service provision. Within the UK, ASSIST Trauma Care is the only service providing evidence-based trauma interventions to those bereaved by homicide. Having considered the evidence base, limitations and recommendations around assessment and interventions for homicide bereavement, the service context within which homicide bereavement assessment and treatment occurs will be explored. This will provide a context for the empirical work presented later.

2.7 Service context

In April 2010, the Victims Minister Damien Green announced a continued grant towards a homicide bereavement service provided by Victim Support. Police family liaison officers provide support for the closest family until the investigations and trial are completed, but they are not a counselling service. Victim Support has a special homicide service run by trained workers who work closely with family liaison officers, and a caseworker can plan free, tailored support to meet people's needs. They also help in practical ways, including making claims for compensation and accompanying clients to a police station and to court for various hearings, as well as the trial. Although Victim Support cannot provide more specialist help, it can put clients in touch with specialist organisations or arrange professional counselling. Initially within ASSIST, five therapists were based in the head office, and were allocated referrals from across the UK.

As the service developed, additional sessional therapists were hired to accommodate UK wide referrals. Currently, there are 43 sessional therapists within the service which is highlighted in Figure 1 below:
The discussion in section 2.3 above, argues that currently, the complex interplay between trauma and grief have led to dichotomous services which focus on either the trauma or the bereavement, leading to potential fragmentation of interventions and service provision and that future service provision and associated research requires a focus on the integrative study of trauma and loss outcomes (Rando, 2015).

2.7.1 Referral process for ASSIST Trauma Care

Following a homicide, families are referred to Victim Support and a caseworker meets with the family to assess whether individuals are better suited to primarily traumatic symptoms (ASSIST) or bereavement interventions (e.g., CRUSE Bereavement Care). These decisions are considered initially by Victim Support caseworkers, based on trauma scores on psychometrics (see Chapter 5 for details), as well as subjective reports about their responses and difficulties. If trauma therapy is required, the caseworker will refer to ASSIST where a therapist is then allocated to the referral and completes an
additional therapeutic assessment to identify specific needs. Should the therapist agree that trauma symptoms are present, therapeutic interventions are recommended to the client and scheduled. Service users are allocated up to 15 sessions of therapy with each session lasting 1-1.5 hours long, depending on the nature of the session such as whether it is an assessment or specific trauma related session which generally last 1.5 hours. Sessions can run weekly, fortnightly or even monthly depending on factors such as therapist availability and preference by service user. This means that the course of therapy can run anywhere between 15 weeks and 1 – 2 years. Interventions consist primarily of TF-CBT, EMDR and other models of trauma therapy and is dependent on the therapists training and the needs of the client. The choice of these methods are based on appropriate evidence-based practice (Kar, 2011; Soloman & Rando, 2012).

2.7.2 Difficulties of streamlining ASSIST service provision

Since September 2014, local police and crime commissioners have responsibility for determining case management of those affected by homicide. This means that following referral of individuals and families, multiple services intervene, potentially at a time when family members are already dealing with many professionals such as Family Liaison Officers and Court officials. It could be argued therefore that interventions with those bereaved fail to deliver a streamlined and linear service which incorporates the multi-faceted cognitive and emotional mechanisms that accompany their experience and the understanding that grief and loss can only be conceptualized within the context that they occur. This may be specific to this particular organisation.
due to current UK legislation and commissioning which may not occur in other services such as those internationally.

Treatment for bereavement by homicide requires the additional focus on specific factors that may not be present following other types of traumatic bereavement (Monk, Neylon, & Sinclair, 2003). It therefore deserves a robust and specific focus towards effective interventions, which include factors that affect family members and loved ones, such as secondary victimisation, the significance of the relationship to the deceased, whether they witnessed the homicide and social stigmatization (Klass & Peach, 1987). The impacts of homicide are multi-faceted and approaches to interventions should be robust enough to accommodate and reflect this. Issues of treatment relating to trauma and bereavement remain relatively independent with fractured services and referral processes that may be as complicated and damaging as the process of traumatic grief itself. As noted earlier, it could be argued that the lack of treatment services partially explains the paucity of literature into the effectiveness of such services. This leads to the rationale and need for the empirical work undertaken in this thesis as the work here aims to evaluate both the process and outcomes of an existing UK based therapeutic service.

2.8 Conclusion and future directions

2.8.1 Recommendations for clinical practice

While it is recognised that the primary focus of interventions following bereavement by homicide focus on PTSD symptoms over grief phenomena, this may lead to a fragmentation of services that provide a singular focus. Service and intervention
A protocol should aim to present a linear care-plan, which integrates a complex matrix of theory and practice in order to address the multi-faceted nature of traumatic bereavement (Cohen, Mannarino, & Deblinger, 2006). In addition, considerations of intervention timing, spontaneous recovery and culturally-determined constructs of traumatic grief should be inherent with assessment and intervention planning.

### 2.8.2 Spontaneous recovery

A common yet significant obstacle to obtaining meaningful evidence regarding efficacy of early PTSD interventions is the high rate of spontaneous recovery (Najdowski, & Ullman, 2009). While it is difficult to ascertain specific rates of spontaneous recovery, a study by Dillenburger and Keenan (2001) specified that spontaneous recovery from violent death was delayed due to repeated exposure to discriminative stimuli, a stimulus in the presence of which a particular response will be reinforced (Malott, 2007), for example, media reports of violence and murder, resulting in delayed and persistent grieving behaviours. In terms of reducing PTSD symptoms Kutz, Resnik & Dekel, (2008) have collated systematic outcome data indicating early EMDR intervention produces positive effects in the majority of those treated, especially for intrusive symptoms. This evidence is contradictory to most in the field which suggests intervention does not enable assessment of whether symptoms will become problematic or simply resolve themselves (Pollock, 2000).

### 2.8.3 Cultural bias in treatment and research

It is acknowledged that most of the research has been conducted internationally, primarily in the United States. This has significant implications for a culturally
determined grief hypothesis and this view is Western in its construct (DeSpelder & Strickland, 2001). Cultural implications relating to the nature of bereavement following homicide require further exploration with implications for policy provision and interventions that are culturally sensitive. It is possible to assume that certain cultures adopt varying mourning processes that are accepted and valued as functional within their specific cultural environment with spiritual (Sharpe, et al., 2014) and religious (Thompson & Vardaman, 1997) factors that facilitate the question of “What is healthy mourning?” A focus on cultural responses exploring the impact of and responses to treatment has indicated similarities across various cultural communities (Ogata et al., 2011). However, the focus of research in this area is predominantly in the United States of America which ignores alternative contexts and may therefore not be generalisable to other countries, such as the UK. Due to the limited research focus in UK contexts, this thesis seeks to add to the literature by focussing on a UK population with the qualitative dimension of the study providing an opportunity for context specific considerations to be investigated.

2.8.4 Research recommendations

Due to the dearth of existing research and services, future research should focus on the process and outcomes of existing homicide bereavement service provision with the aim of determining the efficacy of therapeutic interventions provided as well as exploring the process issues inherent with delivering such a service. Such research will enable

"a quality improvement process that seeks to improve client care and outcomes through systematic review of care and the implementation of change. Aspects of the structure, processes, and outcomes of care are evaluated. Where indicated, changes are
implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery” (NICE, 2002, p. 10).

Research including additional secondary factors that may serve to exacerbate symptoms of traumatic grief such as the relationship to the deceased, the time between the homicide and interventions and whether the bereaved were a witness to the homicide, would enable a fuller investigation into the role these factors play in outcomes and process, informing the development of more effective assessment and intervention techniques. Whilst the diagnosis of PTSD and associated co-morbidities enables specific focus on facets relating to the personal psychological and physiological responses to bereavement by homicide, it ignores the secondary social context as Michalowski (1976) eloquently notes: “It is the manner of dying, and not the death itself, that determines the social meaning of any death” (p. 83). Future research is needed to discern the nature of this social meaning in addition to the complexity of factors that influence this meaning. The duration and timing of interventions would further inform intervention guides, policy development and treatment of those bereaved during criminal proceedings.

As stated previously, there is no literature available to evidence the effectiveness of services and interventions with those bereaved by homicide in the UK. This may be due to the limited development of therapeutic services within the UK and the potential ethical issues associated with researching this population. The empirical work presented in this thesis will add to the available evidence within the political, methodological and practical constraints of service provision within the UK, due the
sensitive nature of researching those bereaved by homicide. Many of the extra problems relating to the difficulty of standardising the design and delivery of the interventions, their sensitivity to features of the local context and the organisational structures inherent with UK provision will be explored.

2.8.5 Conclusion

Homicide is devastating for all close family members involved, infiltrating emotional, physical and mental health among those bereaved. Family systems are shaken, relationships break down and the ability to work is affected with the resultant financial difficulties that ensue (Casey, 2011). The research on the efficacy of interventions following homicide does not equal its impact, with frequent long-term negative effects of homicide such as ill-health, unemployment and relationship breakdown (Casey, 2011). The under-specification of service provision and intervention procedures prevents effective analysis and observable differences in treatment effects. As such, this research highlights the importance of identifying high-risk subgroups for complicated grief such as those bereaved by homicide. Multidimensional and longitudinal approaches to interventions and future research should be prioritised to ensure that those experiencing this unique and devastating bereavement are supported in reconstructing their lives.

The following chapter will provide the study context and methodology underpinning the empirical research work, the aim of which is to explore staff member perceptions of homicide bereavement service provision and to use psychometric pre and post-measurement to gauge homicide bereavement intervention effectiveness.
Specific research questions will be presented in the individual study chapters 4 and 5, however, the primary research question for the research thesis is as follows:

What are the inherent process issues in operating a homicide bereavement therapeutic service and how effective is this type of therapeutic intervention?
Chapter 3
Study Context & Methodology

3.1 Introduction and Service Context

The Homicide Service was initiated and specifically designed to help families cope with the loss of a loved one through murder or manslaughter, ensuring a range of emotional, practical and specialist support was available. Malone (2007) presented a study into the perspectives of bereaved people and personnel from Victim Support, the probation service, the police and voluntary organisations, in which key findings were identified relating to the emotional and practical aspects of traumatic bereavement and the needs that subsequently arise. In particular it was found that traumatic grief is complicated by involvement in the criminal justice system, exacerbating feelings of rage and powerlessness, that different groups will experience bereavement by homicide in different ways, depending on the relationship to the victim, age, gender and other factors, representing a wide range of specific responses and needs. Mental health, physical health and relationships are often adversely affected. In particular, immediate family members are at risk of developing post-traumatic stress disorder (PTSD). In April 2010, the Victims Minister Damien Green announced a continued grant towards a homicide bereavement service, provided by Victim Support. It was during this time that the emotional needs of the families were identified as requiring specialist therapeutic interventions to support the traumatic nature of the bereavement.

I acknowledged from the outset that bereavement by homicide was a complex subject, as there are many factors that may interconnect or overlap to affect a person's grieving
Having worked within the homicide bereavement service since its inception five years ago, I have been saddened to witness the impact the act of homicide has on family members, but feel privileged to support families experiencing such turmoil. This led me to consider how interventions with this population were primarily derived from bereavement and trauma models with little empirical research about the process and effectiveness of intervention types in improving wellbeing by reducing psychological distress. This encouraged me to begin researching this important topic. It has been challenging to develop appropriate research questions which do justice to this population in respect of the improvement and delivery of service provision. This difficulty was exacerbated with the knowledge that research into service provision following the traumatic bereavement of homicide is sparse. Given the lack of research into service provision for those bereaved by homicide, rather than focussing solely on whether the service ‘works’, i.e. does the intervention result in improved psychological outcome for those who undertake it. I decided it was important also to focus on the qualitative processes that underpin the service. Hence a mixed methods approach was adopted in this empirical work.

The overall purpose of this mixed methods study was to evaluate the process of delivering services to those bereaved by homicide and to determine the effectiveness of therapeutic interventions with these clients. This chapter describes the principles of and theoretical rationales behind mixed methods evaluation research. It also reviews the methodology utilised in this study, including encountered methodology, research design, epistemology and ontology.
3.2 Encountered methodology

The overall rationale for adopting a process and outcome methodology was to assess the lived reality of the factors that facilitate or hinder service provision and outcome measures. A central premise of a mixed methods approach is that the use of quantitative and qualitative approaches in combination provides a better understanding of research problems than either approach alone (Creswell, 2006). There has been a growing recognition of the importance of understanding the impact of the delivery and organisation of health services, with a focus on processes as well as outcomes, and the range of methodological approaches required to do this (Steinwachs, & Hughes, 2008). For the purpose of this research it was assumed that in order to justify the unique experience of bereavement by homicide, the robustness of this type of methodological triangulation approach to research design, where two or more methods are used in a study to check the results of one and the same subject, is in its ability to enable the researcher to reach a convergence of findings. In other words, a merging of the qualitative and quantitative data into a singular finding (Driscoll, Appiah-Yeboah, Salib, Rupert, & Douglas, 2007).

3.3 Research Design

Four dominant paradigms are identified within the mixed methods approach by Hall (2012), namely post-positivism, constructivism, transformative and pragmatism. The current research is underpinned by a pragmatist approach, which has gained considerable support as a stance for mixed methods researchers (Johnson & Onwuegbuzie, 2004; Maxcy, 2003; Morgan, 2007; Finkelstein et al., 2015). Within the pragmatist paradigm there is an acceptance that both qualitative and quantitative
methods are compatible (Howe, 1988) with an assumption that ultimately, what works in practice and what promotes social justice is of importance (Fassinger & Morrow, 2013). There were participatory aspects of this approach, which are to be used to directly or indirectly reform or improve current service provision, professional training and policy development. The decision to devise a mixed methods approach is in line with the discipline of counselling psychology which encourages multiple perspectives to understanding the human psyche and its ailments. This lends focus to both the objective in terms of theoretical approaches and the subjective with regards to individual perceptions and experiences. It is the integration of these distinct but relevant pieces of data that provides insight into the development of future service and policy development with those bereaved by homicide.

3.4 Epistemology and Ontology

Epistemology relates to the nature and forms of knowledge (Cohen, 2007, p. 7) with assumptions concerned with how knowledge can be created, acquired and communicated, in other words what it means to know. Guba and Lincoln (1994, p. 108) suggest that epistemology asks the question, what is the nature of the relationship between the would-be knower and what can be known? The underlying epistemology in this investigation eschews the reductionist account of typical psychological theory, instead an emphasis is placed on interrelated, subjective and objective and often oppositional constructs of reality. It further focuses on “What works as the truth regarding the research questions under investigation” (Tashakkori & Teddlie 2003, p. 713). Ontology is the study of being (Crotty, 1998, p. 10). Ontological assumptions are concerned with what constitutes reality, in other words what is. This study assumes that reality is generated from subjective and objective accounts.
3.5 Validity and reliability

There is general agreement that all research studies must be open to critique and evaluation (Long & Johnson, 2000), with a clear imperative for rigour to be pursued in quantitative and qualitative research so that findings may carry conviction and strength. Mixed methods research holds the potential for rigorous methodologically sound investigations into service provision as it engages the variety of questions relevant to the complexity of health care provision. It is important to recognise that all research is conducted by an enquirer, who is the instrument from which all information flows through a single perspective (Smith, 1997, p.77). Ryan, Scapens & Theobald (2002) classified mixed methods validity and reliability with a focus on internal and external validity and reliability of quantitative work and, analogously, on contextual validity, generalisability and transferability, and procedural reliability of qualitative work. All research must address threats to reliability and validity including mixed method designs (Berg, 1998; Maxwell, 2005). I will now explain these concepts and how they were applied or addressed in the qualitative and quantitative research conducted in this thesis.

3.5.1 Qualitative validity and reliability

Qualitative research refers to language versus numbered data (Polkinghorne, 2005) from which the data gathered “builds a complex, holistic picture” (Creswell, 1998, p. 15) to describe and clarify “human experience as it appears in people’s lives” (Polkinghorne, 2005, p. 137). The pursuit of a trustworthy study in qualitative research is approached by applying Guba’s four constructs of criteria: credibility, in which researchers seek to ensure that their study measures or tests what is actually intended; transferability which is concerned with the extent to which the findings of one study can be applied to other situations; dependability, to show that, if the work were repeated, in the same context,
with the same methods and with the same participants, similar results would be obtained and confirmability, which ensures as far as possible that the work’s findings are the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher.

### 3.5.1.1 Credibility

Credibility is associated with confidence in the truth of the findings, which is explored by using staff members that not only work with service users but are aware of the difficulties inherent with service provision. It is proposed that a true picture of the phenomenon being researched, namely those bereaved by homicide, is presented, thus enhancing the credibility of the study.

### 3.5.1.2 Transferability

Transferability shows that the findings have applicability in other contexts. It has been suggested by Bitsch (2005), for example, that the “researcher facilitates the transferability judgment by a potential user through ‘thick description’, which refers to the detailed account of field experiences in which the researcher makes explicit the patterns of cultural and social relationships and puts them in context (Holloway, 1997) and purposeful sampling” (p. 85). The research has sought to include sufficient detail so that judgements about the transferability of findings to similar services, or alternative settings or contexts can be gauged by the reader.

### 3.5.1.3 Dependability

Dependability indicates that the findings are consistent and could be repeated. The issue of dependability is challenging due to the idiosyncratic nature of the population in
question. It is assumed that general themes of service provision are outlined and correspond with the credibility of the study however, this may be achieved through the use of overlapping methods, such as the focus group and individual interviews.

3.5.1.4 Confirmability

Confirmability shows a degree of neutrality or the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest. Confirmability was a process throughout the study as I started with a deductive account of data analysis which is concerned with developing a hypothesis (or hypotheses) based on existing theory, and then designing a research strategy to test the hypothesis (Wilson, 2010, p.7). This was based on my own subjective accounts of service provision. Following discussion in supervision it was clear my rationale for the qualitative analysis required a more inductive process, which is concerned with the generation of new theory emerging from the data. This enabled the data to ‘come alive’ rather than imposing my own view of what I thought needed to be extracted from the data. A reflexive journal (Lincoln & Guba, 1985) was established prior to data collection and has continued throughout the process of data collection, analysis and presentation of findings. It has included personal reflections on the participant responses and engagement as well as the research project itself.

3.5.2 Quantitative reliability and validity

The trustworthiness of quantitative research includes ecological validity, internal validity, external validity, reliability, and objectivity.

3.5.2.1 Ecological validity
Ecological validity refers to the extent to which the findings of a research study can be generalised to real-life settings. As this study is an evaluation of an existing service and has been conducted within the typical constraints of a service evaluation ecological validity can be considered high.

### 3.5.2.2 Internal validity

Internal validity refers both to how well the study was run and how confidently one can conclude that changes in the dependent variable was produced solely by the independent variable and not extraneous variables. Internal validity is moderately supported in this study by appropriate selection of participants who have utilised the service. In order to address the maturation effect, which describes the factor of time and the effect that time has on people, which are natural (rather than experimenter imposed) changes that occur as a result of the normal passage of time. A larger sample size may increase the internal validity of the findings as the findings become more generalizable across the sample. Limitations to internal validity are due to the necessity to conduct a pre-experimental pre-post design for the effectiveness study within the evaluation (see Chapter 5). The lack of a control group, however, was deemed necessary due to the ethical implications of, for example, beneficence and non-maleficence such as withholding timely interventions and because contacting those who had chosen not to engage with the therapeutic input offered, was not possible.

### 3.5.2.3 External validity

External validity refers to whether the findings of a study really can be generalised beyond the present study. External validity can be categorised into four types. Population validity, which questions whether the results generalise to other persons;
Setting validity, which considers whether the findings will apply to other settings, situations or locations, Task/Stimuli validity which assumes the participant is ‘doing something’ that directly or indirectly generates the behaviour that is being measured and whether these results generalise to other tasks or stimuli; and Societal/Temporal validity which asks whether the findings continue to apply ‘as society changes over the years’ (Lucas, 2003). The external validity may be generalised across this population, however, further data gathering of alternative services associated with the service such as Victim Support staff and Family Liaison officers as well as service users themselves may have enhanced the external validity of the study. Additional factors such as type of intervention should be areas for further exploration in the future. The timing of intervention and measurements used, although reflected on, are also areas for future research.

3.5.2.4 Quantitative Reliability

The use of valid and reliable psychometrics and a test-retest method (also known as stability, Kerlinger, 1986) to prove reliability by administering one measure to one group of individuals, wait for a certain amount of time, and then re-administer the same instrument to the same group was used to increase reliability. Internal consistency was addressed in the use of valid psychometrics that purport to measure the outcome constructs of interest within this study, namely: trauma, depression, anxiety and complicated grief.

3.5.2.5 Objectivity

Objectivity is used through the methodology of measurements, data collection, and data analysis through which reliability and validity are established. Objectivity is performed
through methodological procedures such as instrumentation and randomisation.
Objectivity also refers to the appropriate psychological distance between a researcher and participants that lessens bias.

The following two chapters, 4 and 5 present the empirical research conducted in this thesis. Chapter 4, the qualitative study of therapist perspectives on the homicide bereavement service, provides insight into the process of operating such a service, with chapter 5 providing preliminary findings regarding the effectiveness of the service and the role secondary factors play in psychological outcome.
Chapter 4

Juggling the Impacts of Homicide: A qualitative study of the process of providing therapeutic services to those bereaved by homicide

4.1 Introduction

Over the past several decades there has been an increased focus on the psychological and emotional aspects of bereavement which has facilitated research into services providing bereavement care interventions (see Chapter 2). Due to the focus on bereavement research, much is known about the typical manifestations of grief and the efficacy of interventions (Hansson & Stroebe, 2007), (described in Chapter 2, section 2.4.1) however there appears little consensus as to which is the most preferable form of treatment (Forte, Hill, Pazder & Feudtner, 2004; Currier, Holland & Neimeyer, 2010; Rubin, Malkinson, & Witztum, 2013). (Chapter 2, section 2.6).

Whilst most experiences of bereavement may cause significant distress, there is growing evidence detailing the emotional, psychological, physical and financial impact, such as loss of earnings, on those specifically bereaved by homicide (Amick-McMullan, Kilpatrick, Smith and Veronen, 1989; Malone, 2007; Casey, 2011). Casey (2011), in a review of families bereaved by homicide, suggests a paucity of research into the provision of specialist interventions within services providing therapeutic care, recommending the need for further research in this area. Those that exist derive mainly
from the United States of America. Within the UK, existing services were informed by earlier research commissioned by Victim Support (Brown, 1991) which laid the foundations for practical and support needs, with later emphasis on the emotional needs of those bereaved (Paterson, Dunn, Chaston and Malone, 2006).

It has been suggested that service provision, criminal proceedings and community responses to those affected by homicide may contribute to secondary victimisation because service provision is viewed as inadequate, and there is a lack of understanding and reductionist conceptualisation of this experience (Hatton, 2003). Aldrich and Kallivatalil (2013) suggest the impact of homicide has significant implications for the provision of clinical care with no predictable trajectory of intervention due to the varied and wide-ranging issues that each homicide brings. Therapeutic strategies are suggested and include the management of post-traumatic stress symptoms, victimisation and compulsive enquiry (Aldrich & Kallivatalil, 2013). A focus on long-term interventions is noted to accommodate specific and enduring experiences that are likely to unfold in the future and may bring the reality and potential brutality of this experience to the surface, for example anniversaries, parole hearings and release dates (Aldrich & Kallivayalil, 2013).

Interventions can often be wide-ranging and include crisis intervention (Aguilera, 1990), individual counselling (Foa & Meadows, 1997), family and group interventions (Van der Kolk, 1987) and community outreach services (Stern, 2010). These include both time-limited and long-term provision of care. Hatton (2003) in a survey of homicide bereavement counselling providers, gathered the opinions of 116 professional and para-professional homicide bereavement caregivers, presenting recommended
interventions, presenting problems, optimum treatment frameworks, and reasons for treatment failure. Self-help groups were strongly endorsed, as was providing concrete, practical assistance and a preference for a long-term model of assistance than for brief, structured interventions. However the survey indicated a lack of consideration into appropriate intervention timing and efficacy with inconsistent and multi-faceted methods of intervention (Hatton, 2003). This means that it was difficult to generalise these findings across other services. Connolly and Gordon (2014) in a systematic review of the literature presented exposed themes of treatment interventions that consisted of psychoeducation support groups and family therapy across the United States of America. The survey indicates practice issues inherent with homicide bereavement interventions and suggest the need for additional training for professionals such as law enforcement officers and criminal justice personnel to reduce the negative impact and potential secondary victimisation of those bereaved. Additionally, implications for the implementation of school and workplace policies are presented to provide guidance on supporting individuals bereaved by homicide, signalling a multi-dimensional approach to this population (Aldrich & Kallivayalil, 2016).

Due to the limited findings of homicide bereavement service evaluations, alternative literature on other types of bereavement were sourced for the purpose of comparison. Walsh, Breslin, Curry, Foreman, & McCormack, (2013) conducted a qualitative study to address staff’s views of bereavement care in a large hospital setting. The qualitative analysis yielded results that indicated a staff training programme within a structured bereavement care service would give staff a sense of confidence and pride in this aspect of their work. A whole-hospital approach to bereavement care would offer an alternative model to individual clinical services. The question as to whether the use of a
bereavement care plan helps to contain staff anxiety and other painful emotions generated by contact with the bereaved due to knowledge that other agencies and future interventions are in place. A potential role of ancillary staff to support its main activities in bereavement care warrants more study to evaluate its usefulness.

The provision of services offering therapeutic interventions following homicide bereavement, as noted in Chapter 2, is under-examined within the UK and little is known about the nature and quality of such support and in particular, the process involved with service provision (Casey, 2011). Homicide bereavement services do not have the same profile as other bereavement services due to additional complex issues such as the traumatic aspects of the death, criminal justice proceedings and media attention that may not be evident in other forms of death (Williams, Burke, McDevitt-Murphy & Neimeyer, 2012). Stephen, Wimpenny, Unwin, Work, Dempster, Mac Duff & Brown, (2009) argue that the provision of bereavement care within the UK is largely unknown. There is no recognised 'best practice' for homicide bereavement services, which suggests an increased need both in the UK and internationally to address how to support this experience.

This is the first empirical chapter presented in this thesis, which aims to investigate the process and nature of the service from the perspective of therapists working within it. It utilises a qualitative approach to explore the opinions and perceptions of staff members working within a homicide bereavement service exploring the nature of the care offered as well as barriers and facilitators to accessing such service provision. The aim of the service evaluation was to explore and identify the key challenges and issues relating to service provision with this population.
Specific research questions were developed to get a sense of the intricacies of service provision which were thought to be achieved by interviewing professionals who worked within the service. These were developed to answer the questions: What are the issues inherent in the process of delivering therapy to those bereaved by homicide? What would those working in a homicide bereavement service recommend in terms of developments to improve therapy and service provision?

(Specific interview questions asked are detailed below in section 4.2.3, box 4.1)

The aim of this study was to gain an understanding of professional views of service user experience, the type of interventions used within the service and whether those working in the service felt that they were effective in relieving distress for clients. Opinions into potential barriers and facilitators to service provision and use were also explored. Interviewing staff members was deemed essential to understand their ‘frontline’ perspective on what the service was doing well and how it could be improved.

Although it would have been useful to obtain views of all stakeholders such as Victim Support staff and Family Liaison Officers, this was outside the scope of the study so the focus in this study was on professionals working within the homicide bereavement therapeutic service. By gaining an understanding into the intricacies of this type of service provision, positive future changes not only those using the service, but those working within it and alongside it would be realised and achieved. Future service evaluations and feedback would confirm any positive changes made.
4.2 Method

4.2.1 Approach

The first, qualitative phase of the mixed methods evaluation presented was conducted to examine the process of providing a homicide bereavement service in the UK from the perspectives of staff working therapeutically with those bereaved. The study aims to address aspects of staff experience. Interview techniques included a focus group and six individual interviews. This was considered to be an effective means of exploring whether individual interviews and focus group interviews would produce the same or different data (Happell 1996, Mansell, Bennett & Northway, 2004). It was also considered that this technique would enhance the richness of the data and produce (Lambert & Loiselle, 2008). Interviewing was chosen for the current project for the following reasons: It provides the opportunity to generate rich data; language used by participants was considered essential in gaining insight into their perceptions and values and contextual and relational aspects were deemed by the researcher as significant to understanding others’ perceptions of service provision. Strengths and weaknesses of focus groups and individual interviews are explored within the context of the current research methodology with focus groups generating the ability to gather data efficiently. This sounds as if they have an almost magical "synergy" that makes them superior to individual interviews, by extracting group interactions that can provide insight into perceptions and experiences (Acocella, 2012). This is also done in a more time effective way than individual interviews, as multiple perceptions are gathered at once, although the data analysis is more complex (Doody, Slevin & Taggart, 2013). A potential weakness of focus groups is the fact that they are driven by the researcher's interests and
it can be difficult to capture individual responses (Goodwin & Happell, 2009). The fact that the researcher creates and directs the groups makes them distinctly less naturalistic than participant observation so there is always some uncertainty about the accuracy of what the participants say. In particular, there is a concern that the moderator, in the name of maintaining the interview's focus, may influence the group's interactions. I was aware that any relationships that develop between researchers and participants may also threaten procedural reliability during data collection (see Lillis, 2006). With the prior understanding of these potential disadvantages, due consideration to reduce the effect of these restrictions were monitored and conclusions were drawn that relationships with participants were on a professional basis only.

Individual interview strengths are proposed by Gomm (2004) who describes the cooperative nature of the interview as a “fact-producing interaction”. A fuller, robust and true picture of experience can be generated between the interviewer and interviewee. Gomm goes on to describe weaknesses such as demand characteristics pertaining to the interviewee’s responses which may be influenced by what s/he thinks the situation requires. This is one reason to make clear at the beginning of an interview what the purpose and topics are and seek to put the interviewee at ease.

4.2.2 Participant Recruitment & Sampling

Twelve staff members working within the Homicide Bereavement Service as clinicians participated in this research. Each member took part in an individual interview (N=6) or a focus group (N=6) lasting approximately 1 hour, which was designed to gather data relating to service provision. All participants were white and of British nationality. Of
the 12 participants, six were female and six were male. Participants were aged between 39 and 51 with a mean age of 46.

The study utilised a purposive sampling methodology, ensuring participants met the inclusion criteria (see section 4.2.2) and represented the richest and most complex source of information relevant to the current phenomena (Bryman, 2004). The sample consisted of staff members who had worked therapeutically with individuals who had lost an immediate family member, defined as a child, parent, sibling, and/or spouse (including domestic partners), due to a homicide. Participants were sent an email to invite them to participate in a either a focus group or an individual interview. Those that responded were allocated to their preferred mode of participation (either focus group or interview).

With regards to inclusion criteria, all interviewees had been working therapeutically within the homicide bereavement service for at least 6 months and their roles varied including psychotherapists, counselling psychologists and clinical psychologists. All had a minimum training standard that included qualifications in CBT and psycho-traumatology. Participants for both focus group and interviews are detailed in Table 4.1 below:
Table 4.1: Background information about the participants and focus group/interview duration

<table>
<thead>
<tr>
<th>Part. No.</th>
<th>Pseudonym</th>
<th>Focus Group (FG) or Individual interview (II)</th>
<th>Gender</th>
<th>Age</th>
<th>Role</th>
<th>Duration with service</th>
<th>Duration of FG/II</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Carol</td>
<td>FG</td>
<td>F</td>
<td>48</td>
<td>Psychotherapist</td>
<td>7 years</td>
<td>1 hour 5 min</td>
</tr>
<tr>
<td>2</td>
<td>Phillip</td>
<td>FG</td>
<td>M</td>
<td>61</td>
<td>Psychotherapist</td>
<td>11 years</td>
<td>1 hour 5 min</td>
</tr>
<tr>
<td>3</td>
<td>Steve</td>
<td>FG</td>
<td>M</td>
<td>51</td>
<td>Psychotherapist</td>
<td>4 years</td>
<td>1 hour 5 min</td>
</tr>
<tr>
<td>4</td>
<td>Jan</td>
<td>FG</td>
<td>F</td>
<td>39</td>
<td>Counselling Psych*</td>
<td>2 years</td>
<td>1 hour 5 min</td>
</tr>
<tr>
<td>5</td>
<td>Angie</td>
<td>FG</td>
<td>F</td>
<td>42</td>
<td>Psychotherapist</td>
<td>2 years</td>
<td>1 hour 5 min</td>
</tr>
<tr>
<td>6</td>
<td>Simon</td>
<td>FG</td>
<td>M</td>
<td>49</td>
<td>Psychotherapist</td>
<td>3 years</td>
<td>1 hour 5 min</td>
</tr>
<tr>
<td>7</td>
<td>John</td>
<td>II</td>
<td>M</td>
<td>44</td>
<td>Clinical Psych*</td>
<td>2 years</td>
<td>1 hr 10 min</td>
</tr>
<tr>
<td>8</td>
<td>Christine</td>
<td>II</td>
<td>F</td>
<td>39</td>
<td>Counselling Psych*</td>
<td>4 years</td>
<td>56 minutes</td>
</tr>
<tr>
<td>9</td>
<td>Jemma</td>
<td>II</td>
<td>F</td>
<td>38</td>
<td>Psychotherapist</td>
<td>3 years</td>
<td>48 minutes</td>
</tr>
<tr>
<td>10</td>
<td>Susan</td>
<td>II</td>
<td>F</td>
<td>40</td>
<td>Psychotherapist</td>
<td>3 years</td>
<td>55 minutes</td>
</tr>
<tr>
<td>11</td>
<td>Robert</td>
<td>II</td>
<td>M</td>
<td>47</td>
<td>Psychotherapist</td>
<td>2 years</td>
<td>48 minutes</td>
</tr>
<tr>
<td>12</td>
<td>Richard</td>
<td>II</td>
<td>M</td>
<td>51</td>
<td>Psychotherapist</td>
<td>4 years</td>
<td>54 minutes</td>
</tr>
</tbody>
</table>

*Psych is short for Psychologist

4.2.3 Procedure

Potential participants were invited to contact the researcher to arrange their choice of participation (see Appendix 4). Interviews were conducted with the purpose of revealing existing knowledge in a way that can be expressed in the form of answers.
and so become accessible to interpretation.” (Flick, 2006, p. 160). Guidelines for conducting ethical bereavement research were followed (Parkes, 1995) and great care was taken in ensuring confidentiality and protecting the privacy of both participants and service users (see section 4.2.7 for further ethical considerations). Prior to both the focus group and individual interviews, all participants were given a written description of the project (see appendices 5a and 5b respectively) and detailed consent (see Appendix 6) to take part with the knowledge they could withdraw at any point up to data analysis. The focus group was conducted at ASSIST headquarters prior to a training day so that participants did not have to travel specifically from across the UK solely for the purpose of the study. It was considered that if participants were requested to travel for the focus group on a different day, then due to time constraints and additional cost of travel (which was covered by the organisation due to training on the day), participant numbers would be fewer. After making contact with one-to-one interview participants, they were offered the choice of having the interview conducted by phone or in person at a time suitable to them. All 6 one-to-one interviews were conducted by telephone at participant’s convenience.

For both the focus group and individual interviews, semi-structured interview guide questions were designed to elicit experiences of staff in relation to service delivery and opinions on service user experiences (Patton, 1990). One of the main strengths of qualitative research is that analysis and collection of data can occur simultaneously (Curry, Nembhard, & Bradley, 2009). This was evident as a process of familiarisation was utilised within the focus group, with themes that emerged during earlier interviews/focus groups informing subsequent prompts during the individual interviews. Interview questions were delivered to each participant and subsequent questions
followed based on their responses. An interview guide was prepared in advance to address these issues with the following questions outlined in Box 4.1 below:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>What is your opinion on the provision of the Homicide Bereavement Service (HBS) and is it necessary?</td>
</tr>
<tr>
<td>2.</td>
<td>How do you feel service users experience the HBS?</td>
</tr>
<tr>
<td>3.</td>
<td>What factors, if any, impede and facilitate service use in your opinion?</td>
</tr>
<tr>
<td>4.</td>
<td>What is your opinion on the type of intervention used with this population?</td>
</tr>
<tr>
<td>5.</td>
<td>How do you think interventions may be improved?</td>
</tr>
<tr>
<td>6.</td>
<td>How would you describe a successful outcome?</td>
</tr>
<tr>
<td>7.</td>
<td>What factors hinder and facilitate successful outcome for service users?</td>
</tr>
<tr>
<td>8.</td>
<td>What improvements could be made to the Homicide Bereavement Service?</td>
</tr>
</tbody>
</table>

Box 4.1: Interview questions

4.2.6 Data analysis

A total of 7 (1 focus group and 6 individual telephone interviews) interviews were recorded and transcribed with data thematically analysed using NVIVO software. All names and identifying information were removed from interviews and the report to maintain anonymity of participants. Thematic analysis was used to identify, analyse, and report patterns within the data using the six phase recursive process proposed by
Braun and Clarke (2006). These include familiarising yourself with your data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; producing the report (see Appendix 11).

This method offers a way of identifying and providing a rich, detailed analysis of patterns across a data set. Initial (descriptive) coding was developed based on topics outlined and generated from initial focus group and interview experience, transcribing material and reading, with a literature review process occurring simultaneously. Codes were developed based on the frequency of occurrence and eventually culminated in a total of 95 codes. These codes were further delineated at interpretive-level coding, deriving more inclusive categories from the data. Four major interpretive-level areas of interest were identified based on the descriptive codes which will be described in the findings section. The transcription process ensured quotes remained true to the essence of what the person meant however minor alterations such as reduced quotes (indicated by 3 dots), additional clarifications (those non-italicised in brackets) and inverted commas to indicate imitating a client were changed to support comprehension by the reader.

4.2.7 Ethical considerations

Parkes’ guidelines for conducting ethical bereavement research was utilised for this study. Informed choice was given to participants with a written description of the study sent to all of those that suggested interest in participating. This included information on confidentiality and its limitations and how the data would be used in the research. A consent form was also included. No participant names or identifying details were given or used at any stage in the process of collection or analysis. A debrief was conducted
and information provided which indicated routes to explore any difficulties arising from the interviews.

As this study was designed and conducted to explore current service evaluation and the data collected as part of service provision, consent was not needed from external sources associated with ASSIST Trauma Care such as Victim Support or The Ministry of Justice. This research was guided by the principles of ethical research produced by The British Psychological Society (BPS, 2010) in which it states ‘researchers should respect the rights and dignity of participants in their research and the legitimate interests of stakeholders such as funders, institutions, sponsors and society at large’ (p, 4). As staff members were interviewed rather than service users, the risk of harm was viewed as being reduced, however standard BPS protocols were utilised such as full information sheet and debriefing, to ensure no harm was done to participants. Formal consent was gained from the clinical director (see Appendix 7) and ethical approval was requested and granted through the University of Wolverhampton Ethics Committee (see Appendix 1 & 2).

4.3 Findings

The accounts of the participants revealed a number of themes pertinent to the provision of therapeutic input to those bereaved by homicide. Thematic analysis of the data resulted in three global themes, each with subsequent subthemes, namely: 1. the distinctiveness of homicide bereavement; 2. delivering and development of interventions; and 3. the role of society and secondary victimisation. These themes and associated subthemes are outlined in Table 4.2 and are discussed in more detail below.
### Table 4.2: Master themes and sub themes

<table>
<thead>
<tr>
<th>Master theme</th>
<th>Sub theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The distinctiveness of homicide bereavement</td>
<td>1.1 A unique and complex bereavement experience</td>
</tr>
<tr>
<td></td>
<td>1.2 Fractured families</td>
</tr>
<tr>
<td>2. Delivering and developing Homicide Bereavement...</td>
<td>2.1 Parallel processes of traumatic bereavement and reductionist approaches to interventions</td>
</tr>
<tr>
<td></td>
<td>2.2 The timing and duration of therapeutic input</td>
</tr>
<tr>
<td></td>
<td>2.3 Communication and the development of a care plan</td>
</tr>
<tr>
<td></td>
<td>2.4 The overwhelming nature of trauma and fragmentation of service provision</td>
</tr>
<tr>
<td>3. The role of society and secondary victimisation</td>
<td>3.1 Lack of awareness of the impact of homicide within society</td>
</tr>
<tr>
<td></td>
<td>3.2 Forgotten Victims</td>
</tr>
</tbody>
</table>

#### 4.3.1 The distinctiveness of homicide bereavement

Although the impacts of homicide were not a specific focus of the quantitative enquiry, during the interviews and focus groups this theme was evident within all of the narratives of therapist participants. This theme appeared to pertain primarily to process related impacts of homicide bereavement that affected the therapeutic process and family life, rather than the psychological impacts of homicide bereavement. These factors that impacted on the bereavement process were multi-faceted and distinct from
other forms of bereavement. All participants within this study indicated their experience of working with family members following homicide suggesting that to experience the death of a family member in this way is a psychologically, emotionally and physically devastating event. The master theme the distinctiveness of homicide bereavement, divided into two separate subthemes, namely, the unique and complex bereavement experience and that the fracturing of families can accompany homicide bereavement.

4.3.1.1 A unique and complex bereavement experience

There was an overwhelming sense in each participant narrative that this experience was unique and distinct from other forms of death and bereavement. Many accounts indicated that homicide bereavement is different in that it is more complex than other forms of bereavement:

“I think by the general public and by work places and all these sorts of things they get generally treated as normal bereavement and you know a normal bereavement is bad enough as we all know erm but this is far more complex and more complicated” (Phillip).

“I mean when I worked with people who had been in life threatening or even fatal car accidents you know that is completely different (to working with homicide bereavement). (Simon)

The narratives exposed various reasons for the additional complexities involved with this type of bereavement that may have significant implications for service provision
and interventions. Multiple factors serve to complicate traditional understandings of bereavement such as traumatic responses to the death and the immediate practical and public issues that families face. Many experience significant media attention and delays in the release of the body due to multiple post-mortem examinations. This in itself could reportedly exacerbate and prolong avoidant coping strategies which are characteristic of trauma symptomology, as families in turmoil manage the more complex practical issues of the death and the resultant social attention:

“*The fact that that person has died and is no longer with us can’t be the focus. It’s how they died or what’s going on around the death that becomes the significant issue, so those (in normal bereavement responses) that might have been you know the yearning, yeah some of the actual classic bereavement symptoms I think start later.*” (Jemma)

Therapists indicated that bereavement processes may be prolonged for two associated reasons, first the traumatic nature in which the loved one died can extend normal grief responses as their focus of attention leans towards the sudden and violent nature of the death. Secondly, and in relation to this, families face the practical issues such as ongoing and lengthy criminal proceedings, the funeral, which may be delayed due to multiple post mortem examinations and even no funeral as a body has not been found. These additional issues, which can go on for months or even years may contribute to prolonged and complicated grief processes that impinge on the therapeutic progress or outcome.
“I'm thinking about the internalisation of the deceased which is quite an important part of the process of bereavement. I think because you've got so much external stuff going on … I think the shock phase is longer for the one thing because of the nature of the trauma surrounding it and then I think the actual person is almost kept alive through media through the trial happening through all those sorts of things that have to happen in that first 6 to 12 months”
(Jemma)

In addition to prolonging the process, these HB specific factors can also have significant bearing on the process of grief and subsequent therapeutic interventions and service provision, sometimes delaying and interfering with the process of engaging with therapy.

“...when actually they've been so focussed on the trial that they haven’t actually focussed on the trauma, or you know their grief or anything (Carol)”

Often, as a result of the criminal investigations, media attention is pronounced making the private experience of mourning a more public concern. Participants reported that this can exacerbate feelings of traumatic loss for clients which inevitably unfolds within the therapeutic work, as specific circumstances of the death are revealed during criminal proceedings. This means that any work done therapeutically up until the trial is either forgotten about or paused due to the new information about the death being processed. Hence, in homicide bereavement, trauma symptoms are typically perpetuated, prolonged and exacerbated:
“...one of the biggest things I find is when stuff comes out at the trial, erm, they find something out about their person who died and certainly all of that it's just, he died in a different context and (they’re) angry ... You know and if you've used up most of your sessions trying to work with the actual trauma of the murder and then you've got a whole load of other stuff coming up ... Yeah it's just being aware that these things can come up. I think at the beginning when I started, I had no idea” (Jemma)

It appears that a challenge for some clients, who did not previously know the details surrounding the death, is accommodating not only their initial subjective and traumatic interpretation of events, but also the subsequent facts regarding the homicide that are divulged during the criminal process. This adjustment process may be paralleled with the difficulties working therapeutically with those bereaved. Therapists new to this area face the challenge of accommodating the distinct aspects of HB into their therapeutic practice striving to integrate, acknowledge and address the new traumatic experiences of the criminal proceedings as they unfold. Therapeutic processes are hindered as service users present, at times, part way through therapy with initial phases of shock and trauma. This provides empirical evidence that homicide bereavement is distinct from other types of bereavement and is particularly complex.

4.3.1.2 Fractured families

A theme that emerged within the majority of accounts indicated that working systemically with families was an important process
“this (intervention) does involve systems you know, it’s not just the person that it’s happened to, it does involve family systems, doesn’t it?” (Simon)

“It depends on the role that person (the client) plays in the family … because often you’ve got somebody who, the one who’s always been looked after in the family in a way, the therapy can sometimes kind of change that to somebody that is more proactive and can do things and that’s gonna upset the whole family dynamic.” (Christine)

This signals that the dynamics of families can alter and change following homicide, as individual family members define potentially new roles within the family, and also during therapy, as processing of traumatic experiences occurs individually and systemically. These are issues that must be considered when delivering and developing homicide bereavement interventions.

4.3.2 Delivering and developing Homicide Bereavement interventions

The master theme of the delivering and developing homicide bereavement interventions was divided into four subthemes, namely parallel processes of traumatic bereavement and reductionist approaches to interventions; the timing and duration of therapeutic input; Communication and the development of a care plan; and the overwhelming nature of trauma and fragmentation of service provision.
4.3.2.1 Parallel processes of traumatic bereavement and reductionist approaches to interventions

All interview and focus group accounts exposed a belief amongst participants that the combination of trauma and bereavement work was important for this client population, with suggestions leaning towards a more streamline approach to service interventions by integrating trauma and bereavement issues into one service as opposed to services that offer singularly focussed trauma or bereavement approaches.

“I think the combination between trauma and bereavement is something that isn’t present in perhaps any other sorts of death, so I think a bereavement service is probably unaware of the trauma, and a trauma service, erm, a trauma service is less about the bereavement. (Jemma)”

There is a suggestion that singular approaches to traumatic bereavement such as Trauma-focussed Cognitive Behavioural Therapy (TF-CBT) ignores the complex nuances inherent with this type of bereavement. Evidence-based models such as TF-CBT and EMDR are dominant and privilege a positivist epistemology, which is reinforced by a managerial and bureaucratic structure that implements a highly standardised and regulated culture. This means that interventions are delivered over a minimal number of sessions and within a time-limited framework. However, according to participants, such approaches can ignore the relational and complex nature and experience of those bereaved. It appears there is a consensus that it is deemed reductionist to focus solely on singular approaches. Instead respondents indicated that
an integrative approach to therapy was a preferable approach to take with this client group rather than a sole focus on one intervention:

“So I think it’s, it’s not about a particular model, I think it’s about a certain level of approach. So the more erm if we stay stuck in the CBT model, we just narrow it down.” (Simon)

“I think it’s misleading for us to be told to use that particular intervention (TF-CBT). I think really we should be leading which interventions we’re experiencing at work and feeding that back. At the moment it’s quite back to front because at the moment it’s everything trauma focussed CBT it’s far more complex.” (Angie)

4.3.2.2 The timing and duration of therapeutic input

Given the complexities of the distinct nature of homicide bereavement and the therapeutic approaches implemented, consideration of the timing and duration of interventions are explored under the master theme of approaches to interventions. Intervention timings were a significant part of the descriptions relating to decisions about appropriate service provision with conflicting beliefs from therapists regarding when the best time to intervene was and was dependent on the client’s situation. These included how soon specific interventions should be provided after the event as well as how long interventions should last. This may indicate the importance of providing the opportunity for both immediate and long-term interventions.

“So I’m finding a lot that I’m helping them get out of the trauma now after so many years and it’s like ‘gosh if I’d have had that ten years ago’.” (Lynn)
“Whether it’s something that we should be going in a lot earlier, I think
certainly there’s a case for some sort of crisis intervention and immediately in
the aftermath”. (Simon)

Considering the duration of therapeutic input, a longitudinal approach to intervention
was advocated by respondents, with suggestion that the 15 sessions, allocated with in
the Homicide Bereavement Service where respondents worked, were not adequate to
focus on aspects of trauma and bereavement. The complexities (see 4.3.1.1) that unfold
should mean that interventions are extended to accommodate these life-long aspects of
bereavement by homicide, such as parole hearings and release dates, which participants
reported could initiate relapse of trauma symptoms.

“So in a way I guess that (the number of sessions) impedes her wanting to
engage and me, my feeling of hopelessness about it (The amount of time
allocated to therapeutic input) in some ways. Because I know that we’re only
going to be able to hardly scratch the surface.” (Jemma)

“And those that are sort of really traumatised that want to deal with it fairly
quickly and you know that they're likely to be sort of re-ignited (re-traumatized)
at certain points down the line when you’ve got anniversaries coming up and
you know, there's just so many other factors that you are going to be stuck points
for these people (Jemma).
Although there were beliefs from therapists that there needed to be additional sessions for those bereaved by homicide, there was no suggestion regarding the appropriate amount of sessions that should be provided. This may be due to the varying issues and complexities within each case, which may impact on the amount of session needed. This again has implications, highlighting the need for a thorough assessment of their experiences in order to establish explicitly with the client what would be an appropriate number of sessions.

In addition to the factors that may serve to perpetuate trauma symptoms and suggest longer-term service provision, it was acknowledged that service users needed to be ready to engage in the therapeutic process and trauma work.

“It maybe you know, that if we get people referred that eh that’s not quite ready with dealing with the trauma of what’s happened, but are just looking for some sort of gentle support or, or erm or don’t really feel that at this stage that they can go there.” (Robert).

This has implications for appropriate initial assessment and referral processes to address what issues the client is facing now and in future as well as whether they feel they are ready to engage in trauma therapy. If assessment measures are not robust, this may mean an individual is referred when they are not suitable based on lack of trauma symptoms or timing. It may also mean a client is not referred when they need to be.
This further indicates the importance of having an open dialogue with service users that signals the potential uptake of therapy when they feel ready. This readiness for therapy and the acknowledgement that this may impact on their level of engagement suggests that the timing of interventions is crucial in order to reduce barriers to effective engagement with the service and with therapeutic input. In order for readiness to be assessed, therapists should inform clients about the rationale and focus of trauma therapy and the choices they have in terms of when they feel ready to engage and dependant on other issues the client is managing such as criminal proceedings. Readiness ultimately should be jointly considered between the therapist and the client. The majority of therapists interviewed felt that time limited therapy was restricted and caused additional stress to both the client and the clinician as both are continually disheartened by the impact of external complications on the therapeutic process. It appeared that the complexity of the case and whether criminal proceedings were evident during therapeutic interventions played a significant role in decision making around timings and could serve to hinder and undo progress made.

“I mean I’ve got 15 sessions and how am I going to manage this, I don’t know when the trial is going to be” (Jemma)

“It’s such a huge problem if people are coming up to the trial and key witnesses also and a complaint going through or if the, the perpetrator is making an appeal and it, it can really, it really just completely put, put the work that we’d done on hold or it can make people go backwards several steps. Erm that really doesn’t help at all.” (Christine)
This adds additional pressure to the therapeutic work as service user’s experience these ongoing barriers during therapy. This may leave them feeling disheartened as their progress can be thwarted. The pressure is paralleled within the therapist as they are aware that interventions are time limited and they may not have the adequate session numbers to manage additional sources of trauma. This signals the need for an effective communication route between practitioners so that peer support can guide decision making and reduce isolation of these specific difficulties whilst working with this population. It may also suggest that therapeutic input should be placed on hold until the trial has occurred. This may have ethical implications for those cases where criminal proceedings take months and years. It may be that for these cases, therapy is at least placed on hold whilst the trial is occurring, or additional sessions should be provided in order to accommodate the prolonged duration of distress.

4.3.2.3 Communication and the development of a care plan

It was evident in all of the narratives and the preceding themes relating to interventions that effective communication between services was needed to ensure a fuller understanding of how the complexities of the case may impact on therapy.

“I think there should be a meeting perhaps initially of all the different people that are involved perhaps. Because sometimes we don’t meet up (with) various others or FLO’s (Family Liaison Officers), or anybody else involved and I think it might be good.” (Phillip).

This was also signalled by all participants who supported the need for a care plan in order to effectively manage the case over a period of time. Multidisciplinary action was
suggested as facilitating the process of a care plan that incorporated various services such as substance misuse services and GPs (see Chapter 2, section 2.6.6 for substance abuse considerations).

“I quite like care plans because people that have waited a long time for a service have usually got another coping strategy in place, whether that’s drugs or alcohol. That makes it harder and I always put a care package in place so I’ll contact the GP and I also get then involved in either a drug or alcohol worker as well” (Carol, Focus Group).

It appeared there was a confusion regarding overall service provision with service users unaware of what each service offered. It seemed necessary that service users and therapists require an understanding of those services that are available and more specifically an awareness of what each service did.

“I think people need to have an idea of what’s going to happen (general consensus indicated by the group). Of who’s coming in at what point and I always say, when they’ve not seen their caseworker, I say ‘no, your case worker steps back when we step in, and when we step out, your caseworker steps back’.” (Carol, Focus Group).

This theme also included the importance of communicating the impacts of homicide to the wider society and communities that are involved with the service user such as GPs, schools and workplaces in order to reduce societies expectation of returning to normal in an expected timeframe associated with normal grief trajectory.
“We need a package (of care), this is for your employer, this is for your school”
(Simon).

“It’s almost like care managing where you need somebody who is care-managing. Who understands the emotional and psychological impact of the failings of sending things by text or emails like do you want the bits of this body back etc.” (Simon).

4.3.2.4 The overwhelming nature of trauma and fragmentation of service provision

There was a suggestion of an initial flooding of services and an all or nothing sense of intervention that was evident in terms of service provision.

“Some people complain of flooding, they’ve got too many people going in..
(focus group general consensus). Oh I saw so and so yesterday and I’ve got so and so coming today, they’ve just got too much at once and then they have nothing.” (Carol)

“Sometimes it’s the doubling up of, sometimes I’ve found I’ve made appointments to go and see someone and they’re already seeing someone else. You get round it, you just re-arrange, maybe I don’t know, but yeah that kind of flooding, there’s so many people there at the same time.” (Jan)
This service process appears to parallel the overwhelming nature of the bereavement. It appeared that this was merged into a lack of awareness into the varying professional roles between services was felt by therapists as well as service users:

“I’m not sure I even know what, what’s supposed to be expected, who steps in and who steps back and what happens, so I’d find it difficult to kind of explain that (to the client).” (Jan)

4.3.3 The role of society and secondary victimisation

The final master theme, the role of society and secondary victimisation consisted of two subthemes which were; the lack of awareness into the impact of homicide within society; and those who have experienced HB being forgotten victims.

4.3.3.1 Lack of awareness into the impact of homicide within society

There appeared to be a frustration amongst participants with society’s apparent lack of awareness into the nature of this type of bereavement which permeates schools, workplaces and communities as a whole. A heavy emphasis was on a lack of public awareness and the need to educate society about the impact of homicide and how individuals struggle with normal life following such an event:

“Well they appear to be quite supportive on the first fortnight, the first month and expect everyone to be back to normal again because that’s when it happens and that’s when psycho-education, not just to, to the individual, the family, the support structure whether it’s the school or the work” (Susan)
A heavy emphasis on society’s unrealistic expectations regarding homicide bereavement readjustment suggest a need to communicate the impacts of homicide to the wider society and communities that are involved with the service user such as GPs, schools and workplaces in order to reduce society’s expectation of ‘returning to normal’ in an expected timeframe which are associated with normal grief trajectory.

4.3.3.2 Forgotten Victims

There was a sense that this population were forgotten victims, who experienced isolation within communities and their social world, which served to increase feelings of anxiety and social withdrawal. This may further complicate the therapeutic process as a focus towards the traumatic bereavement leans more heavily on re-engaging individuals into social activities and support systems. This means they can access support which would potentially facilitate engagement and process in trauma therapy.

There was a suggestion that those bereaved were often expected by those in the community to ‘just get on with it’, particularly after the trial had finished, with a perception that society as a whole did not understand or tolerate the impact of their experience:

“People are sort of, okay, the trial’s over, that’s the end of it so get on with it.” (Steve)

“Well it is amazing that they’re (clients employer) hassling me to go back (to work). I’ve gotta hand out medication and I’m not ready. You know some of them have got quite responsible jobs. (Carol)
4.4 Discussion

An overarching theme that is presented within the qualitative analysis was the difficulty in juggling psychological interventions and service provision for homicide bereavement, alongside a plethora of pressures that may accompany this type of bereavement. The aim of this study was to gain an understanding of staff members views of service user experience, the type of interventions used within the service and whether they felt they were effective in relieving distress for clients. Opinions into potential barriers and facilitators to service provision and use were also explored. This was achieved by examining the perspectives of staff members providing psychological therapeutic input within ASSIST Trauma Care’s Homicide Bereavement Service. An understanding of the issues in the process of delivering a therapeutic service to those bereaved by homicide with recommendations and developments to improve service delivery and interventions was explored.

4.4.1 Awareness of extensive challenges following homicide bereavement and subsequent interventions

All participants reported the extensive difficulties and challenges faced by families who have experienced bereavement by homicide, a theme that is evident in the existing literature (Rock, 1998; Quinsberry, 2009; Casey, 2011). This difficulty is mirrored in the provision of therapeutic support as professionals find difficulty with the complexities of each family history and current issues involved with the case (Aldrich & Kallivayalil, 2013). These unique dynamics related to homicide may have special circumstances that need to be identified to reduce traumatic symptoms and improve the grieving process. The loss of a loved one alongside the external complexities distinct to
this bereavement can precipitate complications if interventions are not implemented promptly and effectively. There was an acknowledgement by participants of the significance of this type of traumatic bereavement with the impact this has on individuals and family members and how this is distinct from other types of bereavement.

This awareness into the distinctiveness of this type of bereavement was based on various participants working within a variety of other settings that appeared to stand apart from interventions with other forms of bereavement such as suicide and natural death (Range & Niss, 1990; Zinzow, 2011; Sharpe, Joe & Taylor, 2012). This corroborates previous literature that suggests that the anguish of homicide bereavement is overwhelming in nature and that it infiltrates multiple aspects of individual and family lives (Amick-McMullan, Kilpatrick, Smith and Veronen, 1989; Malone, 2007; Casey, 2011). It appears that an important factor in initial service provision was to provide psycho-education to those using the service in order to normalise their initial responses to bereavement by homicide and how this may differ from other bereavements (Miller, 2009; Rynearson, 2012). It also appeared that the potential for significant complexities relating to criminal proceedings and trauma symptomology removes the natural process of traumatic grief as family members manage the practical aspects of the justice system that in itself may be re-traumatising (Theil, 2013).

This serves to distinguish this type of bereavement with others as families are forced into this unknown and bewildering experience. It appears necessary to indicate therefore, that this complexity exists not only to service users but to those working
therapeutically with those bereaved, in order for an awareness of potential barriers to the grief process and interventions to be achieved and explicitly discussed. This recommendation would enable effective formulation and case conceptualisation, with factors such as how much time has elapsed since the homicide and the results of criminal proceedings helping to determine future therapeutic work. This specific understanding would further facilitate more robust interventions due to a focus on the issues currently experienced, for example, whether it is an early referral or, whether they have been be referred years or decades after the homicide, embedded coping strategies and cognitive distortions that may develop over time. Future research in this area is required to document how these factors contribute to potential additional risks that increase vulnerability for trauma reactions and complicated grief.

This impact on relationships within families is in line with previous research with suggestions that a family’s dynamics should be a central focus of interventions (Horowitz, 1997; Schmidt Kashka, & Beard, 1999; Horne, 2003). Current service provisions within ASSIST Trauma Care, lay focus on individual family members and at times, when the therapist feels it would be beneficial, family sessions are conducted. Implications for therapeutic work are evident with those bereaved as families require not only individual input to process trauma, but additional family work to establish effective communication, grief work and potential establishment of new roles. It is particularly important to address the roles the client plays and the deceased played in the family system in order to establish new roles and identities within the family system. This is important, for example, in cases where one parent has killed another and the children are taken in by other family members where support in this form may be essential to the future well-being of those bereaved. It is suggested that homicide
impacts significantly upon relationships within families, with narratives exposing the need for systemic interventions to reduce the fractures that occur within families (Metzger, Mastrocinque, Navratil & Cerulli, 2015; Vincent, McCormack & Johnson, 2015).

In a review of 400 families bereaved by homicide, Casey (2011) reports that nearly half of those who experienced relationship problems with a spouse said it led to divorce or separation and a quarter gained sudden responsibility for children as a result of the killing. This theme corresponds with previous literature, detailed in chapter 2, which suggests an important aspect of interventions following homicide includes working with families to enable effective communication and reorganization of remaining and new family roles and relationships (Horowitz, 1997; Miller, 2009). This is distinct from other forms of interventions following bereavement as families become fractured due to the multi-faceted issues that need to be managed. Family therapy has been indicated as the treatment of choice following homicide (Hatton, 2003). Although it is suggested that family sessions may contrast with the typical CBT protocol in which trauma work requires individual therapy sessions (Little & Akin-Little, 2009), there is strong empirical support for family TF-CBT approaches being effective in improving posttraumatic stress disorder (PTSD), depressive, anxiety, behavioural, cognitive, relationship, and other problems (Cohen & Mannarino, 2015). Family sessions are also needed to address and reduce the impact of trauma within families, such as avoidance behaviours, communication and coping strategies. This would serve to increase their sense of support and decrease feelings of social isolation. Future research should consider issues of coping and communication within family dynamics to address
adaptive and maladaptive strategies and the potential implications for future mental health and well-being.

4.4.2 Delivery and development of interventions

The delivery and development of interventions were discussed at length in the accounts of participants, with a general consensus that indicated a multi-faceted parallel process of homicide bereavement and the delivery of interventions. Professionals indicated significant difficulty in delivering effective interventions against the multitude of issues that surrounded the family and individual. It has been documented in previous research that specific focus on a multi-dimensional formulation needs consideration during interventions such as the criminal justice event (Kashka & Beard, 1999), psychological effects (Connolly & Gordon, 2014), intrapsychic implications (Aldrich & Kallivayalil, 2013) and specific characteristics of the homicide (Gekoski, Gray & Adler, 2012).

These multiple factors were suggested by participants within the study to be limited with the use of purist approaches such as TF-CBT. Participants indicated that multiple interventions from multiple agencies, which integrated both aspects of trauma and bereavement, were required in order to fully and adequately support families. These interventions were suggested to be more effectively delivered over the long-term as opposed to time-limited (Aldrich & Kallivayalil, 2013). This may imply that services should focus on working together to understand the provision each offers as well as limitations of each service in order to effectively refer if necessary. This may be problematic in the current climate of restricted resources and funding, however, the potential resolve may be to integrate trauma and bereavement services, which would
facilitate longer term provision of care as opposed to the fractured service provision which is currently operating.

4.4.3. Individual case conceptualisation involving flexibility and creativity

It was found by participants that interventions were believed to be effective in reducing psychological distress, however, there was strong evidence for a flexible, creative and integrative approach that is based on idiosyncratic case conceptualisation of the client’s circumstances. One interpretation of the descriptions of participants was that a flexible approach to interventions appeared hidden within the service, as therapists upheld the expectations of delivering time-limited, evidence-based practice (NICE, 2009). Although it was not possible to flesh out the theoretical underpinnings and operational implementation of specific interventions and associated mechanisms of change, it is recommended that future research is required to address the identification of therapeutic models that are effective with this population. It should also be considered that one size does not fit all for example a mother who is bereaved may need a different intervention to a more distant relative (Weiss, 1983).

The concept of flexibility was inherent in the accounts about effective timing of interventions, it was evident that a significant barrier to effective interventions was the criminal justice process (Norris, Ruback & Thompson, 1996). This may have implications into how assessments are conducted, so that effective decisions are made regarding when therapy is assigned, due to criminal proceedings that serve to hinder effective therapy. The apparent dichotomy and complication of the criminal and
therapeutic process may indicate that any therapy should be placed on hold until the trial has occurred.

This may not always be possible as some justice proceedings can occur over months and even years, particularly when the homicide occurs abroad. This again has significant implications for service provision and the need for clinicians and professionals to have a full understanding of the impact and the potential barriers to effective interventions such as criminal proceedings. There was a distinct theme around the need for longitudinal interventions with this population that are appropriate to the case. This parallels the life-span impact of homicide as significant anniversaries, parole hearings, updated information on criminal proceedings and perpetrator release dates continually remind those bereaved of the trauma they have experienced.

Communication between justice systems, Victim Support and therapeutic services would facilitate updated knowledge of a case in order to assess the needs of the service user more thoroughly. The development of policies indicating the need and requirement of information sharing between agencies and subsequently systems to formalise and operationalize this communication would facilitate the development of a robust care plan and hopefully improve therapeutic outcome. A care plan would further provide service users with an understanding of what services may be available to them in the short- and long-term. This care plan would facilitate not only the service users’ understanding of choices regarding interventions but also an understanding by the therapists of what was on offer. Training packages for staff members should be
developed which incorporate aspects of assessment that may not be necessary in other forms of bereavement such as following suicide or a terminal illness.

The nature of bereavement by homicide appeared to be accompanied by a flooding of services in the initial stages of bereavement, which often felt overwhelming for service users and therapists alike. This was followed by a distinct lack of intervention once the prescribed number of sessions was finished. The initial phase of shock and disbelief experienced by service users may parallel the experiences of professionals who feel overwhelming difficulties inherent with this work such as the timing and duration of therapy and multiple contextual factors that serve to complicate the therapeutic process. This is soon followed by available services replicating society’s expectations of when typical grief reactions should be managed, with a withdrawal of support over the long-term. This continued to be experienced by the therapists as they felt a lack of awareness about what types of services were available externally to service users. Additionally, an internal sense of fragmentation was felt as therapists reflected how they felt connecting and communicating with other therapists would be beneficial not only to their professional practice but to the clients they work with. The impact of homicide on clinicians was examined by Aldrich and Kallivayalil (2013) who indicate the differential impact of working with those bereaved by homicide who may themselves be unable to imagine that they would cope with such a traumatic loss. This raises the agenda to connect those working within the field, which may help to reduce the impact of isolation and vicarious trauma on therapists (Iqbal, 2015).
Staff members were agreed that the impact appeared hidden and unknown within communities, schools and workplace settings and the criminal justice setting. Neimeyer (2006) suggests that the experience of homicide of a loved one is significantly affected by the larger environment. Community judgements and reactions to family members can serve to stigmatise and differentiate from those affected, causing experiences of secondary victimisation. Social isolation prevails as those bereaved are expected to follow what may be considered a normal grief trajectory, returning to work commitments or education soon after the trial. This may perpetuate victimisation and increase feelings of isolation and social exclusion as those bereaved feel their experience is minimized and misunderstood. Interventions should provide psycho-education and strategies for this social element of adjustment. This also implies that care management of those bereaved should include information sharing and education across multiple agencies and care provision in order to reduce the potential for secondary victimisation. The findings from participants accounts provide evidence that indicates correlations with other studies on violent deaths, during which those bereaved felt victimized multiple times, first by the perpetrator and then by the criminal justice system and society as a whole (Sprang & McNeil, 1995). This suggests further information into the forgotten victims of homicide should be disseminated across professionals working within this field in order for their voices to be heard.

4.5 Limitations

This study was designed to be an exploratory examination of a population that had largely been ignored in the literature, that of staff members working within a homicide bereavement therapeutic service. Limitations are inherent within all research methodology and the current research is no exception. Firstly, the notion of family is limited to the traditional definition and does not extend to non-traditional family
members such as neighbours and close family friends. The participant narratives presented include secondary accounts of those bereaved, heard through the voices of therapists, which were subjective accounts and interpretations of service user experience. The rationale for choosing staff members was born out of a review of the literature that found literature into service users’ experiences. However, no study elicited the opinions of staff members which was felt to be important to better understand the process of service provision. It was noted during the recruitment stage that participants were very willing and eager to engage to ensure positive changes were made for service users and staff alike. This included reducing the isolation that was felt whilst working with this population. In depth consideration was given to whether recruitment of staff members would be able to sufficiently highlight issues relating to service provision and interventions as opposed to service users themselves. Although the descriptive element of qualitative research provides an in-depth exploration into specific phenomenon, it can be limited by the generalisations of the findings. It was considered that although saturation of the data was reached based on similar accounts presented by the participants, these were representative of a sample within one service operating within the UK and so may not be representative and transferable to the population outside of the UK.

In addition, the ethnicity of participants was White British and so was potentially limited in terms of culturally derived accounts. Future studies however, may include additional sources of data collection including voluntary agencies, Victim Support staff and potentially primary care settings in order to fully explore a robust spread of experiences and individuals.
4.6 **Recommendations**

4.6.1 **Recommendations for policy**

Based on the current research, the development of a number of policies would enhance service provision with this population. Due to the shocking and sudden nature of homicide, it appears that timely information should be provided to those bereaved which details the support that is available to them. This should be presented in written form so families can refer back to the information when needed during this often confusing and chaotic time, as they may find retaining information from varying services challenging. It should also inform them about the potential complexities of homicide that are distinct to other types of bereavement. It appears that an important part of service provision and support for those bereaved is to enhance societies understanding of the impacts of homicide on family members. Policies and training packages should be implemented within schools, victims’ services, GPs and employers to provide information regarding the potential impact of homicide as well as how to sensitively respond and support those bereaved. Information provided should consider the ethical implications of sensitive data and informed consent of the service user. Policies should also be developed to define effective and necessary routes of communication between services such as victims’ services, in order to increase the care and support provided. This would ensure due care and attention is taken in communicating delicate information regarding criminal matters and additional complexities of the case.

4.6.2 **Recommendations for service provision and interventions**
Due to the range of difficulties associated with this type of bereavement, interventions should focus on multiple models of intervention that are flexible, creative and client-led. This may include increasing the amount of sessions available to those bereaved which should include family sessions as well as an integration of trauma and bereavement interventions. It has been indicated in the current and previous literature that family therapy is an important aspect of service provision. Future recommendations include the availability and choice of family and group sessions in addition to the individual sessions currently provided. This would be facilitated by a care plan which is available at various points across the life-span, in order to reduce relapse of trauma symptoms. It is further recommended that specific training packages are developed for staff members working therapeutically with those bereaved to inform them of the potential issues that may arise for service users and therapists alike. Policies should also be implemented within schools and workplaces to provide educators and employers with guidance on supporting individuals and families.

4.6.3 Recommendations for future research

There is a significant requirement that more structured and thorough research be conducted in the future to address apparent gaps in the provision of support for families following homicide. Research should explore issues derived from the current research such as effective timing of interventions, the comparison of individual therapy versus family therapy and the long term effects of homicide. Information on culture, religion, socio-economic status and country of origin would enable potential differentiation of responses, coping strategies and thus inform intervention protocol. Research informing these factors should be addressed in order to enhance understanding of assessment and treatment interventions for those bereaved with the hope of improving service provision.
as well as policies and guidance for professionals working with those bereaved by homicide.

4.7 Conclusion

It is surprising that the level of distress and the devastating nature of murder is not matched with literature on service provision and interventions evaluating best practice when supporting those bereaved. The current research is the first in the UK that has explored what the current issues in process in delivering therapy to those bereaved by homicide, providing recommendations and developments to improve therapy and service provision. Factors have been indicated from the perspective of staff members that serve as barriers and facilitators to service provision with those bereaved by homicide. The research provides much needed evidence for the development of sound policies and effective treatment recommendations, as well as future research endeavours that will progress this area of traumatic loss that will inform policy and practice within the counselling psychology domain.
Chapter 5

The impact of a therapeutic service supporting those bereaved by homicide: An outcome evaluation study

5.1 Introduction

As noted in chapter 2, responses and experiences reported following homicide transcend the literature on theoretical underpinnings of typical grief reactions. Family members describe significant distress and mental health difficulties that can persist for many years with a significant increased risk of post-traumatic stress disorder (PTSD) (Laurie & Neimeyer, 2008; Spungen, 1998; Zinzow et al., 2011; Baliko & Tuck, 2008), major depressive disorder (Zinzow et al., 2009), generalised anxiety disorders (Parkes, 1993) and complicated grief (Doka, 2002). What constitutes a traumatic event, according to the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, is "experiencing or witnessing a traumatic event, such as sexual assault or the repeated indirect exposure to adverse events, such as in the case for professionals (e.g., first responders), and requires being explicit about how the event was experienced (i.e., directly or indirectly)" (DSM 5, n.p.). Its impact pervades functioning in many areas of life including family roles, relationships occupation, social networks and community support.
5.1.1 Homicide Related Grief

Previous empirical research indicates that the totality of the experience of bereavement to homicide supersedes normal loss paradigms that are applicable to many other populations (Amick-McMullan, Kilpatrick, Veronen, & Smith, 1989). The trauma imposed on family members frequently results in the development of PTSD symptoms over and above normal grief responses and thus, may contribute to a more severe grief response (Kaltman & Bonnano, 2003). Previous comparative studies have indicated that a higher frequency of trauma related intrusion and avoidance behaviours were found in family members bereaved by homicide than other trauma related incidents including the death of a parent (Zilberg, Weiss & Horowitz, 1982), death through suicide (Wilson, Smith & Johnson, 1985) and rape (Kilpatrick & Veronen, 1984). Immediate grief related responses can be stifled by criminal proceedings and the incumbent intrusive media attention can serve to exacerbate and prolong symptoms whilst simultaneously maintaining a sense of ‘connectedness’ to the deceased. Amick-McMullan, Kilpatrick, Veronen & Smith present findings that suggest that a lack of criminal justice satisfaction resulted in high levels of anxiety, depression and general symptom severity (Amick-McMullan, Kilpatrick, Veronen & Smith, 1989). This indicates it is not just the loss that influences psychological wellbeing but also potentially some of the complications, or secondary factors, that surround homicide bereavement.

The term “secondary victimisation” is frequently used in the literature pertaining to the effects of the criminal justice system which can leave families disempowered, distressed and dictated to (Asaro, 2001; Burgess, 1975; Casey, 2011). Secondary victimization is the perceived socially hostile response after a homicide, regardless of intention, that violates the survivor’s assumptive world, and in doing so, re-victimizes them (Asaro,
Homicide has been distinguished from other forms of death due to the violence (Spungen, 1998), intent and socially deviant nature of the act (Michalowski, 1976) as it originates in the malevolent desire of another person (in the case of murder). This challenges an individual’s belief in the justice and benevolence of the world and the people in it (Magwaza, 1999).

Compared to natural death, violent death is more likely to leave surviving parents, who may carry an additional burden of rage, stigma, and self-blame in contending with the loss (Murphy, 2008). The significance of factors that contribute to mental health difficulties requires further exploration in order to provide suggestions and guidance for clinical implications whilst working with those bereaved by homicide. Whilst there is growing evidence into its impact, which has been described as ‘the blackest hell accompanied by a pain so intense that even breathing becomes an unendurable labour’ (Spungeon, 1998, pg. 9), it is surprising that there is a paucity of research examining specific factors relating to the development and efficacy of specialist interventions with those bereaved. Routine intervention for bereavement has not received support from quantitative evaluations of its effectiveness and is therefore not empirically based (Schut & Stroebe, 2005). As noted in the previous chapter, section 4.1, however, Hatton (2003) in a survey of homicide bereavement counselling providers, suggests high levels of ratings for interventions such as psycho-education and expressing intense emotions, however, each failed to indicate an integrative model of intervention that fits with the specific issues unique to each case. A review of the existing literature revealed no empirical evidence on the effectiveness of interventions following homicide and hence this study is the first of its kind in the UK. For this reason, comparable studies are limited to this chapter. It was therefore deemed important that the secondary data
gathered was utilised in an exploratory way to address the potential impact on efficacy of service provision and interventions. Service evaluations examining outcome measures with those bereaved by homicide are not available in the literature, therefore bereavement service evaluations associated with other forms of death have been sourced for the purpose of comparison literature. Evaluating the effectiveness of remedial interventions for homicidal bereavement presents notoriously difficult methodological challenges as bereavement is not an homogeneous phenomenon (Curtis & Newman, 2001). In a review of evidence evaluating the efficacy of bereavement services with children, Curtis and Newman who found that although all nine studies sought to measure impact on children’s behaviour and emotions quantitatively, there was only moderate empirical evidence of positive effects (Opie et al., 1992; Quarmby 1993; Sandler et al., 1992; Schilling, Abramovitz & Gilbert 1992; Tonkins & Lambert, 1996). The reliability of these findings was undermined by methodological weaknesses of the studies including small sample sizes; lack of a control group; high levels of attrition; short time scale between pre-intervention and post-tests; no measure of outside stressors occurring at the same time as the intervention (Curtis & Newman, 2001). Positive treatment effects were identified however it is suggested the evidence is too weak to speculate about the effectiveness of such interventions.

Secondary factors that may serve to complicate grief reactions have been investigated previously including a lack of social support (Burke, Neimeyer, & McDevitt-Murphy, 2010), which was correlated with negative bereavement outcomes, the relationship to the deceased (Farrugia, 1996; Horowitz et al., 1981; Sprang & McNeil, 1995), in which it is suggested that the closer the relationship, the higher the levels of psychological distress and the elapsed time between the homicide and therapeutic interventions
(Murphy et al., 1999). All studies reported that these secondary factors had a significant
effect on psychological distress relating to this type of bereavement. The length of time
since the death has been assessed as a factor for predicting longevity of grief and
appropriate timings of interventions. Findings suggest symptoms of post-traumatic
stress are uncorrelated with length of time since the death (Amick-McMullan, 1991).

The literature on the relationship to the deceased is contradictory with suggestions that
conjugal or spousal grief results in more significant grief reactions (Sprang & McNeil,
who found that children who experienced the death of a parent experienced more
pronounced grief reactions. An increased relational process suggests the relationship
between the mourner and the deceased before the death is key to understanding the
reorganisation of social roles and representations (see Rubin et al., 2003; Stroebe &
Schut, 2001), with Ogata et al. (2011) suggesting the more intimate the relationship
with the deceased, the more serious the posttraumatic mental distress is. In addition, the
extent of social support has been indicated as a significant factor that predicts
complicated grief, PTSD and depression (Burke et al., 2010; Hibberd, Elwood, &
Galovski, 2010). This psychosocial emphasis overshadows previous traditional models
of bereavement (Kubler-Ross, 1973), which have tended to focus almost exclusively on
sequential processes occurring within the individual mourner. This assumes an
individual progresses through a sequence of distinct psychological phases. Each stage
is described as a discrete phase of grief that is separate from, if not conditioned on the
resolution of, prior grief stages (Kubler-Ross, 1969). It is argued that the progression
through grief is dependent on the responses of communities, social networks and
criminal justice systems, which are often inadequate in circumstances of homicide bereavement and serves to facilitate secondary victimisation (Rando, 1993).

Differences in grief reactions across gender have been proposed due to societal expectations and gender roles with women expressing their grief responses more explicitly than men (Martin & Doka, 2000). Kenney (2003) suggests that men who adhere to traditional masculine gender roles experience more difficulty coping with their grief. This is due to their guilt over perceived failed-protector status which is further complicated by highly avoidant suppression of emotions in order to remain emotionally stable for other family members. Notably, although potentially important, these secondary factors namely: the relationship to the deceased, witnessing the homicide, the complexity of the service user, the type of murder, the time that has elapsed between homicide and referral, and gender and have not been empirically verified as influential in the reduction of psychological distress following bereavement by homicide. No previous studies have evidenced secondary factors that impact on processing traumatic grief responses such as the type of homicide or whether the bereaved was a witness to the homicide. These secondary factors were included as an exploratory aspect of this investigation. The objective of this study is to determine the efficacy of current interventions within a Homicide Bereavement Service in the UK. Efficacy is measured in terms of the reduction of trauma symptomology, depression, anxiety and complicated grief scores following therapeutic interventions.
5.1.2 Research Aims

The aim of this quantitative part of the evaluation was to explore the efficacy of interventions, in other words, the ability to produce a desired or intended result. In this case by assisting in the reduction of traumatic grief related issues. These findings will provide evidence to support policy makers, commissioners and practitioners in the future development and delivery of specialist therapeutic care and interventions. The analysis will take place in two parts with part 1 of analysis exploring whether therapeutic interventions reduce psychological distress over time leading to the first research question and subsequent sub-questions:

1. Does the Homicide Bereavement Service work in reducing the levels of mental health issues relating to homicide bereavement following therapy including trauma symptoms, anxiety, depression and complicated grief?
   i. Does therapeutic intervention reduce levels of trauma symptoms?
   ii. Does therapeutic intervention reduce levels of depression?
   iii. Does therapeutic intervention reduce levels of anxiety?
   iv. Does therapeutic intervention reduce symptoms of complicated grief?

The second part of the quantitative study explored secondary variables and their role on therapeutic outcomes. Secondary variables include age, gender, ethnicity, complexity, relationship to the deceased, the time between the homicide and therapeutic intervention and whether the participant was a witness to the homicide. This leads to the second research question and associated sub-questions:

i. Do secondary variables following bereavement by homicide impact on levels of associated therapeutic outcomes?
ii. Does the relationship to the deceased play a role in the level of mental health issues?

iii. Does witnessing the homicide play a role in the level of mental health issues?

iv. Does the complexity of the service user play a role in the level of mental health issues?

v. Does the type of murder play a role in the level of mental health issues?

vi. Does the time that has elapsed between homicide and referral play a role in the level of mental health issues?

vii. Does gender play a role in the level of mental health issues?

viii. Does age play a role in the level of mental health issues?

An additional aim was to address the clinical significance of score reduction which does not always reflect the statistical significance of score reduction. This is described in section 5.3.2.

5.2 Method

5.2.1 Design

In order to provide a robust and holistic evaluation of this service, a mixed methods approach was adopted using a range of quantitative and qualitative research methods. The current chapter details the quantitative elements of the study, with qualitative findings primarily being reported in the preceding chapter.

Part 1 of the analysis was performed using a repeated Multivariate Analysis of Variance (MANOVA) to measure before and after trauma and psychological
wellbeing/pathology scores to see whether there is a significant multivariate finding on the efficacy of interventions. Pre-experimental pre-post design with one independent variable (IV) representing treatment with measurement on four dependent variables (DVs) taken at two time points (pre/post), which represent the two levels of the IV. The four DVs are the psychology adjustment variables for trauma (IES), anxiety (GAD-7), depression (PHQ-9) and complicated grief (ICG). Clinical relevance of measures was also considered based on standardised clinical significance and is discussed further in section 5.3.2.

Part 2 includes a series of MANOVAs to assess the role of secondary variables on psychological distress such as trauma symptoms, anxiety, depression and complicated grief. MANOVA was deemed the most appropriate inferential statistical procedure on several counts. First, efficacy is typically assessed by considering several scores on several psychological measures, all of which share a common conceptual meaning in that they contribute individually, and in combination to understanding the utility of interventions. Second, the interventions that are the topic of this research are likely to affect the outcome in more than one way and hence need several criterion measures. As such, measures have been considered in combination in the first instance and then further explored by considering the univariate results to determine the role of the secondary independent variables described in 5.1.2, on psychological outcome. The levels for these additional IVs can be seen in Table 5.1.

A control group was not used for this research due to ethical constraints and the use of retrospective data. In order to access a control group those who were bereaved and had
chosen not to engage in therapy would need to be contacted which was perceived as unethical particularly due to the nature of their bereavement and various professional involvement (see Chapter 4 for qualitative theme of service flooding) and to uphold the respect for autonomy and dignity (Code of Ethics and Conduct, 2009, p.10).

5.2.2 Participants

Participants comprised 455 individuals who had been referred to ASSIST’s Homicide Bereavement Service. Participants who were referred to the service were located across the UK and had chosen to engage in therapy following the death of a loved one. Not every individual who was referred to the service chose to engage or dropped out partway through therapy. Additionally, various data were missing from either pre-or post-psychometric scores which were excluded from the analyses. There were various reasons for this, such as refusal to complete pre-or post-scores, drop out before post psychometric data were collected and therapist collecting only some of the data. As part of service initiation and development, data collection methods were introduced during the early phases of the service that included demographics, detailed in table 5.1., including age, gender, ethnicity as well as secondary data (detailed in the introduction, see 5.1) such as whether the participant was deemed complex. Complex participants were deemed so based on issues such as previous mental health difficulties, multiple traumas and maintaining behaviours such as drug and alcohol addiction. It was not possible to distinguish the different aspects of complexity as this information was not collected as part of the service (see Appendix 12). In addition, participants completed various psychometric scales pertinent to homicide bereavement adjustment and service
delivery prior to and following therapeutic intervention, which are detailed later in the Materials, see section (5.2.4).

Table 5.1: Participant demographic and background information

<table>
<thead>
<tr>
<th>Variable</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td>377 (82.9%)</td>
</tr>
<tr>
<td>Child</td>
<td>78 (17.1%)</td>
</tr>
<tr>
<td>Identified gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>145 (31.9)</td>
</tr>
<tr>
<td>Female</td>
<td>310 (68.1)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>White British</td>
<td>380 (83.5)</td>
</tr>
<tr>
<td>Other†</td>
<td>75 (16.5)</td>
</tr>
<tr>
<td>Complex</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>95 (20.9%)</td>
</tr>
<tr>
<td>No</td>
<td>360 (79.1%)</td>
</tr>
<tr>
<td>Relationship to deceased*</td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>153 (33.6%)</td>
</tr>
<tr>
<td>Child</td>
<td>121 (26.6%)</td>
</tr>
<tr>
<td>Sibling</td>
<td>91 (20%)</td>
</tr>
<tr>
<td>Spouse</td>
<td>43 (9.5%)</td>
</tr>
<tr>
<td>Other†</td>
<td>52 (10.3%)</td>
</tr>
<tr>
<td>Time since homicide</td>
<td></td>
</tr>
<tr>
<td>&lt;6 months</td>
<td>212 (46.6%)</td>
</tr>
<tr>
<td>&lt;2 years</td>
<td>171 (37.6%)</td>
</tr>
<tr>
<td>&gt;2 years</td>
<td>72 (15.8%)</td>
</tr>
<tr>
<td>Witness</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>95 (20.9%)</td>
</tr>
<tr>
<td>No</td>
<td>360 (79.1%)</td>
</tr>
</tbody>
</table>

† Other ethnicity include White Irish (n = 3), Other White (n = 16), White and Black Caribbean (n = 6), White and Black African (n = 1), White and Black Asian (n = 2), Other mixed (n = 4), Indian (n = 6), Pakistani (n = 12), Black Caribbean (n = 14), Black African (n = 7), Other Black (n = 2), Other (n = 2).

† Other relationships include grandparents (n = 6), grandchildren (n = 8), stepchild (n = 5), ex-partners (n = 6), cousins (n = 3), niece/nephew (n = 5), aunt (n = 2), uncle (n = 1) close friends (n = 5) and other (n = 11).

* Relationship categories were changed to ‘parent’, ‘child’, ‘sibling’, ‘spouse’, ‘other’ due to low sample sizes.
Participants were family members of the deceased, comprising 310 females and 145 males, 377 adults and 78 children. The relationship to the deceased included parents of deceased child \((n = 148)\), children of deceased parents \((n = 121)\), spouse \((n = 43)\), sibling \((n = 91)\) and others \((n = 52)\), as detailed in Table 5.2. The time between the homicide and therapy was categorised into less than 6 months, between 6 months and 2 years and more than 2 years. This categorisation was established as part of service data collection to address whether the effectiveness of interventions was related to the time lapse between the homicide and when they were referred to the service. Participants were identified as either a witness to the homicide \((n = 95)\) or not a witness \((n = 360)\) and considered clinically complex \((n = 188)\) or non-complex \((n = 267)\).

5.2.3 Inclusion Criterion

Participants were family members of homicide victims referred to Victim Support who were assessed to be experiencing trauma related symptoms based on the assessment of (Victim Support) caseworkers who utilised the Impact of Event Scale to make such a decision. Data collected as part of a service provision was analysed. Those data results that provided a sample size below 5 were not included as part of analysis due to limitations of the sample size and potential risk of type II error (see discussion, section 5.3).

5.2.4 Materials

As part of service provision psychometric instruments relevant to homicide bereavement impact were utilised to assess varying mental health difficulties, specifically, trauma symptoms, anxiety, depression and complicated grief, which were
measured at baseline and post therapy (a description of the duration of therapy is detailed in Chapter 2, section 2.7.1). As detailed above, four dependent variables were investigated in the study: (1) Trauma measurements consist of three psychometrics depending on the age group of the client. The Impact of Event Scale for adults (IES) (section 5.4.3.1); The Children’s Revised Impact of Event Scale (CRIES) for children up to 13 years of age (CRIES 13) (section 5.4.3.2) and the Children’s Revised Impact of Event Scale for children up to 8 years of age (CRIES 8) (section 5.4.3.3). (2) Depression measures consist the BECK Inventory and the Patient Health Questionnaire (PHQ-9). The BECK Depression Inventory was used initially within the service and as new measures were introduced, the decision was made to change the BECK to the PHQ as it was a more time effective way of measuring depression due to fewer questions. (3) Anxiety was measured using the Generalised Anxiety Disorder Scale (GAD-7) and (4), the Inventory of Complicated Grief (ICG) was used to measure grief symptoms in those cases which were 6 months after the death. These are detailed below with copies of each (see Appendix 10).

5.2.4.1 The Impact of Event Scale (IES)

This scale consists of 15 items designed to measure the stress involved in a specific life event (Horowitz, Wilner & Alvarez, 1979) - in this case bereavement by homicide. Participants rate items describing their reactions to the death, such as, “I thought about it when I didn’t mean to” on a Likert scale (0 = not at all, 1 = rarely, 2 = sometimes, 3 = often). Items are totalled to yield complete score with higher scores indicating higher impact and subjective distress. Two subscales are avoidance (8 items) and intrusion (7 items). These subscales which are pertinent to trauma symptoms are taken together to indicate the overall likelihood of trauma related distress. Evidence of reliability is
found in moderate internal consistency (alphas: intrusion: .78; avoidance: .82), and strong test-retest reliability over 1 week \( (r = .87; \text{Horowitz et al.}, 1979) \). The items are scored unevenly with scores of 0, 1, 3 and 5 for “not at all”, “rarely”, “sometimes” and “often” respectively. Items 1, 4, 5, 6, 10, 11 and 14 assess the intrusion subscale and items 2, 3, 7, 8, 9, 12, 13 and 15 assess the avoidance subscale. Cut-off scores are not widely agreed in the literature, however Horowitz (1982) identified thresholds for low, medium, and high symptom levels corresponding to levels of clinical concern using the IES total score: low, \(<8.5\); medium, 8.6 to 19.0; and high, \(>19\)). Some research suggests overall scores between 30 and 60 are typical for PTSD sufferers (Joseph, 2000), with a putative cut off of 35 for PTSD (Neal et al., 1994).

5.2.4.2 The CRIES 8

Reliability and validity of the 8-item version were presented in Yule (1997). There, it was reported that the total score on the 8-item IES correlated highly with the total score on the 15-item version of which it was part \((r = 0.95, \ p < .001)\). In an analysis of the scores of 87 survivors of the sinking of the Jupiter, a Greek-registered cruise ship that sank on 21 October 1988, it was found that the 62 children who received a DSM diagnosis of PTSD scored 26.0 on the 8-item version while the 25 who did not reach DSM criteria for a diagnosis of PTSD scored 7.8 \((p < 0.001)\). Using these data, it was found that a combined score (Intrusion + Avoidance) of 17 or more misclassified fewer than 10% of the children. It consists of 4 items measuring Intrusion and 4 items measuring Avoidance - hence it is called the CRIES-8. If the sum of the scores on these two scales is 17 or more, then the probability is high that that child will obtain a diagnosis of PTSD (Perrin, 2005).
5.2.4.3 The CRIES-13

This version was used in a survey of 2,976 children aged 9-14 years who had experienced the war in Mostar, Bosnia (Smith, Perrin, Dyregrov & Yule, 2002). The scale was translated into Bosnian and back-translated by a separate Bosnian speaker to establish its accuracy. No major differences were found between boys and girls in respect of the factors identified and so only the total results are presented here. The Scales had satisfactory internal consistency. Cronbach alphas were as follows: Intrusion = 0.70; Avoidance = 0.73; Arousal = 0.60; Total = 0.80. If the sum of the scores on these two scales is 17 or more, then the probability is high that that child will obtain a diagnosis of PTSD (Perrin, 2005).

5.2.4.4 The BECK Depression Inventory (BDI)

This measure includes a 21 item self-report measure using a four-point scale ranging which ranges from 0 (symptom not present) to 3 (symptom very intense) and was utilised initially to assess quantifying levels of depression. The BDI-II positively correlated with the Hamilton Depression Rating Scale, \( r = 0.71 \), had a one-week test–retest reliability of \( r = 0.93 \) and an internal consistency \( \alpha = .91 \). The total score ranges from 0-63. A total score of 0-7 is considered within the ‘normal’ range, 8-13 is within ‘minimal’ range, 14-19 as ‘mild’, 20-28 as ‘moderate’, and 29-63 as ‘severe’ (Beck & Steer, 1987).
5.2.4.5 The Patient Health Questionnaire (PHQ-9)

The diagnostic validity of the 9-item PHQ-9 (Kroenke, Spitzer & Williams, 2001) was established in studies involving eight primary care and seven obstetric clinics. PHQ-9 scores greater than 10 had a sensitivity of 88% and a specificity of 88% for Major Depressive Disorder. Reliability and validity of the tool have indicated it has sound psychometric properties. Internal consistency of the PHQ-9 has been shown to be high. A study involving two different patient populations produced Cronbach alphas of .86 and .89. Criteria validity was established by conducting 580 structured interviews by a mental health professional. Results from these interviews showed that individuals who scored high (≥ 10) on the PHQ-9 were between 7 to 13.6 times more likely to be diagnosed with depression by the mental health professional. On the other hand, individuals scoring low (≤ 4) on the PHQ-9 had a less than a 1 in 25 chance of having depression (Kroenke et al., 2001). The total score of first 9 items ranges from 0 to 27. Scores of 5, 10, 15, and 20 represent cut-off points for mild, moderate, moderately severe and severe depression, respectively (Spitzer et al., 1999).

5.2.4.6 The Generalised Anxiety Disorder Scale (GAD-7)

The 7-item Generalized Anxiety Disorder Scale (GAD-7) (Spitzer, Kroenke, Williams & Lowe, 2006) is a practical self-report anxiety questionnaire that proved valid in primary care (Spitzer et al., 2006). A 7-item anxiety scale (GAD-7) had good reliability, as well as criterion, construct, factorial, and procedural validity. A cut-off point was identified that optimized sensitivity (89%) and specificity (82%). Increasing scores on the scale were strongly associated with multiple domains of functional impairment (all six Medical Outcomes Study Short-Form General Health Survey scales and disability
days). Moreover, GAD and depression symptoms had differing but independent effects on functional impairment and disability. There was good agreement between self-report and interviewer administered versions of the scale. GAD-7 ranges from 0 to 21. Scores of 5, 10, and 15 represent cut-off points for mild, moderate, and severe anxiety, respectively. When screening for individual of any anxiety disorder, a recommended cut-point for further evaluation is a score of 10 or greater (Spitzer, Kroenke, Williams & Lowe, 2006).

5.2.4.7 The Inventory of Complicated Grief (ICG).

This measurement indicated reliability and validity of the measure with internal consistency of the 19 item ICG being high (Cronbach’s \( \alpha = 0.94 \)). Test-retest reliabilities were computed for the 28 subjects who had repeated 6-month ICG assessments and were in a steady state of depressive symptomatology. The ICG’s test-retest reliability was 0.80. The concurrent validity of the ICG was assessed in relation to other scales. The ICG total score showed a fairly high association with the BDI total score \( (r = 0.67, P < 0.001) \), the TRIG score \( (r = 0.87, P < 0.001) \), and the GMS score \( (r = 0.70, P < 0.001) \). It is advised that the complicated grief scale is relevant to those scoring high on the measure 6 months post bereavement. A cut off score of 24 or more indicates clinical relevance (Prigerson et al., 1995).

5.2.5 Procedure

All participants were referred to the homicide bereavement service by Victim Support’s Homicide Service after being assessed for signs of psychological trauma using the IES. Psychometric data was gathered at baseline from service users as well as demographic
and secondary data which were decided on during the early stages of service development (see section 5.1). This development of data collection was formed through learning by admin staff as the service grew and developed. Secondary data consisted of the type of homicide (family friend, drug related, club/pub etc.), whether they were a witness to the homicide, the time elapsed since the homicide and referral for therapy, relationship of participant to the deceased, whether the participant was deemed complex, age and gender (see Appendix 12 for secondary factor full description). Not all participants completed each psychometric measure for various reasons such as drop out of therapy prior to ending or refusal to fill out the psychometric measure.

All data sets were anonymised, stored in a database at ASSIST’s head office and extracted onto a Microsoft® Excel spread sheet for data cleaning and coding. Demographic information was entered into SPSS and psychometric pre-and post-measures were taken from individual client records and entered into SPSS. Initial screening of the data to check for missing data, inaccurate data entry and to evaluate the normality of the data, including analysis of skewness and kurtosis were conducted, the latter revealed that data were normally distributed. The decision to use the MANOVA approach rather than the traditional ANOVA was based on the recommendations of Tabachnich and Fidell (1989). Specifically, the MANOVA approach was used due to its robustness with regards to statistical violations in complex research designs. Standardized measures of trauma (Impact of Event Scale; CRIES8; CRIES13); depression (BDI; PHQ-9) anxiety (GAD-7); and complicated grief (IGC); were included in the evaluation protocol. These measures were used due to service decisions based on their demonstration of sensitivity and reliability in measuring dysfunctional responses in relation to bereavement by homicide (see materials section 5.2.4).
5.2.6 Ethical Issues

The respect, the rights and dignity of participants in this research and the legitimate interests of stakeholders such as funders, institutions, sponsors and society at large were kept in mind at all times. Permission to undertake the research and use the data was gathered from the Clinical Director at ASSIST Trauma Care (see Appendix 7). All data were collected as part of service provision and subsequently anonymised at source so that no identifiable information was available and was therefore confidential. All data was stored within the head office computer systems which are secured using a stringent information security management system.

5.2.7 Data analysis

The purpose of this study was to explore the efficacy of therapeutic interventions with those bereaved by homicide. Research questions and subsequent analysis were divided into two parts (see section 5.1.2) to address key questions pertinent to the research namely, the overall effectiveness of service interventions and the role that secondary variables have on the effectiveness of service interventions. Repeated measures MANOVAs were conducted separately to explore these questions.

5.3 Results

5.3.1 Part 1 – The Effectiveness of Therapeutic Interventions on Homicide Bereavement
It was hypothesised that measures of trauma, depression, anxiety and complicated grief following bereavement by homicide would be reduced following therapeutic intervention. In order to assess the difference between intervention, (pre/post) a 2 x 4 within-subjects multivariate analysis of variance was performed on 4 dependent variables (see Table 5.2). Independent Variables were baseline scores (pre therapy) and post therapy scores on the four variables.

SPSS MANOVA was used for the analysis and order of entry of IVs was baseline scores and post scores. Total N was reduced from Trauma IES, 323 to 137; Depression PHQ-9, 204 to 137; Anxiety GAD-7, 205 to 137 and Complicated Grief ICG, 147 to 137, with the deletion of a case missing a score at baseline or post therapy. There were no univariate or multivariate within-cell outliers at p< .001. Results of evaluation of assumptions or normality, homogeneity or variance-covariance matrices, linearity, and multicollinearity were satisfactory. Employing Wilks’s Lambda, a significant, strong multivariate effect emerged on the combination scores variable (comprising a combination of scores on the IES; PHQ-9; GAD-7; ICG), pre and post intervention (4, 133) = 112.36, p< .001). The results reflected a strong association between baseline and post scores and the combined DVs, partial $\eta^2 = .77$.

To investigate where the multivariate effect has emanated from, univariate analysis of participants pre and post scores were considered individually. Significant univariate results emerged for all four measures, Trauma IES scores: $F (1, 136) = 345.91, p< .001$; Depression PHQ-9 score: $F (1, 136) = 309.68, p < .001$; Anxiety GAD-7 score: $F (1, 136) = 294.96, p < .001$; and Inventory of Complicated Grief score: $F (1, 136) = 251.30, p< .001$. These results indicate a significant reduction of overall psychological distress
when considered in combination (MANOVA results), and individually (ANOVA results), following therapeutic intervention for those bereaved by homicide. Each was then repeated with univariate ANOVAs using a Bonferroni correction with the full sample sizes and these were all also significant with an identical pattern of results.

Additional analysis was performed separately on the remaining dependent variables due to low sample sizes for Trauma CRIES13 \((n = 28)\), CRIES 8 \((n = 30)\), and Depression (BDI) \((n = 62)\) (see Table 5.3 below for descriptives). Employing Wilks’s Lambda, a significant, strong univariate effect emerged on the individual scores variable pre and post intervention for CRIES8 \((1, 29) = 89.69, p < .001\) partial \(\eta^2 = .76\); CRIES13 \((1, 27) = 72.66, p < .001\) partial \(\eta^2 = .73\); BDI \((1, 61) = 129.90, p < .001\) partial \(\eta^2 = .68\).

The results reflected strong association between pre and post scores and each individual analysis DVs.

Table 5.2: Shows the pre and post therapeutic intervention scores for the IES, PHQ-9, GAD-7, ICG psychometric outcome scores.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Variables</th>
<th>Scale</th>
<th>Baseline</th>
<th>Post Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Trauma</td>
<td>IES</td>
<td>0.75</td>
<td>47.46</td>
<td>6.97</td>
</tr>
<tr>
<td>Depression</td>
<td>PHQ-9</td>
<td>0.27</td>
<td>26.01</td>
<td>6.24</td>
</tr>
<tr>
<td>Complicated grief</td>
<td>Complicated Grief Scale</td>
<td>19.95</td>
<td>02.83</td>
<td>19.68</td>
</tr>
<tr>
<td>Anxiety</td>
<td>GAD-7</td>
<td>0.21</td>
<td>21.73</td>
<td>4.88</td>
</tr>
</tbody>
</table>
Table 5.3 Showing the pre and post therapeutic intervention scores for the CRIES8, CRIES13, BDI psychometric outcome scores.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Variables</th>
<th>Scale</th>
<th>Baseline range</th>
<th>Baseline Mean</th>
<th>SD</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>N</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma/child</td>
<td>CRIES8</td>
<td>0-40</td>
<td>22.97</td>
<td>30</td>
<td>12.57</td>
<td>4.83</td>
<td>30</td>
<td></td>
<td>29</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>Trauma/child</td>
<td>CRIES13</td>
<td>0-65</td>
<td>40.36</td>
<td>28</td>
<td>23.82</td>
<td>8.09</td>
<td>28</td>
<td></td>
<td>27</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>BDI</td>
<td>0-63</td>
<td>47.73</td>
<td>62</td>
<td>33.90</td>
<td>9.86</td>
<td>62</td>
<td></td>
<td>61</td>
<td>&lt;.001</td>
<td></td>
</tr>
</tbody>
</table>

5.3.2 Clinical relevance

A statistically significant change, though important in assessing the efficacy of the intervention, does not necessarily equate to a clinically significant difference. This section will therefore consider the clinical significance of the changes using information from the psychometric manuals on cut-off for clinical levels of trauma, depression, anxiety and complicated grief. Table 2 below indicates reduction in scores to sub-clinical level (see materials) for each measure. Clinical significance indicates those scores that suggest intervention is advised:
Table 5.4: Clinical relevance of score reduction.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pre mean</th>
<th>Post mean</th>
<th>Clinical score pre</th>
<th>Clinical score post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma IES</td>
<td>47.46</td>
<td>29.80</td>
<td>Clinically significant</td>
<td>Clinically significant*</td>
</tr>
<tr>
<td>Trauma CRIES8</td>
<td>22.97</td>
<td>12.57</td>
<td>Clinically significant</td>
<td>Sub-clinical</td>
</tr>
<tr>
<td>Trauma CRIES13</td>
<td>40.36</td>
<td>23.82</td>
<td>Clinically significant</td>
<td>Clinically significant*</td>
</tr>
<tr>
<td>Depression PHQ-9</td>
<td>26.01</td>
<td>15.71</td>
<td>Severe level</td>
<td>Moderate/severe level*</td>
</tr>
<tr>
<td>Depression BECK Inventory</td>
<td>47.73</td>
<td>33.90</td>
<td>Severe level</td>
<td>Severe level*</td>
</tr>
<tr>
<td>Anxiety GAD-7</td>
<td>21.73</td>
<td>12.96</td>
<td>Severe level</td>
<td>Moderate level*</td>
</tr>
<tr>
<td>Complicated Grief ICG</td>
<td>62.83</td>
<td>42.85</td>
<td>Clinically significant</td>
<td>Clinically significant*</td>
</tr>
</tbody>
</table>

*Although the reduction is statistically significant, the post mean score may suggest further intervention is required.

5.3.3 Part 2: The Role of Secondary Factors in Homicide Bereavement Adjustment

A series of repeated measures MANOVA was performed to answer the question of whether secondary variables (see Table 5.1) impact the reduction of psychological distress following homicide including, trauma symptomology, anxiety, depression and complicated grief. To do this, analyses were conducted to investigate the main effects and interactions of variables over time of demographic and secondary variables on reduction of scores following therapeutic intervention. No significant differences were found in any of the secondary variables aforementioned.
5.4 Discussion

The purpose of this phase of the evaluation was to identify whether there was a significant effect over time in the reduction of trauma, depression, anxiety and complicated grief scores following therapeutic interventions. Secondly, variables that were considered as having an impact on score reduction over time were analysed to explore the relationship between each factor and score reduction over time. The overall results are encouraging and demonstrate that integrative, trauma-focussed CBT therapeutic interventions following bereavement by homicide have a large and statistically significant positive impact in reducing trauma related symptomatology, depression, anxiety and complicated grief over time. Only the CRIES8 variable indicated a movement from clinical to sub-clinical levels and as discussed in the previous section, this may indicate that longer term therapy is needed to enable a significant clinical reduction across the range of variables.

This finding contrasts with a growing body of evidence that the passage of time frequently does not alleviate difficulties associated with maladaptive reactions to loss (Bonanno et al., 2002). The results support previous grief and trauma literature indicating high levels of trauma symptomology following bereavement by homicide (Zinzow et al., 2011; Rynearson, 2012; Parkes, 1993) that warrants specialist therapeutic intervention. A significant reduction in outcome measures post therapy was found, indicating efficacy of service provision for those bereaved (Sharpe, et al. 2014). These reductions over time are evident across co-morbid levels of depression (Amick-McMullan, Kilpatrick & Resnik, 1991), anxiety (Schaal, Dusingizemungu, Jacob, Neuner & Elbert, 2012) and complicated grief measures (Farrugia, 1996). The present findings for traumatic grief interventions are similar to those observed for other generic
trauma experiences (van Emmerik, Kampshuis, Hulsbusch, & Emmelkamp, 2002). These results correspond with the conclusions drawn from other studies in the field that suggest a relationship between the level of bereavement distress and the likelihood of achieving successful outcomes with bereaved individuals (Jordan & Neimeyer, 2003).

In contrast to previous literature, this study found no evidence that secondary interpersonal and situational stressors such as the relationship to the deceased (Sprang & McNeil, 1995; Farrugia, 1996) and characteristics of the homicide (Shapiro, 1995) impacts on levels of distress following therapeutic intervention. Although the exploratory phase of this study found that secondary factors did not influence the reduction or maintenance of outcome scores that were statistically significant, consideration of these demographic factors contributes to understanding of the diverse needs of this population and specific implications for the practice of counselling psychology in supporting them.

Although it is evidenced that the traumatic grief experienced following homicide is unique and specific to the nature of the death and trajectory of the criminal proceedings, recognition of relatively specific patterns of responses may enable effective referral protocols and intervention guidance. In presenting secondary factors that may further intensify and complicate grief responses, clinicians may be alerted to indicators of dysfunctional and prolonged responses. Further empirical evidence is needed to fully explore the role secondary factors play in effective traumatic grief resolution. In order to assess whether these gains are maintained in the long-term, a follow-up study would need to be conducted to assess the long-term effects.
It was considered that due to the low sample size of the CRIES 8 and CRIES 13 children’s trauma scale that they should be removed from the study. However, due to the limited research into child homicide bereavement outcomes, it was decided to continue with analysis of these measures. It must be noted that this may have placed results at a greater risk of a type II error whereby the researcher fails to reject the null hypothesis when it should be rejected based on lack of generalisation due to small sample size. As it stands, a statistically significant difference was found.

It must be noted that although a statistically significant reduction in psychological distress was found in the current study, not all those who experience homicide bereavement will need specialist therapeutic referral. As Parkes (1988) comments: “To be of benefit, counselling needs to be provided for the minority of people who are faced with extraordinary stress, who are especially vulnerable and/or see themselves as lacking support.” Additionally, interventions and services not tailored to the needs of individuals and which they do not find appealing are not likely to be utilized (Mittelman 2008; Zhang El-Jawahri & Prigerson (2006), and represent an inefficient use of resources (Bergman & Haley, 2009). This has implications for assessment and therapeutic input alongside contextual factors. Furthermore, a considerable task for clinicians and researchers is to flesh out the theoretical underpinnings of such interventions in detail. This would serve to aid our understanding of the idiosyncratic needs of those bereaved by homicide in the hope that clearer guidelines and policies are developed for practitioners and more accessible and effective interventions are available for service users.
5.5 Limitations

The primary limitation of this study is the lack of a control group comparison. Goldstein and Ford (2002) argued that a control group should be used to “eliminate the possibility of other explanations for the changes between pre-test and post-test scores” (p. 182). It would have proved more beneficial to compare the findings from this group intervention to perhaps a waiting list or no-treatment control group to see if the benefits were due to the treatment and not recovery over time unrelated to the therapeutic intervention. Conducting such research however would raise ethical issues in recruiting this potentially vulnerable population at a time when other services may be flooding them and then offering them no intervention. Further investigation is required to assess control groups within this population, a multiple baseline design might be useful here but still holds the ethical difficulty of delaying therapeutic support. Secondly, no follow-up was conducted to determine if reduction in psychological trauma, depression, anxiety and grief continued. A follow-up study to explore the lasting effects of interventions would provide more robust evidence of service provision efficacy.

In considering the secondary variable information that were collected as part of the service, the level of witness exposure to the event could not be ascertained as this was not recorded. Furthermore, the level of closeness to the deceased could not be ascertained and it cannot be assumed that the relationship to the deceased represented the quality of that relationship. A final difficulty is that the specific definition and interpretation of intervention techniques conducted within the study could not be
extracted although qualitative measures were included as part of the study that indicates an integrative, trauma-focussed CBT model. These qualitative results were not included in the current paper to simplify statistical presentation.

5.6 Conclusion

This quantitative evaluation has demonstrated that the HBS served a client group that clearly represented a clinical population. It has also shown that by the end of their involvement with the services, the majority of clients exhibited a significant reduction in psychological distress to the extent that a majority could be said to have clinically recovered within the definition currently employed for interpretation of the measures used. Qualitative findings from the evaluation that are reported elsewhere, reinforce these quantitative findings, indicating some of the ways in which staff members perceive the benefits of the HBS service, helping to explain the levels of clinical improvement. These results may contribute to the development of the existing literature on therapeutic interventions with bereavement populations and inform future development of policies and practitioner interventions.
Chapter 6
Discussion and critical appraisal

6.1 Overall discussion

This thesis aimed to establish the efficacy of service provision and interventions used with individuals and family members bereaved by homicide and presents some promising findings. Included in this thesis is a review of current intervention status and the development of recommendations for future research, service provision and policy improvement. Previous literature on the specific nature of this type of bereavement is sparse and there is a significant need to establish both efficacy of interventions and general professional provision. This research evaluation has provided preliminary evidence of the efficacy of psychological intervention in the reduction of psychological distress pertaining to trauma symptoms, depression, anxiety and complicated grief trajectory, specifically the efficacy of using integrative, trauma-focussed CBT. A mixed methods approach was utilised due to its accessible and theoretically flexible approach to analysing qualitative data, which allowed an uncovering of novel features around the topic being investigated. Qualitative and quantitative findings have significant implications for professionals working with this specific type of bereavement as well as for policy development and service provision.

Although the quantitative and qualitative aspects of the research sought differing information, both set of findings illuminate potential barriers to service provision and interventions as well as suggesting factors that serve to benefit service user outcomes. Additionally and expectedly, each project offered similarities and differences in their
findings. Whilst the qualitative findings addressed issues at the subjective level with practitioners indicating a potential disconnect between evidence based interventions and the practical nuances of working with this population, quantitative data showed a significant reduction in trauma symptoms, depression and anxiety following an integrative, trauma-focussed CBT approach (see section 5.3). It was indicated that practitioners used a variety of intervention models driven by a flexible and idiosyncratic approach to each client they had worked with. Although it was difficult to develop specific intervention guides due to the need for flexibility, this potentially has implications for training requirements and provision of those professionals working therapeutically with bereavement by homicide, with multiple models of intervention required and development of specific programmes of intervention and service provision that highlights some of the difficulties faced by the families.

Findings from the quantitative study showed an overall reduction in psychometric scores following the homicide of a family member. These findings suggest that the interventions used are effective overall and serve to reduce mental health difficulties such as post-traumatic stress symptoms, depression and anxiety. However, the lack of a control group means that these findings are tentative. Currently, they appear to present the best available evidence which is based on the largest existing sample size.

The findings here may also suggest that although statistically significant reductions were evident, these changes did not always translate into a clinically relevant change, with some psychological difficulties remaining within the clinical range. This may be due to the design of interventions which are potentially of insufficient duration to reduce distress levels effectively. Future research is required to indicate whether long-
term therapeutic intervention models yield more effective results than have been found in the current study.

This recommendation is further supported by the qualitative aspects of this study which illuminated the difficulties associated with time-limited interventions and the suggestion of longer term work for those bereaved. Moreover, whilst there is a general clinical impression of service efficacy, this study concludes that the efficacy of formal interventions with this population has yet to be adequately, empirically and scientifically established.

In addition, other potentially salient factors that serve to impact on outcomes for service users were explored such as the type of homicide, whether the client witnessed the homicide, the time elapsed since the homicide, the relationship to the deceased and whether the individual was deemed complex in terms of previous mental health difficulties or current case conceptualisation (see appendix 16). Age and gender were also factored in as potentially influential variables.

The present study found that the relationship to the deceased yielded similar scores across all symptoms suggesting that differences between the type of homicide and psychological distress was not evident in this investigation. Although the qualitative findings suggest findings do not fully accord with the quantitative findings, instead being more in line with previous literature, the quantitative findings were not significant enough to support their importance. As mentioned earlier, further research could aim to extract more specific data on each of these secondary factors in order to explore in
depth how these serve to exacerbate difficulties and thus inform service provision and therapeutic input.

Practitioners working within this service, in their qualitative accounts, detailed the difficulties sourcing guidance on working effectively with a suggestion that peer information sharing is essential to their support working within this type of service. Isolation reportedly permeated not only the service user experience but that of the professionals, indicating the benefits of developing a network of professional sharing, training and support.

Qualitative findings can be used to direct and inform professionals in their approach to working with those bereaved by homicide as well as adding to the limited extant literature about this provision, particularly in the UK. It highlights the need for multi-agency approaches and the development of a more streamline case management system that informs service users from the outset about their options and choices with regards to support and intervention. It further suggests that purist approaches to interventions are not effective and that flexibility and creativity are necessary in order to manage the terrain of experience following the death of a loved one by homicide. Narratives from participants highlighted the need for long-term access to therapeutic interventions that facilitated their ability to manage life-long markers of the event such as anniversaries, conviction, parole hearings and release dates.

In terms of service provision, it appeared that a flooding of services was evident. In order for individuals to receive appropriate support, they need information regarding
what services are available to them early on. Additionally it appears important that professionals share information and provide a managed care-plan of intervention to eliminate service fragmentation.

Although quantitative findings indicate effective interventions in the reduction of overall symptoms including trauma, depression and anxiety, these results did not indicate the specific issues that qualitative findings illuminate that were potentially specific to each case and therefore clinical intervention. This highlights a significant finding relating to not only how research into those bereaved by homicide is undertaken, but the ability to understand how training methods and interventions should be addressed. To utilise one method without the other may be deemed reductionist and adds to the debate of whether working with human experience can be done using a singular approach. The practice of psychology as a professional discipline is more than simply the mechanical implementation of proven scientific techniques. Rather, it requires the practitioner’s use of professional experience, manner of delivery, empathic intuition, and judgment.

Limitations may be acknowledged in the present study based on the participant selection in each method of enquiry. Quantitative findings presented are specific to those individuals who chose to engage in therapy. This research was not able therefore to find any difference in those that do not to engage in therapy or those that dropped out of therapy. Future studies would be needed to address these gaps in analysis to enable a more robust approach to the efficacy of interventions. During the interview stage, participants were staff members of the ASSIST Trauma Care team. On reflection, it may have more fully encapsulated the whole of service provision if participants from
Victim Support, Family Liaison Officers and other agencies were interviewed. This was difficult for the current study due to time restrictions and the initial purpose of the study, which was focused on interventions.

Additionally, the findings from each method showed that professionals should seek to identify the idiosyncratic nature of each homicide bereavement with services aiming to develop and sustain a holistic approach to therapeutic interventions. It further indicates a movement away from fragmented services towards an information sharing protocol between not only services but those using the services.

6.2 Critical Appraisal

6.2.1 Counselling Psychology and clinical implications

Counselling psychologists working within the field of trauma are trained to be specifically adept at utilising the type of therapeutic skills that recognise the contextual embeddedness of human lives (McLeod, 2001). This means that a primary focus on the therapy relating to the whole context of the client (Duffy, 1990) is retained which is imperative to service provision and interventions with those who are bereaved by homicide. The evidence in this study has suggested that a flexible approach to trauma-focused interventions are necessary and effective. These findings require further expansion with more robust evaluations of this type of service provision. In addition, the counselling psychology training includes a variety of different therapies, enabling the psychologist to effectively utilise the evidence-based methodological approaches in the work with those bereaved.
The findings of this study have implications for the assessment and treatment of those who have been bereaved as a result of homicide. In terms of assessment, coping styles and increased depression and anxiety may be useful in assessing the risk for prolonged and complicated grief symptoms. With regard to treatment, many factors serve to complicate and exacerbate mental health difficulties and an understanding of these particular issues is of primary importance for those working in the field.

The findings of the Homicide Bereavement Service evaluation has indicated a significant need for counselling psychology within this type of service provision stemming from the understanding that counselling psychologists are able to utilise the depth of skills acquired in their training. In addition, the use of a flexible and creative approach whilst working with complex client groups is best understood from a client-led perspective.

Further difficulties were found during data collection of quantitative measures. Data that was collected a part of service provision did not always fit best to the research design and some data were removed (ethnicity), adapted (see Table 5.1) or not used altogether (participant feedback)( See Appendix 2). As the research progressed it appeared consuming in terms of time and its complexity and the researcher found certain elements needed revision in order to enable the work to be feasibly completed within the allocated time frame. It should also be noted that as this research was conducted and analysed by the author it is possible that the data, in particular the qualitative data, was interpreted through a single lens, although regular checks were
made by the supervisor team. Furthermore, there was no outside auditor so alternative theories for emerging themes could have been discussed.

Although this research indicates findings that may be significant in terms of working clinically with this population, the state of knowledge into how best to intervene in this complex phenomenon currently appears rather primitive in nature and there is much research needed in order to validate the findings and further explore the utility of therapeutic approaches, specifically with this type of bereavement. Each finding presented relates back to the initial rationale of the research, which was to give context through narratives and outcome measures into an evaluation of a homicide bereavement service.

Further research should aim to investigate the secondary factors that serve to impact prolonged mental health issues that emerged from this research and observe how they may impact on professionals' way of working to gain a more in depth understanding of the dynamics when working within this specific service provision as well as the inclusion of robust comparison measures to facilitate scientific knowledge. There is a general lack of consensus regarding whether a universal pattern of responses are evident or secondary factors serve to alter and influence therapeutic interventions with those bereaved. This poses additional questions for the similarities and differences between this type of bereavement and any other. This suggests rigorous research is needed to produce evidence into which factors produce certain responses in certain bereavement groups (Farberow, 2001).
Current theories specifying grief responses simply do not reflect the range of reactions that homicide survivors present that are indicated in the present research. Grief is a significant aspect of the death and one that should be taken with the complexities of symptoms with which those bereaved present.

6.2.2 Critical appraisal introduction

This chapter (section 6.2) offers a reflective critical appraisal of the research process. The following subheadings will be used to guide the reader: (i) reflection on contribution; (ii) reflections on the process and progression of the research; and (iii) reflection on researcher influence and perspective.

6.2.3 Reflection on Contribution

This study provides an original contribution to the understanding of service provision and interventions with those bereaved by homicide, the first of its kind in the UK. Although methodological limitations are evident, the mixed methods approach to the study has elicited rich data that contributes to existing knowledge in an area of research that is sparse. It has shown various barriers and facilitators to both service provision and intervention development and it is proposed that the findings will generate interest in this area and facilitate future research development.

6.2.4 Reflections on Process and Progression of the Research

The process of identifying the appropriate paradigm for this research was challenging and complex. The importance of this decision was significant due to my desire to deliver a robust account of service provision that ‘did justice’ and felt worthwhile to the
service users. A pragmatic paradigm was used which focuses on the 'what' and 'how' of the research problem (Creswell, 2003, p.11). The mixed methods approach was imperative to this area of research in order to understand both subjective and objective accounts of the research aims. There have been numerous reflective points that led me to question my choice and epistemological positioning such as a preferential IPA study and whether interviewing staff members would truly grasp the nature of the service and interventions inherent with this type of bereavement, rather than service users. Through the process of examining literature on those bereaved by homicide, the paucity of research with those working with those bereaved led me to question whether I was missing a vital part of the research by not including service users. My purpose was to add to existing literature which has focussed on those working with those bereaved, rather than those bereaved. Although I continue to oscillate in decisions made, I feel I grasped both aspects of research, with both practitioners (process measures) and service users (outcome measures).

As this was a retrospective study, quantitative data was collected as part of service protocol. This had both a positive and negative impact on the research. Data was already collected and robust in number, however the data that was collected was chosen by the service and I perhaps may have chosen additional factors to facilitate the depth of analysis. For example, specific ages were not noted, rather categorised into child, teen and adult. In terms of recruiting participants for interviews and the focus group, I had an overwhelmingly positive response with practitioners extremely willing and eager to participate. This positive response fed into my desire to continue, as it appeared to be a much needed research area in the eyes of practitioners working in the field.
As the research progressed, it was clear that the mode of intervention practised by each practitioner was difficult to identify. Each used varying models with a central theme that they used what they felt best fit the client. In addition to this, some practitioners practised models more systematically than others, such as those using a CBT approach and it was difficult to identify what impact this had on outcome measures. It was also important to reflect on my own engagement within the process and distinguish between my own subjective accounts of interventions and the service and the participants involved.

I found the development of research questions a difficult process at the beginning, as I was unclear how to best design questions that would elicit the information relevant to the research aims. As a novice interviewer, the task was daunting, however I felt this eased and became more natural as the interviews progressed. I was aware again of my role as the researcher with colleagues who knew me to be a practitioner in the field. I considered the extent that this may influence their responses and perhaps question the true purpose of the research.

Analysing qualitative data was the process that I found most enjoyable. I began utilising an inductive account, focussing on my subjective viewpoints on what I felt the participants were trying to tell me. Following supervision that highlighted this fact, the process of deductive analysis was illuminating and exciting. It was at this point that the research began to ‘come alive’ for me and I slowly began to see that there was a point to my research. I did find it challenging to include important points that captured the themes inherent in each narrative and felt at times that I would have enjoyed an IPA
study more. I reminded myself that to challenge oneself was imperative to the research in hand and this served to drive my focus. I enjoyed the fluid nature of qualitative analysis with the understanding that there was no right answer, rather a focus on what was revealed as part of the analysis.

The research process has been a personal journey that has tested and challenged my own perceptions of gathering information and what is deemed to be an addition to psychological knowledge. I have at times felt I was on the wrong track, particularly with the challenge of quantitative analysis which I felt would be the demise of my research due to my initial lack of understanding in this area. With commitment and dedication to my own endeavour of the counselling psychology domain, those service users that I have the privilege to work with and the service within which I work, I have overcome these challenges and gradually paced my impatience to deliver what I believe is an important piece of research.

Difficulties and confusion ensued again as I considered how I would marry together both quantitative and qualitative aspects of the research and was concerned that they were each telling a different story. I reassured myself that although parts of analysis were stand alone, each contributed to the understanding of the other and the research as a whole.

It is recognised that specific interviews to explore service user experience were not provided in the current study and this would be beneficial to future literature on service provision and interventions. Future research should acknowledge those individuals that
do not engage in interventions of any kind. This would enable an awareness of factors that enable self-adjustment and factors that affect service engagement such as cultural belief systems and stigma. Longitudinal research is also needed to explore whether interventions are beneficial across the life span as well as other factors that may impact on symptom management such as anniversaries and release dates.

The research journey has been particularly challenging and just as rewarding. I felt I was swimming in the deep end, treading water often and at times drowning (in paper and data). I continually reminded myself that this research was mine, which at times contributed to my fastidious desire to do it well. I felt reassured that there may not necessarily be a right way and this allowed a freedom of development through the process and identity creation.

As I progressed, I felt confident that the mixed methods approach was fitting to the exploration of service provision. I felt overwhelmed at times with the scope of this study and reprimanded my choice to conduct a mixed methods approach and the extent of analysis. I found myself envying others with what I felt was a more contained method of analysis. I was also aware that other methods and choices may have provided more in-depth analysis such as IPA with service users, however, I was concerned initially about the ethical implications of recruiting participants and the impact of my role within the organisation. On reflection, I am confident that my next research endeavour will address these issues and contribute further to the literature. Supervision has been a key part in the process as I literally fought my way through quantitative and thematic analysis. My difficulty in interpreting results was how to articulate why
certain themes had been grouped, and how they could be collapsed further without losing the essence of the responses given. The eventual list of master themes offers a frame within which to understand the factors that have informed the findings from the research. I retain a sense that interpretations can be proposed in many ways and there were times I wanted to adjust or amend themes. I recognise that this is inherent in the majority of research and feel confident that the themes are appropriate to the purpose of investigation and adequately encapsulate and reflect the accounts given by the participants.

6.2.5 Reflection on Researcher Perspective and Influence

Whilst the themes and outcomes which generated from and grounded in the data, it is possible that my own identity and commitment to the service as an employee led to a lack of distinctiveness at the outset of the study and may have introduced a bias impacting upon the data gathering and interpretation. This may have led me to prioritise certain issues over others. This is evident across the quantitative data that was routinely collected as part of service delivery which informed the outcome evaluation section of the research. There were times when I felt that the data collected did not inform the research appropriately. On reflection, it may have been more informative to develop the outcome data from the beginning. As there was a large body of data that was already collected as part of the service approach, I felt at that time that the data would be useful as it was. In hindsight, it proved more time-consuming translating the data into a manageable format for analysis.
In terms of developing questions for staff members, I recognised that the focus group was a significant forum for staff discussions that did not regularly take place. I considered whether this had the potential of turning into a ‘peer support group’ rather than as the intended interview agenda. My concerns were unfounded as staff members remained focussed on the interview questions. My role within the organisation may have also impacted on the subjective accounts of participants and may have softened or adjusted their responses with participants having concerns about how I may share the information within the organisation despite my assurances of confidentiality. In addition, my role as a therapist for 5 years working with this particular population, within the organisation, meant I had developed my own subjective accounts of interventions and service provision. This meant I frequently had to revisit my sensitivity to deductively hypothesize qualitative data, ensuring that I was extracting rich information that was inductively grounded in the data, rather than deductively informing the process of information based on my own preconceptions of the service interventions and service user experience. This led to a richer and deeper understanding of staff responses to interventions and service provision for this population.

During interviews, I was aware that I identified with some aspects of the participants narratives more than others. Participants worked in a variety of settings in conjunction with their role at ASSIST. This made me reflect on my role as a counselling psychologist in training who has worked only in this service and how this may transfer to wider settings such as the NHS context. These various contributions served to increase not only the research perspective but also my identity as a counselling psychology, providing at times a different lens with which to view the context within which I work.
As I reflect on the development of my identity as a counselling psychologist, my concerns about the restrictive nature of my research has reduced. It is in fact the diversity of various professions and their backgrounds that contributes to the foundations and definition of a profession rich in curiosity and development. I feel that I have a greater awareness of my own professional strengths and contributions to the profession of counselling psychology and along with the philosophical underpinnings of my training and connection with other professionals offers a different way of conceptualising and working with client’s difficulties.

My professional and personal identity perhaps mirrors the subject of investigation within the research. It is evolving and complex in nature as various factors contribute to development and growth. My exploration during my training has been multi-faceted. I have immersed myself in the process of self-development and understanding in parallel with the research process and the diversity of client needs and presentations. In doing this, and arriving at my own research conclusions, I have furthermore appreciated and accepted the diverse nature of the profession, and this has allowed me to develop and grow into the counselling psychologist I aspire to be. Whilst this journey has propelled me into a world of emotion and challenge, with the support of my supervisor, family and friends feel that I have been able to achieve a positive outcome and one that I am proud of.

6.3 Conclusion
Following an initial search into the literature for this study, I was alarmed at the lack of research that had been conducted with or about service provision and interventions with those bereaved by homicide. It may be assumed by researchers that homicide is a rare occurrence that affects very few, however, the impact on individuals and loved ones is immense and overwhelming. From the author’s perspective, it is inconceivable a more robust effort in this area has not found its way in the literature and appears to have been ignored. Within the counselling psychology profession, we have a duty to inform policy makers, service users, professionals and society about the complexity and impact of this type of bereavement in order to better inform and develop specific interventions that can improve psychological outcomes. My hope is that by researching this topic, there will be a better understanding of the difficulties faced by those bereaved by homicide and that empirical evidence continues to grow to support effective interventions that practitioners can utilize with their clients.


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APPENDICES

Appendix 1: Student Management Board research approval.

18th November 2013

Dear Jill

Re: The effectiveness of a homicide bereavement service: a process and outcome evaluation submitted to The Faculty of Education, Health and Wellbeing Ethics Sub-Committee Board (Health Professions, Psychology & Social Care)

The Faculty Ethics Sub-Committee (Health Professions, Psychology & Social Care) met on 11th November 2013. Your project was considered and reviewed at this meeting.

On review your Research Proposal was passed and given full approval (Code 1 - Pass). You are free to continue with your study. We would like to wish you every success with the project.

Yours sincerely

H Paniagua
Dr. H. Paniagua PhD, MSc, BSc (Hons) Cert. Ed. RN RM
Chair – School Ethics Committee

Chadwick
Dr. D. Chadwick PhD, MSc, BA (Hons). PGCE
Chair – School Ethics Committee
Appendix 2: Complete BSEC ethical approval form.

Ethical Approval Form

Please complete and submit the three components, which together make up the ethical approval form document – (i) The Researcher Checklists; (ii) Investigator, Supervisor & Research project details; and (iii) your Protocol.

**Researcher Check Lists (Part A)**

Once you have answered all the questions below and the relevant documents have been included please send this to your supervisor for submission.

<table>
<thead>
<tr>
<th>Procedural Aspects Prompts</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tr>
<td>1. Have you completed and included all three parts of the submission document?</td>
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<tr>
<td>i. Researcher Checklists</td>
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<td>ii. Researcher, Supervisor &amp; Research Project details</td>
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<td>iii. Your Research Protocol with Appendices</td>
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<td>2. Does your project protocol include an electronic signature from your supervisor? (For supervised projects only)</td>
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<td>3. Is your proposal 1,500 words (+ or – 10%)?</td>
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<td>4. Have you included ALL necessary Appendices documents?</td>
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<td>i. Original letter of access and/or approval letter from organisation</td>
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<tr>
<td>ii. Letter/Email Inviting participants to take part</td>
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<td>iii. Consent form</td>
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</table>
Ethical Approval Form

Ethical Consideration Prompts

This is the second researcher checklist and aims to help ensure you have addressed all the salient ethical issues. It also aims to help you to decide if your study is a category A or category B project. It should be submitted completed as part of your ethics application form.

1. Will you describe the main research procedures to participants in advance, so that they are informed about what to expect?  
   Yes ☒ No ☐ N/A

2. Will you tell participants that their participation is voluntary?  
   Yes ☒ No ☐ N/A

3. Will you obtain written consent for participation?  
   Yes ☒ No ☐ N/A

4. Will you avoid coercion?  
   x

5. If the study involves observational data collection, will you ask participants for their consent to being observed?  
   Yes ☐ No ☒ N/A

6. Will you tell participants that they may withdraw from the research at any time without giving a reason and with no repercussions?  
   Yes ☒ No ☐ N/A

7. With questionnaires, will you give participants the option of omitting questions they do not want to answer?  
   Yes ☒ No ☐ N/A

8. Will you tell participants who will have access to their data?  
   Yes ☒ No ☐ N/A
9. Will you tell participants that their data will be treated with full confidentiality (detailing data protection and storage procedures) and that, if published, data will be anonymised?

Yes ☒ No ☐ N/A

10. Will you debrief participants at the end of their participation (i.e. give them a brief explanation of the study).

Yes ☒ No ☐ N/A

11. Will you provide participants with the option of receiving a lay summary of the main findings?

Yes ☒ No ☐ N/A

12. Will your study involve deliberately misleading participants in any way? (Category B)

Yes ☐ No ☒ N/A

13. Is there any realistic risk of any participants experiencing either physical or psychological distress or discomfort? If Yes, give details in the ethical issues section of in Part B and/or in your Protocol (Part C) and state how this will be handled (e.g. who the participant can contact for help). (Category B)

Yes ☐ No ☒ N/A

14. Does your study involve work with animals? (Category B)

Yes ☐ No ☒ N/A

15. Do participants fall into any of the following special groups? (Category B)

Schoolchildren (under 18 years of age)

Yes ☒ No ☐ N/A

People with learning or communication difficulties

Yes ☒ No ☐ N/A

Note that you may also need to obtain satisfactory CRB clearance (or equivalent for overseas students).

Patients/Clients (including people with diagnosed psychological of health conditions)

Yes ☒ No ☐ N/A

People in custody or offenders

Yes ☒ No ☐ N/A

Other vulnerable groups (e.g. victims, homeless people, substance misusers, etc.)

Yes ☒ No ☐ N/A

16. Does your study involve collecting sensitive secondary data (e.g. records regarding cause of death, abuse, neglect etc.) (Category B)

Yes ☒ No ☐ N/A

17. Is this study going to an external ethical review committee (e.g. IRAS, REC, NOMS etc.), if so please give details below.

Yes ☐ No ☒ N/A

External Approval will be sought from: Following contact with the ministry of Justice, it was advised that external approval is not required. Ethical approval is required only
for data which is not routinely collected as part of the service and staff based research does not require IRAS approval.

You must bring to the attention of the Ethics Committee any additional issues with ethical implications not covered by the above checklist

Ethical Approval Form

Investigator, Supervisor & Research Project details (Part B)

Investigator’s Details (Must be completed)

Title: Miss
Forename: Jill
Surname: Mack
Position: Trainee Practitioner Doctorate in Counselling Psychology
Email address: J.Mack@wlv.ac.uk
Address: 16 Clinton Road, Coleshill, Warwickshire
Postcode: B46 3NP
Telephone number: 07970 079938
Alternative contact number: 01675 430118

Supervisor’s Name & Contact details: Dr Darren Chadwick & Coral Dando.
Are you as the Investigator or is your Supervisor a member of the ethics committee?: Yes, Darren Chadwick and Coral Dando.

Title of the Research: The Effectiveness of a Homicide Bereavement Service: A Process and Outcome Evaluation.

Please indicate the type of submission (See Section 3 of Guidance Pack):

☐ Category 0 Undergraduate project self-certification
Please indicate whether the study is:

- Staff Research (Externally funded)
- Staff Research (University funded)
- Postgraduate student Project
  - Programme of study: Practitioner Doctorate in Counselling Psychology.
- Undergraduate student project - Programme of study:
  - Programme of study:

How many words is your proposal: 1800

Key Words: Evaluation, Homicide, Intervention, Process, Outcome.

Please LIST below the major ethical issues you have discussed in the attached research protocol.

Anonymity and confidentiality – assured by organisation and researchers professional contract.
Conflict of interest and coercion – people may feel obliged to take part due to researcher being co-worker – prior approvals from managers and employees who are keen to explore issues of service provision.
Sensitive data – the topic and population under review is deemed sensitive and as such there is an ethical responsibility to adhere to key ethical principles such as respect, informed consent, beneficence, non-maleficence with data remaining anonymous at all times.

The researcher is an employee as Assist, working therapeutically within the service that is to be evaluated and therefore is in receipt of a full CRB check and bound to confidentiality. All data will remain anonymous.

Note for clarity: The research consists of two phases. The current ethical approval is
sought only for ethical issues outlined in Phase 1. This phase, consisting of interviews, does not routinely operate as part of the service. Phase 2 contains anonymous data which is routinely collected as part of the Homicide Bereavement Service outcome measures. A smaller scale service evaluation has been commissioned by the Ministry of Justice, with the current research being an extension of this, conducted for the purpose of doctoral programme research.

Research Protocol (Part C)

Title of the proposed research.

The effectiveness of a Homicide Bereavement Service: A Process and Outcome Evaluation.

Theoretical & Literature Based Background to the Study

The number of homicides in England and Wales was recorded at 551 for the year ending September 2012 (Guardian, 2013), with murder, manslaughter and infanticide offences constituting homicide. Research indicates a distinction between bereavement reactions following natural death and homicidal death (Rynearson & McCreery, 1993). Findings indicate typical reactions to bereavement by homicide including feelings of rage, revenge, stigmatization, extreme guilt and fear (Burgess, 1975; Parkes, 1993). Varying symptomatology and subsequent therapeutic interventions have been suggested in the literature, however there is inconsistency throughout. There is limited research to suggest how therapeutic interventions impact on those bereaved by homicide (Hatton, 2001; Malone, 2007) with little assessment of specialist support within the counselling psychology domain. The current study will explore the impact of homicide on those
bereaved, as well as the effectiveness of therapeutic interventions by adopting a process and outcome service evaluation of a Homicide Bereavement Service (HBS).

Rationale & Research Question/Aims/Hypotheses

The impact of homicide on those that are left bereaved receives limited research focus. Evaluations of services that provide support are also lacking, particularly within the UK. Following a review of the literature, the author offers an intended process and outcome evaluation of a Homicide Bereavement Service. Its aim is to evaluate a single service which offers therapeutic interventions to those bereaved, in order to address its effectiveness. It will examine varying issues such as symptoms experienced by those bereaved, as well as exploring the impact of specific therapeutic interventions on outcomes. Research sub-questions are to include:

Process
i. What factors facilitate service provision?
ii. What factors hinder service provision?
iii. How do service users experience service provision?

Outcome
i. How does therapy affect outcomes?
ii. How do service user characteristics affect outcomes?
iii. What factors hinder positive outcome measures?

Research Design/Approach.
A pragmatic, mixed methods design will gather both qualitative and quantitative data to allow triangulation of data and methodology (Morse, 1991). This method is deemed suitable due to the complex nature and impact of bereavement by homicide. The evaluation will encapsulate this complexity with an exploration into varying factors that both facilitate and hinder service provision and outcome measures. The research will have two phases, as follows:

**Phase 1**

Phase 1 offers a process evaluation to explore service activities that are implemented, including policies and procedures that are in place.

This prospective aspect of the evaluation, for which approval is sought, will consist of semi-structured, in-depth interviews to be held with staff members within the Homicide Bereavement Team. As therapy takes place primarily in the service users own home, staff members include not only office staff, based at head office, also ‘outreach’ therapists are employed in various regions of the country to accommodate the nationwide service and accessibility to clients. The aim is to establish their viewpoints on factors that facilitate or hinder service provision. In addition to interviews, service user evaluation questionnaires, which are routinely and anonymously collected, will be descriptively and inferentially analysed to look at the experiences of those using the service. These will be used to extract subjective experiences on process measures.

**Recruitment, Sampling & Study Participants.**

**Interviews**
A purposive maximum variation sample of 12 participants will be recruited to take part in either a focus group interview or individual interview. The director of client services will make initial contact indicating the choice of interview and request to state preference, with follow-up contact 2 weeks after. Should there be more participants than required, they will be chosen based on their centrality to the head office (focus group) and availability. Participants will have worked within the HBS for at least 6 months, include counselling psychologists, psychotherapists as well as management and head office staff. Using this sample, it is hoped that common patterns that emerge from great variation present particular interest and value in capturing the core experiences and central, shared aspects or impacts of a program (Patton, 1990, p. 172). It is hoped this sample enables saturation of themes, otherwise the sample size will be extended until saturation is evident. The phase 1 process interview stage has been added to an evaluation instigated by the service for the purpose of the thesis. Preliminary approval for the evaluation has been successfully gained from the Assist Trauma Care Director of Services (Appendix 1).

Feedback Questionnaires

A purposive sample of participants for this phase will consist of all those who have been through and completed intervention evaluation forms for the HBS. As the service is still receiving feedback returns, the quantity is not yet known. Only those that return complete data sets will be used for this phase of research. All data is anonymised.

Materials/Data Collection Method(s)

Interviews
Participants who work in the service will be asked via email whether they would like to take part in either a focus group interview or individual interview (Appendix 2). Participant information sheets will be provided should they wish to take part (Appendix 3/3a), with informed consent gained prior to interview stage (Appendix 4). Interview questions are designed to target the questions set out in the research (Appendix 5). Following interviews, a debriefing sheet will be given to participants. (Appendix 8).

Feedback Questionnaires

As part of service follow-up measures, a bespoke feedback questionnaire (Appendix 6) is routinely posted to service users following service intervention, with a request that they are returned to Assist head office.

Data Collection Procedure

Interviews

The focus group will be conducted at Assist head office in a designated room. Individual interviews will be conducted either via telephone or in person depending on participant’s availability and location in the country. Interviews will be digitally recorded and stored in a secure location. Knowledge that interviews will be recorded and that all data will be destroyed following analysis for service evaluation and publication (estimated at 3 years post submission) will be given. Participant’s demographic data will be noted as well as role, length of service and type of primary intervention used if applicable.

Data Analysis
Interviews will be transcribed, coded and thematically analysed in accordance with Braun & Clarke’s phases of analysis (2006)(Appendix 9), extracting themes relevant to the questions set out in the research evaluation. Feedback questionnaire data will be collected, coded and analysed using SPSS and NVIVO, relating to the process questions that are set out in the research.

**Phase 2**

Phase 2 consists of an outcome evaluation, using data routinely collected by the service to measure results, or outcomes, in a way that determines whether the service and intervention produced changes in service users and system-level outcomes that the programme intended to achieve. As in phase 1, both quantitative and qualitative outcome measures will establish, for example, whether particular therapeutic interventions were more effective in terms of a reduction in symptoms of Post-traumatic Stress Disorder, anxiety and depression. Phase two will therefore address the effectiveness of the service relating to correlations between interventions, demographics of service users and reduction of symptoms. Although phase 2 does not require ethical approval for the psychometric measures due to the service’s routinely anonymised collection of this data, it has been included in the protocol to highlight the breadth and nature of the proposed evaluation in its entirety.

**Recruitment, Sampling & Study Participants.**

**Service user Outcome Evaluation**

Retrospective data from a convenience sample of the complete population that have used the HBS will be used for this phase of the study (N=1500). Complete data sets, consisting of pre and post scores are not available for all and only completed data sets
will be included in the evaluation. Pre scores for those that did not engage will be compared with those that did, to establish factors that indicate reasons for not using the service. All data is collected, anonymised and coded numerically routinely by the service.

**Interviews**

See Phase 1

**Psychometrics**

Retrospective data will incorporate anonymised psychometric measures, routinely collected prior to and following therapeutic input which include: The Complicated Grief Scale (Appendix 7), PHQ-9 (Appendix 7a), GAD-7 (Appendix 7b), and Impact of Events Scale (Appendix 7c)*. Each psychometric has high reliability and validity scores in assessing these common traumatic grief reactions. These measures will comprise the outcome measures for this sub study (DVs). In addition, demographic information routinely collected during the referral process, will be anonymously transferred to the research database.

*Although ethical approval is not being requested for these measures, they have been included in the reference and appendix section for information only.

**Data Collection Procedure**

Retrospective data from the HBS database will be used. This system was in use by Assist prior to the commencement of the HBS. Data is totally anonymised and stored at Assist head office.

**Data Analysis**
Psychometrics

Retrospective data will be extracted from the HBS database and entered onto SSPS (v.20, 2013). A quasi experimental design will be used to compare outcome across the type of therapy used (IV1) over time (pre and post therapy (IV2)) to evaluate the effectiveness of interventions. A mixed MANOVA will analyse intervention type (IV’s) on outcome measures (DV’s) outlined in the design section.

Interviews

See Phase 1

Ethical considerations.

The researcher will ensure risk management as an integral part of the project design due to the sensitive nature of the topic under review with access to personal, confidential and sensitive data through secondary sources.

Confidentiality will be maintained in this study by not divulging information to other personnel, except for those directly involved in the study, such as research supervisors and examiners. It will not be possible to link any data to participants as all data is anonymised. All data collected will be stored in a secure location until completion of research, after which it will be destroyed. Issues relating to confidentiality, anonymity and potential disclosures of are noted in the potential problems section below.

Potential problems.

Ramos (1989) described three types of problems that may affect qualitative studies: the researcher/participant relationship, the researcher’s subjective interpretations of data, and the design itself. Conducting research in an area the researcher works raises several
issues and ethical considerations. Participants may feel obliged to take part or provide limited information. In order to reduce this impact, the researcher will be explicit in both the purpose of the research and expectations of the participant and will request that the director of client services makes initial contact with participants with a follow-up reminder to those who do not respond. The researcher will be aware of researcher bias throughout the process and whilst interpreting data. The design of the research will be continually monitored to ensure validity, reliability and meaningfulness of the data is maintained.

Pilot study.

A pilot study will not be conducted as part of this research due to restrictions on resources such as participant recruitment. Questions on the interview schedule may be added following analysis of initial data if there appears to be alternative explorations that need to be made as part of the evaluation.

References


Appendix 3: Ethical acceptance confirmation

Name: Jill Mack

‘The effectiveness of a homicide bereavement service: a process and outcome evaluation’

Date: 11th November 2013

Decision of School Research Ethics sub-Committee

Code 1. Pass. Approval with no amendments. Continue with study (proceed with study, following procedures within your local Trust/HA).

1) The method of qualitative analysis, e.g. discourse analysis, thematic analysis, IPA, etc., should be indicated.

Signed H Paniagua and D Chadwick (Chair of School Research Ethics sub-Committee)
Appendix 4: Invitation to participate in a focus group or individual interview

Dear……………..

You are invited to take part in some research which will evaluate a Homicide Bereavement Service (HBS) that currently operates nationwide. The research will offer valuable information on the impact of homicide on those bereaved as well as both effectiveness and challenges of service provision. This phase of the research will consist of a focus group and individual interviews which will require responses to broad questions relating to the HBS.

I would like to invite you to participate in either the focus group or an individual interview depending on your preference and availability. The focus group will consist of 6 to 10 members, including therapists, management and admin staff and will last up to one hour. It will be facilitated by a focus group leader and held at Assist head office at a time suitable to those attending. Individual interviews will be held at a time convenient to you, either face to face at head office or via telephone. It is hoped that the interviews will illuminate themes that both facilitate and hinder service provision.

It should be advised that all interviews will be recorded using a digital device and any data collected may be used in the research report. All data will be anonymised. You have the right to withdraw from the research however data collected can only be removed prior to analysis stage of which you will be advised.

This is an exciting opportunity to be involved and provide information regarding the HBS and you input would be gratefully received. Should you be interested in taking
part please respond by stating your preference in either the focus group or individual interview. Please contact me for further information or clarification.

Kind regards.
Barbara Goodfellow
Assist Trauma Care
Mobile: 01788 551919

Appendix 5a: Participant information sheet – Focus Group

‘The effectiveness of a Homicide Bereavement Service: A Process and Outcome Evaluation’.

You are invited to take part in a research study. It is important that you are aware of what it will involve before you decide whether you would like to take part. Please take some time to read through this information sheet and discuss with friends or relatives. If there is anything you are unsure about or would like additional information then just ask. You have the opportunity to take your time to decide whether you wish to take part. Thank you for taking the time to read this.

What is the purpose of the study?

Research into service interventions for people bereaved by homicide is limited and there is little assessment of specialist support for both individuals and family units within the counselling psychology domain. The current study will form part of an evaluation of the Homicide Bereavement Service (HBS) to explore factors that facilitate and hinder service provision and outcome.

Why have I been chosen?
You have been chosen to participate because you are a member of staff at Assist’s HBS. It is therefore assumed that you will be able to provide valuable information regarding interventions for those bereaved by homicide. Other staff members working within the HBS will also be interviewed.

**Do I have to take part?**

It is entirely your choice whether to take part or not. If you decide you do wish to take part you will be able to take this information sheet to keep and will be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any point without providing a reason.

**What will happen if I decide to take part?**

You are requested to take part in a focus group interview. The date and time of the focus group will be arranged at a time to suit you. A focus group leader will facilitate the group in answering a series of general questions about the HBS. Your responsibility is to answer those questions you feel able to answer, as honestly as possible. The group interview will be digitally recorded, transcribed and analysed using NVIVO, a computer package used to analyse qualitative data. This will extract common themes relating to the questions presented in the focus group and the HBS. If at any point you decide that certain answers you have given should not be included in the research, data can be removed up until the point of analysis.

**What are the potential benefits and risks of taking part?**

By taking part you will be contributing to a particularly under researched area and it is likely that you will be able to facilitate improved service provision and service user
experience. There are no expected risks in taking part however, by taking part, you may remember things that you may find upsetting. If this occurs, the researcher will ask you if you want to continue to participate in the interview. Any decision you make will be respected.”

**Will my taking part in the study be kept confidential?**

Yes. All the information about your participation in this study will be kept confidential unless safeguarding issues arise. The transcription of the interview you participate in will be stored on a password protected computer in a locked office. Only the researchers working on the project will have access to the information. You will not be identifiable in any publication or report as the data will be grouped together and all identifying information will be removed.

**What will happen at the end of the research study?**

The research results will be published in a journal not yet stated as part of a Practitioner Doctorate Programme in Counselling Psychology at Wolverhampton University. Please contact the researcher should have any further questions or wish to obtain a copy of the results which will be published by September 2015.

**What if I have a problem or concern?**

If you have any concerns about any aspect of the study, the research supervisor should be contacted. The Wolverhampton Research committee has reviewed and verified the research.

Contact for more information:

**Thank you for your time**

Researcher - Jill Mack – 07970 079938 – J.Mack@wlv.ac.uk
Assisst Trauma Care
Appendix 5b: Participant information sheet – Individual interview

‘The effectiveness of a Homicide Bereavement Service: A Process and Outcome Evaluation’.

You are invited to take part in a research study. It is important that you are aware of what it will involve before you decide whether you would like to take part. Please take some time to read through this information sheet and discuss with friends or relatives. If there is anything you are unsure about or would like additional information then just ask. You have the opportunity to take your time to decide whether you wish to take part. Thank you for taking the time to read this.

What is the purpose of the study?

Research into service interventions for people bereaved by homicide is limited and there is little assessment of specialist support for both individuals and family units within the counselling psychology domain. The current study will form part of an evaluation of the Homicide Bereavement Service (HBS) to explore factors that facilitate and hinder service provision and outcome.
Why have I been chosen?

You have been chosen to participate because you are a member of staff at Assist’s HBS. It is therefore assumed that you will be able to provide valuable information regarding interventions for those bereaved by homicide. Other staff members working within the HBS will also be interviewed.

Do I have to take part?

It is entirely your choice whether to take part or not. If you decide you do wish to take part you will be able to take this information sheet to keep and will be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any point without providing a reason.

What will happen if I decide to take part?

You are requested to take part in an individual interview which will be conducted either face-to-face or via telephone. The date and time will be arranged at a time to suit you. A series of general questions about the HBS will be asked and your responsibility is to answer those questions you feel able to answer, as honestly as possible. The interview will be digitally recorded, transcribed and analysed using NVIVO, a computer package used to analyse qualitative data. This will extract common themes relating to the questions presented in the interview and the HBS. If at any point you decide that certain answers you have given should not be included in the research, these can be removed up until the point of analysis.

What are the potential benefits and risks of taking part?
By taking part you will be contributing to a particularly under researched area and it is likely that you will be able to facilitate improved service provision and service user experience. There are no expected risks in taking part however, by taking part, you may remember things that you may find upsetting. If this occurs, the researcher will ask you if you want to continue to participate in the interview. Any decision you make will be respected.

**Will my taking part in the study be kept confidential?**

Yes. All the information about your participation in this study will be kept confidential unless safeguarding issues arise. The transcription of the interview you participate in be stored on a password protected computer in a locked office. Only the researchers working on the project will have access to the information. You will not be identifiable in any publication or report as the data will be grouped together and all identifying information will be removed.

**What will happen at the end of the research study?**

The research results will be published in a journal not yet stated as part of a Practitioner Doctorate Programme in Counselling Psychology at Wolverhampton University. Please contact the researcher should have any further questions or wish to obtain a copy of the results which will be published by September 2015.

**What if I have a problem or concern?**

If you have any concerns about any aspect of the study, the research supervisor should be contacted. The Wolverhampton Research committee has reviewed and verified the research.

Contact for more information:

**Thank you for your time**
Appendix 6: General Consent Form and Right to Withdraw:

**Title of Project:** Effectiveness of a Homicide Bereavement Service: A process and outcome evaluation.

**Name of Researcher:** Jill Mack – J.Mack@wlv.ac.uk – 07970 079938

**Name of supervisor:** Dr Darren Chadwick -

University of Wolverhampton

Millennium City Building

Wolverhampton

WV1 1SB

**Please read the following:**

I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving any reason and that any data collected may be withdrawn up until analysis begins.

I understand that I will be required to answer questions related to the above project and that I can decline to answer questions should I not wish to answer them.
I understand that the researcher may wish to publish this study and any results found, for which I give my permission. All data will be anonymised and remain confidential unless safeguarding issues arise.

I agree for this to be digitally recorded and for the data to be used for the purpose of the above study.

**I hereby give my consent to take part in the study**

Name  Date  Signature

Reseacher  Date  Signature

---

**Appendix 7: Consent Letter to Director of Client Services - ASSIST**

Dear ......................

As part of my doctoral programme at Wolverhampton University, I am to undertake research in an area of interest. I am proposing a research project into those bereaved by homicide. This will be a process and outcome evaluation of the Homicide Bereavement Service at Assist Trauma Care, which will enable an exploration into factors that both facilitate and hinder service provision. This will be a valuable and much needed opportunity to present research on this population.

I am therefore writing to seek your permission to conduct research at Assist Trauma Care and enclose a copy of the research proposal. If you are happy for the research to go ahead, would you please sign your consent below.

Thank you and kind regards.

Jill Mack
I …………………………………………………. agree for Jill Mack to conduct research into the Homicide Bereavement Service as part of a Doctoral Programme at Wolverhampton University. I have read and understood the research proposal attached.

Signed………………………………………….  Date………………………………

Appendix 8: Interview Questions

Opening questions will extract background information such as their role in the organisation, length of service and what primary therapeutic model is used if applicable.

1. What is your opinion on the provision of the Homicide Bereavement Service (HBS), i.e. is it necessary?
2. How do you feel service users experience the HBS?
3. What factors impede service use in your opinion?
4. What factors facilitate service use in your opinion?
5. What is your opinion on the type of intervention used with this population, i.e. does it fit?
6. How do you think interventions may be improved?
7. How would you describe a ‘successful outcome’?
8. What factors hinder successful outcome for service users in your opinion?
9. What factors facilitate successful outcome for service users in your opinion?
10. What improvements could be made to the HBS?
Appendix 9: Debrief Sheet

DeBriefing Form

For the Study entitled:

The effectiveness of a Homicide Bereavement Service: A Process and Outcome Evaluation.

Dear Participant;

During this study, you were asked to take part in an interview designed to elicit your opinions on a Homicide Bereavement Service. You were told that the purpose of the study was to explore factors that facilitate and hinder good quality service provision and outcome measures. This forms part of the evaluation of the service designed to extract subjective viewpoints thus providing a rich source of data. In addition to this phase, data relating to service users outcomes, such as psychometric measures and demographics were also analysed to ensure a robust and informative evaluation.
If you have any concerns about your participation or the data you provided following interviews, please discuss this with the group facilitator or contact the researcher or the researcher’s supervisor using the contact information below. We will be happy to provide any information we can to help answer questions you have about this study.

If your concerns are such that you would now like to have your data withdrawn, and the data is identifiable, we will do so.

If you have questions about your participation in the study, please contact me at J.Mack@wlv.ac.uk Mobile: 07970 079938 or the Director of Client Services, Barbara Goodfellow on 01788 551919. Research supervisor, Dr Daren Chadwick can be contacted via email: D.Chadwick@wlv.ac.uk

If you have experiences distress as a result of your participation in this study, a referral list of mental health providers is provided below. (Please remember that any cost in seeking assistance is at your own expense.)

- Mind infoline PO Box 277 Manchester, M60 3XN 0300 123 3393 info@mind.org.uk

Mental Health Matters
0800 616171
Or text 07786202242

Thank you for participating in this study.

Jill Mack
### Inventory Of Complicated Grief

Please tick the boxes that best describe how you feel, where **never** is taken to mean less than once monthly, **rarely** means more than once monthly but less than once weekly, **sometimes** more than weekly but less than daily, **often** about daily, & **always** means more than once daily:

<table>
<thead>
<tr>
<th></th>
<th>0: never</th>
<th>1: rarely</th>
<th>2: sometimes</th>
<th>3: often</th>
<th>4: always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I think about this person so much that it’s hard for me to do the things I normally do</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>memories of the person who died upset me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I cannot accept the death of the person who died</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>I feel myself longing for the person who died</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I feel drawn to places and things associated with the person who died</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>I can’t help feeling angry about his/her death</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I feel disbelief over what happened</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I feel stunned or dazed over what happened</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>ever since s/he died it is hard for me to trust people</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>ever since s/he died I feel like I have lost the ability to care about other people or I feel distant from people I care about</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>I have pain in the same area of my body or I have some of the same symptoms as the person who died</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>I go out of my way to avoid reminders of the person who died</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>I feel that life is empty without the person who died</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>I hear the voice of the person who died speak to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>I see the person who died stand before me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>I feel that it is unfair that I should live when this person died</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>I feel bitter over this person’s death</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>I feel envious of others who have not lost someone close</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>I feel lonely a great deal of the time ever since s/he died</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**scoring:**

Total score =
### Appendix 10b: PHQ-9 Depression

**PHQ-9 (Depression)**

Over the last 2 weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**PHQ9 total score**

---

Date Compiled:
# GAD-7 (Anxiety)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Feeling nervous, anxious or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>Being so restless that it is hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

GAD-7 total score

Date Compiled:
# Appendix 10d: Impact of Events Scale

**HOROWITZ’S IMPACT OF EVENT SCALE**

Below is a list of comments made by people after stressful events. Please check each item, indicating how frequently the comments were true for you during the past seven days. If they did not occur during the time, please mark the ‘not at all’ column.

<table>
<thead>
<tr>
<th></th>
<th>Not at all (0)</th>
<th>Rarely Experienced (1)</th>
<th>Sometimes Experienced (2)</th>
<th>Often Experienced (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I thought about it when I didn’t mean to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>I avoided letting myself get upset when I thought about it or was reminded of it</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>I tried to remove it from my memory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>I had trouble falling asleep or staying asleep</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>I had waves of strong feelings about it</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>I had dreams about it</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>I stayed away from reminders of it</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>I felt as if it hadn’t happened or it wasn’t real</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>I tried not to talk about it</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Pictures about it popped into my mind</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Other things kept making me think about it</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>I was aware that I still had a lot of feelings about it, but I didn’t deal with them</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>I tried not to think about it</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Any reminder brought back my feelings about it</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>My feelings about it were kind of numb</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Intrusion subset = 1, 4, 5, 6, 10, 11, 14
And avoidance subset = 2, 3, 7, 8, 9, 12, 13, 15
Reproduced from Horowitz (1986)

**DATE COMPILED** ……/……/……

**SCORE** 1 ……….

A ……….
## Revised Child Impact of Events Scale

Below is a list of comments made by people after stressful life events. Please tick each item showing how frequently these comments were true for you *during the past seven days*. If they did not occur during that time please tick the ‘not at all’ box.

Name: …………………………………………… Date: ………

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you think about it even when you don’t mean to?</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>2. Do you try to remove it from your memory</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>3. Do you have waves of strong feelings about it</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>4. Do you stay away from reminders of it (e.g. places or situations)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>5. Do you try not talk about it</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>6. Do pictures about it pop into your mind?</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>7. Do other things keep making you think about it?</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>8. Do you try not to think about it?</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

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### Revised Child Impact of Event Scale

Below is a list of comments made by people after stressful life event. Please tick each item showing how frequently these comments were true for you during the past seven days. If they did not occur during that time please tick the ‘not at all’ box.

Name: ..................................................  Date: .......

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Not at all</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Do you think about it even when you don’t mean to?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Do you try to remove it from your memory</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Do you have difficulties paying attention or concentrating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Do you have waves of strong feelings about it</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do you startle more easily or feel more nervous than you did before it happened?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Do you stay away from reminders of it (e.g. places or situations)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Do you try not talk about it</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Do pictures about it pop into your mind?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Do other things keep making you think about it</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Do you try not to think about it</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
11. Do you get easily irritable

12. Are you alert and watchful even when there is no obvious need to be?

13. Do you have sleep problems?

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Phase Description of the process

1. Familiarising yourself with your data: Transcribing data (if necessary), reading and rereading the data, noting down initial ideas.
2. Generating initial codes: Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes: Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes: Checking in the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic „map” of the analysis.
5. Defining and naming themes: Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
6. Producing the report: The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.
Appendix 12: Secondary factors descriptors

Homicide type

As part of service data collection, the type of homicide was recorded. This included the following categories:

<table>
<thead>
<tr>
<th>Family member</th>
<th>Drink driver</th>
<th>Colleague</th>
<th>Organised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stranger</td>
<td>Pub/club</td>
<td>Corporate</td>
<td>Racist</td>
</tr>
<tr>
<td>Close friend</td>
<td>Terrorist</td>
<td>Burglary</td>
<td>Unlawful</td>
</tr>
<tr>
<td>Drugs connected</td>
<td>Gang related</td>
<td>Football fight</td>
<td>Ex-partner</td>
</tr>
<tr>
<td>Knife crime</td>
<td>Neighbour</td>
<td>Friend</td>
<td>Unsolved</td>
</tr>
<tr>
<td>Road rage</td>
<td>Alcohol</td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

Initial recording suggested that some cases yielded more than one category. In the final stages of analysis it was deemed appropriate to the analysis that categories were pooled into two distinct categories, namely, ‘family friend’ and ‘other’. This was due to the small sample sizes and it was assumed that most appropriate analysis could yield results relating to whether the homicide was committed by a family member or friend as opposed to the other categories.

Witness

This category was recorded to provide information and analysis on whether the individual receiving therapy witnessed the homicide in person to address whether this had significant impact on their psychological distress and reduction of psychometric scores.

Time since homicide and referral
The date that the homicide occurred and amount of time until referral was recorded in categories of less than 6 months, between 6 months and two years and more than 2 years. This was to examine whether there was a significant difference in score reduction over time depending on how long ago the homicide occurred.

Relationship to the deceased

Initial recording of the relationship to the deceased included the following categories:

- Mother
- Father
- Child
- Brother
- Sister
- Aunt
- Uncle
- Grandparent
- Grandchild
- Partner/spouse
- Stepchild
- Ex-partner
- Niece/nephew
- Close friend
- Cousin
- Other

As with the homicide type categories, these were simplified into 5 categories, namely, parent; child; sibling; spouse, other in order to increase the sample sizes and facilitate statistical analysis.

Complex

This category was developed to establish whether additional difficulties pertaining to the individuals experience impacted on therapy and psychological difficulties. Factors that served to ascertain whether an individual was deemed complex included mental health difficulties, substance abuse, case complexity (no verdict, no body found), family complexities, multiple homicide and significantly high profile media interest. These categories were decided as part of service development between various clinical members of the team.

Age and gender

These basic demographic details were recorded and are self-explanatory.
End of document