Trauma Practitioners' Lived Experience of the Impact of Therapy on Trauma Recovery Outcomes

Francess M. Day
Edith Cowan University

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Trauma Practitioners' Lived Experience of the Impact of Therapy on Trauma Recovery Outcomes

Francess M. Day

A report submitted in Partial Fulfilment of the Requirements for the Award of Bachelor of Arts/Science (Psychology) Honours, Faculty of Computing, Health and Science, Edith Cowan University

Submitted August, 2009

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Trauma Practitioners' Lived Experience of the Impact of Therapy on Trauma Recovery

Outcomes

Abstract

Much has been written about evidence-based treatments for Posttraumatic Stress Disorder (PTSD). A number of treatment guides have been written (e.g. AMCPH, 2007; Briere 2006; Foa Keane, & Friedman, 2000;). Medicare criteria based on empirical research and outcome measures stipulate which treatments and practitioner qualifications will be funded. However, little is known about the relationship between these guidelines and what clinicians actually utilize in trauma treatment and use as indicators of good outcomes. The research studies compromise external validity by excluding the majority of typical PTSD clientele, necessitating exploration of treatment effectiveness in diverse real-life populations (Spinazzola, Blaustein, & van der Kolk, 2005). This qualitative study explored how trauma practitioners defined good outcomes and their experiences of how these are achieved effectively. Trauma counsellors (n=22) participated in one of five focus groups. The thematic analysis undertaken within a phenomenological theoretical framework showed the importance of therapeutic process and relationship. Trauma clients' needs of safety, trust, empowerment, therapeutic window coupled with their degree of resilience were emphasized. Findings provide important information to policy makers, trauma practitioners and research about effective practice by describing both positive and negative outcomes. The direct and indirect implications of managed care systems such as Medicare are elucidated.

Ms Frances Day

Supervisor: Associate Professor Denise Charman

Supervisor: Dr Justine Dandy
I certify that this thesis does not, to the best of my knowledge and belief:

(i) incorporate without acknowledgement any material previously submitted for a degree or diploma in any institution of higher education;

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Signed

Dated 23/11/09
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Trauma Practitioners’ Lived Experience of the Impact of Therapy on Trauma Recovery Outcomes

The impact of therapy on trauma clients’ recovery outcomes is an important research area due to the widespread nature of Post Traumatic Stress Disorder (PTSD). Only since 1980, has the Diagnostic Statistical Manual (DSM IV-TR) (American Psychiatric Association, 2000) described symptomology of acute and chronic levels of PTSD as resulting from a definable event that threatens a person’s life or integrity (Lanius, 2007). Various studies showed that over 69% of people had been exposed to trauma, with about 30% experiencing multiple traumas, but there are conflicting estimates of PTSD prevalence (Foa, et al., 2000). PTSD lifetime prevalence is about 8% (DSM-IV-TR) but higher if one was female or previously married (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). However, neither the widespread impact of relationship breakdown on PTSD nor a proposed diagnosis of complex PTSD have been included in DSM descriptions of PTSD (Zlotnick et al., 1996; Herman, 1994). Of the 8%, one third do not recover and comorbidity is strongly linked to other lifetime disorders (Yen et al., 2002). There are a number of populations where prevalence is higher than 70% (e.g., war veterans, personal assault, rape), and there are possible associated biological, social or psychological differences. In the US, PTSD only trails substance abuse, major depression and social phobias in prevalence (Keane, Keane, Weathers, & Foa, 2000), thus trauma therapy is clearly an important area of research.

Practice and Research Interplay

A gulf between research and practice arises from differing viewpoints. Researchers believe that research must occur in controlled settings, and clinicians resist being told to ‘give way’ to randomised controlled trial (RCT) results-based recommendations (Greenberg, 1994). Contrary to how “clinicians are often depicted”, results from practitioners who received research
information were positive however survey results indicated persistence of "research-practice gaps in clinical psychology" (Stewart & Chambless, 2007, p. 267). Assumptions that the discovery of effective treatments will be readily taken up by community practitioners have resulted in highly polarised debates (Cook, Schnurr, & Foa, 2004).

Clinicians have criticised meta-analytic comparisons of quantitative results, questioned technique selection criteria, and relevance of RCT’s to practice. Clinicians have also rejected technique-focused research based upon singular theoretical perspectives and diagnostic criteria, where therapist role and clinical situational factors were disregarded (Addis & Krasnow, 2000). Given the gap between empirical research and clinical practice, there is a need to publish more process research (PR) findings from everyday clinical settings in clinical language that is applicable to practitioners' treatment experiences. Additionally, there is limited evidence for real-world PR research and psychodynamic psychotherapy (PDT), despite PDT being the most widely practiced approach in the general therapy profession (Fonagy, Roth, & Higgitt, 2005; Knekt et al., 2004; Milrod et al., 2001; Shadish, Matt, Navarro, & Phillips, 2000). The absence of such data increases the gap between researchers and practitioners (Milrod et al., 2001).

Treatment research. Research has generally been concerned with evaluating one treatment technique against another, usually using tightly prescribed research designs like RCTs that are considered to be the "gold standard" for evaluating treatment efficacy (Charman, 2003). However, Seligman's (1995) Consumer Report indicated that there were no differences between therapeutic modalities, or psychotherapist qualifications. Results also revealed that when people could not choose between practitioners, due to managed care restrictions, they did worse. Seligman also found that long-term treatment was more effective than short-term. Shadish, Matt, Navarro, and Phillips's (2000) meta-analysis of 90 studies, ranging from research-oriented
to clinically representative, provided evidence that higher effect size resulted with *longer term* therapy.

Recovery outcomes are generally limited to measuring symptoms (Harms & Talbot, 2007). However, therapist effects accounted for a mean of 8% of total variance (range 1-50%) in ‘between-treatment comparisons’ (Crits-Christoph & Gallop, 2006; Kim, Wampold, & Bolt, 2006). Thus, Lutz, Leon, Martinovich, Lyons, and Stiles (2007) and Wampold and Bolt (2006) assert that regarding any therapist as an outlier is inappropriate. Blatt and Shahr’s (2004) results supported previous research showing that client differences (i.e., attachment characteristics) and concomitant therapist responses elicit different change mechanisms, hence stable but differing outcomes relevant to different therapeutic methods appeared in all studies. Reflective functioning abilities in clients also contribute to outcomes as elucidated in *process* correlated definitions of high and low capacity (Karlsson & Kermott, 2006). Lutz et al.'s naturalistic study of therapist effects highlighted the need to further investigate how and why some therapists have more effective outcomes. More open study process research is needed to provide empirical evidence of what treatment *process factors* contribute to effective outcomes (Lewis, 2008).

**Benefits of RCT therapy findings.** The greatest outcome of the publicised list of RCT supported treatments is the scientific evidence which shows that psychotherapy is as good as, if not more, effective than pharmacotherapy for many psychological symptoms. These results were evident particularly in longer term follow-ups (Beutler, 1998, 2000; Crits-Christoph & Gallop, 2006). However, Guthrie (1999) showed how RCT researchers erroneously assume groups are homogeneous based upon a diagnosis, despite other personal, social, and life experience differences. Guthrie showed how a switch to emphasizing *specific symptoms versus diagnostic syndromes* has resulted in exciting new psychological techniques. Results show that brief
psychodynamic interpersonal therapy significantly decreased hospitalisations, doctor visits and medication over six months, compared to a control group. Another switch required is investigation of practice-based evidence in order to establish evidence-based practice (Fonagy et al., 2005; Grissom & Lyons, 2006). The present study collated evidence derived from practice.

**PTSD Therapy Findings**

A comprehensive review of PTSD psychosocial treatment efficacy by Foa, Rothbaum and Furr (2003) showed that cognitive behavioural therapy (CBT) was shown to be most efficacious, and prolonged exposure (PE) the most widely assessed and strongly validated in various PE clinics for various traumas (Rothbaum, Meadows, Resick, & Foy, 2000). PE use is controversial, however when used by a skilled practitioner, it is a powerful technique and process (Briere & Scott, 2006). Increasing, although disparate empirical evidence has been found for Eye Movement Desensitisation and Reprocessing (EMDR), introduced by Shapiro in 1989 (Zimmerman, Biesold, Barre, Lanczik, 2007). However, it has become comparable to CBT in efficacy studies. Long-term follow-up especially with war veterans, has shown a deteriorating effect over time. Non-combat soldiers involved in non-war traumas improved with EMDR if not confronted with death. Zimmerman et al. (2007) concluded that therapeutic effects cannot be sustained when treatment only lasts a few weeks, and showed that spiritual aspects or additional groupwork were also necessary to provide supportive social skills and relationships to prevent relapse. In summary, ample explication of PTSD therapeutic techniques which show amelioration of the impact of client’s experience appears in published findings of RCT research. However, most PTSD clients have complex presentations, thus are excluded from RCT so effectiveness cannot be generalised to most PTSD clients (Spinazzola, Blaustein, & van der Kolk, 2005).
Integrated PTSD treatment packages have been developed due to high rates of comorbidity (Amstadter, Mccart, & Ruggiero, 2007). Co-morbid disorder symptomology (e.g., affect dysregulation, poor attention, concentration and impulsivity) may be resolved via appropriate treatment. PE and cognitive processing techniques reduced depressive symptoms in PTSD sufferers (Owens & Chard, 2003; Resick, et al., 2002). Panic disorder symptoms and substance abuse problems, appeared less responsive to trauma-focused interventions, and Falsetti, Resnick, and Davis (2008) recommended multiple-channel exposure therapy, with integrated intervention techniques for these comorbid problems. A good example of successful implementation of an integrated approach is Linehan's (1993) dialectical behaviour therapy (DBT). It is a long-term, disorder-driven behavioural, collaborative problem solving approach, incorporating intrapersonal and interpersonal processes, which has attracted much research attention (Glass, Arnkoff, & Rodriguez, 1995).

Trauma triggers, and persistent symptoms put PTSD sufferers at risk of self medicating and substance abuse relapse, thus both conditions are best treated concurrently (Brown, Stout, & Mueller, 1999; Coffey et al., 2002; Back, Dansky, Carroll, Foa, & Brady, 2001). Klein, Milrod, Busch, Levy, and Shapiro's (2003) process research showed the precise interaction of transference with panic symptom alleviation. Another persistent PTSD problem is anger, and interviews of long-term trauma therapy clients indicated that counsellors' emotional disclosure, rather than 'blank screen' approach produced better client satisfaction, as did counsellors taking some responsibility for disagreements. Both factors implicate the importance of therapists' active involvement in relationship (Dalenberg, 2004). These results indicate a need for more process research. Seligman's (1995) research, and other's publications (e.g., Briere & Scott, 2006; Day, 2004; Herman, 1994; Rothschild, 2003) emphasise that complex PTSD requires experienced
practitioners to be engaged in long-term therapy with flexible, complex approaches, because simple treatments are not applicable to complex PTSD. In summary, RCT research has provided only limited direction for practitioners working with traumatized individuals.

Alternative Research Approaches.

The strengths and limitations of RCT research and practice-based case studies (Caspar, 2007) may be complemented via a proposed electronic database of rigorously conducted case studies (Fishman, 2000, 2005, 2006, 2007). Seligman suggested it will also allow researchers to correlate treatment outcomes with process and client variables. Suggested applications included: a) data correlations by researchers, and b) practitioners being able to input case factors into the database and subsequently derive clinical evidence of successful or contraindicated treatment approaches. Fishman’s proposed database could expedite interest and efficiency in accessing data to apply emerging process methodologies.

Process research (PR). An alternative methodology which could add to RCT research is PR. A prerequisite to proving an effect has occurred in therapy involves macro and micro detailing of each therapy hour, as it is not enough to just know that a treatment occurred (Bambery, Porcherelli, & Ablon, 2007). Bambery et al. (2007) advocated that practitioner (e.g., techniques, therapeutic alliance rupture and response); client (e.g., treatment motivation); and interaction (e.g., client-practitioner collusion when aspects of therapy are avoided) factors be analysed. However, PR is complex, time-consuming and costly, so research designs must be clinically relevant and methodologically rigorous. Bambery et al. describe a rating procedure that describes therapy interactions so that results can also be used in quantitative analysis.
What do Practitioners Recommend for Research?

A study which investigated the *practice wisdom* of 22 prominent integrative *psychotherapists*, was Norcross and Goldfried's (2005, p. 393) third “roundtable” which elucidated the following recommendations for future research: Roundtable respondents Stricker and Gold asserted that research must focus on the *interactions* between therapeutic *relationship* and specific therapy *tasks* in order to understand *why* therapy works, because RCTs do not provide this information. Pachankis and Bell suggested that due to a general understanding of what treatments are optimal for many primary clinical disorders, there is a need to move from comparative designs to fine-grained PR analyses of the *change process* and *mechanisms* of effective treatment, using value-neutral coding schemes to determine *what therapists actually do* in session. Such analysis may allow more in depth comparison of therapies and may establish where the effectiveness of particular techniques occurs within sessions. Roundtable respondent Goldfried, described how PR can identify the *what* and *how* of change, and the findings from such research could better inform therapy manual development, rather than deriving content from a theoretical stance.

Measurement needs to develop measures of therapists’ implementation skills, as such measures are virtually non-existent, and must involve more than therapist *adherence* to a particular therapeutic approach, principles or techniques (Wolfe, 2005). Other roundtable respondents, Consoli, Beutler, and Lane explained that complex research designs and analytic procedures including assessment and measurement of client-therapist *relationship, situational factors* and other matching variables that emerge from the data. Such data may provide the situational information deficiencies identified by practitioners in Addis and Kraskow’s (2000)
survey. Additionally, Hoffart, Borge, Sexton, and Clark's (2009) PR precisely identified predictive common factors of therapeutic alliance and empathy during the therapeutic process.

Treatment outcomes conceptualised as simple, dichotomous variables, (e.g., depressed or not depressed, improved or not improved), need to be replaced by a wide range of therapeutic process marker, moderator, and mediator variables related to the change process. Research needs to shift from using simplistic diagnostic category conceptualizations in an attempt to understand complex change processes. (DiClemente in Norcross & Goldfried, 2005). Another suggestion by roundtable respondents is that PR can provide the “building blocks” for principles which underpin psychotherapy integration that may produce innovative solutions to individual problems (Pachankis & Bell, p.421).

Trauma treatment in practice

Non-empirical literature describes trauma practice as a process of providing a safe environment and safe interaction for the client to engage in ‘sense-making’ to enable changes in affect, thoughts or behaviours that may be impeding the client’s sense of well-being (Briere & Scott, 2006; Charman, 2003). Rothschild (2003) advocated training in multiple methods so as to tailor therapy to each client’s individual needs, and emphasized the importance of “common sense” to recognize when interventions that “should” be helping the client are in fact causing harm, and vice versa (p. xiii). There is only limited empirical data showing what practitioners do with any client population. A study of generalist psychotherapists showed that a large majority endorse eclectic or integrative approaches to therapy (Jensen, Bergin, & Greaves, 1990). These approaches involve combinations of techniques from various sources (technical eclecticism) and/or theoretical integration of various psychoanalytic constructs to develop treatment frameworks (Magnavita & Carlson, 2003). A potential benefit is creative inclusion of various
theoretical frameworks. Limitations may include random improvisation and absence of detailed theoretical framework definition. For example, Starcevic (1997) questioned the ability of a technique without the meaning of a theoretical framework to convince practitioner or client. Eclectic or integrative approaches are frequently practiced with PTSD clients, yet have not been evaluated (Spinazzola, et al., 2005). Given there is still a need to develop innovative treatments which address the complexity of PTSD presentations, a clear direction for researchers is to investigate what is working or not, in everyday practice.

Research into what General Therapists Do with clients in Practice

Other than Norcross and Goldfried's (2005) previously mentioned roundtable, and a few surveys of practitioners about general use of techniques, there is still little systematically and rigorously collated knowledge of what practitioners actually do regardless of the research findings. Jensen et al.'s (1990) national survey of 423 of different professions was intended to avoid biases associated with professional training. When asked to specify what combination of theory they used, the spread was quite even across Dynamic, Cognitive, Behavioural and Systems theory, in that order, and 59-72% ticked 'eclectic'. Psychiatrists indicated they used the largest number of different techniques and psychologists the least. The detailed responses to writing in 'other' orientations indicated eagerness of respondents to complete the survey, thus it may be inferred that practitioners were keen to contribute their practice wisdom to research.

A questionnaire investigating what practitioners consider important in therapy processes was sent to 380 therapists to rate set questions (Larsson, Kaldo, & Broberg, 2009). Most defined themselves as psychodynamic therapists, followed by a large group using eclectic combinations. The common focus was on the interaction of client behavior, thoughts, and feelings; and client attitudes to the therapeutic relationship. Characteristics of a good therapist included: knowledge,
happily functioning in everyday life, and communicating clearly and simply. Elements of good therapy were: interest in the patient's present situation, working alliance, client's acceptance of own emotions, positive self-image experiences, understanding and acceptance on the part of the therapist. Finally, as described previously, practitioners rejected technique-focussed research where therapist role and situation were disregarded (Addis & Kraskow, 2000).

Research into Trauma Therapists' Practice

Surveys at only two locations, both university-based war veteran Medical Centres, investigated how often practitioners used specific empirically based practice principles (EBPP) recommended by the International Society for Traumatic Stress Studies (ISTSS) guidelines (Rosen et al, 2004). Table 1 shows the findings.

Table 2.

ISTSS EBPP's used by practitioners

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<th>Most often used</th>
<th>Practised to a lesser extent</th>
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<tr>
<td>psycho-education</td>
<td>practices for PTSD</td>
</tr>
<tr>
<td>coping-skills training</td>
<td>trauma assessment</td>
</tr>
<tr>
<td>attendance to trust</td>
<td>Anger management</td>
</tr>
<tr>
<td>depression and substance abuse screening</td>
<td>Sleep hygiene</td>
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An internet survey of attitudes and use of EBPPs by 461 members of ISTSS and other trauma interest groups revealed that practitioners held varying evidence standards, with attitudes toward EBPPs being generally positive, however many also used non EBPP techniques (Gray Elhai & Schmidt, 2007). Integrative practitioner-friendly therapy models produced improvement in both
trauma client and practitioner’s tolerance of exposure as indicated in anecdotal feedback from Becker, Zayfert, and Anderson’s (2004) survey, where PE via flexibly applied manual based exposure was combined with a CBT group and integration of Linehan’s DBT. Generally, practitioners’ wisdom or concerns are often ignored in surveys where they are asked to evaluate techniques, however there is much to be learned from conducting detailed qualitative discussions with practitioners (Addis, Wade, & Hatgis, 1999).

Integration of Research with Practice

Psychotherapists’ historical reluctance to engage in research may be overcome by developing research methods that centre on research questions that are of concern to therapists. (Ryle in Norcross & Goldfried, 2005). Other roundtable respondents Arnkoff, Glass and Schottenbauer suggested that an empirically derived theory of decisional processes, which is flexible and applicable to a range of symptoms and problems, could assist psychotherapists. Goldfried (2005) described numerous possible research questions including questions of how much, and what kinds of emotional experiencing, or insight and awareness are needed, plus when action or corrective experiences are called for. Dismantling research could enhance the efficiency of treatment through identifying patient variables associated with treatment efficacy which would also facilitate practitioner’s decision-making processes to determine the best match for their clients’ needs (Amstadter et al., 2007).

Implications of Review Findings

On the basis of RCT findings, Medicare (Australian Government healthcare system) and other managed care systems worldwide have set criteria limiting which practitioner qualifications are registered, and prescribed what treatments will be funded (Medicare, 2007). Clinical practice guidelines for trauma therapy have also been published,(e.g., ACPMH, 2007).
Not all techniques shared amongst trauma therapists (e.g., personal communications, ESTSS conference, 1997) and described in other literature are included in the recommendations made in these documents. Additionally, gold standard PTSD efficacy studies exclude the majority of typical PTSD clientele, thus compromising generalisability and applicability to diverse clinical practice. Real-life practice models need to be process researched (PR) in order to develop an evidence based database of effective treatment components (Spinazzola, et al., 2005).

Research factors referred to as 'nonspecific' (p. 297) including therapeutic alliance (TA); setting, and creating a climate of trust and confidence; principles; procedures; and processes which raise hope, add emotional re-experiencing, increased self-confidence and self trust (Starcevic, 1997). Some PR studies highlight these factors’ importance over specific techniques. In addition, common psychotherapeutic elements suggest TA underpins effective therapy. Stacevic (1997) suggested that a new psychotherapeutic model stating these factors as key elements is the way to implement and research integrative psychotherapy. However, Barber, Trifeman, and Marmar (2007) noted that trauma therapy PR is still at infancy level; limited to proving treatment discriminability or demonstrating practitioner adherence and competence.

Recent emphasis by funding agencies on using typical therapists in natural settings shows increased support for a “real world approach” (Charman, 2003, p. 41). Broader naturalistic studies with participants whose primary PTSD may already be manifested as other psychopathology (McFarlane & Bookless, 2001) may now be researched. Some ‘clinician friendly’ and practice applicable research methodologies have been published (Charman, 2003; Horowitz, 1994). As Spinazzola, et al., (2005) recommended, significantly more research with new innovative treatment approaches is needed to enable practitioners to evaluate their own work against the positive and negative experiences of other practitioners. An innovative
approach was demonstrated in Cloitre's phase-oriented skills training, affect and interpersonal regulation (STAIR) treatment with adults who had experienced childhood trauma (Cloitre, Koenen, Cohen, & Han, 2002).

Given that varied approaches are frequently practiced, and few have been evaluated, there is still a need to develop innovative research in dialogue with practitioners, to address the complexity of PTSD presentations (Spinazzola et al., 2005). Addis and Hatgis (2000) suggested that the bridge between research and practice may need to move from top down to a more egalitarian – bidirectional approach. Shared cross-fertilization or partnerships of practitioner-researchers in research projects (Cook et al., 2004) could involve direct open consultation with practitioners about what is practiced and what are the outcomes related to their practice processes or techniques.

There is a need to add depth to previous surveys using qualitative research into what is practiced by trauma practitioners. This study provides a logical link to future PR. The research question in the current study was to explore practitioner’s observations of the impact of therapy on trauma client’s therapy outcomes.

Thus the aims of this study were to:

i) elucidate what and how therapeutic techniques are used in everyday practice by practitioners working with traumatised people;

ii) discover how practitioners define outcomes, and how the practitioners know that they have achieved these outcomes;

iii) illustrate typical lived experiences of practitioners in their therapy of traumatised people;
iv) describe practitioners' perceptions of the impact on therapy processes of environmental factors such as Medicare and guidelines produced by ACPMH and ISTSS.

Method

Research Design

The study utilised a qualitative focus group design to explore the everyday lived experience and concerns of trauma practitioners in assisting a client's trauma recovery. A qualitative approach was required due to the exploratory nature of the study (Duggleby, Abdullah, & Bateman, 2004). Practitioners' experience and wisdom were explored not as an "intellectual endeavour but as a personal journey" (Ponterotto & Park-Taylor, 2007, p. 282) The phenomenological methodology was informed by phenomenological and hermeneutic theoretical frameworks (Liamputtong & Ezzy, 2005). In phenomenological approaches understanding is sought via description of lived experience of participants' life world. The hermeneutic framework acknowledges that the researcher's interpretations of the data and meanings are involved in data analysis and presentation. Both are derived within constructivist and subjective epistemology. Constructionism is described by Crotty (1998) as the emergence of subject and object, as meaning is generated subjectively by participants and researcher. The meaning of trauma therapy processes attributed by participants was analysed using my identification of key words and phrases. My interpretations of their experiences as recorded in the focus group verbatim transcript, co-constructed an account. The method employed was theme identification (Crotty, 1998).

Studying practitioners' lived experiences was particularly suited to a focus group design as groups generate rich discussion which can comprehensively elucidate practitioners'
experiences (Kitzinger, 1994; Orr, Willis, Holmes, Britton, & Orr, 2007). Interactions assist
participants to explore and clarify perceptions through their sharing of experiences (Morgan,
1988; Orr et al., 2007) more than a simple self-report opinion or individual interviews may do
(Dein & Abbas, 2005). Morgan emphasized that livelier discussions emanate because people are
happier to share experiences than challenge opinions, and that examining perspectives provides
more breadth than its components of opinions or attitudes. It is also argued that acquired
knowledge becomes more extendable and applicable with more ‘illustrative, explanatory, and
sophisticated’ methods of data collection and reporting (Mantzoukas, 2004, p. 994). Morgan
purports that the major advantage of focus groups is the capacity to observe copious discussion
on a topic in a small amount of time. The weakness of the researcher having less control over the
data is countered with generation of possible future researchable models from topic exploration
(Morgan, 1988). Thematic analysis enables the researcher to examine participants’ life world in
detail; exploring their personal experiences and perceptions or account of phenomena
(Liamputtong & Ezzy, 2005). Transcript analysis using principles of hermeneutic theory made
my active interpretation of a dynamic process transparent. Key features of certain phenomena
and themes defined by meaning commonality across multiple participants’ accounts were
collated (Lev-Wiesel & Doron, 2004). The combination of phenomenology with questioning
hermeneutics, emphasizes the participants’ points of view through the researcher’s data account
(Smith & Osborne, 2003).

Recruitment and Participants

Purposive convenience sampling (Duggleby et al., 2004) enabled recruitment of groups
of at least three participants who met the following criteria: at least five years practice working
with PTSD; English speaking, and aged above 18 years. Such a level of homogeneity of
specialists with sufficient experience ensures knowledge and experience are relevant (Morgan, 1988). Five discussion groups generated sufficient data to reflect the range of views within the study population (Kitzinger, 2006), and substantial contributions were enabled by keeping participant numbers minimal in each group (Duggleby et al., 2004; Morgan, 1988).

Members of the Australian Society for Traumatic Stress Studies West Australian (ASTSSWA) chapter were invited via the emailed invitation (see Appendix A) sent by the Chair, after permission letters were obtained from the executive committee. As insufficient numbers were obtained through the ASTSSWA database, the process was repeated with the Psychotherapists and Counsellors Association of West Australia (PACAWA). Fliers were distributed at a Jungian Association workshop about working with trauma. In addition, snowballing techniques (Liamputtong & Ezzy, 2005) produced a significant number of participants. Three dates were publicised after a pilot study where feedback on processes used was obtained (Kreuger, 1998). The largest group from a regional town in the southwest asked to be included, and the researchers travelled to that location.

In total, data from 22 participants' were used in the study (18 females, 4 males). No attempt was made to balance gender or other participant characteristics. Experience ranged from 6 to 30+ years and 14 were currently in private practice. Additionally, 16 reported working in these areas: hospital inpatient [2], outpatient PTSD programs [1]; prisons, schools, employee assistance [2 each], academia [3]; clients: sexually abused as children [4+]; domestic violence [3]; youth, guardianship, and bereaved survivors [1 each]. Table 2 provides a summary of participant qualifications. Some had multiple qualifications.
Table 2.

Numbers of participants having each qualification

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Psychologist</td>
<td>7</td>
</tr>
<tr>
<td>Social work</td>
<td>4</td>
</tr>
<tr>
<td>Art Therapist</td>
<td>2</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>1</td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td>4</td>
</tr>
<tr>
<td>Psychotherapist</td>
<td>4</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>1</td>
</tr>
<tr>
<td>Nurse</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: Other training included: Psychological Analysis @ Churchill Clinic; Transpersonal psychology; Holistic Counselling; Theosophical Ministry; Certificate IV in Crisis Intervention.

Procedure

Screening for group suitability by the researcher was arranged via email (Orr et al., 2007). Participants were advised of two hour session duration, so as to alleviate disruptions that possible early leavers may cause (Morgan, 1988). A 90 minute semi-structured discussion was recorded.

Thick description was elicited via an initial guiding question which facilitated participants to write brief notes of their experiences with techniques prior to group discussion (Charmaz, 2003). Probing was generally not required and skill was directed to unobtrusively introduce subsequent topics (e.g., describe outcomes) without interrupting the lively conversation. Five general topics with two or three probes each (Liampittong & Ezzy, 2005) are shown in the session guide (Appendix B). A video-tape recorder captured a full record of each focus group session enabling accurate identification of speakers for transcription accuracy (Busch et al., 2000). Additionally, a backup audio tape recorder, notepad and pen was used to
record speaker names with their first word uttered, along with any procedural adjustments (Hansen, 2006; Orr et al., 2007). Feedback regarding the focus group experience was sought at the end to help build reflexivity into data (McLeod, 2003).

**Researcher positioning and ethical considerations.** As the researcher, I am an experienced trauma therapist and member of the ASTSSWA committee, and some participants knew me from these roles. I am also a trauma survivor. Due to the professional nature of the group participants, an agreement to maintain confidentiality was included in the written consent form (Appendix C). Pseudonyms were allotted to participants as a group number and a letter (e.g., 1A).

**Analysis**

Reflexivity was maintained by holding the data close and foremost through immersion in the multiple realities and meaning analysis of the constructivist data through rereading and recoding (Charmaz, 2006). All my actions, thoughts and questions about the data, the analysis process, and the session process were recorded in a journal. This audit trail of ideas, associations and reflexivity added to the rigor of the research (Liamputtong & Ezzy, 2005). Participants’ language guided category labels which generated underlying themes (Morrow & Smith, 1995).

Rigor and validity were maintained by selecting meaning units from the transcript. ‘Descriptive expressions’ were intuitively categorised onto Excel spreadsheets representing “dimensions” based on similarities in content and context (Creswell, 2003; Looman, 2004, p. 417). The term dimensions was initially derived from the session guide topics (Appendix B), and then modified by emergent data. Each group’s data were analysed separately, and the front pages of each dimension were printed and manually collated to nine data dimensions in order of decreasing amount of data units. An ‘iterative process’ of re-reading transcripts to verify the
context, was employed throughout the processes of categorising and searching for common elements in each dimension (Creswell, 2007; Looman, 2004, p. 416).

Spreadsheet data were transferred to a word document, and reanalysed in a fine-grained manner (Morrow & Smith, 1995) to select major themes which appeared to cut across many data dimensions. This ongoing checking and re-sorting data contributed to validity. Morrow and Smith (1995) stated that a rigor concern in qualitative research is adequate evidence, thus analysis continued until no more new themes emerged from 50 single spaced pages of direct quotes.

Findings and Interpretations

This thesis elucidates three major areas in the practitioner's experiences of working with traumatised people data. These metathemes (Corley & Gioia, 2004; Detert & Pollock, 2008; Reitmanova, & Gustafson, 2008) were identified after collation of the themes as shown in Table 3. The sub-themes are interwoven in the text which describes each of the themes.
Table 3:  

*Metathemes, major themes and related sub-themes from thematic analysis.*

<table>
<thead>
<tr>
<th>Metathemes</th>
<th>Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD Knowledge and clinical</td>
<td>Flexibility</td>
<td></td>
</tr>
<tr>
<td>judgement</td>
<td>Assessment</td>
<td></td>
</tr>
<tr>
<td>Supervision or personal therapy</td>
<td>Process guidance and information</td>
<td></td>
</tr>
<tr>
<td>of Trauma work</td>
<td>Vicarious trauma</td>
<td></td>
</tr>
<tr>
<td>Environment constraints</td>
<td>Medicare</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bureaucratic policies</td>
<td></td>
</tr>
<tr>
<td>Trust</td>
<td>Time needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Relationships</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attachment experiences</td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td>Validation needs</td>
<td></td>
</tr>
<tr>
<td>Special Needs of PTSD clients</td>
<td>Arousal containment</td>
<td></td>
</tr>
<tr>
<td>Empowerment</td>
<td>Internal locus of control</td>
<td></td>
</tr>
<tr>
<td>Therapeutic window</td>
<td>Resourcing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sense-making</td>
<td></td>
</tr>
<tr>
<td>Resilience</td>
<td>Complicating factors</td>
<td></td>
</tr>
<tr>
<td>Some general indicators</td>
<td>Insight</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physiological</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lifestyle changes</td>
<td></td>
</tr>
<tr>
<td>Outcomes</td>
<td>Meaning change and spirituality</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Existentialism</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Worldview</td>
<td></td>
</tr>
<tr>
<td>Interpersonal support network</td>
<td>Improved communication</td>
<td></td>
</tr>
<tr>
<td>(Re) built sense of Self</td>
<td>Integration</td>
<td></td>
</tr>
</tbody>
</table>

*Data Overview*

The diversity of *dimensions* captured in the data, necessitates a brief overview of the interrelationships as interpreted by the researcher, before discussing the metathemes. The
majority of data was contained in the dimensions: therapeutic process, relationships, outcomes and principles/knowledge, as shaded in Figure 1. Pseudonyms identify participants via group number and a letter (e.g., 1A). Two practitioners illustrated most participants' experience of therapeutic process and outcomes in trauma work: ‘It’s the journey that counts, maybe endpoint is not what [outcomes are] about, but quality of the journey. Hopefully [it] improves’ (5C). ‘We are not there to fix it – we’re there for the journey’ (5A). In fact, it became clear that practitioners are only part of the journey as conveyed by 3B’s client feedback: “I’m OK and thought I might take a break for awhile”.

The impact of process and relationship rather than techniques, on therapeutic outcomes was highlighted by practitioners as illustrated in the theme descriptions. Techniques were referred to as “adjuncts” (3B) by practitioners. Most groups avoided speaking about techniques initially, preferring to emphasise the principles or knowledge as illustrated by 2A: “I couldn’t quite go straight to techniques, because I had to think first about what are the principles and my ways of conceptualising, that actually make me choose how I work with a person”. These results substantiate (Addis & Krasnow, 2000) findings. Sprenkle and Blow’s (2004, p.114) description of “non-specific outcomes” such as behaviour dysfunction changes; cognitive and meaning changes; and emotional (re)experiencing are also substantiated in the theme descriptions.
Figure 1. Interplay of data dimensions: arrows indicate the direction a dimension informs another.
Metatheme 1: Practitioners' Experience of Trauma Work

PTSD Knowledge and Clinical Judgement

The volume and emphasis of 'principles and knowledge' discussions in all groups indicated to me that this dimension guided trauma practitioners' approach and use of techniques and models as shown in the theme descriptions.

Flexibility. There were many examples of practitioners 'going extra miles', however the following quotes most clearly summarise the challenge to be flexible and the need to go outside ones's boundaries on rare occasions: “We get confronted with the situation where all these standard, typical professional boundaries of services ... just [make me] stand back and [conclude]: this person is more than what the system is about” (2B). An example was depicted by 1A: “My most important learning experience ... broke every rule in the book about treating trauma ... [with] a work colleague, who said 'if I don’t talk to you, I won’t talk to anybody'”. Practitioners' eclectic application of techniques is illustrated by 1B: “[It] has to be very individualised ... I use everything from narrative exposure therapy to EMDR”.

Assessment. It was clear that continuous “assessment is primary ... [e.g.,] individual vulnerability, degrees of resilience .... But ... [issues are] often only apparent after ... awhile, so ongoing assessment” (5B). A clinical psychologist’s “first session is straight assessment ... [they do] three questionnaires ... before I see them”. However, private practice was often contrasted with the formality of medical approaches as shown in Extract 1.
Extract 1.

Extract 1: Assessment diversity

[1D] I don’t use assessments ... [hospital] program ... [we did] assessments. But ... I’m not having to make a diagnosis at this stage

[1B] I supervise some psychologists’ ... clinical registration. Some use tests all the time ... [I] listen to how ... they’re using them to understand the case.... I ask “are you sure you feel that the cost in terms of alienation in terms of what you gain ...?”

[1A] [It] depends on your audience though

[1B] [yes] working in the Health Department or something like that. It facilitates communication [with] multiple therapists over many years

There was concordance between participants and across groups as to how long it takes to familiarise oneself with the person and their history: “Spend time at the beginning trying to know the person. If I pick up a thread ... [and] run with that, I’ll miss out this whole picture” (1C). Some worked intuitively: “first two connections ... [are] absorbing the person ... and feeling the vibes that come from them” (1D). These results conflict with various views in the literature and ISTSS (1995) recommendations for standardisation of assessment (Keane et al., 2000). It was clear in the current data that practitioner needs and styles vary, thus standardisation per se is questionable when you consider 1B’s practice wisdom: “different styles for different [people] ... know the limitations of your style”.

**Dissociation**

Dissociation constituted a large part of the 'clinical knowledge' theme discussion, and cognitive or body experiences served to partially describe this trauma phenomenon: “body memories, but no memories of the trauma ... [nor] memories of her life before 6 or 7 either.... Complaint is a sensation of a red-hot ball in her throat... she [said it’s] probably something in her background that she can’t remember” (5B). There are physical indicators which practitioners observed, such as a client who appeared to be "absolutely invisible ... could hardly be seen in the waiting room”. These observations concur with those presented by other trauma practitioners (personal communications, Warwick Middleton, 14th and 15th July, 2006 workshop) and *DSM-IV-TR* criteria (p. 519-533).

One participant, who reported to “have worked a lot with dissociation” (4B), summarised some relevant knowledge and principles:

[Dissociation] is not ... 10 people in the same body... often it's an internal system – just holding trauma...just holding the memory with just emotions coming or there may be somatic symptoms. [It is important to] acknowledge that they [might not] consciously feel the pain ... but I ask “then who else is holding whatever?” Later they came back and had a hunch that something happened to [them] when little ... So until they are ready to work on it, just ask what the body is saying. [Often they have] given themselves a narrative to cover [childhood memory] losses – which is typical of dissociation: to confabulat[e] a story to cover what should have happened or [yeh, yeh (4F)].... However it is important to take the time – and you can’t rush them (4B).

This concurs with the metatheme 2, sub-theme ‘time needs’: not rushing or pushing a traumatised person to explore or process material.
Experiences of working with dissociation highlighted the controversy surrounding the use of hypnosis: "Hypnosis isn’t for memory uncovering and revisiting... can do more harm" (4E). Later 4E explained that hypnosis is "a very useful tool for management of memories, and recurring thoughts – to regain control of ... intrusive and obsessive thoughts", all of which concurred with Carderia, Maldonado, van der Hart, and Spiegel’s (2000) research. Scientific research using DNA microarrays has also shown effectiveness of therapeutic hypnosis and positive expectation of psychotherapy to reduce stress (Rossi, Iannotti, Cozzolino, Castiglione, Cicatelli, & Rossi, 2008).

Despite this advanced research, dissociation research is sparse and this gap has an impact as 1A described: “there isn’t enough research on it – but it’s …oppressive … to be told that what’s happened … [or been] experienced hasn’t really happened”. There is much to be researched in this challenging area of trauma work. Napoli, Gerdes, and De Souza-Rowland’s (2001) case study illustrating integrative therapy for after-effects of sexual abuse (e.g., dissociation) supports many of this study’s case scenarios which may provide valuable data for future process research and would add to Fishman’s (2000) proposed database.

Supervision and Personal Therapy

Process guidance and information. Given the lack of research and clinical guidelines about treating dissociation, supervision is clearly important when working with trauma as shown in 1B’s dilemma: “code of ethics: … [says you] won’t operate outside your area [however] trying to refer … is … damaging … when they’re revealing their trauma.... Tried to [and] had to do a lot of damage control because they’ve never gone”. There can be urgency in trauma supervision as 1B stated: “knew quickly that I needed to go seek supervision as I [was] personally out of my depth ... [so as to] conserve the client”. Supervision validated 1C’s work:
"discovered ... keep doing what I was ... she was being reborn .... Once I understood that, there was a HUGE piece of sense for me, and ...I was able to just go with her - go with the flow" (1C).

Vicarious trauma. As evidenced by a number of participants, 5B’s practice wisdom about: “Awareness of ones’ own internal dynamics and counter-transference ... [being] very important ... with trauma,” highlights how trauma work challenged practitioners to attend to: “transference issues...own responses and selfcare ... [as] hearing trauma [can lead to] vicarious trauma [and] like any trauma...” (3B). This comment elicited animated group discussion, however 5B provided a suitable ending to the sentence: “[the therapist] needs personal therapy. [Especially] for the [psychodynamic] therapist: ... [its] important for how we work with people. Emotional exhaustion comes from working with people who are in resistance mode”. Larsson et al.’s (2004) survey indicated that 54% principally use psychodynamic therapy substantiating the importance of 5B’s recommendations. This risk of trauma work particularly with ‘complex PTSD’ survivors is evidenced in the literature (Jenmorri, 2006).

Environment Constraints

Medicare. The central needs of trauma clients as described in metatheme 2, are sabotaged by the limited number of sessions, as put bluntly by 4E: “with only six sessions [and] another possible six [later] ... can only have an hour and have to stick with their standards” and 3B: “Politically correct therapies... have really made it sound like five to six sessions will ... [be] OK”. 3B goes on to say that complex trauma needs “therapy ...long term, [but] in our culture ... its the opposite”. 4E adds to the premise: “Trauma...is a whole different way of working”. 4A only does “long-term in-depth therapy”. The question posed by 4E, “How can we develop relationship in six sessions?” does have some solutions in that 3B’s: “initial time ... advises ... of long term therapy choices ... private health funds or ... wait until next year [and occasionally
is]... a little flexible” with fees. Another option is to “work ... fortnightly - to make that time go further” (2A). Occasionally, 1D was able to “apply for exceptional circumstances to push through to 18 sessions”. Some achieved an optimal outcome: “never had anybody who has not been willing to continue as a private client” (1B).

The ramifications of Medicare criteria are extensive as illustrated by 4A, who said it is “excluding a lot of expertise from the system” and 5A:

people ... ill-qualified to be working with people with high levels of trauma ... [e.g.,] four year trained psychologists who don’t do any clinical training at all ... [plus] new ... post graduates ... being plucked up by the private practitioners and ... ring ... and say “Help, [client] referred [with] multiple trauma and I’ve got six sessions – what do I do” and I answer: “you shouldn’t be doing anything!”

Additionally, 2B was concerned about a “negative effect” where a person may see a counsellor for a few times, and tells others “it doesn’t help”.

Bureaucratic policies. Therapeutic goals, processes and outcomes were perceived as being limited by policies in a similar way to Medicare:

Constraints placed upon us to do 12 weeks, meant that I just wouldn’t start a whole lot of things.... [Clients]... self censor.... A lot ... stayed ... less than 12 sessions; and that was used as explanation for why only 12 sessions were necessary (1A).

Other organisational inadequacies, which impeded practitioners’ capacity to provide for PTSD clients’ critical ‘needs’ as outlined in metatheme 2 were highlighted by 3D as “The government system...[has] restrictions ...[of two counsellors for] 12-1500 cases annually... [which are compounded by] problem[s] referring elsewhere”.

Metatheme 2: Special Needs of PTSD Clients

Trust

Trust was identified as a key need of PTSD clients as articulated by 3D “inability or reluctance to trust the world generally ... themself, ... own emotions”, and 2A has a “very distinct emphasis on building trust with people who have survived really complex trauma ... before I do any technique ... that’s the foundation for it all”. Trust building as the first step reverberated through other groups as 3A said: “Trust and solidness [is needed] to allow the work to occur ... that’s the work first”. Time was needed as “some clients take a year to develop trust—especially abused [eg.,] female abused by brother” (3A). It appeared that opposite gender may require greater time, with 4G adding that: “especially young men; its building the relationship first”. 3D indicated that it was “difficult to put a timeframe” on trust building.

Relationships. The key way to rebuild trust as 3D indicated was in “Therapeutic alliance ... without; there is no rapport or trust ... [these are] two key things that have to be established for anything to eventuate”. Nurturing parent figure role appeared important in providing a (re)parenting experience, as shown in 2B’s work: “holding the space for the parent to ... step back into that role ... In trauma, the nurturing is the most needed thing at least with children” (2B).

When working with adults, the focus was to empower the client to “self nurture... [It] has to go back to them more, rather than somebody else providing it.... [I] look at ... how they ... care for themselves” (2A). However, 2C indicated that “often when people don’t have the capacity ... they are looking for their mother or father figure”. In a discussion about transference, 5C explained that therapists “can’t avoid being the mother ... work with that”, and elucidated psychodynamic therapy that “takes [a] client to the place of the child where you can
do the nurturing in a very conscious fashion, or ... they will see an inner critic ... [and the] power of ... what that’s actually doing to them”. Attachment experiences underpinned discussions about reparenting trauma clients: “An outcome of working with attachment problems - is adult attachment” (5B; Salo, Qouta, & Punamaki, 2005). Seeing clients “for a very long time” (3B) appeared to be important in providing a stable “somebody being there for [them]” (2C), and was a thread underpinning many participants’ discourse. An Australian study substantiated both vicarious trauma and PTSD attachment issues elucidated in the current data (McFarlane & Bookless, 2001).

Practitioners’ emphasis on relationship and trust, is supported by literature and concurs with the DSM-IV-TR (p. 468) criteria: “sense of a foreshortened future (e.g., doesn’t expect to have a career, marriage, children or a normal lifespan)” and “avoidance of (e.g., people)”. Herman (1994, p. 133) categorically stated: “Recovery can take place only within the context of relationships; it cannot occur in isolation.” Literature (e.g., Day 2002, 2004; Herman, 1994) elucidating what makes trust such a critical issue for traumatized people, supports the emphasis placed by the current participants. Avoidance was depicted as an adaptive response by 3D where clients, “fearful of own emotional intensity ... sometimes adopt avoidance behaviours ... [so that] they don’t confront the extent or intensity of their grief”. Morrow and Smith’s (1995) survivor adaptive responses findings validated this observation. As discussed in the ‘environmental constraints’ theme, providing long term therapy is amplified by PTSD clients’ attachment, nurturing and trust needs.

Safety

PTSD clients’ trust needs highlight the importance of safety, as 3D stated: “People need the safety of the therapeutic environment in order to access the memory material and the
emotions that go with that”. Processes of achieving safety were elucidated by 1B: “get to know ... the mental set ...[the] person is working from” Although a safe therapeutic environment can be established in the counselling room, sometimes a person needs to be protected from external elements for a period of time, as 5C says: “Therapeutic communities ... [are] an ideal environment because of the safety”. Group model benefits included: “collective trust ... [which] creates that safety net.... Group process creates ... trust” (1D) and a situation “where they can have a bridge” (1B) in addition to individual work.

Validation needs. Another ‘special need’ of traumatised people, who often have almost unbelievable stories, is to be “heard” (2A), and “believed” (2C). This manifests as “take the person seriously ... so its meet them where they are at” (1C) and “validating the fact that they’re coping” (2A). The focus of “Imago [relationship therapy is] on validation and empathy ... coaching them in [the] ... skills” (3C). Clients’ feedback from 3D’s groups showed how “meeting with others with similar experiences ... [gave] validation and normalization”. These practitioners’ experiences substantiated Day and Davidson’s (1997) groupwork findings. There is substantial empirical evidence for groupwork effectiveness per se (Foy et al., 2000; Ouimette et al., 2001), but process research is needed to identify specific factors.

Arousal. As 4E explained: “clients want ... that feeling overwhelmed by the pain or fear ... decreased”. “Trauma work ... can open things up ... like a funnel that keeps opening .... As they leave the session it keeps opening further.... [Practitioners] need to be able to contain that, before ... processing ... [and processing] is not the emphasis” (2A). Many used Babette Rothschild’s (2003) notion of “putting on the brake” (1D) on the arousal mechanism by saying “that’s enough for today, you’ve told me enough ... we wont go any further” (1D). In summary, 5B emphasized “the wisdom of Judith Herman’s stages of safety and stabilisation before ...
remembering and processing, [then] … connecting and reconnecting with community”. 5B went on to emphasise that these stages were “overlapping and ongoing parts of the journey”. However, there were conflicting views about containment (e.g., contain versus allow clients to “just emote” (3D), and “appointment” time constraints versus client determined timelength (4G). It is interesting to note containment is not included in the ISTSS (2000) index or any text in ACPMH (2007) guidelines.

**Empowerment**

Empowerment included developing capacities such as “affect tolerance... setting of limits and the ego boundaries” (1D), “autonomy” (5B), and “mak[ing an] … agreement” (2B) for managing PTSD recurrences. A “client led” (4G) technique most widely used by the trauma therapists was narrative therapy, and 4D described it as an empowerment process:

Not actually going back and being re-traumatised ... [but] putting meaning:

making a story – *not being* there. Keeping them focussing on telling a story about their strengths that helped them survive the abuse … and [describing] their resilience....Go back from a *position of strength*. Client chooses where to go back.

Many practitioners teach *containment* as a way of empowering clients to self manage arousal.

“It’s not about clearing – it’s about managing the arousal and managing the … *anger* … communication and *anxiety*” (1D). The client “can’t change [the story] but has a *changed reaction* to trauma and triggers (especially recurrences). So when it happens again, which it inevitably will, it will gradually become weaker [as] their reactions won’t be totally overwhelmed” (4F). *Internal locus of control* was developed with “grounding” (1D) processes such as: “Reconnecting [with environment] and … self through [mindfully] keeping … in touch
with reality, and acknowledging energy exchange.... Using here and now ... really simple strategies” (4D).

**Resourcing.** This involved both information giving and eliciting awareness of what clients already knew. The latter was observed by 4G in a client who “had the most incredible resourcefulness within herself [as she] ... wrote of the actual incident ... her story.... Her general health improved”. It entailed the therapist “not having to fix” (1A) the client. *Psychoeducation* was described by a number of participants and information was presented in various forms. For example, 1A reported teaching clients thus:

> Its not that you are not going to have the same thoughts ... [you are] just going to catch them faster and stop them and know what’s going on, so ... you don’t wait six months before ... [you] notice ... *ruminating*....That’s where tools come in handy [e.g.,] sheets of paper or things to refer back to... some concrete skill that [you] can go back to.

**Shame reframement** was another source of empowerment, and 1B described implementing it via “reality grounding [by]... tak[ing] people out to ... look at playgrounds ... [to] see if six year olds are really being flirtatious”. An outcome to achieve was described by 5B: “no longer acting out of shame”. Shame about strong emotions and rage attacks can cause traumatised people to withdraw socially (Day, 2002) so 3C’s approach of “Coaching [couples] ... to increase their ways of dealing with frustration [using Imago relationship therapy]” appeared to provide a possible avenue of empowerment with regard to emotional expression and reconnection with significant others.

**Sense-making** is a term also used in the literature (Briere & Scott, 2006) and defined by 2A as: “giving ... a space ... [to] do with that what makes sense to them. Not as a logical rational process but as something of their life ... [with 2A] offering ideas and thoughts....To make sense;
they need to get words and concepts that help them to do that’. The ‘dimension’ of client led process, when working with trauma triggers was emphasised clearly by 1B:

... intuitive wisdom of the client.... This woman, ... said to me ‘I actually need to see a man therapist as well’. She didn’t want to leave me because of the trust ... I suggested the guy from my practice – [she said] ‘no, no they are much too safe – I need to see a male therapist who is about 40’ and I found her one ... but really recognised that she needs ... to be in the triggering circumstances

Lived experiences for clients surpass cognitive insight as explained by 5C: “understand how to be ... centred in the feeling self in the somatic sense.... [It’s] important ... [to] experience life as a heart being.....We don’t really experience it with our head at all”. Research evidence for these self-help methods is scarce, and future process research is needed. However, from studies on family support, the ISTSS guidelines recommend all of these therapy adjuncts, especially psychoeducation (Penk & Flannery, 2000). Current participants’ choice of techniques were similar to Rosen et al.’s (2004) survey results...

Therapeutic Window and Medication

A therapeutic window was defined by 5B as “the ideal amount of arousal and not being too high or too low”. In general, therapy was reported as effective when “[clients] start to trust their own judgement, [and have a] sense of control over their emotional dysregulation” (2B), which was reported as showing “less overburden, putdowns [and clients saying] ‘this is me’ instead of putting out ‘don’t come near me with this big problem’” (4E). As 5B explained, the role of medication is to enhance psychotherapy: “People can actually do better with their [psychotherapy] when ... on their medication ... because it helps to bring their anxiety experiences into a more useful range”. A non-prescribing practitioner observed clients being
“level when on their medication, but as soon as they go off it … anger starts to come up again”

(5C). Practitioners’ experiences are supported by both ISTSS (2000) and ACPMH (2007) guidelines which discuss how selective serotonin reuptake inhibitors (SSRI) should be the first choice for both general practitioners and mental health specialists when contemplating medication as an *adjunct* to PTSD psychotherapy.

**Resilience**

The varying levels of resilience as elucidated in Extract 2, implicate the importance of client-centred outcome expectations.

Extract 2.

*Extract 2: Resilience attributes*

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[5B] [people experience] such appalling treatment – yet they are terribly together.

[5C] [they] abuse …substances and yet there’s something really integral about them, it’s all very available to work with

[5B] the further … back in their history [trauma occurs], the more crucial it is … [If] the first 2-3 years are really good, then … [they are] resilient to a lot of awful stuff happening later on

[5A] [some have] tremendous resilience [despite] lots of horrendous trauma … really make it socially…. [They have] huge shifts and change how they feel about things; about themselves and the world…. [Whereas] some people at the … other end of the *spectrum*, who are so damaged … really our roles are in rehabilitation

[5B] [for them] staying alive is an achievement
Complicating factors such as previous history, and complicated grief can impede recovery as 3D described: “person’s background [determines] ... recovery.... Experiences earlier ...may not have been worked through or processed... [or when somebody] discover[s] ... own child dead ... [sees] horrific graphic [deaths] ... [it] brings up the past traumas and compound[s] issues”. Glicken’s (2006) research confirms this observation. As 5B adds: “some people ... never recover enough to not need some form of help.... But ... stay alive year after year” demonstrating resilience at perhaps a less than desired level of functioning. Current results seem to support Grissom and Lyons’ (2006) findings where ‘patient characteristics’ were found to be important in therapists’ outcome observations. It appears that the basics found in workbooks (e.g., Day, 2004) are perhaps all the progress that can be expected of very complex PTSD in short-term therapeutic approaches.

Building resilience using empowerment processes has been demonstrated in the current study in the ‘empowerment’ theme, and adds to research into predictors of resilience (i.e., age, education, level of trauma exposure, income change, social support, chronic disease, other life stressors) (Bonanno, Galea, & Bucciarelli, 2007). The literature describes resilience characteristics as: positive social functioning; present and future orientation; invisibility; optimism; high aspirations; internal locus of control; desire to help others; ability to learn from others; problem-solving skills; self-help and assistance-seeking; and humour, especially self-directed (Anderson, 1993; Frankl, 1978; Glicken, 2004, Lifton, 1993a, 1993b; Tech, 2003). Morrow and Smith’s (1995) research into the nature of childhood sexual abuse survivors’ coping strategies, encouraged practitioners to view clients’ adaptive responses as strengths rather than pathology. Process research would facilitate clearer direction on building resilience
for trauma therapy and research, and the current study has provided detailed cases, therapeutic process and relationship data with which to begin this work.

Metatheme 3: Outcomes

Participants struggled to define outcomes and measures: “I’m struggling with [the] question of how do I measure” (2A), and it is “so hard to do… Results don’t [show] for several years” (5A). It was described as a “complicated question … [indicated by] signs over time (5C). Eventually, 2A came up with a framework: “there’s two elements: … behaviour … and different ways of thinking”. Client feedback was the most frequently used indicator as described by 3B: “usually feedback from client…. But people in … private practice … and public service … suddenly … just stop”. Sometimes 3B followed up, to find that most say: “I’m OK and thought I might take a break for awhile”. The struggle and indicators are also illustrated in the literature (e.g., Botella, et al., 2008).

Some General Indicators

Indicators described by participants were not derived from formal assessments as stated by 3D: “never used any formal outcome measures” and 3A simply observed people having “more comfort talking through issues [versus] avoid. Sitting with feelings and talking it out is a good outcome”. The PTSD literature would term this a form of ‘processing’ (Rothbaum et al, 2000). Learning, insight and history discussions included both indicators and processes of achieving insight: “Insight that past is history. Not imagining [it], and…not crazy” (4B). Clients’ realisations were summed up by 4E:

Can’t change history – but can learn from it. … [They can] look back and see it for what it is and not be overwhelmed…. [They are] able to move on and make … social
connections to family, to own feelings and emotions so as to have a sense of control over ... life ... destiny.... [This] allow[s a] ... positive outlook for future.

Listening to people’s thoughts via their talk facilitated observation of: “Cognitive distortions ... [which] are the most difficult and last to shift.... [When they] start to show ... [it] indicates ... work you’ve not done yet; ... a new phase or belief that they are bringing” (2B). Additionally, body manifestations of trauma were identified by 2A’s client who wanted to: “work on ... weight [loss] ... [but] realised ‘it’s stuck in my body”. 4A’s client described creating new “experiences, and bedding those experiences down”. Insight was achieved by: “build[ing] a bridge back to who they were, but from the place of who they are now” 2A.

Physiological indicators were also identified by practitioners. These included: “freeze response was reduced.... At the completion of treatment, ... she talked about ... could paint [perpetrator], ... could STOP him, could confront him, ... was totally relaxed .... laughed, smiled”(2B). It became clear that outcomes were part of continuous feedback and assessment. Indicators that were part of ongoing monitoring included: “eyes flicker or [the client] go[es] a bit white – colour change, ... stop and check with them” (2B). “Arthritis ... physical health problems ... clear” (2A) along with the more obvious signs as shown in extract 3:
Extract 3.

Extract 3: Some indicator measures

[3B] physically ... change – sit up straighter, looking happier in themselves ... there’s colour in the face ... they tell you. You just start noticing.

[3C] grooming improves

[3B] clothing ... neater

[3C] [They say they can] ‘feel the music in ... [body parts] that they weren’t actually aware that they had ... [and it] wasn’t necessarily the part that had been traumatised

Empirical studies referred to in the ISTSS guidelines only measured changes in symptoms pre and post-treatment, by applying a PTSD diagnostic test (Harms & Talbot, 2007). In contrast, only three participants reported current use of structured tests, although one said: “I hardly do post-testing now” (3B). Another used them when providing depression/anxiety management self-help community based workshops, and the third was: “checking with [client] ... and feedback from family and others; particularly with young people” (3A). Lifestyle changes described by 2A included: “Look[ing] at the way they live.... Usually I see some stark shift in relating to others, in relating to life, in engaging to life, and also their relationship to themselves [as] important indicators”. 5B noted new activity developments such as: “getting more in touch with their creative side and developing their music, painting or woodwork creativity”.

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Meaning change and spirituality

There is a dearth of outcome literature in relation to meaning (Solomon, 2004), however it was emphasised by so many participants, and whole groups, as in extract 4,

Extract 4.

Extract 4: The importance of meaning

[1B] Meaning is important ... also ... pairing of a new emotional experience with the triggering event or stimuli.... People don’t get better unless you find a new power ... creating a new meaning of the memory from the present time, ... [and] get a new emotional response to what [otherwise] stays complex ... [where] it’s theoretical, rather than experiencing

[1D] I go with the meaning – what does it actually mean for them. Sometimes it’s quite existential

[1C] absolutely

[1A] I agree

The process was described by 2A as “Recreating a life meaning and a life trajectory that ... is freer.... Flow ... is moving.... Trauma is part of their life story, but is not their life story”.

Spirituality was discussed by a significant number of participants from different groups and 5C defines its importance:

Working holistically with physical emotional, mental and spiritual models.... Seeing the role of spirituality in their life and in the future.... A lot of people have rejected that.... It’s important ... [they] don’t reject that kind of resource ... [as it] might be the
difference between success and failure.... [I] see spirituality as integrity and idealism and
love of humanity.... Not necessarily any kind of religious spirituality.

Spirituality was described as a significant trend amongst many of 2A’s clients: “Spiritual
awareness or a spiritual OKness.... A large number ... have taken their sharing into the world of
spirituality ... and a deeper search of meaning.... [and there are] issues of forgiveness to God
when things have gone really really bad”. An unfavourable outcome was illustrated by 4B:
“They may feel angry .... But forgiveness, unforgiveness is a trap ... it doesn’t actually set the
balance”. Research findings show positive and negative influences of spirituality on people’s
health and well-being (Culliford, 2002; Harris et al., 2008; Powell, Rosner, Butollo, Tedeschi, &
Calhoun, 2003; Powell, Shahabi, & Thoresen, 2003). Process research would elucidate helpful
aspects or impediments to resolve conflicting evidence and confirm the importance of spirituality
as indicated in the current data. As Cadell, Regehr and Hemsworth (2003, p. 280) summarised,
meaning reconstruction “is necessary because trauma works by threatening or dismantling the
individual’s view of the self and of the world”.

Existentialism is defined by 2A as questioning: “Who am I? ... [and what is] my place in
existence?” 4E describes how clients’ “whole worldview can change”. Although empirical
outcome measurements may include the DSM-IV-TR symptom of ‘foreshorted sense of future’,
results are only reported as symptoms being present or not (Foa, et al., 2000). Frankl (1978)
pioneered evidence and insight into existentialism, and Jenmorri (2006) reinforces this concept
in relation to working with childhood trauma survivors. Recent literature findings on concepts
like Posttraumatic Growth (Cryder, Kilmer, Tedeschi, & Calhoun, 2006; Harms & Talbot, 2007;
Ickovics, et al., 2006; Linley & Joseph, 2004; Park, Mills-Baxter, & Fenster, 2005; Tedeschi &
Calhoun, 1996) and the current data add to that body of evidence.
Interpersonal Support Network

Generally, participants described how the aim was to facilitate “healthy relationships, healthier couples and better parenting. Trying to break the cycle of transgenerational trauma and ...substance abuse” (5B). Group 1 agreed that “giving up dysfunctional relationships and stop trying to get from a dysfunctional family what they have never been [able] to get from them... [was a] really solid and positive outcome” (1B). Trauma was observed by 2A to create an “image of humans [as] evil, rather than deeds [and noted] shifts [to where clients] talk more neutral or more positively about people”.

Improved communication skills. When “communication improves ... intimacy improves” (1D). Intimate relationships were indicated as pivotal influences, to enable the client to have a healthy support network, thus decrease reliance on a therapist as 1D said: “they become a team which ... gives the client extra strength to ... feel supported”. During couples therapy, 3C noted that both “can really listen ... hear and allow the other person to show up... [and] get their [own] story out of the way”. These observations are supported by research evidence showing that good quality social support is associated with recovery (Brewin et al., 2000; Ozer et al., 2003).

(Re)built sense of Self

Extensive discussion of the (re)building of a sense of self included direct and indirect references to client’s experience of dissociation as described by 5A:

Initial cognitive description [of] “I’m feeling like I’m not here anymore, these men took me away”.... [With EMDR she] relived the rape and ... at the end of it, she ... said ‘5A I’m here, all of this is irrelevant, I’m in here, I’m in touch with me’.

It was observed by 4F as: “Stopped identifying with burden because that is not who they are.... wonderful feeling for them”. PTSD arousal management outcomes were attributed to a real sense
of self by 4A: "They find real identity – not their abused self.... Fully know who [they] are, and when [they] know, its bedded down [which] controls intrusiveness”.

Integration. A definition described by 5C was a capacity “to be energetically present and whole”. Co-participant 5B added: “Being more comfortable with oneself, better symptom control, more effective relationships, more effective functioning in different realms.... Being able to keep the journey going without the doctor”. 5A described how: “they reconceptualise themselves so that they form a core... [which is] like a change in identity”. An example from 4D described how a “Regained sense of self.... [after] living in an abusive relationship for a long time – living in fear: [is] offering them choices ... [instead of] self blame where they ask: “what can I do to change myself because he won’t?” (4D). A co-participant 4F added:

“Death of the dream of what could’ve been or what should’ve been and will be no more.... They can move on to coming to terms with it and accepting the reality of what is. Once they can do that, then that– changes the whole dynamics”.

It was observed by 1C that after traumatic “grief ... [the person gets] back onto the track of living life, and [knows] it’s really not [their] fault”, or as 2C observed: “felt at peace enough to let go [die]”. General trauma literature (e.g., Day, 2004; Rothschild, 2002) describes creating a sense of self and processes for therapy, however there is a dearth of empirical evidence where clients express it as an outcome of PTSD recovery, other than publications by survivors. General psychotherapy and resilience building literature (e.g., Glicken, 2006) supports these notions, but research seems to discard them as “non-specific factors” (Starcevic, 1997, p. 297).

Summary

Although the topics explored a link between techniques and outcomes, practitioners emphasised how the work with traumatised clients focuses on therapeutic process and
relationships. Practitioners clearly elucidated the needs of clients and therapist. Trauma client needs were prioritised as a need for trust, safety, empowerment, and establishment of a therapeutic window whilst working within the client’s resilience capacity. Practitioners need: PTSD knowledge for ongoing clinical judgement; personal therapy and supervision; and flexibility in adapting therapy to environmental constraints.

Outcome measurements and dimension descriptions surpassed simplistic symptom measurement. Outcomes were described as complicated, layered, multiple processes (e.g., relationships, existentialism and self-identity) sometimes taking years to show up. There was a spectrum of what could be expected, depending on multiple factors (e.g., client’s resilience, social supports, trauma history, or length of therapy). Outcomes reflected client perceptions of improvement, plus practitioner observations of clients’ capacity (i.e., additional supportive relationships) to progress in the broader life context, without therapy. This capacity indicated to practitioners that empowerment, thus recovery had been achieved.

Conclusions

The most striking aspect of the data was the emphasis on therapeutic process and long-term relationship rather than techniques, which overturned the original premise that there must be some techniques which result in better outcomes. An old adage has been modified by the data in the following way: “It is [both] what you know [and] how much you care”. Glassgold’s (2007) description of liberation psychology based upon existentialism, sums up some of the philosophy manifested in the current study participants’ discourse: constantly create flexibility to allow for constant change, empower agency, activism and avoid being part of an oppressive, labelling system. The current therapists emphasised flexibly empowering clients by sharing appropriate
knowledge and understanding in a supportive long-term relationship and follow the client’s needs. This demands that research focus on process and relationship analysis.

Outcome data complexity concurs with Russell, Jones, and Miller’s (2007) review of process research (PR) studies, where they suggest that future research divert from acontextualising, partitive analyses to PR, which captures process multiplicities and complexities. Spirituality data reflected Zimmerman’s (2007) results in that it was shown to be important in trauma work and PR could elucidate when and how spirituality is beneficial.

Dissociation case histories obtained in this study add to the limited research about dissociation and may provide valuable data for future PR. In addition to Napoli, et al.’s (2001) PR results, a number of case results could then be included in Fishman’s (2000) proposed database, thus providing practice-applicable and practice-based research data. Practitioners could search for cases with variables matching those they input to the database. Clinical judgement would guide application to their situation.

This study has provided preliminary data about facilitating resolution of the central trauma problem of trust. PR would identify the operative factors that facilitate or impede trust building. Results have substantiated previous clinical observations and research where it was indicated that therapeutic alliance (TA), integrative modification and flexibility may underlie psychotherapeutic efficacy (Norcross & Goldfried, 2005; Starcevic, 1997). This real world naturalistic study revealed some common principles which guide the processes used by practitioners and adds a deeper level of evidence to support practitioner experience in survey results (e.g., Gray et al., 2007; Jensen, et al., 1990; Larsson et al., 2009; Norcross & Goldfried, 2005; Rosen et al., 2004), and previously cited publications (e.g., ACPMH, 2007; Briere & Scott, 2006; Day, 2000, 2004; Ochberg, 1988; Rothschild, 2002). Specific elaborations described how
techniques employed were chosen on the basis of suitability to the practitioner's philosophy, background training and their guiding principles, and were sometimes constrained by external environmental factors such as Medicare and workplace session number restrictions. Environmental constraints clearly restricted therapists' capacity to establish long-term relationships with clients. Results support the Addis and Krasnow (2000) survey findings, where therapist role and clinical situational factors were emphasised as important factors to be included in research.

The current results are consistent with Lev-Wiesel and Doron's (2004) PR where TA, process, intrapsychic and relationship improvements were also the major outcomes reported by clients. It was concluded that effectiveness measures may not be the focus of therapy. Problems with outcome definition and measurements which in turn, impact on discernment of variables accounting for overall therapy efficacy reflected previous research findings (Starcevic, 1997) and highlight how the resolution of this dialectical problem may lie with practice-based research. Starcevic (1997) and Rothschild (2003) suggested that theoretical knowledge and skill in a wide range of techniques are imperatives for an effective integrative approach to therapy. This data may be considered as preliminary evidence for such a premise.

The qualitative exploratory focus group research aims have facilitated whole picture evidence to be analysed, whereas quantitative data would have been restricted to forced choice selections. Thus this study has gone beyond the limitations of most previous research, overcoming RCT difficulties indicated by Ryle in Norcross and Goldfried's (2005) roundtable who emphasised a variety of research modes are needed. The phenomenological approach has added trauma practitioners' lived experiences of trauma therapy to the existing body of knowledge. The current methodology further bridged the gap between research and practice in
that participants indicated that they gained rare insights from others, making their time away from work a worthwhile investment.

Although much is still to be learned about new models of therapy from naturalistic studies, PR can separate [without excluding] the impact of specific techniques from the more general, common therapeutic influences. The current data's conflicting views on assessment; containment versus trauma processing; and appointment time constraints emphasises the need for more PR and qualitative analysis of clients feedback on these factors, especially investigating client reflections about the possible benefits of alternative approaches (e.g., emotive versus learn containment). Future PR of therapeutic communities and groupwork, along with focus groups of practitioners are needed to elucidate what factors clients benefit from.

This study has provided direction for research to involve practice, especially PR of trauma therapy. It also informs policy makers and practitioners working with traumatized people. PR would overcome limitations such as relying on practitioner's memory, and their data presentations possibly reflecting personal biases. Clearly this paper was constrained in that there were numerous dimensions in the client focussed therapeutic process which needed further elucidation, however only trauma related themes could be illustrated in this thesis. This research needs validation by other researchers and practitioners conducting similar studies in other geographic locations, thus giving more practitioners a voice in research, increasing the sample and achieving increased integration of practitioners in research.
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[Comment/Reply]


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Appendix A

Invitation to participate in a Research Focus Group
Trauma Counsellors Lived Experience of Therapeutic Techniques in Relation to Trauma Recovery Outcomes

Thank you for your interest in this study. My name is Francess Day and I am currently completing my Psychology Honours at Edith Cowan University, Joondalup Campus. This research is part of the requirements to complete the qualification. My supervisor is Associate Professor Denise Charman. The methods of this study have met the strict guidelines laid down by the Faculty of Computing, Health and Science Ethics Committee. Subject to any legal obligations, all data remains confidential and publication of the results will not reveal your personal identity, and at no time will your name be reported. If you are interested, the research project outcomes will be made available to you after completion in October, 2008. The aim of the research is to explore the experiences of trauma counsellors in facilitating client’s recovery from trauma. It is hoped that this research will illustrate various therapeutic techniques and methodologies you have experienced as being effective in achieving desired outcomes.

Your involvement in this study will be to participate in one of 3 focus groups (suggested dates: June 17th [6.30-8.30pm or 19th [9.30-11.30am]) or 24th (2-4pm) or an interview and to respond to general questions in relation to your experiences of trauma counselling and outcomes. Your participation in a focus group will provide you with an opportunity to share detailed experiences of various therapeutic techniques with other experienced trauma colleagues, and have your valuable experiences heard. If you know of any other trauma counsellors who may be interested in participating in this project, please invite them to phone or email me.

Should you wish to participate in this study, it is requested that you complete a consent document which includes a confidentiality agreement. We are seeking your permission to video and audio record the session. The reason for recording the session is to ensure that an accurate record of the discussion can be transcribed verbatim and analysed. Once transcribed, the recording will be erased and anonymous transcripts stored securely, with only the researcher and supervisor to have access to it. After the study is complete, the data collected will be stored, securely at Edith Cowan University. Please understand that your participation in this study is totally voluntary and you are free to withdraw at any time without need to explain or justify yourself, and to have any data that you may have contributed destroyed. As anonymity cannot be guaranteed in a focus group you may wish to adjust your level of participation accordingly.

It is anticipated that this study will not be stressful for participants, however if you do feel stressed then you may contact either of the following staff. If you have any concerns or any questions about the project, please do not hesitate to contact me via the details below, or my supervisor, Associate Professor Denise Charman on d.charman@ecu.edu.au, (Ph 6304 5393), or if you would like to talk to an independent person, you may also contact Associate Professor Lynne Cohen, School of Psychology 6304 5575, l.cohen@ecu.edu.au. If you are interested or would like further information, I would be pleased to hear from you via email:

Yours sincerely,

Francess Day
Appendix B

Focus Group Session Guide

Before we begin, I would like to thank you for your time and decision to participate in my research. I assure you that there are no right or wrong answers and your comments will be valuable. Also, as this is focus group, anonymity is not assured, however we have all agreed to adhere to strict confidentiality regarding what is said and identity of participants.

1. I am interested to know about your experiences of working with clients who have experienced trauma. In particular, you could talk about the therapeutic techniques that you use with trauma clients. I am interested in hearing your experience of these techniques. Are there typical technique combinations that you find more effective? Please take a few minutes to write a few notes for yourself.

2. What would you say was the outcome for each of those techniques? Please explain which outcomes are possible and those that are not.

3. Can you talk about good or positive outcomes in your clients? Prompt: What are positive outcomes in your clients: behavioural, affective, cognitive, spiritual, work, love and play?

4. Please describe a successful case: that is one leading to a good outcome. What made it a good outcome? Prompt: What was good about the outcome? Please describe a less successful case with a poorer outcome.

5. Please comment on the interaction of positive outcome in clients and managed care such as Medicare and the Australian Centre for Posttraumatic Mental Health treatment guidelines (ACPMH, 2007).
Appendix C

Trauma Counsellors’ Lived Experience of Therapeutic Techniques in Relation to Trauma Recovery Outcomes

Participant Consent Form

I ________________________________ have read the information sheet provided and agree to participate in the research study conducted by Fransess Day of Edith Cowan University.

- I have read the information sheet and understand the purpose and nature of the study and am participating voluntarily.
- Questions I have asked have been answered to my satisfaction and I am aware that I can ask additional questions from the contacts on the information sheet.
- I grant the permission for the data to be used in the process of completing a Psychology Honours Project and acknowledge that it may be published.
- I understand that my identity and other demographic information, which might identify me, will be kept confidential, nor used.
- I understand that I can decline to answer questions and can withdraw from this study at any time.
- I realise there will be no adverse consequence, should I decide to cease my participation.
- I agree to maintain confidentiality in regards to focus group discussion content and identity of its participants.
- I give consent for a notetaker (the supervisor) to be present in the group discussion.
- I give consent for the session to be audio recorded and understand that the recording will be erased once the session is transcribed.
- I give consent for the session to be video recorded and understand that the recording will be erased once the session is transcribed.
  - I require the video to be turned away from me.

Signed: Research Participant __________________________ Date __________

Contact Number to notify you of any last minute changes.

Witnessed: Student Researcher __________________________ Date __________

Fransess Day (frday@student.ecu.edu.au)