A QUALITATIVE EXPLORATION OF BASIC EMOTIONS AND THE AFFECTIVE PHENOMENA OF POST-TRAUMATIC STRESS DISORDER

A thesis submitted to The University of Manchester for the degree of Doctor of Clinical Psychology (ClinPsyD) in the Faculty of Medical and Human Sciences

2015

TREVOR LANDRY

SCHOOL OF PSYCHOLOGICAL SCIENCES
Section for Clinical and Health Psychology
Contents

List of tables .................................................................................................................. 7
List of figures ................................................................................................................. 7
Abstract .......................................................................................................................... 8
Declaration ..................................................................................................................... 9
Copyright and ownership ............................................................................................. 10
Acknowledgements ..................................................................................................... 11

Paper 1: Literature Review .......................................................................................... 12
The experience of psychotherapy for post-traumatic stress disorder: a meta- synthesis of qualitative studies .............................................................................. 12

Abstract .......................................................................................................................... 13

Introduction .................................................................................................................... 15

Method ............................................................................................................................ 18
Research design ............................................................................................................. 18

Phase 1: Finding the studies and searching the literature ........................................... 19
Phase 2: Reading the studies and quality assessment ............................................... 22
Analysis ......................................................................................................................... 23

Phase 3: Determining how studies are related ......................................................... 23
Phase 4: Translating the studies into one another ...................................................... 24
Phase 5 & 6: Synthesising the translations and reporting conclusions ............... 24
Trustworthiness ............................................................................................................. 25

Results ............................................................................................................................ 25
Quality and characteristics of the included studies .................................................... 25

Meta-synthesis ............................................................................................................... 27
Second-order interpretation ........................................................................................ 30

Trauma shatters safety schemas: .............................................................................. 30
Relational ‘non-specifics’ encourage treatment engagement: ................................... 30
Participants feared reliving trauma in psychotherapy: 31
Emotion regulation strategies reduced PTSD symptoms: 32
Resolving existential dilemmas in psychotherapy restores self-identity: 32

Third order interpretation: 33

Expectations of the psychotherapeutic relationship differ across cultures: 33
Psychotherapy for PTSD nurtures personal growth: 34

Discussion: 35

Implications for clinical practice: 38
Strengths and limitations: 39

Conclusions: 40

References: 42

Paper 2: Empirical study: 50

Basic emotions and the affective phenomena of PTSD: 50
A deductive-inductive thematic analysis: 50

Abstract: 51

Introduction: 53
SPAARS theory applied to PTSD: 53
Psychopathology of basic emotions and PTSD: 54
Justification for a qualitative inquiry: 55
Study aims: 56

Method: 57
Ethics statement: 57
Version of thematic analysis: 57
Trustworthiness: 58
Reflexivity: 59
Recruitment and measures: 59
Participants: 61
Interview guide ................................................................................................................. 62
Data analysis .................................................................................................................... 65

**Results** ......................................................................................................................... 65

- *Living with fear:* ........................................................................................................ 66
- *Anger and injustice:* ................................................................................................ 67
- *Self-blame and shame:* ............................................................................................ 68
- *Tormenting and toxic emotions:* ............................................................................. 68
- *Sadness and lost self-concept:* ............................................................................... 69
- *Suppressing and avoiding unwanted emotions:* ...................................................... 70
- *Discovering the right to emotions:* ....................................................................... 71
- *Developing new emotion regulation strategies:* ..................................................... 72

**Discussion** .................................................................................................................. 73

How individuals with PTSD conceptualised basic emotions ..................................... 73
Psychotherapy for PTSD and basic emotions ............................................................. 74
How participant accounts confirm or extend theory ................................................... 76
Limitations ....................................................................................................................... 79
Recommendations for future research ....................................................................... 80

**Conclusions** ............................................................................................................... 82

**References** .................................................................................................................. 83

**Paper 3: Critical Reflection** .......................................................................................... 89

An exploration of basic emotions and the affective phenomena of PTSD: Reflections on research .................................................................................................................... 89

**Introduction** ............................................................................................................... 90

**The literature review** ................................................................................................. 90

Rationale for topic .......................................................................................................... 90
Literature search ............................................................................................................. 92
Critical appraisal of studies ......................................................................................... 93
Synthesis of papers ....................................................................................................... 94
List of tables

Paper 1 .................................................................................................................. 12

Table 1: List of search terms .................................................................................... 20
Table 2: Definition of terms ...................................................................................... 25
Table 3: Quality and characteristics of the included studies ..................................... 29
Table 4: Second and third order interpretations ....................................................... 34

Paper 2 ..................................................................................................................... 41

Table 1: Participant characteristics ......................................................................... 54

List of figures

Paper 1 ..................................................................................................................... 12

Figure 1: PRISMA informed search ......................................................................... 27
Abstract

The thesis includes three papers: paper 1 is a literature review, paper 2 is an empirical study and paper 3 is a critical reflection. Paper 1 and 2 have been prepared for submission to Clinical Psychology and Psychotherapy. Paper 1 systematically reviews the qualitative literature pertaining to individual experiences of psychotherapy for PTSD. A meta-synthesis of twelve studies was facilitated using the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) principles. The meta-synthesis aimed to explore aspects of psychotherapy for PTSD that were deemed helpful or unhelpful. The strengths and limitations of the study are considered, as are their implications for clinical practice.

Paper 2 was a qualitative exploration of basic emotions and the affective phenomena of PTSD. Semi-structured interviews were conducted with ten participants and transcripts were analysed using a deductive-inductive thematic analysis. The results highlight the importance of considering a range of basic emotions in the assessment, formulation and psychotherapy relating to PTSD. The strengths and limitations of the study are considered, as are their implications for clinical practice.

Paper 3 is not intended for publication and is a critical reflection of the overall study process. It evaluates the strengths and limitations of both paper 1 and paper 2 in more detail, in addition to offering a critical and reflective account of conducting the research.
Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.
Copyright and ownership

i. The author of this thesis (including any appendices and/or schedules to this thesis) owns certain copyright or related rights in it (the “Copyright”) and s/he has given The University of Manchester certain rights to use such Copyright, including for administrative purposes.

ii. Copies of this thesis, either in full or in extracts and whether in hard or electronic copy, may be made only in accordance with the Copyright, Designs and Patents Act 1988 (as amended) and regulations issued under it or, where appropriate, in accordance with licensing agreements which the University has from time to time. This page must form part of any such copies made.

iii. The ownership of certain Copyright, patents, designs, trade marks and other intellectual property (the “Intellectual Property”) and any reproductions of copyright works in the thesis; for example, graphs and tables (“Reproductions”), which may be described in this thesis, may not be owned by the author and may be owned by third parties. Such Intellectual Property and Reproductions cannot and must not be made available for use without the prior written permission of the owner(s) of the relevant Intellectual Property and/or Reproductions.

iv. Further information on the conditions under which disclosure, publication and commercialisation of this thesis, the Copyright and any Intellectual Property and/or Reproductions described in it may take place is available in the University IP Policy (see http://documents.manchester.ac.uk/DocuInfo.aspx?DocID=487), in any relevant Thesis restriction declarations deposited in the University Library, The University Library’s regulations (see http://www.manchester.ac.uk/library/aboutus/regulations) and in The University’s policy on Presentation of Theses.
Acknowledgements

I would like to thank my supervisors Dr John Fox, Dr Daniel Pratt and Dr Liz Ballinger for their encouragement and guidance throughout this project. I would also like to thank all of the NHS clinicians who helped with recruitment.

I am grateful to the individuals who took part in the empirical study and admire their honesty, bravery and desire to help others by telling their stories. I am also indebted to my family and friends for your patience and support over the last three years as I have immersed myself in the training.

Finally, to my wonderful wife and two beautiful daughters, without whom this thesis would not have been written. Your hugs, patience, hard work and love made it possible for me to somehow believe that I could, even when I felt I couldn’t. Thank you and I look forward, more than anything, to having more time with all of you.
Paper 1: Literature Review

The experience of psychotherapy for post-traumatic stress disorder: a meta-synthesis of qualitative studies

Paper 1 has been formatted for submission to Clinical Psychology and Psychotherapy in line with the published guidelines for contributors (Appendix A). Tables and figures have been incorporated into the text in the thesis for ease of readability; however, for submission to the journal these will be submitted as separate sheets as suggested in the guidance. Formatting guidelines for the journal have been adhered to as closely as possible, whilst following The University of Manchester Presentation of Thesis Policy.

Paper 1 is a systematic review of the qualitative literature concerning the experience of psychotherapy for post-traumatic stress disorder (PTSD). The review produced a meta-synthesis of twelve qualitative studies in order to understand valued aspects of psychotherapy for PTSD.

The research team are referred to in the paper by their initials:

Trevor Landry (TL) Main researcher
Dr Daniel Pratt (DP) Academic supervisor
Dr Liz Ballinger (DB) Field supervisor
Dr Julie Wisely (JW) Field supervisor
Dr John Fox (JF) Academic/Field supervisor

Word Count: 6314
(excluding contents, appendices and references)
Abstract

Context: Historically, Post-Traumatic Stress Disorder (PTSD) has been categorised and treated using exposure based therapies; however, this study has illustrated how other critical psychotherapeutic components may be helpful including feeling safe, a trusted relationship and managing difficult emotions.

Objectives: The current review produced a synthesis of qualitative studies pertaining to the experience of psychotherapy for post-traumatic stress disorder (PTSD) in order to inform clinical practice.

Method: Literature databases were searched for all relevant articles published until the end of June 2015. The Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) principles were applied in order to conduct a meta-synthesis of qualitative studies.

Results: Twelve studies, representing the views of 180 participants, met the inclusion criteria. Five second order interpretations were derived from the synthesis: trauma shatters safety schemas; relational ‘non-specifics’ encourage treatment engagement; participants fear reliving trauma in psychotherapy; emotion regulation strategies reduced PTSD symptoms; resolving existential dilemmas in psychotherapy restores self-identity. The interrelationship of second order interpretations were considered in context and two, third order interpretations were conceptualised that were congruent with the original studies, yet went beyond them.
**Conclusions:** Recovery from PTSD is a very difficult process; practitioners require skills that go beyond conventional psychotherapy. A good therapeutic relationship and interventions that address a broad range of emotional and cognitive phenomenon can aid personal growth.

**Key Practitioner Message**

- ‘Person-centred’ service delivery is a necessary and important aspect of clinical work. There is a need for improved understanding of what constitutes valued psychotherapy from the perspectives of PTSD survivors.

**Keywords:** Post traumatic stress disorder (PTSD), psychotherapy, meta-synthesis.
Introduction

Given the range of procedures that are considered ‘psychotherapy’ arriving at a comprehensive definition for the word is challenging. Psychotherapy has been used to describe a variety of interventions including art therapy, equine therapy and ‘eco’ therapy amongst many others (Chalquist, 2009; Lobban, 2014; Masini, 2010). However, for the purpose of this review psychotherapy refers to ‘talking therapies’ whereby psychological problems are treated through communication and relationship factors between individuals and psychotherapists (Butler & Strupp, 1986). Psychotherapy differs from other interactions as it is grounded in a professional relationship that is based on psychological theory, process and technique (Butler & Strupp, 1986; Dryden, 2007).

What constitutes ‘good’ psychotherapy has been thoroughly debated throughout the history of clinical psychology (Butler & Strupp, 1986; Frank & Frank, 1993; Rosenzweig, 1937; Roth & Fonagy, 2013). There have been a number of processes and techniques in psychotherapy that have been investigated for their efficacy including the therapeutic relationship, expectancy effects and specific psychotherapeutic techniques (Lambert, 1992; Martin, Garske, & Davis, 2000; Wiggins, Elliott, & Cooper, 2012).

Psychotherapy for post-traumatic stress disorder (PTSD) has been influenced by a range of psychological theory and perspectives. Conventionally, psychotherapy for PTSD has been based on fear conditioning models and focused on processing fear related memories using trauma focused cognitive behavioural therapy (TF-CBT) interventions and eye movement desensitisation and reprocessing (EMDR)
Although exposure based interventions have been found to be effective for reducing stress and anxiety with PTSD patients (Bisson et al., 2007), further research has indicated that more than half of individuals with PTSD consider other emotions problematic and did not benefit from exposure based psychotherapy (Grey, Holmes, & Brewin, 2001; Power & Fyvie, 2012). Clinical trials indicate that TF-CBT may not be effective psychotherapy for ‘complex’ PTSD (Bisson et al., 2007; Herman, 1992; Holmes, Grey, & Young, 2005). For example, ‘Type I’ single event trauma may be more responsive to brief manualised psychotherapy while ‘Type II’ PTSD may benefit from more integrative formulation and psychotherapy (Herman, 1992; Lee, Scragg, & Turner, 2001). Therefore, there is mounting evidence that current guidelines directing practitioners to use exposure based interventions for the treatment of PTSD may be insufficient, particularly for complex presentations.

Psychotherapy for PTSD and other mental health difficulties have typically been evaluated using self-report measures to assess symptom changes (Beck, Steer, & Carbin, 1988; Beck et al., 2008; Glad, Jensen, Holt, & Ormhaug, 2013; Keane, Weathers, & Foa, 2000). Although this approach is necessary to evaluate the efficacy of psychotherapy upon symptom change, the lived experience of psychotherapy should be understood regardless of impact on symptoms in order to determine difficulties with accessibility and acceptability of interventions. Qualitative methods can add to outcome based studies in order to help understand complex processes and skills used by practitioners in psychotherapy (Rennie, 1994). Consequently, psychotherapy researchers have been using qualitative
research methodologies to explore the complex processes and skills that are valued aspects of psychotherapy. They argue that qualitative inquiry methods allow a focus on subjectivity that is appropriate for understanding what processes and interventions used in psychotherapy are valued by patients in service (McLeod, 2012; Rennie, 1994). By doing this psychotherapists may gain added insight into what processes and interventions are favoured by patients accessing psychological support for PTSD. This may in turn help to increase patient satisfaction, reduce dropout rates and improve treatment outcomes.

Noblit and Hare (1988) suggest there is an inherent lack of effort to ‘put together’ the findings from qualitative research. Sandelowski (1996) adds that in order for qualitative research to have an impact it should be situated in a larger interpretive context. Therefore this paper aims to review and synthesise qualitative studies relating to the topic, in order to inform clinical practice. Thorne, Jensen, Kearney, Noblit, and Sandelowski (2004) described meta-synthesis as an effective method for ‘bringing together’ qualitative research. Morse (1997) also suggested that meta-synthesis can be used to expose essential phenomena in existing qualitative research and transform data into an integrated whole. In addition, the drive to put patients first is ethically and organisationally imperative (NICE, 2012; Norcross & Wampold, 2011). Meta-synthesis has helped mental health services to go beyond cause and effect conclusions towards explanatory theories about recovery from anorexia (Espindola & Blay, 2009) and sexual violence (Draucker et al., 2009). Meta-synthesis has also been used to explore aspects of PTSD including childhood experiences of trauma and treatment (van Floryt, Alisic, & Boeije, 2014; van Floryt, Boeije, Alisic, & Drost,
2012), vicarious trauma (Cohen & Collens, 2012) and traumatic child-birth (Beck, 2011). However, to date there does not appear to be a meta-synthesis of the qualitative literature pertaining to adult experiences of psychotherapy for PTSD. It was anticipated that by synthesising a diverse range of personal views on psychotherapy for PTSD that this review would help to inform psychotherapists and service providers of which processes and techniques were perceived as helpful or unhelpful.¹

**Method**

**Research design**

The synthesis was conducted using principles of meta-ethnography and followed guidance published by Noblit and Hare (1988). Meta-ethnography consists of six intersecting and often parallel phases: finding relevant studies, reading and rereading selected studies, determining how studies are related, translating the studies into one another, synthesising the translations and reporting conclusions (Noblit & Hare, 1988). The review was conducted using Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) principles to ensure transparency (Appendix B; Moher, Liberati, Tetzlaff, & Altman, 2009)

¹ Discussed further in paper 3, p. 75
Phase 1: Finding the studies and searching the literature

Published articles investigating participant experiences of psychotherapy for PTSD were identified using computerised searches of the following databases: Allied and Complimentary Medicine Database (AMED), British Nursing Index (BNI), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Excerpta Medica Database (EMBASE), Medical Literature Analysis and Retrieval System Online (MEDLINE), Ovid Technologies (OVID) and the American Psychological Association database (PsycINFO). All original articles that had been published until the end of June 2015 were included in the review. Reference lists for the included articles were also scrutinised for additional articles that may be relevant for review. Influential journals related to the topic were also searched manually (European Journal of Psychotraumatology Journal of Aggression, Maltreatment & Trauma, Journal of Loss and Trauma, Journal of Trauma & Dissociation, Journal of Psychological Trauma, Journal of Traumatic Stress, Psychological Trauma: Theory, Research, Practice and Policy, Trauma, Violence & Abuse, Traumatology).

Due to a dearth of qualitative literature relating to the topic it was necessary to include articles from a variety of qualitative traditions to ensure ‘conceptual saturation’ (Thomas & Harden, 2008). Daly et al. (2007) suggest using clear search criteria to enable the synthesis to be strategically focused and identify the most relevant data. PICO (Population/problem, Intervention/exposure, Comparison, and Outcome) is a widely used tool for helping to streamline systematic reviews (Booth, O’Rourke, & Ford, 2000; Sbardt, Adams, Owens, 2000).

---

2 Discussed further in paper 3, p. 76
Keitz, & Fontelo, 2007; Villanueva, Burrows, Fennessy, Rajendran, & Anderson, 2001) and has been adopted by the Cochrane Collaboration (Higgins & Green, 2008). PICO has been adapted and used in qualitative research (Cooke, Smith, & Booth, 2012; Smith & Lavender, 2011; Sykes & Temple, 2012). The ‘C’ in PICO stands for comparison which is relevant only in quantitative research, therefore, the first author used a more fitting category of ‘conceptualisation’ related to qualitative design. Including research design in search terms has been found useful when completing a qualitative meta-synthesis (Evans, 2002; Shaw et al., 2004). See table 1 for further details on search criteria, terms and combinations used.

**Table 1: List of search terms**

| P | Population/problem Terms relating to the population being investigated | "POST TRAUMATIC STRESS DISORDER*" OR "POSTTRAUMATIC STRESS DISORDER*" OR PTSD OR "POST TRAUMATIC STRESS" OR "POSTTRAUMATIC STRESS"

| I | Intervention/exposure Terms relating to the interventions used. | PSYCHOTHERAP* OR THERAP* OR COGNITIVE OR BEHAVIOUR* OR TFCBT OR CBT OR EMDR OR "EYE MOVEMENT DESENSITISATION" OR REPORORCESSING OR EXPOSURE OR COUNSELLING OR PSYCHODYNAMIC OR SCHEMA OR "COMPASSION FOCUS*" OR MBCT OR MINDFULLNESS OR EMOTION* OR "ACCEPTANCE AND COMMITMENT" OR ACT OR DIALECTICAL OR DBT OR GROUP OR RESTRUCTUR* |

| C | Conceptualisation/Method Terms related to the qualitative research design. | QUALITATIVE OR "MIXED METHOD*" OR “QUALITATIVE INQUIRY” OR ETHNOGRAPH* OR "GROUNDED THEORY" OR PHENOMOLOG* OR NARRATIVE* OR DISCOURSE* OR THEMATIC* OR HEURISTIC OR HERMENEUTIC OR IPA |

| O | Outcome Terms relating to the outcomes and experiences of participant’s | EXPERIENCE* OR PERCEPTION* OR PERSPECTIVE* OR VIEWS* OR "PATIENT SATISFACTION" OR "PATIENT REPORTED OUTCOME*" OR PREFERENCE* |
The following criteria were used to decide whether studies were included in the review:

- Published, peer-reviewed study
- Original study published until the end of June 2015
- Qualitative research study with an identifiable theoretical framework and analysis based on interpretive qualitative research methods (e.g. grounded theory, interpretative phenomenological analysis, narrative analysis and thematic analysis)
- A study written in English
- A study focused on patient experiences of psychotherapy for PTSD.
- A study including adult (over 18) participants of any gender or nationality.

Studies that met the following criteria were excluded from the review:

- A study that used a quantitative design
- A study that used integrative analysis and involved the quantification of data (e.g. content analysis)
- A study written in a language other than English
- A study that involved a secondary analysis of original studies
- A study analysing the views of others (e.g. family, carers)
- A study lacking a specific focus on psychotherapy for PTSD
- Case studies and books.
**Phase 2: Reading the studies and quality assessment**

Initially the articles were read and re-read by TL enabling a process of immersion and familiarisation with the included studies. At this stage methods, quality, ethical procedures, and research context were evaluated using the CASP (Critical Appraisal Skills Programme) qualitative research checklist (Appendix D; CASP, 2014). Each of the 10 items were rated:

Score 1 = the study did not meet the criteria;
Score 2 = the study partially met the criteria;
Score 3 = the study fully met the criteria.

All studies were evaluated using the CASP and assigned a quality classification of: ‘A’ ‘B’ or ‘C’. Articles were ranked as follows:

A) = The study was of high quality, with no or few flaws (total score ≥ 20).
B) = The study was of moderate to good quality, with few or some flaws (total score ≥ 10 but <20)
C) = The study was of low quality, with significant flaws (total score < 10).

No studies were excluded on the basis of quality, with the aim of being as inclusive as possible and ensuring that relevant studies were not missed (Sherwood, 1997). However, the quality of studies did impact on the sequencing of analysis and priority being given to ‘A’ rated articles which were reviewed first according to chronology. Campbell et al. (2003) suggest that the order in which articles are reviewed gives weight to the overall synthesis as concepts are produced inductively.

---

3 Discussed further in paper 3, p. 77
In order to enhance the rigour and validity of the quality ratings the research articles were reviewed by an external moderator using the CASP. Although there are no strict guidelines on the level of agreement using the CASP, Andersson & Nilsson (1964) suggest an acceptable level of agreement between reviewers in qualitative research should be 75-85%. In the present study, the average percentage of agreement between TL and the external moderator was 92% which indicated a high level of agreement in terms of the overall scoring of the CASP. Where there was disagreement a consensus score was determined.

**Analysis**

Unlike meta-analysis of quantitative research, meta-synthesis is interpretive rather than aggregative, requiring the researcher to engage in an inductive process of constant comparison and analysis of qualitative articles, creating new interpretations in the process (Britten et al., 2002; Walsh & Downe, 2005). Schutz's (1971) notions of first, second and third order interpretations were used to determine concepts related to participant experiences and author interpretations (see table 2 for definitions).

**Phase 3: Determining how studies are related**

Studies were initially reviewed for relatedness and suitability for synthesis (Noblit & Hare, 1988). Each study was examined thoroughly for details that may be relevant to the concept including participant perceptions, psycho-social factors, type of psychotherapy and cultural factors.
**Phase 4: Translating the studies into one another**

Next concepts were revised and merged into categories; for example, ‘trust’ became a more encompassing category of ‘positive relationships in psychotherapy’ by considering how they were related and by referring to the original text. This enabled metaphors and concepts to be compared between articles using reciprocal translation analysis (Noblit & Hare, 1988; Walsh & Downe, 2005; see table 2 for definitions).

**Phase 5 & 6: Synthesising the translations and reporting conclusions**

In a similar manner to which a primary study aims to move beyond description towards an explanatory theory, a meta-ethnography can often produce third-order interpretations that are not only consistent with the original results but also extend beyond them (Britten et al., 2002; Campbell et al., 2003). ‘Line of argument’ synthesis (Noblit & Hare, 1988) was used to construe third order interpretations from first and second order interpretation of the primary studies (Britten et al., 2002; Walsh & Downe, 2006; see table 2 for definitions)

**Table 2: Definition of terms**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>First-order interpretation</td>
<td>Interpretations of participant experiences, as indicated in the studies</td>
</tr>
<tr>
<td>Second-order interpretation</td>
<td>Interpretations of the authors understanding of patient experience</td>
</tr>
<tr>
<td>Third- order interpretation</td>
<td>The synthesis of both first and second order interpretations into a new model or theory about a phenomenon</td>
</tr>
<tr>
<td>Reciprocal translation</td>
<td>Comparing and contrasting concepts across studies in order to capture a common interpretation.</td>
</tr>
<tr>
<td>Line of argument synthesis</td>
<td>The development of a new model, theory or understanding by synthesising and interpreting first and second order concepts found in the text.</td>
</tr>
</tbody>
</table>
**Trustworthiness**

Several methods were used to achieve trustworthiness during the analysis (Lincoln & Guba, 1985). First of all TL used evidence based procedures to enhance the reliability of the review and analysis using principles of meta-ethnography by Noblit and Hare (1988). TL read and re-read the articles while noting down initial thoughts and concepts in an ongoing research journal. Although the analysis was completed by TL, regular supervision and peer support from DP and JK contributed to the development of concepts and interpretations. This was also a forum at which to explore disconfirming cases and rival hypotheses when the data did not unanimously support the analysis and offered an additional means of triangulation (Morse, 1997; Patton, 1990).

**Results**

**Quality and characteristics of the included studies**

There were 2330 potentially relevant studies identified using the search terms in combinations that maximised access to potentially relevant articles (see Appendix C for details). After screening for eligibility using the inclusion and exclusion criteria, 12 studies were included in the review. Figure 1 details the results of the search strategy.
The 12 studies selected included the accounts of 109 women, 61 men and 10 participants with unknown genders predominately from high income countries including Canada, Denmark, Israel, Norway, UK and USA. The papers consisted of primarily mixed samples of genders and ages ranging between 18 and 70 years old. Participants engaged in a range of psychotherapies including trauma, focused cognitive behavioural therapy, compassion focused therapy, mindfulness based stress reduction and other integrative psychotherapies. Most papers did
not account in much detail what specific psychotherapeutic interventions and protocols were used. Eleven studies used individual interviews to collect data and one used an impact statement questionnaire. Data were originally analysed using a variety of methodologies; for example, grounded theory, interpretative phenomenological analysis (IPA), narrative analysis and thematic analysis. Table 3 shows additional information pertaining to the 12 studies.

The quality ratings of the studies ranged from 14 to 27 out of 30, results indicated that five were classified as ‘A’, of high quality, with no or few flaws and seven classified as ‘B’ indicating moderate to good quality, with few or some flaws. Priority was given to articles with a category ‘A’ ratings and these were reviewed first when conducting the synthesis. Only six articles acknowledged ethical approval and most articles do not discuss consent, confidentiality and personalisation when arranging interviews. There was; however, evidence of good research aims, participant selection, amply described analysis and outcome reporting across most articles.

**Meta-synthesis**

Five second-order concepts emerged from the synthesis of articles including safety, positive relationships in psychotherapy, fear and anxiety, emotion regulation strategies and self-integration. These concepts were used to derive five second-order interpretations discussed further below and summarised in table 4.

---

4 Discussed further in paper 3, p. 78
<table>
<thead>
<tr>
<th>Author/year</th>
<th>Country</th>
<th>Participants</th>
<th>Confirmation of PTSD</th>
<th>Psychotherapeutic intervention</th>
<th>Data collection</th>
<th>Data analysis</th>
<th>Quality rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ajdukovic et al., 2013</td>
<td>International</td>
<td>20 women and 23 men (age 27-57): 17 ongoing symptoms of PTSD 26 past symptoms of PTSD</td>
<td>Screened for DSM-IV criteria Screened for current or past professional diagnosis</td>
<td>Integrative psychotherapy</td>
<td>Interviews</td>
<td>Thematic analysis</td>
<td>A</td>
</tr>
<tr>
<td>Bermudez et al., USA</td>
<td>USA</td>
<td>10 women (age 31-62) 9 African American 1 Asian American 6 with children 5 employed 5 unemployed</td>
<td>Experienced trauma, including intimate partner violence, and had scores of 35 or above on the Post-traumatic Stress Check List (PCL).</td>
<td>Group Mindfulness Based Stress Reduction (MBSR)</td>
<td>Interviews</td>
<td>IPA</td>
<td>B</td>
</tr>
<tr>
<td>Harvey, 2001</td>
<td>USA</td>
<td>3 women (age 28-42): 1 single 2 parents</td>
<td>Self-reported 3/3 = had received psychiatric treatment</td>
<td>Individual Narrative Therapy</td>
<td>Interviews</td>
<td>Narrative analysis</td>
<td>B</td>
</tr>
<tr>
<td>Kallivayalil et al., USA</td>
<td>USA</td>
<td>13 women and 1 man (age 24-62) 13 Caucasian 1 Asian</td>
<td>Screened for professional diagnosis and engaged with treatment programme</td>
<td>Narrative psychotherapy</td>
<td>Interviews</td>
<td>Grounded theory</td>
<td>B</td>
</tr>
<tr>
<td>Lawrence &amp; Lee, 2013</td>
<td>UK</td>
<td>5 women and 2 men (age 30-54): 4 group psychotherapy 3 individual psychotherapy</td>
<td>Screened for DSM-IV criteria</td>
<td>Mixed individual and group based Compassion Focused Therapy (CFT)</td>
<td>Interviews</td>
<td>IPA</td>
<td>B</td>
</tr>
<tr>
<td>Mirdal et al. 2012</td>
<td>Denmark</td>
<td>7 women and 9 men(age 31-55): 12 married, 2 single, 2 divorced 4 employed 11 unemployed 13 have children 15 Muslim 1 Christian</td>
<td>Successful completion of treatment; met diagnostic criteria on admission</td>
<td>Unspecified psychological treatment</td>
<td>Interviews</td>
<td>IPA</td>
<td>A</td>
</tr>
<tr>
<td>Author/year</td>
<td>Country</td>
<td>Participants</td>
<td>Confirmation of PTSD</td>
<td>Psychotherapeutic intervention</td>
<td>Data collection</td>
<td>Data analysis</td>
<td>Quality rating</td>
</tr>
<tr>
<td>-------------</td>
<td>---------</td>
<td>--------------</td>
<td>----------------------</td>
<td>--------------------------------</td>
<td>-----------------</td>
<td>--------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Parker et al. 2008</td>
<td>Canada</td>
<td>6 women (31-70) 1 single 3 married 2 divorced 4 have children 5 employed 1 unemployed</td>
<td>Self-report of history and participation in treatment programme</td>
<td>Group Psychotherapy Women Recovering from Abuse Program (WRAP)</td>
<td>Interviews</td>
<td>IPA</td>
<td>B</td>
</tr>
<tr>
<td>Price, MacDonald, Adair, Koerner, &amp; Monson, 2014</td>
<td>International</td>
<td>2 women, 13 men (mean age 52.87) 10 married 12 Vietnam veterans</td>
<td>Screened for professional diagnosis and engaged with treatment programme</td>
<td>12 sessions of Cognitive Processing Treatment (CPT)</td>
<td>Impact statement questionnaire</td>
<td>Thematic analysis</td>
<td>B</td>
</tr>
<tr>
<td>Shearing, Lee, &amp; Clohessy, 2011</td>
<td>UK</td>
<td>6 women, 1 man (age 20-50) 2 married with children 2 in relationships 3 single</td>
<td>Diagnosis of PTSD (type 1) and currently receiving CBT treatment</td>
<td>Individual Trauma Focussed Cognitive Behavioural Therapy (TFCBT)</td>
<td>Interviews</td>
<td>IPA</td>
<td>A</td>
</tr>
<tr>
<td>Stige, Rosenvinge, &amp; Traen, 2013</td>
<td>Norway</td>
<td>13 women (age 18-60): 10 have children 4 study or working 9 unemployed</td>
<td>Current active symptoms according to ICD-10 PTSD Dislosed exposure to trauma Completed treatment</td>
<td>Inclusive stabilisation group approach</td>
<td>Interviews</td>
<td>IPA</td>
<td>A</td>
</tr>
<tr>
<td>Tummala-Narra, Kallivayalil, Singer, &amp; Andreini, 2011</td>
<td>USA</td>
<td>18 women, 3 men (age 24-62): 19 Caucasian 1 Asian American 1 African American</td>
<td>Screened for professional diagnosis and engaged with treatment programme</td>
<td>Mixed group and individual psychotherapy using ecological and stage model perspectives (Harvey, 1996; Herman, 1992)</td>
<td>Interviews</td>
<td>Grounded theory</td>
<td>A</td>
</tr>
<tr>
<td>Vincent, Jenkins, Larkin, &amp; Clohessy, 2012</td>
<td>UK</td>
<td>3 women and 4 men (age 19-42):</td>
<td>Screened for professional diagnosis and engaged with treatment</td>
<td>Individual Trauma Focussed Cognitive Behavioural Therapy (TFCBT)</td>
<td>Interviews</td>
<td>IPA</td>
<td>B</td>
</tr>
</tbody>
</table>
Second-order interpretation

*Trauma shatters safety schemas:*

Participants described ongoing struggles with their perception of safety, such as diminished trust in others and a general appraisal of the world as an unsafe place. As one participant noted, “*I feel extremely vulnerable and powerless in the world. I see people as vicious*” (Tummala-Narra et al., 2011). This may explain, at least partially, why PTSD patients are reluctant to engage in psychotherapy (Hembree et al., 2003; Schottenbauer, Glass, Arnkoff, Tendick, & Gray, 2008). Participants used a variety of safety strategies in order to feel safe including avoidance, suppression, denial and self-criticism (Mirdal et al., 2012; Price et al., 2014; Tummala-Narra et al., 2011; Vincent et al., 2012). Participants valued psychotherapists that addressed practical safety concerns (problem solving on issues of housing, finance) and psychological safety concerns (developing emotion regulation strategies).

*Relational ‘non-specifics’ encourage treatment engagement:*

Participants esteemed psychotherapists who were trustworthy, kind, challenging, good-listeners and knowledgeable (Bermudez et al., 2013; Lawrence & Lee, 2013; Shearing et al., 2011; Tummala-Narra et al., 2011; Vincent et al., 2012). Some non-western participants described their psychotherapist as ‘family’ and felt ‘appreciated and loved’ by them (Mirdal et al., 2012) going beyond traditional boundaries in psychotherapy. Psychotherapist that were perceived as overly passive and uninterested were described as irritating and ‘a waste of time’, adding to emotional difficulties (Ajdukovic et al., 2013). Given that participants described entering services distrusting professionals and experiencing a great
deal of fear about psychological procedures, good psychotherapeutic relationships had to initiate and maintain a safe place for participants to confront their difficulties.

**Participants feared reliving trauma in psychotherapy:**

Traumatic events seemed to unveil the possibility of threat and increase personal vulnerability. This was exacerbated by PTSD symptoms that made participants feel out of control of their thoughts, emotions and bodies. Participants experienced a great deal of anticipatory anxiety about engaging with psychotherapy, particularly when interventions involved reliving traumatic memories such as TFCBT. “I’d been avoiding it for ages, [...] I’m just scared of it.” (Shearing et al., 2011). However, with careful support, and with the use of psychological techniques individuals faced their fear and realised that they did not need to be so scared “...my misgivings and my concerns about how I was going to feel and how awful it was going to be were unfounded” and TFCBT helped participants to regain a sense of control over flashbacks and intrusive thoughts, ‘I don’t feel as scared of the memory if that makes sense’ (Shearing et al., 2011). Sheer desperation to relieve PTSD symptoms and feel normal seemed to be primary motivators to engage with psychotherapy; however, participants accounted for the importance of the therapeutic relationship and learning skills to regulate difficult emotions when preparing for exposure work (Shearing et al., 2011; Vincent et al., 2012).
Emotion regulation strategies reduced PTSD symptoms:

“Emotions seemed to change, they were more sensitised” (Harvey, 2001). Emotions were appraised differently after the trauma occurred leaving participants experiencing their emotions as sensitised. The word ‘sensitised’ was used to illustrate how emotions had become quick to initiate, overwhelming and difficult to control. A variety of intrusive and difficult emotions were described throughout the papers including fear, sadness and anger. Participants initially attempted to repress and avoid these emotions. Some criticised themselves harshly for their role in traumatic experiences and for having these emotions which seemed to initiate other tertiary emotions of guilt and shame. Psychotherapy helped participants to develop new emotion regulation strategies, such as self-compassion, self-soothing, relaxation, acceptance and mindfulness (Bermudez et al., 2013). Paradoxically by rejecting the strategy of suppression and starting to accept difficult emotions participants seemed to regain a sense of agency and control.

Resolving existential dilemmas in psychotherapy restores self-identity:

Kira (2010) reasoned that the integration of affect and cognition can enable a more coherent and cohesive sense of self. Traumatic experiences rendered participants questioning their values, purpose and even who they were; “I didn’t have myself, a sense of myself as being a child even or a little girl. I had a sense of myself as being somehow monstrous I think” (Kallivayalil et al., 2013). Participants experienced ego-dystonic thoughts and emotions and strategies used to suppress them were ineffective rendering individuals in a feeling overwhelmed by their emotions. Trauma engenders helplessness, meaninglessness, and
disconnection from self and others (Lebowitz, Vitiello, & Norquist, 2003). Accordingly, participants valued psychotherapy that provided a safe place that helped them to address (or redress) these issues. Papers were sparse about how this was achieved but participants rated highly being able to re-evaluate their values, relationships, purpose and setting goals for the future.

**Third order interpretation**

*Expectations of the psychotherapeutic relationship differ across cultures:*

There is a clear need for cultural specific and relevant psychotherapy (Pederson, Lonner, Draguns, Trimble, & Scharrón-del Río, 2015). Second-order interpretations highlight how valuable the therapeutic relationship was across all studies; however, the appraisals of these relationships varied comparatively and participants from non-western cultures appeared to have a different expectation and/or experience of the therapeutic relationship. This seemed particularly important with PTSD patients who were seeking asylum. There were explicit cultural differences in accounts of the ‘depth’ of relationship experienced in psychotherapy. For example, accounts of asylum seekers with a diagnosis of PTSD described their psychotherapist as ‘family’ or ‘a friend’ and described feeling ‘appreciated or loved’ (Harvey, 2001; Vincent et al., 2012). Some participants in non-western cultures valued support that would go beyond traditional clinical boundaries such as their therapists lending them money or contacting them out of clinic hours (Mirdal et al., 2012). This third-order interpretation supports the importance of cultural ‘responsiveness’ and specifically illustrates how PTSD patients from diverse culture backgrounds may expect a closer, less boundaried, therapeutic relationship.
Psychotherapy for PTSD nurtures personal growth:

Second order interpretations seemed to illustrate how participants engaged in a process of personal growth as the result of their experiences in psychotherapy. Psychotherapy provided safe space where participants began to appraise their circumstances and future differently, “I feel like I've got a future now, which I didn't feel like six months ago” (Lawrence & Lee, 2013) and some had developed a greater appreciation for life in general; “I look forward to every day, I get a real sense of happiness and a real sense of achievement” (Lawrence & Lee, 2013). Although not expressed explicitly in the papers, second order interpretations of valued aspects of psychotherapy seemed to initiate an overall shift in core beliefs, “I just look at things completely differently now” (Shearing et al., 2011). Therefore, psychotherapy appeared to enable ‘metacognitive reconfiguration’ (Joseph & Linley, 2006) and to enable growth from trauma.

Table 4: Second and third order interpretations

<table>
<thead>
<tr>
<th>Concepts</th>
<th>Second -order interpretations</th>
<th>Third-order interpretations</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAFETY: vulnerability, helplessness, psychosocial stability, loss of control</td>
<td>Trauma shatters safety schemas</td>
<td></td>
</tr>
<tr>
<td>POSITIVE RELATIONSHIPS IN PSYCHOTHERAPY: authentic, trusted witness, kindness, sincerity</td>
<td>Relational ‘non-specifics’ encourage treatment engagement</td>
<td>Cultural expectations of psychotherapeutic relationships are different</td>
</tr>
<tr>
<td>FEAR AND ANXIETY: ambivalence, fear of trauma memories, fear of reliving trauma, psychotherapy was ‘hard work’.</td>
<td>Participants fear reliving trauma in psychotherapy</td>
<td></td>
</tr>
<tr>
<td>EMOTION REGULATION STRATEGIES: Coping with basic emotions, managing tertiary emotions of guilt and shame, emotion overwhelm.</td>
<td>Emotion regulation strategies reduced PTSD symptoms</td>
<td></td>
</tr>
<tr>
<td>SELF-INTEGRATION: reconnecting, negotiating values, changing beliefs, planning for the future, recovery.</td>
<td>Resolving existential dilemmas in psychotherapy restores self-identity</td>
<td>Psychotherapy for PTSD nurtures personal growth</td>
</tr>
</tbody>
</table>
Discussion

Five second-order interpretations emerged through translating concepts across the studies into each other, which illuminated valued aspects of psychotherapy for PTSD. Second-order interpretations were used to construct two third-order interpretations which were not only congruent with second-order interpretation but went beyond these descriptions (see table 4).

Historically, overcoming fear has been the focus of psychotherapeutic interventions for PTSD because traumatic events have been found to cause fragmented beliefs and assumptions about safety (Brewin & Holmes, 2003; Horowitz, 1976). Hembree and Foa (2000) suggested that this fear is different from other anxiety disorders because core beliefs about safety have been shattered. In fitting with the literature, the current synthesis highlighted how fear and safety concerns were experienced by some of the participants which may account for poor levels of engagement in therapy across mental health services (Hembree et al., 2003; Schottenbauer, Glass, Arnkoff, Tendick, & Gray, 2008; Tarrier, Liversidge, & Gregg, 2006; Wierzbicki & Pekarik, 1993). Participants also expressed fearing psychotherapy. This was maintained by the fear of reliving trauma and exacerbated by shattered safety schemas. Meeting basic safety and esteem needs, according to Maslow (1955), is essential to connecting with others and experiencing growth. Participants prioritised the need for a basic level of psycho-social and emotional safety in order to engage with psychotherapy. Additional, psychotherapeutic techniques including exposure and relaxation also helped participants to gain a sense of control and regulation of uncontrollable symptoms, such as dissociation and flashbacks. However, fear and
anxiety were not the dominant difficulty for all participants who seemed to struggle with a range of difficult emotions and symptoms which is supported in the literature (Power & Fyvie, 2012). Non-anxious participants valued learning new emotion regulation strategies in order to regulate a variety of difficult emotions including being more accepting, compassionate and mindful. This replaced prior strategies of repression, denial and avoidance which are prolific coping strategies found in PTSD patients (Bisson et al., 2007).

Qualities of the therapeutic relationship including authenticity and trust were valued by participants and were key to successful psychotherapeutic engagement. There exists an abundance of literature supporting the psychotherapeutic relationship as ‘necessary’ for trust, engagement, change and to foster self-actualisation (Mearns & Cooper, 2005; Rogers, 2012). Valued features of psychotherapeutic relationships expressed in the articles included various non-specific qualities; being non-judgemental, sincere, and kind; however, participants also valued an active and knowledgeable psychotherapist who could give advice and help them to understand PTSD symptoms. This was particularly relevant to a PTSD population who may be reluctant to engage in therapy and may have difficulty in trusting professionals. A positive therapeutic relationship helped participants to trust again and feel safe enough to continue with therapy. However, expected boundaries and the depth of the therapeutic alliance were described differently by non-western participants. Although there is likely a great deal of cultural and diagnostic heterogeneity, this synthesis has highlighted that non-western PTSD patients may expect a deeper and less boundaried relationship with their psychotherapist. A mismatch in expectations between therapist and
patient may lead to further marginalisation and difficulties being experienced by patients. Hall (2001) argues that developing culturally responsive therapy is not only supported in evidence but is ethically imperative. Therefore, it is paramount that practitioners and services take into account these differences and the need to offer psychotherapy that is cultural competent (Pederson et al., 2015).

PTSD symptoms inundated participants with overwhelming thoughts, sensations and emotions that were ego-dystonic. This rendered some individuals with a lost sense of identity. Gaining a deeper understanding of symptoms, assurances of normality and developing new ways to manage difficult emotions helped participants to rebuild their identity, gain confidence and feel safe again. This interpretation was cross cutting and was used to develop a third-order interpretation that went beyond the articles in what has been described as personal growth in psychotherapy. Growth seemed to be nourished in psychotherapy through a gradual process of regenerating meaning, reconnecting with self and learning ways to cope with difficult symptoms. Prominent theorists in the area of post traumatic growth (PTG; Joseph & Linley, 2006; Tedeschi & Calhoun, 2004) suggest that trauma challenges an individual’s model of the world (schemas). Schemas can stay the same (assimilation), become enhanced (positive assimilation) or become diminished (negative accommodation). Joseph and Linley (2006) equate positive accommodation with growth and negative accommodation with psychopathology and distress. Accounts in the papers attest to changed schemas, potentially PTG, although the mechanisms for this change are not entirely clear from the accounts in the paper, psychotherapy seems to
involve a process of regenerating self-identity and meaning making that can change schemas relating to trauma in a positive manner.

**Implications for clinical practice**

As illustrated above, a key role for research and clinical practice may be to consider how best to help PTSD patients to access, enervate and/or create positive schemas, beliefs and/or meanings relating to trauma. There are interventions that show promise in helping PTSD patients to change trauma schemas including cognitive restructuring (Mueser, Rosenberg, & Rosenberg, 2009) and schema therapy (Lee et al., 2001) that could be considered alongside principles of PTG.

Overall the second-order interpretations seemed to mirror an existing protocol for treating complex trauma called the ‘stage model of trauma recovery’ (Herman, 1992), which is comprised of the following three stages:

1. Focus on establishing safety, developing the psychotherapeutic alliance, symptom mastery (control), routines of self-care (connecting with self, emotions);
2. Carefully paced in-depth exploration and processing of the traumatic experiences (connecting with trauma);
3. Reconnecting with self, others and relationship skills.

Herman’s (1992) ‘stage model of recovery’ seems to capture qualities deemed helpful in psychotherapy by PTSD patients. Some of the components of the ‘stage model of recovery’ for PTSD exist in current recommended protocols such
as TFCBT and EMDR that use grounding techniques and carefully consider exposure to trauma memories (Bisson et al., 2007; Kelley & Benbadis, 2007; NICE, 2005). However, there may be other relevant aspects of psychotherapy that can be gleaned from this synthesis which are consistent with Herman’s (1992) model including prioritising safety and managing difficult emotions.

**Strengths and limitations**

Given that there has been no prior synthesis of adult experiences in this area it seemed a necessary endeavour to collate these experiences and reflect on them in a new way. The synthesis demonstrated a diverse range of experiences which enhances generalisability and contributes to new insights into how patients perceive psychotherapy for PTSD. The review maintained methodological rigour by adhering to PRISMA guidelines, engaging with a critical appraisal of the quality of the articles using CASP, and synthesising the articles according to evidenced guidelines (Noblit & Hare, 1988).

There remains; however, some criticism for using meta-synthesis to review articles. Inherent to this method is a necessary deconstruction of original articles that some suggest may lead to an overly subjectivist perspective that is remiss of the original findings (Sandelowski, Docherty, & Emden, 1997). This paper was not intended to replace the original papers, but to reformulate their findings in an effort to produce new interpretations. Arguably qualitative research does not postulate positivist assumptions of truth in any analysis and forms part of the iterative process of regenerating meaning in context (Flyvbjerg, 2006). Although TL and the research team enlisted a variety of measures to maintain the
trustworthiness of the analysis throughout the project and to protect the valuable contributions from each of the articles reviewed, the qualitative of analysis present in the papers varied significantly. For example, first-order interpretations were difficult to access as participant accounts had already been interpreted and diffused by the authors interpretations rendering only a partial account of their experience (Schutz, 1971). Authors also varied greatly in their ability to provide second-order interpretations and many articles were highly descriptive. Furthermore, it was often difficult to distinguish first-order from second-order interpretations or to decipher to what extent the authors interpretations were influenced by their own background or theoretical standpoint. There was also an overall weakness of the studies to account for what participants found to be difficult or unwanted aspects of psychotherapy which has led to an overwhelmingly positive account of psychotherapeutic experiences. Some articles can be criticised for other potential biases and methodological challenges including participants being interviewed by known associates and recruitment from PTSD patients in treatment only. Only five articles account reflexively for some of these difficulties. Although it may present a formidable challenge, future research should attempt to capture experiences that offer constructive criticism for methods used in psychotherapy and interview participants who may have dropped out of psychotherapy.

**Conclusions**

The review provides a valuable insight into several key aspects of psychotherapy that were valued by PTSD patients. The findings highlight the need for psychotherapies to be flexible and ‘person centred’. There are clear challenges
for clinicians to be relational and formulation driven, accounting for a diversity of difficulties that emerge from the experience of PTSD.
References


Morse, J. (1997). *Completing a Qualitative Project: Details and Dialogue*. SAGE Publications. Retrieved from https://books.google.co.uk/books/about/Completing_a_Qualitative_Project.html?id=R6hkQgAACAAJ&pgis=1


Paper 2: Empirical study

Basic emotions and the affective phenomena of PTSD:

A deductive-inductive thematic analysis.

Paper 2 has been prepared for submission to the Journal of Clinical Psychology and Psychotherapy in accordance with the guidelines for contributors (Appendix A). Tables and figures have been incorporated into the text in the thesis and single spaced for ease of readability; however, for submission to the journal these will be submitted as separate sheets and double-spaced as per the guidelines. Formatting guidelines for the journal have been adhered to as closely as possible, whilst following The University of Manchester Presentation of Theses Policy.

Paper 2 explores the basic emotions and affective phenomena of PTSD from the perspective of ten individuals with a history of PTSD and discusses the implications of the findings on clinical practice. Pseudonyms have been used to preserve the anonymity of the participants in this paper. In addition, the term ‘patient’ has been pragmatically chosen to consistently describe those with PTSD in this paper although TL acknowledges that other terms including survivor, service user or client may be preferred terms for some. The research team are referred to in the paper by their initials:

- Trevor Landry (TL) Main researcher
- Dr Daniel Pratt (DP) Academic supervisor
- Dr Liz Ballinger (LB) Field supervisor
- Dr Julie Wisely (JW) Field supervisor
- Dr John Fox (JF) Academic/Field supervisor

Word Count: 8051
(excluding contents, appendices and references)
Abstract

Objectives: The aim of this study was to explore basic emotions and the affective phenomena of PTSD from the perspectives of individuals in psychotherapy with a diagnosis of Post-Traumatic Stress Disorder (PTSD) and to discuss implications for clinical practice.

Design: A qualitative design was used, given the exploratory nature of the study and the need to gain rich and in-depth data regarding the topic under investigation.

Method: Semi-structured interviews were conducted with ten participants who had a history of PTSD. Interview transcripts were analysed using a dual inductive-deductive thematic analysis.

Results: Eight core themes relating to the experience of basic emotions and affective phenomenon in PTSD were developed; living with fear; anger and injustice; self-blame and shame; tormenting and toxic emotions; sadness and lost self-concept; suppressing and avoiding unwanted emotions; discovering the right to emotion and developing new emotion regulation strategies.

Conclusion: Some emotions are ego-dystonic and appraised negatively by participants with PTSD. Discovering the right to have these emotions and learning strategies to regulate them helped. The findings have important implications for PTSD psychopathology and theory.
**Practitioner Points:**

Clinical implications:

- This study has highlighted the need for clinicians to consider the importance of basic emotions when assessing, diagnosing and treating PTSD.
- Formulation and psycho-education may play a valued role for those with PTSD; because this helped participants understand and contextualise their emotions.
- Opportunities in psychotherapy for individuals to change their appraisals of emotions may improve overall affect.
Introduction

After a century of research on emotions there remains no consensus on a general definition for this term (Izard, 2009). Within these theoretical perspectives emotions are a subset of a broader class of affective phenomena including affect, physical sensations, attitudes and mood (Ekman & Cordaro, 2011; Gross, 1999). However, researchers agree that there are different forms of emotions; for example, basic emotions based on biological and evolutionary perspectives and emotion schemas which are rooted in cognitive and social constructionist perspectives such as happiness, anger, fear, sadness and disgust (Izard, 2009; Panksepp, 2007). Power and Dalgleish (1999, 2008) proposed the Schematic Propositional Analogical Associative Representation Systems (SPAARS) theory of emotions which integrates these perspectives within a multilevel model.

SPAARS theory applied to PTSD5

Although SPAARS is an emotion theory that can account for ‘normal’ emotional experiences it has been used typically to understand psychopathology including anorexia (Fox & Power, 2009), bi-polar disorder (Carolan & Power, 2011) and post-traumatic stress disorder (PTSD; Dalgleish & Power, 2004). Dalgleish and Power’s (2004) SPAARS model suggests that PTSD sequelae (avoidance, re-experiencing and existential affect from appraisals) are emotion non-specific processes which occur when cognitive systems attempt to resolve the discrepancy between trauma sequelae and pre-existing schemas. It also suggests that emotion-specific symptoms are reliant on the emotions elicited by the

---

5 Discussed further in paper 3, p. 81
traumatic event; however, emotions are not solely predicted by the event (associative level) but involve subjective appraisals made by the individual (schematic level). Significantly, a traumatic event will be appraised differently by different individuals producing different emotions. The proposition is that the five basic emotions; happiness, sadness, fear, anger and disgust emotions are associated with distinct categories of cognitive appraisal and their relation to life goals (Dalgleish & Power, 2004; Power & Dalgleish, 2008). Power and Dalgleish (2008) suggest that experiencing negative emotions in PTSD is contingent upon several appraisal dimensions; for example, fear and threat; sadness and loss; anger and impeded life goals; disgust and appraisal of a person, object or idea that is repulsive to the self, values and/or goals. Similarly, Greenberg (2004) describes basic emotions as primary, direct reactions to a stimulus and secondary emotions as appraisals of a stimulus which can be either negative or positive. Greenberg (2004) and Power and Dalgleish (2008) propose that these appraisals are susceptible to transformation which has clinical relevance for the provision of psychotherapy.

**Psychopathology of basic emotions and PTSD**

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; APA, 2013) criteria, indicates a move beyond conceptualising PTSD as a fear response (Shin & Liberzon, 2010) and now acknowledges that basic emotions of happiness, sadness, fear, anger and disgust are vulnerable to dysregulation (Resick & Miller, 2009). Power and Fyvie (2012) found that more than half of PTSD patients in therapy experience difficulties with emotions other than fear including sadness, disgust and anger. However, these changes have yet to be
implemented in clinical practice and guidelines which favour exposure based Cognitive Behavioural Therapy (CBT; Ehlers & Clark, 2000; NICE, 2005; Power & Fyvie, 2012). Power and Fyvie (2012) also found exposure based CBT unhelpful for non-anxious participants with PTSD. Therefore, it is imperative for clinicians to understand how a range of basic emotions can impact on PTSD symptoms and what implications this may have on assessment, formulation and intervention protocols.

**Justification for a qualitative inquiry**

A review of the qualitative literature (Landry et al., in preparation) has highlighted how a range of emotions can contribute to the development and maintenance of PTSD. However, despite these theoretical advances there remains a dearth of research considering the lived experience of basic emotions for PTSD patients (Oatley & Johnson-Laird, 2014; Power & Dalgleish, 2008). Exploring patient experiences can help clinicians to understand what emotions may help or hinder recovery from PTSD. In addition, qualitative methods can help to advance theoretical understanding when there are significant gaps in the knowledge base (Elliott, Fischer, & Rennie, 1999) which has been achieved using qualitative inquiry to explore a variety of PTSD related phenomena including hope (Levi, Liechtentritt, & Savaya, 2012), psychotherapy (Ajdukovic et al., 2013; Bermudez et al., 2013; Lawrence & Lee, 2013; Murphy, Hunt, Luzon, & Greenberg, 2014; Stige et al., 2013) and vicarious trauma (Cohen & Collens, 2012). Snape and Spencer (2003) suggest that qualitative methods are an effective way to capture

---

6 Discussed further in paper 3, p. 80
the complexity of human experience and unravel the idiosyncrasies of phenomena. Flyvbjerg (2006) argues that qualitative research methodologies offer a means from which to capture phenomena in context and take an idiographic approach to the development of practice. A qualitative inquiry into the emotional and affective phenomena of PTSD using thematic analysis may therefore help to extend theory and develop clinical practice.

Study aims

The overall aim of the study was to explore the subjective experience of basic emotions and the affective phenomena of PTSD. In qualitative research aims are generally operationalised by research questions that are focused on individual experiences and/or the understanding, perceptions and views they associate with their experiences (Braun, Clarke, & Cooper, 2012; Smith, Flowers, & Larkin, 2009). As this study was grounded in basic emotions theory and participants were all in psychotherapy, three core questions were developed to explore the topic including:

1. How do individuals with PTSD conceptualise basic emotions?
2. How does psychotherapy for PTSD impact upon an individual’s conceptualisation of basic emotions?
3. To what extent do participant accounts confirm or extend theory relating to basic emotions and PTSD.

A review of theory and literature relating to the topic including SPAARS happened a priori to the research. Braun and Clarke (2008) remarked that
reviewing established theory can sensitise us to possible theoretical threads in qualitative research findings. However, caution was taken to assure that the research aims and analysis were derived inductively and not as a means to test hypothesis.

Method

Ethics statement

The study was awarded approval from the National Research Ethics Service North West Committee (REC reference: 14/NW/0309) and subsequent NHS R&D approval across three NHS trusts in the Northwest of England (Appendix E).

Version of thematic analysis

Thematic analysis (TA) is a qualitative method for identifying and analysing patterns of meaning in data (Braun & Clarke, 2008). The aim of TA is to discover what themes are important about the phenomenon being studied (Daly et al., 2007). Themes may consist of patterns of explicit ‘manifest’ and/or implicit ‘latent’ phenomena observed in the data. Themes may also be determined deductively through means of grounding in theory or inductively by allowing themes to arise organically from participants’ accounts. Joffe and Yardley (2004) suggest that good quality TA incorporates a dual manifest-latent and deductive-inductive perspective which was used for this study.
Trustworthiness

Koch (2006) suggests one way that trustworthiness can be established is if a reader is able to understand the events, influences and actions of the researcher. Throughout the project the first author, TL, maintained field notes which were used to reflect upon interviews and coding. TL also used various mechanisms of triangulation to enhance the trustworthiness of coding and analysis (Creswell & Miller, 2000). As the project took a dual inductive-deductive approach, codes and themes were formulated inductively alongside data collection (Guest, 2006), yet were also compared and reviewed alongside established theory as a further means of triangulation (Creswell & Miller, 2000). Some suggest that input from more than one researcher during analysis can improve the consistency and trustworthiness of analysis (Pope, Ziebland, & Mays, 2000). Although the responsibility of analysis rested primarily with TL, coding and themes were reviewed regularly in supervision with the research team as a means of ongoing triangulation and refinement (Barbour, 2001; Graneheim & Lundman, 2004). In addition, final themes along with a cover letter were emailed to participants in June 2015 with consent for review and comment prior to the final draft of the study. TL received feedback from six participants which did not indicate any significant alterations and attracted several positive comments about their research experience (Appendix F; Lincoln & Guba, 1985). Furthermore, direct participant quotes were used to ensure the themes were grounded in their lived experiences and as a means of transparency.
**Reflexivity**

It was necessary for TL to take a reflexive stance throughout the project in order to protect the integrity of the analysis (Willig, 2001). Reflexivity was enhanced by ensuring that any prior values, experience or knowledge were not *imposed* but were used to *sensitise* TL to the data (Elliott et al., 1999). The research was approached from a post-positivism perspective driven by a passionate interest in the topic and desire to gain insight into emotions and PTSD (Creswell, 2013). TL was a qualified integrative humanistic psychologist with prior clinical and qualitative research experience in the field of traumatology and a trainee clinical psychologist working within a health psychology context. These experiences helped TL to become more *sensitised* to the topic and with some of the skills required for interviewing participants. However, emotions theory was a relatively new area of research for TL requiring additional support, supervision and readings. TL endeavoured to maintain a reflexive stance through the use of a reflective journal and via regular peer/academic supervision with co-authors DP, LB and JF who brought significant clinical experience and qualitative research expertise to the study.

**Recruitment and measures**

The most commonly used participant recruitment method in qualitative enquiry is the non-probabilistic, purposive sampling strategy which was used for this study (Guest, 2006; Mays & Pope, 1995; Miles & Huberman, 1994). The purpose of this strategy was not to establish a random or representative sample drawn from a

---

7 Discussed further in paper 3, p. 80
8 Discussed further in paper 3, p. 82
population but rather to identify specific groups of people who either possess characteristics or live in circumstances relevant to the research topic (Patton, 1990). In fitting with thematic analysis recruitment persisted until the study produced sufficiently ‘thick data’ from which to derive a robust analysis (Geertz, 1973). Actual numbers recommended for qualitative interviews varies significantly and Sandelowski (1996) argued that it is the responsibility of the researcher to strike a balance between being able to manage the amount of data and the aim to thoroughly explore the topic. Braun and Clarke (2013) suggest a sample size of six to ten when conducting in depth interviews with participants. Participants were recruited opportunistically from local NHS services that included two health psychology settings and one specialist PTSD service. These settings were chosen in order to include participants who have an informed perspective on the phenomenon under investigation (Creswell, 2009; Willig, 2001). Clinicians from NHS services identified participants following standard ethical procedures for recruitment which included clinicians identifying participants that met the project inclusion criteria and having an informal discussion with them about the project aims. If the participant stated that they were interested they were given a participant information sheet by their clinician and a consent form to complete if they wished to participate. Informed consent was sought initially from clinicians and later reviewed by the first author prior to interview (Appendix G).

Inclusion criteria was comprised of: (i) current or past diagnosis of PTSD (APA, 2013) criteria, (ii) current or past engagement in psychotherapy for PTSD, (iii) aged 18 or over, (iv) sufficient oral English proficiency to understand and
complete study-related procedures, (v) capacity to understand and give written informed consent. In order to confirm diagnosis of PTSD, TL conducted a case file review with eight participants. In two cases where the files were not accessible TL confirmed diagnosis with the participant’s case manager. The impact of events scale (IES; Horowitz, 1976) and a demographic proforma were used to situate the sample and to substantiate the case note diagnosis (Appendix H).

Participants

Five men and five women participated in the study. Participants ranged in age between 19 and 57 (mean 39.3 years). Participants were all White British and lived in England. Six were married or in committed relationships, and four of the participants had children. Six participants were gainfully employed and four participants were not working or on sick leave. Time since the traumatic event varied from five months to four years and all participants were currently receiving psychotherapy. IES measures were used to situate the sample at the time of the interviews with an overall average score of 41.6 (powerful impact). Scores ranged from 21 (possible impact) to 52 (severe impact). The two lower scores of 21 were from participants who were nearing discharge from psychological therapy. Their symptoms had improved significantly since their initial admission to therapy. Table 1 describes participant characteristics in more detail.


**Interview guide**

Semi-structured interviews were conducted by the first author (TL) with all participants using an interview guide to facilitate the exploration of the research questions in an open and inductive manner (Appendix I). The interview guide was developed through conversations and ongoing review with DP and JF. The interview guide was designed to explore participant perceptions of basic emotions, emotion interplay and appraisal processes in PTSD. The interview guide was reviewed by a former PTSD patient and psychotherapist prior to the start of research which helped to refine the prompts, questions, order and time required for the semi-structured interviews. The topic guide was altered in sequence and not following feedback from interviews. The interview guide consisted of 17 open-ended questions with corresponding prompts, outlining topics pertinent to the exploration of basic emotions. Interviews were semi-structured and participant centred, with the interviewer developing concepts that emerged and staying with these experiences in order to derive as rich an account as possible. Interviews lasted between 40 and 70 minutes: eight interviews were face-to-face in a NHS service and two participants elected to meet in their home. The interview guide, interviews and other research materials were discussed regularly in supervision with JF and DP, after which, revision and refinements were made when necessary.

---

9 Discussed further in paper 3, p. 83
<table>
<thead>
<tr>
<th>Participant and pseudonym</th>
<th>Age</th>
<th>Ethnic origin</th>
<th>Relationship/cohabitants/employment/education achieved</th>
<th>Type of trauma</th>
<th>Months elapsed since event(s)</th>
<th>Date of diagnosis</th>
<th>Self-reported support and/or psychotherapy</th>
<th>IES score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Alan)</td>
<td>37</td>
<td>White English</td>
<td>Married/Children/Unemployed/A-level</td>
<td>Motoring accident</td>
<td>52</td>
<td>04/2010</td>
<td>CBT/Family</td>
<td>48</td>
</tr>
<tr>
<td>2 (Beth)</td>
<td>19</td>
<td>White British</td>
<td>Single/Parents/Employed/A-level</td>
<td>Work accident/Burn/Explosion</td>
<td>60</td>
<td>11/2014</td>
<td>CBT/Family</td>
<td>46</td>
</tr>
<tr>
<td>3 (Carl)</td>
<td>41</td>
<td>White English</td>
<td>Divorced/Parents/Employed/GCSE</td>
<td>Traumatic loss</td>
<td>14</td>
<td>02/2014</td>
<td>Medication/Psychotherapy</td>
<td>49</td>
</tr>
<tr>
<td>4 (Donna)</td>
<td>37</td>
<td>White British</td>
<td>Married/Children/Unemployed/A-level</td>
<td>Interpersonal trauma/Violence</td>
<td>58</td>
<td>02/2011</td>
<td>CBT &amp; EMDR/Medication/Family</td>
<td>52</td>
</tr>
<tr>
<td>5 (Eve)</td>
<td>46</td>
<td>White British</td>
<td>Married/Partner/Employed/A-level</td>
<td>Near fatal medical trauma</td>
<td>22</td>
<td>04/2013</td>
<td>CBT, EMDR &amp; Mindfulness/Medication/Family &amp; friends</td>
<td>50</td>
</tr>
</tbody>
</table>

CBT = Cognitive behavioural therapy  
EMDR = Eye movement desensitisation and reprocessing

Table 1: Participant characteristics
<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Ethnic origin</th>
<th>Relationship/ cohabitants/ employment/ education achieved</th>
<th>Type of trauma</th>
<th>Time elapsed since event(s)</th>
<th>Date of diagnosis</th>
<th>Self-reported support and/or psychotherapy</th>
<th>IES total score</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 (Frank)</td>
<td>57</td>
<td>White British</td>
<td>Single/ Parents/ Employed/ A-level</td>
<td>Burn</td>
<td>17</td>
<td>11/2013</td>
<td>CBT</td>
<td>42</td>
</tr>
<tr>
<td>7 (Gina)</td>
<td>21</td>
<td>White Welsh</td>
<td>Single/ Parents/ Medical leave/ Degree</td>
<td>Motoring accident</td>
<td>9</td>
<td>07/2014</td>
<td>CBT</td>
<td>59</td>
</tr>
<tr>
<td>8 (Hannah)</td>
<td>43</td>
<td>White British</td>
<td>Separated/ Partner/ Sick leave/ Degree</td>
<td>Interpersonal trauma/ Violence</td>
<td>8</td>
<td>10/2014</td>
<td>CBT</td>
<td>21</td>
</tr>
<tr>
<td>9 (Ivan)</td>
<td>45</td>
<td>White British</td>
<td>Married/ Children/ Employed/ Trade</td>
<td>Work accident/ Fall/ burn</td>
<td>8</td>
<td>07/2014</td>
<td>CBT/ Family</td>
<td>28</td>
</tr>
<tr>
<td>10 (John)</td>
<td>47</td>
<td>White British</td>
<td>Married/ Children/ Employed/ A-level (trade)</td>
<td>Work accident/ Burn</td>
<td>9</td>
<td>06/2014</td>
<td>CBT</td>
<td>21</td>
</tr>
</tbody>
</table>

CBT = Cognitive behavioural therapy
EMDR = Eye movement desensitisation and reprocessing
Data analysis\textsuperscript{10}

Thematic analysis was used for analysis (Braun et al., 2012) by TL incorporating a dual manifest-latent and deductive-inductive perspective (Joffe & Yardley, 2004) which was achieved by engaging in the following stages:

1. Familiarisation with the data through reading and rereading the transcripts and noting areas of potential interest
2. Initial coding: systematically coding novel and relevant concepts
3. Grouping codes into themes
4. Reviewing themes and matching themes to transcribed data
5. Naming and refinement of themes
6. Selecting extracts related to the research question and producing a report

Themes were developed through discussions in supervision and written iterations produced in dialogue with LB, JF and DP.

Results

The overall aim of the study was to explore the subjective experience of basic emotions and the affective phenomena of PTSD. Thematic analysis was used to derive six themes relating to how participants conceptualise basic emotions including living with fear; anger and injustice; self-blame and shame; tormenting and toxic emotions; sadness and lost self-concept and suppressing and avoiding unwanted emotions. A further two themes relevant to how psychotherapy impacted on participant conceptualisations of basic emotions were also explored including discovering the right to emotions and developing new emotion regulation strategies. Each of these themes are discussed in greater detail below followed by a

\textsuperscript{10} Discussed further in paper 3, p. 86
discussion of how the study findings confirm or extend theory and the relevance of the study to clinical practice.

**Living with fear:**
‘I live with the fear that, is it going to happen again and next time will I be as lucky?’ (Eve).

Most participants described life and their emotions as ‘normal’ before the traumatic event; however, after the trauma ‘normality’ was lost and replaced by the ongoing torment of PTSD symptoms. Although not all experienced fear, accounts of four participants illustrated how their beliefs about personal safety had changed rendering them feeling vulnerable and scared. Donna described her experience as, ‘it’s not being able to protect myself any more as well, cos physically and mentally I don’t feel strong’. PTSD symptoms such as flashbacks subjected participants to ongoing terror, fear and vigilance, ‘...it seems like every day I am in fear of that happening because I don’t like it, it’s a horrible feeling and you want to avoid it’ (Beth). Fear was appraised as an unwanted ‘horrid’ emotion that participants initially sought to suppress and avoid. Hannah described how fear related to secondary emotions of anxiety and an appraised need to control her emotions; ‘I’ve sort of turned agoraphobic since the incident [...] the fear comes in and I have anxiety, what can I control, what can’t I control, what’s going to happen, what isn’t going to happen’. Hannah’s account demonstrates how fear and other trauma sequelae can leave an individual paralysed by attempts to control and avoid this difficult emotion. Although fear was considered a dominant difficulty with four participants, it did not exist apart from other primary emotions. In fact, participants became angry that traumatic events had left them feeling unsafe and vulnerable. The emotion ‘coupling’ of fear and anger has been hypothesised in SPAARS theory of PTSD and seems present in the accounts of participants (Dalgleish & Power, 2004). However, the emotion of
anger also seemed to invoke secondary appraisal and emotions which are discussed throughout the next theme.

**Anger and injustice:**

‘It’s like something’s been taken and I can’t get it back […] like someone’s broken into your house and done something to your house and something’s been spoilt’ (Frank)

It was as though something precious had been stolen from the participants and that a grave injustice had occurred. For victims of violence or traumatic injury, participants harboured resentment, hatred and anger towards the perpetrators; ‘I always felt angry towards the guy that had crashed into us, because obviously we found out that he had been taking drugs and he was speeding’ (Gina). Anger seemed to be a nuanced and complex reaction to the trauma determined by a range of factors, some primary and specific to the actual traumatic event and others secondary. Gina mentioned how her anger seemed heightened by the secondary appraisal that the perpetrator of the accident had been using drugs at the time of the accident. Gina’s anger was also maintained by ongoing flashbacks brought on by her physical injuries which served as reminders of the accident. Looking in the mirror and seeing her injuries reinforced her hatred towards the perpetrator. Others experienced secondary anger related to the ongoing problems of PTSD as Beth describes; ‘at first there will be like a hatred, like I hate that this still happens, then I will get angry and then it will be sad, I am sad that it’s still happening and that I have these emotions I get angry with’. Beth hated what happened to her and the onslaught of difficult emotions that she had to endure. Beth did not appear to want these emotions they were somewhat abhorrent to her which may be indicative of secondary disgust (shame) for experiencing and demonstrating her angry emotions.
**Self-blame and shame:**
‘...it’s the what could have happened, [...] yeah, I mean what would happen, would she have to give up work? What would happen to the kids? What would happen? (Donna)

Half of the participants experienced secondary emotions of anxiety and PTSD sequelae such as intrusive thoughts about traumatic events and worried a lot about their own role in the traumatic events. Some participants blamed themselves for the trauma which led to self-hatred ‘I hated myself, resentment, why did I pick that job, why did I go into that profession, I should have known something bad could have happened’ (Donna). Those that blamed themselves experienced secondary emotions of guilt and shame, Ivan expressed that ‘...guilt is a big one, because of what could have happened to, people around me’ (Ivan). Guilt was maintained by emotion non-specifics such as ongoing self-criticism which involved ‘I should have...’ judgements of past actions. Anger, fear and to a lesser extent even sadness were perceived differently post trauma leaving participants with predominantly negative appraisals of these emotions.

**Tormenting and toxic emotions:**
‘I’d say that it’s made me see the emotions in a different way, I might have felt anger and sadness before and anxiety before but never to this level, so its sorta like seeing them in a new light and seeing the extremes that they can reach’ (Beth)

Beth and other participants described how they appraised and described their emotions differently after the traumatic event. ‘Raw’, ‘weird’, ‘sensitised’ ‘out of control’ and ‘overwhelming’ are just a few ways in which participants appraised their emotions as tormenting. These appraisals seemed to be perpetuated by PTSD symptoms including ongoing reminders and flashbacks. Beth describes, ‘I feel like they are always in the back of
my mind and that they can just pop up’. Therefore, some participants experienced impaired controllability of some emotions which could be set off by innocuous cues. In addition, the frequency and duration of emotions seemed to change, Eve explains; ‘you know we all have anger, we all get angry, but it felt like I couldn’t walk away from this anger, ‘cos it was constantly there, constantly with me.’ Emotions such as fear, anger and sadness were appraised negatively by most participants. Hannah mentioned ‘I was embarrassed about my emotion [...] I saw it as a weakness’. Thus, primary emotions including fear, anger and sadness were bound to secondary emotions of embarrassment and shame. Therefore, participants were initially reluctant to talk to others about these emotions which of course had implications on social relationships and led some to delay seeking support. Similarly, some participants including John appraised emotions such as fear as a burden or potentially toxic to others ‘...if I’d have spoken to like me wife about it, then she’s got it in her head.’ Again, the negative appraisal of fear as toxic caused some participants to suppress difficulties and endure in isolation which subsequently maintained PTSD symptoms and impeded recovery. Most participants expressed how these emotions seemed foreign and ego-dystonic, ‘I’ve always been a positive person [...] I’m not an angry person, never’ (John). Therefore some emotions were appraised as toxic to the self which rendered participants experiencing a great deal of confusion about their self-concept.

Sadness and lost self-concept:
‘yeah, I can start, I’m starting feeling a bit angry now, yeah, because I loved the person that I was before, I was outgoing, I was happy, I were and now I, I’m scared of me own shadow [...] it took me a while to accept that person’s gone’ (Donna)

Donna reflects on how trauma had transformed her and her experience of emotions. She remembered fondly a joyous and happy self prior to the traumatic event. However, she
described how her self-concept had since changed and what remained she appraised as incredibly vulnerable. Loss of self-concept was described by some as a bereavement and caused participants to experience primary emotions of anger and sadness. Others seemed to experience secondary shame of who they had become and yearned to return to their idealised former self, Frank expressed; ‘I want to get me back, the old Frank, maybe he’ll never come back’. There was sadness and frustration in Frank’s voice as he contemplated never returning to who he was. A few participants mentioned how striving to return to their ‘former’ self led to secondary emotions of frustration and anger. While others became jealous of their peers as Donna explains; ‘a lot of jealousy then crept in from like my friends, being able to get on with their lives.’ In order to manage these changes to self-concept participants largely adopted strategies to avoid or suppress emotions that were perceived as ego-dystonic.

Suppressing and avoiding unwanted emotions:
‘...the emotions that I don’t like I suppress [...] and don’t really let out. I suppose in a way [...] I get up every morning, I sort of put me face on, and I will get out that door’ (Carl)

Driven by negative appraisals of emotions and their perceived toxicity participants attempted to control them by means of suppression and avoidance. Ivan describes how others may have expected him to move on soon after his trauma; ‘emotional scars are hidden, others expect its over after the hospital’. Participants experienced internal and external pressure to move on from their traumatic experiences which seemed to initiate an intrapersonal conflict between rationalising ‘I should be grateful I survived’ yet ‘I am suffering’. This statement seemed to indicate secondary guilt and shame, ‘I should be grateful, and I feel guilty that I’m not feeling that way’ (Eve). Some chose to suppress their experience as they held appraisals that others could not possibly understand or may not be interested, Alan explains ‘I think that is probably one of the biggest frustrations for me. He does not know how I am now he is not
interested’. Appraisals that others cannot understand or do not care led to secondary emotions including worthlessness and shame.

**Discovering the right to emotions:**

‘knowing that I am normal, everything that I’m feeling is normal, it’s like, you know when you breathe and you go (sigh) oh God, thank God. (Hannah)

Emotions such as sadness, anger and fear were suppressed because participants appraised them as abnormal and weak. However, learning about PTSD symptoms and receiving assurances from a psychotherapist was experienced as liberating and a positive step towards recovery. Accounts from other participants who had progressed in later stages of their recovery suggested there may exist a desire or need to endure hurtful emotions, to uncover them and accept them. Eve reflected on a particular insight derived through her psychotherapy about having ‘...a right to feel angry and frustrated in a way, giving myself permission to, to feel like that’. Later in recovery participants became aware that suppressing and avoiding emotions contributed to more difficulties and was not sustainable:

‘it felt like, at times, that it just…happened, I couldn’t control that, and my thoughts were, if I didn’t let it out, and kept it to me and kept it all about me that was my control, I was controlling it, but in reality it was controlling me and I didn’t, I couldn’t see that, so by not talking I was making myself worse by not letting people know, I was making me worse’ (Ivan)

Most participants accounted for using strategies of suppression and avoidance to manage their difficult emotions prior to experiencing trauma; however, most came to understand that these strategies were no longer adequate and may in fact be part of the problem which seemed to
relate directly to participant engagement in psychotherapeutic support and the ability to engage in processes which challenged prior schemas and appraisals relevant to emotions and learning new and more effective strategies to manage symptoms.

**Developing new emotion regulation strategies:**
There seemed in most to be a strong drive to ‘carry on’ in the face of adversity, Carl said, ‘*I think in me head that, you know, like pull yourself together, you know, you’ve got to get up and go*’. This drive led participants to search for ways to cope with their symptoms and to seek psychotherapeutic support. In therapy, participants developed new emotion regulation strategies which helped them regulate difficult emotions:
‘*…the psychological aspect of it, I have been taught to understand the situation better and evaluated it better it keeps the raw emotion under control, [...] because if I don’t do that there is frustration and the frustration then becomes an anger and I can become a total spear head it’s that bad. So it’s that talking through, that rational voice...*’ (Alan)

Alan learned to track and monitor his emotional processes, knowing his emotional triggers and the consequences of these emotional states with the help of a psychotherapist. Many can recover from trauma without developing PTSD or the need for psychotherapy (Tedeschi & Calhoun, 2004); however, individuals with poor coping strategies are particularly at risk of developing symptoms (Agaibi & Wilson, 2005; Feeny & Foa, 2006). As discussed earlier many participants were reliant on strategies including suppression and avoidance which have been found to maintain symptoms of PTSD (Amstadter & Vernon, 2008; Feeny & Foa, 2006; Shepherd & Wild, 2014). Therefore, participants valued learning new methods and strategies to manage their symptoms. Eve explains how acceptance has helped her to manage difficult emotions:
‘...you can accept things a little bit better, and then from there on it's a way of coping with those feelings, they'll never go away probably, they'll always be there, and they’ll always be the chance, but if you can deal with them and that’s what we doing with psychol-, you know with Dr (psychologist), she’s helping an awful lot’

Alan describes how he also had begun to feel proud of himself and attributes this change to a new found acceptance and the need for support, ‘I pride myself on trying to continue I now got to understand and I am beginning to, I will get it through that I can’t do what I did, I can’t work like I used to and I understand that.’ Other strategies that participants found useful included; imagery, mindfulness and relaxation. These strategies were revered by participants and were used to help moderate difficult physical and emotional symptoms.

**Discussion**

The overall aim of the study was to explore the subjective experience of basic emotions and the affective phenomena of PTSD, more specifically how individuals with PTSD conceptualised basic emotions; how psychotherapy for PTSD may impact upon an individual’s conceptualisation of basic emotions and to what extent participant accounts confirm or extend theory relating to basic emotions and PTSD.

**How individuals with PTSD conceptualised basic emotions**

This study’s findings included six themes which highlighted how participants conceptualised basic emotions before and after a diagnosis of post-traumatic stress disorder. PTSD symptoms left some participants feeling vulnerable and experiencing fear and anxiety. Fear was appraised negatively and participants sought initially to control and suppress their fears. However, fear was only a difficulty for a minority of participants and patients experienced a
wide range of difficult emotions and affect other than fear and anxiety. For example, several participants experienced anger which was linked with secondary appraisals of injustice. Emotions such as anger and fear were viewed as weak, abhorrent and incited secondary emotions of shame and guilt. Participants described how their appraisals of emotions had changed, trauma left some feeling overwhelmed and others appraised their emotions as ego-dystonic and toxic. These experiences were sufficiently different that some felt as though they had lost their ‘self’ and were left feeling ashamed about who they had become. The extent of shame and personal disdain for these emotions led most initially to strategies of suppression and avoidance in order to protect themselves and others. However, these strategies seemed to maintain and exacerbate PTSD symptoms making participants desperate for support and change, which motivated them to engage with psychotherapeutic support for PTSD.

**Psychotherapy for PTSD and basic emotions**

This study challenges the dominant focus of fear conditioning in PTSD literature and highlights the need for clinicians to consider the importance of a range of emotions when diagnosing patients and planning clinical interventions. The findings are congruent with recent changes in DSM-5 criteria and the necessity to consider a range of emotions when completing diagnosis (APA, 2013). Two themes relevant to the impact of psychotherapy on the conceptualisation of basic emotions were construed including: discovering the right to emotions and learning new emotion regulation strategies. Participants who had progressed in psychotherapy described how their appraisal of suppression and avoidance changed and that they became aware that by using these strategies their emotions and PTSD symptoms became worse. This theme went in tandem with accounts from participants about how they began to accept that they had ‘the right’ to feel angry, sad or fearful. There appeared to be a new
meaning for these emotions as justified and an acceptance that participants may have to endure them, rather than fight against them. This can be conceptualised in SPAARS as new information about emotions being ‘justified’ and ‘normal’ changing prior negative schemas. When the ‘meaning’ of emotions changed they were no longer appraised negatively by participants alleviating secondary emotions of guilt and shame. Greenbergs (2004) discusses this process further in his emotion focused therapy (EFT) model of PTSD. This study therefore supports current clinical evidence for the benefit of interventions such as EFT and cognitive restructuring which may reduce shame and help to restore the self-concept (Foa et al., 2005; Ford, 2010).

Participants also valued learning new emotion regulation strategies to manage difficult emotions, including acceptance, self-compassion and grounding oneself in the present moment. Accepting emotions rather than repressing and avoiding them seemed to have a paradoxical result on affect and mood leaving participants feeling better, which is supported in the theoretical underpinnings of compassion focused therapy (CFT; Gilbert, 2009) and acceptance and commitment therapy (ACT; Hayes, Luoma, Bond, Masuda, & Lillis, 2006) that advocate a non-judgemental and compassionate appraisal of emotional experiences. Participants also valued learning practical skills for managing psycho-physical symptoms including relaxation and strategies to ground them in the present moment such as those used in mindfulness (MBCT; Kabat-Zinn, 2003).

Finally, participants also said that receiving a diagnosis and learning about PTSD symptoms almost immediately helped participants to feel better. The positive influence of ‘normalising’ symptoms and emotions has been evidenced throughout PTSD research (Coates & Gaensbauer, 2009; Mott et al., 2012). Therefore, formulation and psycho-education may play
a valued role for those with PTSD experiencing a range of ego-dystonic and confusing emotions. Clinicians may also benefit from using emotion measures such as the Basic Emotions Scale to monitor progress (Power, 2011) as traditional tools such as the Impact of Events (Beck et al., 2008) and Clinician-Administered PTSD Scale for DSM-5 (CAPS-5; Weathers et al., 2014) do not sufficiently address emotional dysregulation.

How participant accounts confirm or extend theory

The study findings confirm theoretical postulations made by Dalgleish and Power (2004), but also extend theory and capture some of the complex processes involved with basic emotion and the affective phenomenon of PTSD.

There is prolific evidence for the psycho-physical fear processes involved with PTSD (Bisson et al., 2007; Brewin & Holmes, 2003). Participants held pre-trauma appraisals of their emotions as ‘normal’ and manageable. Bisson et al. (2007) and Ehlers and Clark (2000) discuss how trauma may lead some to experience a shattered schema about safety, rendering individuals vigilant to threat and experiencing ongoing fear which seemed present in the accounts of the participants. However, relatively few of the participants regarded fear as their primary difficult emotion accounting for difficulties arising from a variety of specific emotions. This theme supports the theory postulated by Dalgleish and Power (2004) which suggests that participants are likely to experience a range of emotions that they found difficult to regulate including, anger, sadness and those of disgust (guilt and shame). Participant accounts of anger suggest that it may relate to an appraisal of traumatic events and sequelae as unjust. Power and Dalgleish (1999) SPAARS model discusses appraisal as the ‘central executive’ critically important to how emotions are interpreted. Participants became angry at the individuals who they felt to be the causal agents of their traumatic experiences, which is
fitting with empirical findings (Chemtob, Novaco, Hamada, & Gross, 1997). Anger at others was relevant in the accounts of accidents and interpersonal trauma, particularly when agents were deemed to be at fault or negligent. Dalgleish and Power (2004) suggest that anger in PTSD may arise through appraisals of ‘blocked goals’ and subsequent agent negligence. The theme of anger and injustice seemed to confirm and support this theoretical assumption highlighting how the victimisation of trauma can instil appraisals of unfairness and injustice, leaving participants feeling angry at individuals. This also illustrated the importance of trauma type on subsequent emotional difficulties. For example, survivors of car accidents where others were perceived to be at fault seemed to instigate anger. The notion of ‘blocked goals’ seemed relevant because traumatic events also caused additional symptoms and physical changes which impeded personal and professional goals. Flashbacks and other emotion non-specific symptoms triggered anger at the unjust circumstances resulting from the trauma.

Some participants became angry at themselves; however, this appeared secondary to the primary difficult emotion of guilt and shame. This theme was particular to those who appraised themselves as the agents of the trauma and the causal factor. Although the traditional emotional experiences of disgust may be relatively uncommon, complex emotions allied to self-disgust including guilt and shame are relevant areas of research in PTSD (Power & Dalgleish, 1997), particularly with interpersonal trauma (Brewin, Andrews, & Valentine, 2000; Lee, Scragg, & Turner, 2001). In addition, emotions non specifics including intrusive thoughts about the traumatic events and ‘should have...’ criticisms causing further shame. Therefore when participants perceived themselves to be responsible for the trauma they were left experiencing the unpleasantness of shame.
Emotions including fear, anger and shame were perceived as ego-dystonic and were perceived as new, unwanted phenomenon. Power and Dalgleish (1997, 2008) argue that basic emotions are modularly developed and susceptible to appraisals that may ‘invalidate’ emotions that are perceived as ego-dystonic. This account is congruent with theory that trauma not only poses a threat to one’s physical integrity but also a ‘psychological threat’ to one’s identity (Conway & Pleydell-Pearce, 2000; Ehlers & Clark, 2000). Most participants cited how they had to endure significant changes to their self-concept leaving them experiencing sadness and anger. Dalgleish and Power (2004) suggest that emotional disorders can arise in complex grief as the result of the coupling of anger-sadness. The interrelationship of PTSD and grief has been documented thoroughly in research (Artra, 2014; Bartone & Wright, 1990; Pivar & Field, 2004). However, this has mainly involved the traumatic loss of others (Boelen, Van Den Bout, & De Keijser, 2003). This study has indicated a new insight that participants may be experiencing a significant change to their self-concept causing symptoms of grief.

Participants expressed how their appraisals of emotions had changed often describing them negatively as raw or overwhelming. Emotion overwhelm has been described throughout the PTSD literature (Amariglio, 2014; Krause, DeRosa, & Roth, 2002; Rauch & Foa, 2006; Van Der Kolk & Fisler, 1995; Vermetten, 2013). Participants made attempts early on in their recovery to repress and avoid ego-dystonic and perceived negative emotions. Suppression has been found to be a dominant coping style found in survivors of PTSD (Brewin & Holmes, 2003). However, something new indicated in this study was that the motivation to suppress these emotions was also driven by a perception that emotions were a burden and potentially toxic to self and others. Participants were therefore reluctant to talk to their family or friends for fear that in doing so may burden or hurt them. Also, emotions such as fear, anger, sadness
and shame were perceived as toxic to the self rendering individuals experiencing a fractured self-concept. Emotional toxicity may explain why some are reluctant to engage with psychological support for PTSD (Frost, 2003; Hembree et al., 2003; Schottenbauer et al., 2008).

**Limitations**

There are a number of potential limitations of this study that need to be highlighted. Firstly all of the participants were receiving psychotherapy at the time of the interviews. Although this was aligned with the aims of the project to add to the body of clinical knowledge about emotions and PTSD, accounts may differ from those who were not in psychotherapy. There is a significant research base that illustrates how most who have experienced trauma can recover and experience growth without the need for psychotherapy (Tedeschi & Calhoun, 2004); however, there appears to be a gap in recruiting those individuals who have clinically relevant symptoms of PTSD, yet, do not enter services. These difficulties were mediated by asking participants about their emotions prior to the trauma. Given that some participants did not come into psychotherapy until up to a year after their traumatic incident there was some discussion on how emotions were experienced prior to psychotherapeutic support. Some may criticise significant variation in the time elapsed since the traumatic event which ranged from eight to sixty months. However, this allowed for varied and complex processes to be explored. In addition, having participants at different stages of their ‘recovery’ allowed for a fuller investigation of emotions in PTSD. Likewise, it could be argued that recruiting only ten participants may not be sufficient to reach data saturation. However, the aim of this qualitative inquiry was not saturation or generalisability rather it was to take an ideographic

---

11 Discussed further in paper 3, p. 88.
approach and provide ‘thick data’ on which to derive contextually relevant information that can inform front line practice (Flyvbjerg, 2006; Geertz, 1973).

A non-probabilistic, purposive sampling strategy was used for this study (Guest, 2006; Mays & Pope, 1995). The benefit of using this strategy was that it helped to recruit candidates from services whom had insight into the area of interest and could meet the study inclusion criteria. In addition, Flyvbjerg (2006) argues the importance of context relevant research that can inform local practice. Opportunistically, patients that met the inclusion criteria were approached by their case manager which resulted in an equal number of men and women candidates who all identified as white British. Although generalisability is not the aim of qualitative enquiry or indeed this study (Flyvbjerg, 2006; Guest, 2006), emotions may be experienced differently across cultures (Ekman & Cordaro, 2011; Russell, 2003) and this study may reflect those of a predominately western context.

Finally, it could be argued that the researcher’s previous experience and knowledge may have unduly influenced analysis of the data. TL maintained a reflexive stance throughout, using prior experience and knowledge to sensitise him to the topic as Braun and Clarke (2008) suggests. In addition, ongoing supervision during analysis and maintaining an open and transparent coding process helped to mediate some of the risk of potential bias and enhance the trustworthiness of the analysis (Appendix J).

**Recommendations for future research**

Power and Dalgleish (2008) highlight the importance of early development and the social construction of basic emotions. This study has illustrated that most participants had a negative appraisal of emotion including anger, fear and sadness. Participants used strategies
including suppression and avoidance to manage emotions that were perceived as ego-
dystonic. What was not entirely clear from the accounts of participants was how and when
they developed these strategies. Qualitative enquiry could be used to ascertain answers and
develop theory from a more developmental perspective which may be achieved by exploring
qualitatively childhood experiences of emotions for individuals with PTSD or by using
narrative inquiry to explore dominant developmental discourses pertaining to emotions.
Exploring these issues seems particularly relevant given strong evidence for the role of
coping strategies with developing PTSD (Bisson et al., 2007; Feeny & Foa, 2006) and may
provide additional information on how emotion appraisals are formulated in childhood.

The study has highlighted that psychotherapy can enable participants to engage in a process
of regenerating the meaning of emotions. Brewin and Power (1999) discuss how the
 transformation of meaning in psychotherapy has the potential to unify differing approaches;
however, there is a dearth of clinical understanding of how this can be used in practice.
Future research may wish to explore trans-theoretical models in practice or further illustrate
their relevance in case study designs.

Furthermore, consideration of the SPAARS emotions model may not be pertinent merely to
experiences of PTSD. Several patients also suffered victimisation, physical injuries and
chronic pain as the result of traumatic events. Therefore research relating to victims of crime,
disfigurement and enduring pain may advance theory and understanding of basic emotions
across a variety of phenomena which clinicians encounter regularly.
Conclusions

This study has examined the perception of the basic emotions within participants with post-traumatic stress disorder. Fear, anger, sadness and shame were recognised as problematic for participants and related to emotion non-specific components of PTSD symptoms. Contrary to conventional thinking about PTSD only four participants experienced fear as problematic and fear was experienced in tandem with other primary, difficult emotions including anger. Anger was linked with the injustice of trauma and anger at agents involved with the events. Some participants blamed themselves and felt a great deal of guilt and shame. The intensity and duration of these emotions was significantly different to how participants experienced their emotions prior to PTSD. Participants appraised these emotions negatively which led to further guilt and shame. Anger and fear were also ego-dystonic causing participants to lose a sense of who they were which was linked to sadness. Realising the right to have these emotions and learning ways to regulate difficult emotions caused a positive affective shift in primary and secondary emotions.

Basic emotions including fear, anger, disgust and sadness were appraised as tormenting and toxic for participants with PTSD. Strategies to suppress or subdue these emotions in an effort to protect their identity only served to worsen symptoms. Psychotherapy supported a process for which participants discovered the right to experience a variety of difficult emotions and learned new emotion regulation strategies which in turn reduced negative appraisals and facilitated changed emotional schemas which improved affect. The findings have important implications for PTSD psychopathology and theory.
References


Paper 3: Critical Reflection

An exploration of basic emotions and the affective phenomena of PTSD:

Reflections on research

Paper 3 is not intended for publication. This paper explores my personal experiences and reflections on the research as a whole. The strengths and limitations of paper 1 and paper 2 are discussed and related to clinical practice.

The research team are referred to in the paper by their initials:

Trevor Landry (TL) Main researcher
Dr Daniel Pratt (DP) Academic supervisor
Dr Liz Ballinger (DB) Field supervisor
Dr Julie Wisely (JW) Field supervisor
Dr John Fox (JF) Academic/Field supervisor

Word Count: 5935
(excluding contents, appendices and references)
Introduction

This paper critically reviews my experience of completing a qualitative exploration of basic emotions and the affective phenomena of post-traumatic stress disorder (PTSD). I will reflect on the literature review, developing the research, my views on theories of emotions and on carrying out the empirical study. I will also discuss how this research has impacted on my clinical and academic skills. The paper will conclude by considering what can be drawn from the research as a whole.

The literature review

Rationale for topic

The topic of the literature review was selected as a means to explore and enhance psychological understanding of PTSD. There is a rich history depicting the significant contribution of reviewing and reflecting on qualitative research and the benefits of doing so on policy development and clinical practice (Denyer & Tranfield, 2006; Walsh & Downe, 2005). Equally, I have a passionate interest in the topic largely driven by a professional curiosity of what constitutes good psychotherapy and an epistemological position of post-positivism (Creswell, 2013). I hoped that by reviewing the literature across a variety of qualitative papers relating to PTSD psychotherapy that it may help me and other clinicians to understand what patients found helpful or unhelpful aspects of psychotherapy. Ultimately, with the hope that this may influence clinical practice.

Many individuals can cope and recover from traumatic events and circumstances without the need for psychotherapy (Tedeschi & Calhoun, 2004); however for those that develop PTSD engagement in psychotherapy remains low and there are high dropout rates (Hembree et al.,
2003). Equally, evidence suggests that psychotherapy for PTSD remains predominantly
guided by the fear conditioning paradigm. However, this paradigm is now being challenged
by evidence that PTSD patients experience a wide variety of psycho-social difficulties and
that current exposure based interventions may not be helpful, particularly with presentations
of ‘complex’ PTSD (Bisson et al., 2007; Herman, 1992; Holmes et al., 2005). Psychotherapy
for PTSD has typically used outcome measures to assess PTSD symptom changes (Beck,
Steer, & Carbin, 1988; Beck et al., 2008; Glad, Jensen, Holt, & Ormhaug, 2013; Keane,
Weathers, & Foa, 2000). However useful these measures are for accounting for successful
treatment and symptom outcomes, there are a number of biases and limitations to this model
of assessment (Levitt, Stanley, Frankel, & Raina, 2005; Oei & Free, 1995) and as a clinician
working with patients I have a desire to look beyond symptom improvement at the quality
and accessibility of interventions used. Consequently, I felt that a review of the qualitative
research on the topic may assist to enlighten some of the complex processes and skills that are
valued aspects of psychotherapy (Rennie, 1994). Initial scoping identified that meta-synthesis
had been used to explore other PTSD phenomena including: childhood experiences of trauma
and treatment (van Floryt et al., 2012), vicarious trauma (Cohen & Collens, 2012) and
traumatic child-birth (Beck, 2011); however, there was no review of the qualitative literature
pertaining to adult experiences of psychotherapy for PTSD. Therefore, completing a
quantitative review of the literature on participant’s experiences of PTSD psychotherapy
seemed necessary in order to gain detailed information on the processes and skills that were
found helpful or unhelpful. I hoped that by doing this that the review would be able to gain
insightful first-hand knowledge from PTSD patients on what aspects of psychotherapy were
valued or not and that by doing this how best to work therapeutically with this population.
Although quantitative research gives some insight into what categorical factors may be useful
to produce a positive outcome, I felt that qualitative inquiry could enlighten what trans-theoretical mechanisms are at play and valued in psychotherapy.

**Literature search**

In order to ensure a thorough and transparent review of the literature the search was completed using the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) principles (Moher et al., 2009). Daly et al. (2007) attest to the importance of having clear search criteria in qualitative research so I turned to the Cochrane Collaboration and found PICO (Population/problem, Intervention/exposure, Comparison, and Outcome; (Higgins & Green, 2008) which has been adapted and used in qualitative research (Cooke et al., 2012; Smith & Lavender, 2011; Sykes & Temple, 2012). I adapted the tool slightly to capture qualitative design as other researchers deem this an important consideration when reviewing qualitative studies (Thorne et al., 2004). Criteria and terms were discussed in supervision and reviewed throughout the entire process of the review. The final review took place in June 2015 prior to the final draft of the thesis. It was imperative to ensure that search criteria and terms produced a sufficient appraisal of all the relevant papers while maintaining focus on the topic under investigation (Appendix C). Striking this balance was a difficult process and required several trials prior to settling on terms. The process also led to some material being omitted including unpublished papers and non-English publications, which some could argue may have contributed further to the study. However, others suggest that excluding unpublished material may enhance the overall quality of the review (Campbell et al., 2003). In addition, using translations of qualitative papers may further hinder the necessary interpretation of researcher and participant accounts (Sandelowski et al., 1997). As a further measure to ensure inclusivity of appropriate studies a manual search of a variety of
topic specific journals was completed. The final papers seemed to capture a variety of papers specific to the topic.

**Critical appraisal of studies**

The necessity to appraise qualitative studies has been the subject of ongoing debate (Walsh & Downe, 2006). Some studies, particularly those grounded in critical realism appear to make critical appraisal of studies more explicit while others do not (Barnett-Page & Thomas, 2009). Walsh & Down (2006) argue that critical appraisal is crucial in order that qualitative reviews, such as meta-synthesis, are perceived as a credible method. I turned to the literature in order to determine the most commonly used tools in practice by reviewing prior thesis and meta-synthesis. I also discussed this in supervision with JF who suggested reading about the Critical Appraisal Skills Programme (CASP; 2013). I discovered that the CASP tool has been used widely in qualitative studies in mental health and with meta-synthesis (Campbell et al., 2003). As applied in other studies each item of the 10 items in The CASP (2013) checklist was awarded a score of one, two or three. The total score was used to derive a quality rating of ‘A’, ‘B’ or ‘C’. Using these ratings also helped with subsequent discussion about similarities and differences when reviewing the ratings with the independent researcher, who rated a third of the studies for reliability purposes. Although there was a high level of agreement, interpretation of important elements in the papers were highly individualised and the CASP did not address important details in the papers such as type of psychotherapy. Therefore, some papers scored rather highly on the CASP because of methodological and reporting strengths yet did not clearly describe the type of psychotherapy that the participants had undertaken. This made interpretation of findings and identifying key aspects of psychotherapeutic interventions difficult for some papers. The nature of qualitative enquiry may be such that it is not possible to eliminate these particular confounds, in fact, statistical representativeness is not a primary component for qualitative data collection (Mays & Pope,
Barbour (2001) explains that the degree of agreement between researchers is not as important as the subsequent insights derived from discussion with others, which is particularly important during the synthesis of papers.

**Synthesis of papers**

The synthesis was completed using principles of meta-ethnography and followed guidance published by Noblit and Hare (1988). However, due to a dearth of literature on the topic it was necessary to include studies from a range of different methodologies to ensure ‘conceptual saturation’ (Thomas & Harden, 2008). Although somewhat controversial (Dixon-Woods, Booth, & Sutton, 2007), others advocate for inclusivity of a range of methods citing that it can actually benefit the synthesis (Campbell et al., 2003). The synthesis took many drafts and feedback throughout the process from JF and DP was crucial in evolving the concepts and keeping them focused on the topic. I found it easy to drift into other areas of interest; such as post traumatic growth and even into paper two phenomena involving emotions. It was useful to take a reflexive stance and I utilised supervision with JF and DP to discuss the blurring that often took place and to redirect the analysis back to the aims of the project.

**Conclusions**

The meta-synthesis conceptualised and interpreted participant experiences of PTSD psychotherapy in a new way. The results highlighted key processes and skills that were valued components of psychotherapy, and to a lesser extent, explored aspects of psychotherapy that were found unhelpful. Second-order interpretations were used to draw on cross cutting themes that were not only present in the accounts of the participants but went beyond these papers to offer new ideas and hypothesis for considerations. Some may criticise
this review for lacking objectivity and scientific reliability; however, I believe that the synthesis offers useful insight into the experience of psychotherapy from the perspective of PTSD patients. In a health economy driven by patient centred services and care (NICE, 2012), it seems incredibly important to reflect on aspects of patient care in light of their experiences in order to inform future policy and clinical practice. I think this study achieves this objective and helps to categorise existing studies on the topic in a way that I hope is accessible and useful for practitioners and patients.

The empirical study

Research development

I have a long standing interest in trauma psychopathology which stems from both personal and professional experiences over the course of my life. Having worked within mental health services with complex presentations for the last decade has alerted me to how prolific the diagnosis was and how difficult it can be to recover from PTSD. Yet, symptoms and difficulties were highly subjective and often required close formulaic assessment rather than prescribed interventions. Admittedly, I have never been comfortable with overly reductionist intervention models and I have always been concerned about diagnostic criteria that depicting PTSD as an anxiety condition which was influenced by my work with PTSD patients who often presented with a variety of complex and difficult emotions. Over the years there have been breakthroughs and empirical developments to support my assumptions on the role of a variety of basic emotions in PTSD (Power & Fyvie, 2012). Even the most recent Diagnostic and Statistical Manual fifth edition (APA, 2013) makes explicit reference to dis-regulation across a broad range of emotions. However, NICE (2005) guidelines remain largely unchanged and clinical practice still seems to favour the older fear conditioning paradigm which fuelled a passionate interest in the topic and a desire to understand how PTSD patients
experienced emotions. Upon reviewing the background literature on the topic I realised how research tended to favour empirical data and there was little published qualitative research on the topic, hence, JF, DB and myself felt a study was warranted.

**Pragmatic choices and evolving methods**

My research project has changed significantly over the three years of study. Initially, I was involved with a quantitative study involving self-affirmation theory in a prison with DP and a theory expert. I progressed to proposal stage only to find out that the prison was facing a major restructure and could not accommodate my study. This was the first hurdle which caused significant delays early on in the research project. Thankfully, I made enquiries with the course team and met with JF who agreed to support a qualitative study involving emotions and PTSD. The aim of the research was to understand basic emotions and the affective phenomenon of PTSD. Gaining insight into the role of basic emotions would help services and clinicians to further understand what maintains the disorder, which could inform best clinical practice. The study used a qualitative design as quantitative research seemed to favour outcomes from clinical trials. A qualitative design could explore beyond this paradigm, towards understanding underlying interplay and mechanisms involved with basic emotions that I hoped would contribute to theory and understanding PTSD and emotions. There is a wealth of qualitative research and methods used to explore PTSD, some of which have been reviewed in paper 1 and 2. The empirical research initially was going to use grounded theory as a methodology (Charmaz, 2014). Although I had some experience with qualitative methods I was unfamiliar with grounded theory; however, JF was an expert and had several published studies using this methodology. Grounded theory seemed to meet the aims of the project and could be used to develop a theoretical explanation of basic emotions and PTSD. However, at a crucial stage during recruitment and interviewing JF left the course.
team to work in the south of England. Although JF offered to continue to have a role in the project and has continued to be involved with reviewing drafts, as I was a novice researcher with no experience of grounded theory I felt the level of supervisory support was not sufficient during this crucial stage. Therefore I then took it upon myself to take action and made enquiries within the broader networks within the university which led me to a very accommodating and knowledgeable supervisor LB who had experience with supervising qualitative studies and with methods including thematic analysis and interpretive phenomenological analysis (IPA). LB and I met swiftly and discussed the project and the potential for methodological difficulties. After discussion and consideration for what qualitative methods would be most suitable and careful consideration for trustworthiness in methodological, I decided with the support of JF, DP and LB to use an inductive- deductive thematic analysis on the basis that it fit best with how the project had been conducted until that point. Pragmatically, due to the absence of expertise in grounded theory on the course team it was also necessary to consider using a contingent method that could be appropriately supported during data collection and analysis.

**Theories of emotions**

One of the founders of psychology, William James (1884) asked the question: ‘what is an emotion?’ or did he mean mood, affect or feeling? Emotion research has been riddled with disagreement, controversy and discursive ambiguity (Huebner, Dwyer, & Hauser, 2009; Izard, 1992; Oatley & Johnson-laird, 1987). I quickly became immersed in an overwhelming body of literature about emotions having to make somewhat controversial choices about my position within theory while at the same time protecting the inductive nature of qualitative inquiry. My initial concern was that using basic emotions as a theoretical basis for my study would not be sufficient to capture the complex affective phenomenon taking place for PTSD
patients. However, I also had to consider how I would ask about emotions without using words that are accessible to participants such as anger, sadness, fear, shame etc. Therefore it seemed necessary to use basic emotions theory initially to make enquiries into the topic. Turning to the literature, I also discovered a growing consensus for the five basic emotions and that appraisals of these emotions are determined by emotional schemas that develop throughout our lives (Izard, 2009; Panksepp, 2007). The emotion-schema link helped me to understand why for some anger can be viewed as righteous and in a positive light while others may be repulsed by this emotion. I turned to Power and Dalgleish (1997, 2008) who proposed the Schematic Propositional Analogical Associative Representation Systems (SPAARS) model of emotions which seemed to integrate these perspectives within a multilevel model. I was also drawn to SPAARS because it had been developed to understand psychopathology, including PTSD (Dalgleish & Power, 2004). Greenberg (2004) also featured in the project this research because it linked theory and practice which seemed appropriate to the enquiry.

**Recruitment and sample size**

A nonprobabilistic, purposive sampling approach was used. Purposive sampling is used prolifically in applied research (Miles, 1994). Although there are many different types of purposive samples, the most commonly used strategy involves recruiting participants according to predetermined criteria who meet the aims of the project (Patton, 1990). How many and knowing when to stop recruitment is a point of considerable ambiguity and debate (Guest, 2006). Grounded theorists suggest data collection should be determined inductively to the point of theoretical saturation; however, in fitting with thematic analysis we adopted a more pragmatic target of ‘thematic exhaustion’ which was achieve when interviews stopped producing significant new themes or insights (Guest, 2006). Actual numbers vary and
Sandelowski (1996) argued that it is the responsibility of the researcher to strike a balance between the being able to manage the amount of data and the aim to produce a thorough understanding of participant experience. Braun and Clarke (2013) suggest a sample size of six to ten when conducting in depth interviews with participants. Participants were recruited from one specialist PTSD NHS service and two hospital trusts which helped to recruit a broad range of participants with a variety of PTSD experiences and symptoms. In accordance with NHS ethics and guidelines, participants were contacted initially by their primary clinician which in all cases was a clinical psychologist (see research protocol; Appendix K). Clinicians were asked to opportunistically approach individuals on their case load who they felt met the inclusion criteria. I initially received the details of twelve participants who wanted to be involved with the project; however, one was unreachable and another went on an extended holiday.

**Interviews**

**The interview schedule**

The interview schedule was developed from discussions in supervision and through literature relating to the topic under review. Questions were open-ended and designed to explore participant experience of basic emotions (Appendix I). The questions were temporal in order to explore how emotions may have changed before, during and after traumatic experiences. After the first interview we decided to start by questioning the present prior to moving closer to the past. It felt like a more gentle progression towards potentially difficult experiences of the past and offered time in the interview to develop rapport, safety and to enlighten how participants came to tolerate difficult symptoms. The schedule was helpful to ensure that the interview remained on topic and covered areas of interest relating to the aims of the study; however, this was just a guide and areas of interest were explored opportunistically.
Exploring emergent data in situ was a skill that developed over the course of the interviews and often led to new and interesting data. It was also fitting with qualitative interview best practice guidance on conducting in-depth research interviews (Dickson-Swift, James, Kippen, & Liampittong, 2009; Guest, 2006).

**Experience of interviewing**

Participants had the choice of either being interviewed at their local NHS premises or in their home. Eight participants chose to be interviewed on NHS premises while two preferred to be interviewed at home. Consent was reviewed with each participant prior to starting the interview, emphasis was put on their right to stop the interview at any time if they felt distressed. A distress protocol was devised and used throughout the project to ensure the safety of participants and pathways for support (Appendix L). None of the participants became distressed or wanted to stop the interview; therefore, the distress protocol was not invoked. Participants were also debriefed after each interview, consent reviewed once again and I assessed levels of distress. The participants were also given a written debrief sheet which had contact information in case they became distressed after leaving the interview (Appendix M). When visiting participants at home, The University of Manchester’s lone working policy was followed. For each home visit I ensured that a professional colleague was aware of the particulars of my visit and when I had concluded the interview included calling in prior to the interview and after, additionally we devised a code word which would be used in case of emergency.

I think having a clinical background and my humanistic values helped to establish a safe, non-judgemental environment for the interviews. I was clear at the outset with each participant that the interviews were ‘not psychotherapy’ and that it may be a different way of
reflecting on their experiences. I also advised the participants that reliving would not be necessary, instead we would be discussing what emotions may have been present before, during or after and what their experiences or appraisals of these might be. Equally, I asked each of the participants what they have learned to do, or how they cope when they experience flashbacks or other distressing symptoms and asked permission to use these strategies if needed during the session. I think by doing this participants felt assured that they had control over the interview and had the right to stop if they felt distressed. Using active listening skills promoted exploration of areas of interest and complexity. However, some participants required a more direct approach as they would digress significantly onto other topics or too far into emotion non-specifics relating to PTSD. Participant accounts were profound, touching and inspiring. I began to cherish rather deeply their accounts and hold precious their stories which sustained me through the difficulties of writing up and drove me to want to represent their accounts as best I could.

Developing interview skills took time; initially I was reluctant to direct the participant and allowed stories to develop with prompts from the topic guide which worked sufficiently with most participants; however, some participants required that I ask specific questions about the basic emotions. Flexibly adapting the interview style to suit these idiosyncrasies was necessary and was aided by my clinical background.

I noticed when reviewing transcripts that I would often reflect emotions or interpretation made by the participants. Sometimes these were summary reflections that amalgamated some of the emotional latencies. These were mostly met with affirmation, occasionally being denied and inviting further investigation. Although these were not explicit in the topic guide they did lead to further and deeper levels of understanding and deemed useful in qualitative research (Gubrium & Holstein, 2002). I was shocked later when completing the analysis that
initial themes and some latent themes were present in these reflections. Considering that the analysis was derived from participant accounts and utterances, to then read more closely around some of what I was picking up on even at the time of the interviews was encouraging.

The interviews by the nature of the topic exposed me to potentially harmful content. Although I have clinical experience prior to coming on the course, I would sometimes feel overwhelmed by the stories of participants. I was able to contain these emotions in sessions but sometimes would leave thinking about some of the content. After the first couple of interviews I realised that I would need to talk through some of these difficulties and fortunately my clinical supervisor was able to discuss any issues as and when they would arise. Equally I made sure that I was engaged with my self-care strategies including exercising and time with my family.

Analysis

Although I wanted to transcribe all of the data myself, changes in supervision and time constraints rendered this impossible. Therefore, I was only able to transcribe three of the ten interviews. The remaining interviews were transcribed by an experienced administrator on the course team. There are mixed opinions on the benefit of researchers transcribing their own research interviews with some adopting a view that it is a necessary aspect of the interview and analysis processes, while others take a more pragmatic view that it may be overly time consuming and argue there exists little evidence to support claims that it makes for a better analysis (Forbat & Henderson, 2005; Oliver, Serovich, & Mason, 2005). For these reasons I felt that the project could not be sufficiently described as grounded theory due to the necessity to slow down at this stage, transcribe and code iteratively which was not possible due to changes in supervision during data collection. Thematic analysis; however, abides to a
different set of principles and can be conducted with data at any stage of analysis (Braun & Clarke, 2008). In thematic analysis researchers are not required to transcribe all of their own data. However it is considered helpful to transcribe a sample of the interviews in order to enhance ‘familiarisation with data’ amongst other efforts including, reading and re-reading the data and noting down initial ideas. I chose to only transcribe three interviews due mainly to pragmatic reasons including project deadlines and timing. The remainder of the interviews were transcribed by an experienced professional. For me, transcribing a sample of interviews was sufficient to orientate me to the data, yet I also enlisted a range of other strategies including listening to audio recordings of the interviews, reading and rereading transcripts, whilst all the time noting down initial codes and ideas presented in the data which was vital in order to immerse myself in participants’ stories and to critically reflect on my interview skills. However, this constant and ongoing immersion into participants’ personal stories of traumatic events was often overwhelming. It went beyond interviews and was also felt during the analysis of their stories, constantly reflecting on themes and words relating to horrific events was hard at times and I am thankful to my supervisors, colleagues and family for their ongoing support. However difficult this was, I felt like a ‘trusted witness’ to participants, which drove further personal commitment to honour their stories as best I could throughout the analysis.

Following transcription, thematic analysis (TA) was used to identify and analyse patterns of meaning from participant accounts (Braun & Clarke, 2008). The research abided to good practice guidelines put forth by Joffe and Yardley (2004) and included a dual manifest-latent and deductive-inductive perspective. As mentioned in paper 2 the study was necessarily deductive as it required a choice of emotion theory upon which to ask questions; however, steps were taken to promote trustworthiness so that themes were also derived inductively.
Seale (1999) suggests that truth is not the ambition of qualitative research as analysis rests in the subjective accounts of researchers involved with the study. However, as illustrated in paper 2 efforts were made to increase the trustworthiness of the analysis including gaining ongoing feedback on codes in supervision (Mays & Pope, 1995), reflexivity (Willig, 2013, Treharne, 2011); transparency (Koch, 2006); using participant words and member checking (Lincoln & Guba, 1985).

Limitations

A number of potential limitations were mentioned in paper 2. The first limitation was that all of the participants were receiving psychotherapy at the time of the interviews. I was unaware of how competitive and difficult it may be to recruit potential candidates for the research project. The research team agreed that due to limited time and multiple demands placed on trainees on the programme that the study would benefit from a focused and contained recruitment strategy. Hence, we called upon services and practitioners whom we were equally passionate about the aims and topic of the study. However, in doing this we were unable to recruit participants who dropped out or did not access psychotherapy. The topic guide was used to explore emotions prior to psychotherapy in an attempt to mediate this risk somewhat. In addition, some participants did in fact drop-out and then reengage with services at different stages in their recovery. Some may criticise the study as it has engaged with participants who are at different stages in their recovery from PTSD; however, I feel this gave added insight into the range of emotions experiences at different stages of recovery. Equally, the project may have benefited from more participants; however, themes were derived inductively until the point that that the interviews produced sufficiently ‘think data’ (Flyvbjerg, 2006) upon which to conduct the analysis and according to the guidance of Braun and Clarke (2008). In addition, although the purposive sampling strategy enlisted (Patton,
1990) produced a well-balanced gender sample of 10 participants there were no non-western candidates recruited which was not intentional as all of the recruitment took place opportunistically and the project was equally advertised in all services. Although it is not the intention of qualitative inquiry to make results generalisable or relevant to all people future research may wish to target different cultural contexts.

Conclusions

Completing the empirical study helped me to develop skills and experience as a research practitioner (Raimy, 1950). This was the biggest challenge I faced on the course by far as I came onto the course with novice research skills. The project has immersed me in a topic which I feel passionately about, now even more so. Many of my assumptions and clinical experiences were affirmed by this research which I am hoping other practitioners may benefit from. I am hoping to take this research forward and share it with others either via publication or with new opportunities for further research and development.

Reflecting on learning

Hindsight

“Before, you are wise; after, you are wise. In between you are otherwise” (Miller, 2007, p. 31)

Although I came onto the course with some clinical skills and have managed well in this aspect of training I did not have very much research experience of writing for publication. Some colleagues on my programme seem to struggle with the clinical aspects of the programme and view the writing as an important but easy aspect of the course, conversely, for myself the research and subsequent write up has been extremely challenging. Firstly,
when making choices early on in the project relating to methodologies and reviews, I did not realise how much theoretical rigour and time was needed in qualitative research. For example, I had never completed a meta-synthesis and with hindsight I would probably have avoided this as it felt as though I was completing two empirical papers. The requirements of a meta-synthesis in terms of coding and interpretation were at par with the process intensity of paper 2. Given that we are allotted essentially one day per week over the course of three years to complete the thesis it was essential to manage time effectively. I became concerned about project timing around November 2014 when there were longer than expected delays with ethics decisions and unexpected leave within one of the recruiting services which consequently meant delays with recruitment and interviews which was around the time that I found out that JF would be leaving the course team. Anxiety prompted me to create an action plan with DP which helped me to gain control of the mounting tasks of the project. We reviewed this timeline weekly in supervision and I believe that without this I would have been constantly feeling overwhelmed.

Writing skills

The ‘pain of critique’ (Aitchison, Kamler, & Lee, 2010) is well documented in the pedagogy of doctoral publishing. I had low confidence in my writing skills and always knew that writing up the final report would pose a challenge. Feedback on my initial drafts confirmed my suspicions and I felt distressed, frustrated and embarrassed. My writing was criticised often for being ‘verbose’ and with hindsight it was, for the purpose of publication which prompted discussion with DP about the process of writing for publication that I have never been involved with. DP mentioned the iterative process of writing and the distilling of information, which helped me to objectify the writing more and realise that the feedback that I was getting was meant to improve the paper. Aligning feedback with the overall aims and
The purpose of the study and with personal values has been found helpful when writing for publications (Stenhouse, 1981) and helped my appraisals to shift from self-criticism to wanting more feedback to ensure the development of the paper.

**Implications for my clinical practice**

Prior to the study I was sceptical about overly simplistic assumption about the nature of emotions and PTSD. Some of my assumptions were challenged by accounts of participants who valued exposure based interventions. Although there were relative few who had experienced exposure only psychotherapy, exposure was found useful for some participants experiencing anxiety. Undergoing gradual exposure to fearful stimulus helped participants to regain a sense of control over seemingly out of control symptoms. Yet, most experienced a range of other primary and secondary emotions that were perceived as difficult. I became curious about the negative perception that participants had of some of their emotions and was often challenged in supervision by LB about my positive or negative assumptions about emotions. Emotions such as anger are often categorised negatively and the accounts of participants highlight the depth and impact of these appraisals which was clinical relevant to me as I began to see the potential for changing emotion appraisals which could render some in psychotherapy more accepting of a range of emotions. Reducing these negative appraisals also seemed to help some to feel less secondary guilt, shame and anger at having these emotions, rendering the potential for improved affect. I have become affair in my clinical practice of formulating and understanding these idiosyncrasies. In addition, clinically I was drawn to the importance for interventions to help participants to understand their ‘right’ to these emotions and how some may value learning strategies to tolerate and accept them.
Completing the project has improved both my reflective and analytical skills, which I believe has benefitted my clinical practice in terms of how I approach the issues brought by patients. Holding a reflexive stance throughout the research has also led me to become a more reflective clinician, having greater awareness of the relationships I build and maintain with patients, including the contribution of my own assumptions, beliefs and values to that relationship.

Managing mid-life

Mature students are presented with a variety of unique challenges while completing post graduate learning including identity diffusion and the added responsibility of raising children (Baxter & Britton, 2001). I was the oldest on the course and raising two children who were aged three and six when I started this research which reared several challenges including finding time to be a dad and husband while submitted to the ongoing demands of completing a thesis while on clinical placement. Finding quiet time after the children were asleep in the evening required ongoing motivation and determination as it was simply not feasible to write when they were around. Some may perceive having a family as a hindrance but I believe that they were my rock, motivation and purpose for completing clinical training. I would quickly be recharged by their ongoing encouragement and love. In addition, coming on the course meant sacrificing an existing career trajectory and joining the ranks of a trainee psychologist. Being exposed to ongoing evaluation and criticisms as the course demands rendered me feeling disenfranchised and low in confidence at times. I imagine this is part of the training and refinements necessary to becoming a clinical psychologist, and although I found the challenges overwhelming at times I can now see how some of the learning has become embedded and an emerging confidence.
Overall conclusion

Papers 1 and 2 attest to the complexity of PTSD and the challenges faced by theorist and clinicians to help individuals recover from trauma. Each of the papers account for ways in which PTSD patients can be supported to manage a variety of difficult symptoms and emotions in order that they can lead a more meaningful and purposeful life. Clinical psychologists have a vital role to play in offering a supportive and understanding relationship that provides a sense of safety for PTSD patients. A good psychotherapeutic relationship can help to encourage an individual to learn to manage their emotions on their own and feel whole again. In doing so, patients may overcome their symptoms and may even experience personal growth from having survived PTSD.
References


APPENDIX A: Clinical Psychology and Psychotherapy author guidelines

MANUSCRIPT SUBMISSION

Clinical Psychology & Psychotherapy operates an online submission and peer review system that allows authors to submit articles online and track their progress via a web interface. Please read the remainder of these instructions to authors and then visit http://mc.manuscriptcentral.com/cpp and navigate to the Clinical Psychology & Psychotherapy online submission site.

IMPORTANT: Please check whether you already have an account in the system before trying to create a new one. If you have reviewed or authored for the journal in the past year it is likely that you will have had an account created.

Pre-submission English-language editing

Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. A list of independent suppliers of editing services can be found at http://wileyeditingservices.com/en/. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

All articles must be submitted via the online system.

File types. Preferred formats for the text and tables of your manuscript are .doc, .docx, .rtf, .ppt, .xls. LaTeX files may be submitted provided that an .eps or .pdf file is provided in addition to the source files. Figures may be provided in .tiff or .eps format.

NEW MANUSCRIPT

Non-LaTeX users. Upload your manuscript files. At this stage, further source files do not need to be uploaded. LaTeX users. For reviewing purposes you should upload a single .pdf that you have generated from your source files. You must use the File Designation "Main Document" from the dropdown box.

REVISED MANUSCRIPT

Non-LaTeX users. Editable source files must be uploaded at this stage. Tables must be on separate pages after the reference list, and not be incorporated into the main text. Figures should be uploaded as separate figure files. LaTeX users. When submitting your revision you must still upload a single .pdf that you have generated from your revised source files. You must use the File Designation "Main Document" from the dropdown box. In addition you must upload your TeX source files. For all your source files you must use the File Designation "Supplemental Material not for review". Previous versions of uploaded documents must be deleted. If your manuscript is accepted for publication we will use the files you upload to typeset your article within a totally digital workflow.

COPYRIGHT AND PERMISSIONS
Copyright Transfer Agreement

If your article is accepted, the author identified as the formal corresponding author for the article will receive an email prompting them to login into Author Services; where via the Wiley Author Licensing Service (WALS) they will be able to complete the license agreement on behalf of all authors on the article.

For authors signing the copyright transfer agreement

If the OnlineOpen option is not selected the corresponding author will be presented with the copyright transfer agreement (CTA) to sign. The terms and conditions of the CTA can be previewed in the samples associated with the Copyright FAQs below:

CTA Terms and Conditions

For authors choosing OnlineOpen

If the OnlineOpen option is selected the corresponding author will have a choice of the following Creative Commons License Open Access Agreements (OAA):

Creative Commons Attribution License OAA

Creative Commons Attribution Non-Commercial License OAA

Creative Commons Attribution Non-Commercial -NoDerivs License OAA

To preview the terms and conditions of these open access agreements please visit the Copyright FAQs hosted on Wiley Author Services and visit http://www.wileyopenaccess.com/details/content/12f25db4c87/Copyright-License.html.

If you select the OnlineOpen option and your research is funded by The Wellcome Trust and members of the Research Councils UK (RCUK) you will be given the opportunity to publish your article under a CC-BY license supporting you in complying with Wellcome Trust and Research Councils UK requirements.

For more information on this policy and the Journal’s compliant self-archiving policy please visit: http://www.wiley.com/go/funderstatement.

Permission grants - if the manuscript contains extracts, including illustrations, from other copyright works (including material from on-line or intranet sources) it is the author's responsibility to obtain written permission from the owners of the publishing rights to reproduce such extracts using the Wiley Permission Request Form.

Submission of a manuscript will be held to imply that it contains original unpublished work and is not being submitted for publication elsewhere at the same time.

Title and Abstract Optimisation Information. As more research is read online, the electronic version of articles becomes ever more important. In a move to improve search engine rankings for individual articles and
increase readership and future citations to Clinical Psychology & Psychotherapy at the same time please visit

[Optimizing Your Abstract for Search Engines](#) for guidelines on the preparation of keywords and descriptive titles.

**Manuscript style.** The language of the journal is (British) English. All submissions must have a title, be printed on one side of A4 article with numbered pages, be double-line spaced and have a 3cm wide margin all around. Illustrations and tables must be printed on separate sheets, and not incorporated into the text.

**MANUSCRIPT STYLE**

The language of the journal is English. 12-point type in one of the standard fonts: Times, Helvetica, or Courier is preferred. It is not necessary to double-line space your manuscript. Tables must be on separate pages after the reference list, and not be incorporated into the main text. Figures should be uploaded as separate figure files.

During the submission process you must enter the full title, short title of up to 70 characters and names and affiliations of all authors. Give the full address, including email, telephone and fax, of the author who is to check the proofs.

Include the name(s) of any sponsor(s) of the research contained in the article, along with grant number(s).

Enter an abstract of up to 250 words for all articles [except book reviews]. An abstract is a concise summary of the whole article, not just the conclusions, and is understandable without reference to the rest of the article. It should contain no citation to other published work.

All articles should include a **Key Practitioner Message** — 3-5 bullet points summarizing the relevance of the article to practice.

Include up to six **keywords** that describe your article for indexing purposes.

**Research Articles:** Substantial articles making a significant theoretical or empirical contribution.

**Reviews:** Articles providing comprehensive reviews or meta-analysis with an emphasis on clinically relevant studies.

**Assessments:** Articles reporting useful information and data about new or existing measures.

**Practitioner Reports:** Shorter articles that typically contain interesting clinical material.

**Book Reviews:** Published on invitation only. Critical summaries of recent books that are of general interest to readers of the journal.

**Reference style.** The APA system of citing sources indicates the author's last name and the date, in parentheses, within the text of the article.
### APPENDIX B: PRISMA checklist

<table>
<thead>
<tr>
<th>Section/topic</th>
<th>#</th>
<th>Checklist item</th>
<th>Reported on page #</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TITLE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>1</td>
<td>Identify the report as a systematic review, meta-analysis, or both.</td>
<td>Page 12</td>
</tr>
<tr>
<td><strong>ABSTRACT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Structured summary</td>
<td>2</td>
<td>Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.</td>
<td>Page 13</td>
</tr>
<tr>
<td><strong>INTRODUCTION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rationale</td>
<td>3</td>
<td>Describe the rationale for the review in the context of what is already known.</td>
<td>Page 15.</td>
</tr>
<tr>
<td><strong>METHODS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protocol and registration</td>
<td>5</td>
<td>Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.</td>
<td>N/A</td>
</tr>
<tr>
<td>Eligibility criteria</td>
<td>6</td>
<td>Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.</td>
<td>Abstract, page 13.</td>
</tr>
<tr>
<td>Information sources</td>
<td>7</td>
<td>Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.</td>
<td>Research design, page 18.</td>
</tr>
<tr>
<td>Search</td>
<td>8</td>
<td>Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.</td>
<td>Appendix C</td>
</tr>
<tr>
<td>Study selection</td>
<td>9</td>
<td>State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).</td>
<td>Research design, page 18.</td>
</tr>
<tr>
<td>Data collection process</td>
<td>10</td>
<td>Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.</td>
<td>Analysis, page 22.</td>
</tr>
<tr>
<td>-------------------------</td>
<td>----</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Data items</td>
<td>11</td>
<td>List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.</td>
<td>Page 12.</td>
</tr>
<tr>
<td>Risk of bias in individual studies</td>
<td>12</td>
<td>Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.</td>
<td>Quality assessment page 24.</td>
</tr>
<tr>
<td>Summary measures</td>
<td>13</td>
<td>State the principal summary measures (e.g., risk ratio, difference in means).</td>
<td>N/A</td>
</tr>
<tr>
<td>Synthesis of results</td>
<td>14</td>
<td>Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I²) for each meta-analysis.</td>
<td>Results, page 24.</td>
</tr>
<tr>
<td>Risk of bias across studies</td>
<td>15</td>
<td>Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).</td>
<td>Quality assessment page 24.</td>
</tr>
<tr>
<td>Additional analysis</td>
<td>16</td>
<td>Describe methods of additional analysis (e.g., sensitivity or subgroup analysis, meta-regression), if done, indicating which were pre-specified.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**RESULTS**

<table>
<thead>
<tr>
<th>Study selection</th>
<th>17</th>
<th>Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.</th>
<th>Research design, page 18.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study characteristics</td>
<td>18</td>
<td>For each study, present characteristics for which data were extracted (e.g.,</td>
<td>Quality and characteristics of the included studies, page 24</td>
</tr>
<tr>
<td>Risk of bias within studies</td>
<td>19</td>
<td>Present data on risk of bias of each study and, if available, any outcome-level assessment (see Item 12).</td>
<td>Quality and characteristics of the included studies, page 24</td>
</tr>
<tr>
<td>Results of individual studies</td>
<td>20</td>
<td>For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group and (b) effect estimates and confidence intervals,</td>
<td>N/A</td>
</tr>
</tbody>
</table>
ideally with a forest plot.

<table>
<thead>
<tr>
<th>Item</th>
<th>Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Variables were no used as the review is a qualitative meta-synthesis. PICO was used the ‘C’ was adapted for qualitative research and referred to conceptualisation and the design of the qualitative study being sought.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>12</td>
<td>Risk of bias was assessed through the quality assessment. See page 24.</td>
</tr>
<tr>
<td>13</td>
<td>Summary measures were not used as the review was a qualitative meta-synthesis</td>
</tr>
<tr>
<td>16</td>
<td>Additional analysis were not used as the review was a qualitative meta-synthesis.</td>
</tr>
<tr>
<td>20</td>
<td>The studies under review did not involve outcomes.</td>
</tr>
<tr>
<td>22</td>
<td>The methodological limitations of meta-synthesis are discussed on page 40.</td>
</tr>
<tr>
<td>23</td>
<td>Additional analysis were not used as the review was a qualitative meta-synthesis.</td>
</tr>
</tbody>
</table>
APPENDIX C: Critical Appraisal Skills Programme (CASP) guidelines

10 questions to help you make sense of qualitative research

How to use this appraisal tool

Three broad issues need to be considered when appraising the report of a qualitative research:

- Are the results of the review valid?
- What are the results?
- Will the results help locally?

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is “yes”, it is worth proceeding with the remaining questions.

There is some degree of overlap between the questions, you are asked to record a “yes”, “no” or “can’t tell” to most of the questions. A number of prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

There will not be time in the small groups to answer them all in detail.

©CASP This work is licensed under the Creative Commons Attribution - NonCommercial-ShareAlike 3.0 Unported License. To view a copy of this license, visit http://creativecommons.org/licenses/by-nc-sa/3.0/ www.casp-uk.net

©Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist 31.05.13

121
Screening Questions

1. Was there a clear statement of the aims of the research?

   HINT: Consider
   - What was the goal of the research?
   - Why it was thought important?
   - Its relevance

2. Is a qualitative methodology appropriate?

   HINT: Consider
   - If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
   - Is qualitative research the right methodology for addressing the research goal?

Is it worth continuing?

© Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist 31.05.13
Detailed questions

3. Was the research design appropriate to address the aims of the research?

☐ Yes  ☐ Can't tell  ☐ No

HINT: Consider
• If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)?

4. Was the recruitment strategy appropriate to the aims of the research?

☐ Yes  ☐ Can't tell  ☐ No

HINT: Consider
• If the researcher has explained how the participants were selected
• If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
• If there are any discussions around recruitment (e.g. why some people chose not to take part)
5. Was the data collected in a way that addressed the research issue?
   - Yes  ■  Can’t tell  ■  No

**HINT:** Consider
- If the setting for data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviewers were conducted, or did they use a topic guide)?
- If methods were modified during the study, if so, has the researcher explained how and why?
- If the form of data is clear (e.g. tape recordings, video material, notes etc)
- If the researcher has discussed saturation of data

6. Has the relationship between researcher and participants been adequately considered?
   - Yes  ■  Can’t tell  ■  No

**HINT:** Consider
- If the researcher critically examined their own role, potential bias and influence during
  (a) Formulation of the research questions
  (b) Data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design
7. Have ethical issues been taken into consideration?  ☐ Yes  ☐ Can’t tell  ☐ No

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained.
- If the researcher has discussed issues raised by the study (e.g., issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study).
- If approval has been sought from the ethics committee.

8. Was the data analysis sufficiently rigorous?  ☐ Yes  ☐ Can’t tell  ☐ No

HINT: Consider
- If there is an in-depth description of the analysis process.
- If thematic analysis is used, if so, is it clear how the categories/themes were derived from the data?
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process.
- If sufficient data are presented to support the findings.
- To what extent contradictory data are taken into account.
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation.
9. Is there a clear statement of findings?

HINT: Consider

- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researchers' arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy? Or relevant research-based literature?
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used
APPENDIX D: Ethical approval

Health Research Authority
National Research Ethics Service

NRES Committee North West - Lancaster
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ
Telephone: 0161 625 7109
Fax: 0161 625 7919

14 July 2014
Mr Trevor Landry
Trainee Clinical Psychologist
Greater Manchester Mental Health and Social Care Trust
School of Psychology
2nd Floor, Zochonis Building
University of Manchester
M13 9PT

Dear Mr Landry,

Study title: Subjective accounts of the emotional experience of PTSD
REC reference: 14/NW/0309
IRAS project ID: 146391

Thank you for your email of 11th July 2014. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 17 June 2014

Documents received
The documents received were as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copies of advertisement materials for research participants</td>
<td>1.2</td>
<td>01 July 2014</td>
</tr>
<tr>
<td>Participant consent form</td>
<td>1.2</td>
<td>01 July 2014</td>
</tr>
<tr>
<td>Participant information sheet (PIS) [Information for Professionals]</td>
<td>1.2</td>
<td>01 July 2014</td>
</tr>
<tr>
<td>Participant information sheet (PIS)</td>
<td>1.2</td>
<td>01 July 2014</td>
</tr>
</tbody>
</table>

Approved documents
The final list of approved documentation for the study is therefore as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copies of advertisement materials for research participants</td>
<td>1.2</td>
<td>01 July 2014</td>
</tr>
<tr>
<td>Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interview schedules or topic guides for participants</td>
<td>1.1</td>
<td>30 April 2014</td>
</tr>
<tr>
<td>Letter from sponsor</td>
<td></td>
<td>03 April 2014</td>
</tr>
<tr>
<td>Non-validated questionnaire [Validated- Impact of Event Scale]</td>
<td></td>
<td>30 December 2013</td>
</tr>
<tr>
<td>Other [Debriefing Sheet]</td>
<td>1.1</td>
<td>30 December 2013</td>
</tr>
</tbody>
</table>

A Research Ethics Committee established by the Health Research Authority
You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor’s responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

14/NW/0309 Please quote this number on all correspondence

Yours sincerely

Ms Margaret O’Connor
REC Assistant

E-mail: nrescommittee.northwest-lancaster@nhs.net

Copy to:  Ms Lynne Macrae
            Ms Lisa Dowell, Manchester Mental Health & Social Care NHS Trust
Our Ref: GW/HAA 07 October 2014

Mr Trevor Landry
Trainee Clinical Psychologist
Greater Manchester Mental Health and Social Care Trust
School of Psychology
2nd Floor, Petherton Building
University of Manchester
M13 9PT
Email: trevor.landry@postgrad.manchester.ac.uk

Dear Mr Landry

R&I Ref 1881

<table>
<thead>
<tr>
<th>Study Title:</th>
<th>Subjective accounts of the emotional experience of PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>REC reference:</td>
<td>14/NW/0309</td>
</tr>
<tr>
<td>HRA project ID:</td>
<td>148391</td>
</tr>
</tbody>
</table>

Thank you for submitting the above study for NHS R&I permission. Lancashire Teaching Hospitals NHS Foundation Trust is the host site for this non-HAR portfolio study.

I am pleased to confirm that the Research Office has now received all necessary documentation, and the appropriate governance checks have been undertaken. This letter is issued subject to the research team complying with the attached `conditions of permission`, Trust SOPs, the DH Research Governance Framework, and any other applicable regulatory requirements.

List of documents reviewed as part of the Trust permission process:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>REC Application Form</td>
<td>3.5</td>
<td>15 April 2014</td>
</tr>
<tr>
<td>Letters for Establishments</td>
<td>1.1</td>
<td>30 December 2013</td>
</tr>
<tr>
<td>Dissease and Risk Protocol</td>
<td>1.1</td>
<td>30 December 2013</td>
</tr>
<tr>
<td>Contact Form</td>
<td>1.1</td>
<td>30 December 2013</td>
</tr>
<tr>
<td>Participants consent form</td>
<td>1.3</td>
<td>01 July 2014</td>
</tr>
<tr>
<td>Participants information sheet (PIS)</td>
<td>1.2</td>
<td>01 July 2014</td>
</tr>
<tr>
<td>Participant information sheet (PIS) [Information for Professionals]</td>
<td>1.2</td>
<td>01 July 2014</td>
</tr>
<tr>
<td>Research protocol or project proposal</td>
<td>1.1</td>
<td>01 April 2014</td>
</tr>
<tr>
<td>Summary CV</td>
<td>Draft</td>
<td>Trevor Landry</td>
</tr>
<tr>
<td>Summary CV (PI)</td>
<td>Draft</td>
<td>Trevor Landry</td>
</tr>
<tr>
<td>GCP Certificate - 19 December 2012</td>
<td></td>
<td>Trevor Landry</td>
</tr>
<tr>
<td>Validated questionnaire [Non-Validated: Demographic]</td>
<td>1.1</td>
<td>30 December 2013</td>
</tr>
<tr>
<td>Copies of advertisement materials for research participants</td>
<td>1.2</td>
<td>01 July 2014</td>
</tr>
<tr>
<td>Evidence of Sponsor Insurance or indemnity (non NHS Sponsors only)</td>
<td>03 April 2014</td>
<td></td>
</tr>
<tr>
<td>Interview schedules or topic guides for participants</td>
<td>1.1</td>
<td>30 December 2013</td>
</tr>
<tr>
<td>Letter from sponsor, University of Manchester</td>
<td>03 April 2014</td>
<td></td>
</tr>
<tr>
<td>Non-validated questionnaire [Validated: Impact of Event Scale]</td>
<td>30 December 2013</td>
<td></td>
</tr>
<tr>
<td>Debriefing Sheet</td>
<td>1.1</td>
<td>30 December 2013</td>
</tr>
<tr>
<td>NHS Feedback Opinion Letter, Conditions Met</td>
<td></td>
<td>14 July 2014</td>
</tr>
</tbody>
</table>

Trust Permission Letter | Page Number. | Page 1 of 3

129
To meet Department of Health benchmarks, the target date for 1st recruitment is 30 days from the date of this letter – 6th November 2014.

I would like to take this opportunity to wish you well with your research.

Yours sincerely

[Signature]

Mrs Gemma Whiteley
Head of Research and Innovation

Dr John Fox
School of Psychology
2nd Floor, Zoological Building
University of Manchester
M13 9PT
Email: john.fox@manchester.ac.uk

Dr Daniel Pratt
Address School of Psychology
2nd Floor, Zoological Building
University of Manchester
M13 9PT
Email: daniel.pratt@manchester.ac.uk

Dr Helen Ridley
Principal Clinical Psychologist in Physical Health
Lancashire Teaching Hospitals NHS Foundation Trust

Mrs Lynne Macnee
Address Faculty Research Practice Coordinator
FMHS Research Office, 3.53 Simon Building
University of Manchester
M12 9FL
Email: lynne.macnee@manchester.ac.uk

Mr Lisa Dowall
Manchester Mental Health & Social Care NHS Trust
Manchester Mental Health and Social Care Trust
R&D Office, 3rd Floor
Roundhay Building, Higherhouse Road, Manchester
M13 9HL
Work Email: lisa.dowall@mmh.nhs.uk

---

**Important:** Please read and sign the Conditions of Trust Permission overleaf, and return to:

Heather Adams
RM & G Coordinator
The Centre for Health Research and Innovation
Royal Preston Hospital
Stone Green Lane
Preston
PR2 9HT

<table>
<thead>
<tr>
<th>Trust Permission Letter</th>
<th>Page Number.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Page 2 of 3</td>
</tr>
</tbody>
</table>
Standardised Process for Electronic Approval of Research

27 October 2014

Mr Trevor Landry
School of Psychology
2nd Floor, Zachonis Building
University of Manchester
Brunswick Street
Manchester
M13 9PT

Dear Mr Landry

Re: Research Governance Decision Letter

SPEAR/Trust Project Reference: 1362
CRN/CSP Reference: n/a
Project Title: Subjective accounts of the emotional experience of PTSD
REC No: 14/NW/0109

Further to your request for research governance approval, we are pleased to inform you that this Trust has approved the study and all REC amendments up to the date of this letter. A condition of approval is that you comply with the Trust’s Argyll (Lone-Working Policy) System (Contact Phil Moffatt on 0161 277 1231) where appropriate. Please note when contacting the R&D office about your study you must always provide the project reference numbers provided above.

Trust R&I approval covers all locations within the Trust, however, you should ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing your research. This letter also gives NHS permission, on behalf of Rotherham Doncaster and South Humberside NHS Foundation Trust, to undertake the protocol specified research activities within the Early Intervention Service.

Please take the time to read the attached ‘Information for Researchers – Conditions of Research Governance Approval’ leaflet, which give the conditions that apply when research governance approval has been granted. Please contact the R&I Office should you require any further information. You may need this letter as proof of your approval.

We would like to point out that hosting research studies incurs costs for the Trust such as: staff time, usage of rooms, arrangements for governance of research. These are demonstrated in the enclosed proforma invoice. We can confirm that in this instance we will not charge for these. However we would like to remind you that Trust costs should be considered and costed at the earliest stage in the development of any future proposals.

Where People Matter Most

A partnership between the NHS and Manchester City Council
You will need to contact us before any new researchers join your team as they will need Trust permission before they start work on the project.

It is your responsibility to contact us a week prior to the expiry date we have recorded for this project to let us know if you wish to extend it, as we will need to send a new approval letter. You will also need to let us know immediately if for any reason the project finishes earlier.

It is a condition of our Trust approval that on completion of this study we are in receipt of an end of study report summary and a copy of the Ethics letter confirming that they have closed the study, we will remind you of this nearer the time. You will also be asked to complete an audit form for each year your study is supported by this Trust (including the year of its completion) this approval requirement and failure or refusal to complete it may result in Trust approval being withdrawn.

By beginning your research you are agreeing to all the terms and conditions as stated within this letter.

May I wish you every success with your research and if you have any queries do not hesitate to contact the R&I Team.

Yours sincerely

[Signature]

Dr. Andy Mee
Research & Innovation Manager

cc: Research Governance Sponsor: Ms Lynne Macrae
Supervisor: Dr John Fox and Dr Daniel Pratt

Enc: Approval Conditions Leaflet: Induction & ID Badge Information, TrustTECH Leaflet, Proforma invoice
11th November 2014

Mr Trevor Landry
Trainee Clinical Psychologist
Manchester Mental Health and Social Care Trust
School of Psychology
2nd Floor, Zochonis Building
University of Manchester
Manchester
M13 9PT

Dear Mr Landry,

Re: NHS Trust Permission to Proceed

Project Reference: 14/27

Project Title: Subjective accounts of the emotional experience of PTSD

I am pleased to inform you that the above project has received research governance permission.

Please take the time to read through this letter carefully and contact me if you would like any further information. You will need this letter as proof of your permission.

Trust R&D permission covers all locations within the Trust; however you will only be allowed to recruit from the sites/services you have indicated in section 3 of the SSI application form. If you would like to expand recruitment into other services in the Trust that are not on the original SSI then you must contact the R&D department immediately to discuss this before doing so.

You also must ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing recruitment in that service and you must contact the relevant service/ward managers prior to accessing the service to make an appointment to visit before you can commence your study in the trust.

Please make sure that you take your Trust permission letter with you when accessing Trust premises and please include the Trust reference number on any correspondence/emails so that the services are assured permission has been granted.
Honorary Research contracts (HRC)
All researchers with no contractual relationship with any NHS body, who are to interact with individuals in a way that **directly affects the quality of their care**, should hold Honorary Research NHS contracts. Researchers have a contractual relationship with an NHS body either when they are employees or when they are contracted to provide NHS services, for example as independent practitioners or when they are employed by an independent practitioner (Research Governance Framework for Health and Social Care, 2005). If a researcher does not require an HRC, they would require a Letter of Access (LoA). For more information on whether you or any of your research team will require an HRC or LoA please liaise with this office. It is your responsibility to inform us if any of your team do not hold Honorary Research NHS contracts/Letters of Access.

Staff involved in research in NHS organisations may frequently change during the course of a research project. Any changes to the research team or any changes in the circumstances of researchers that may have an impact on their suitability to conduct research **MUST** be notified to the Trust immediately by the Principal Investigator (or nominated person) so that the necessary arrangements can be put in place.

Research Governance
The Research Governance Sponsor for this study is The University of Manchester. Whilst conducting this study you must fully comply with the Research Governance Framework. This can be accessed at:

For further information or guidance concerning your responsibilities, please contact your research governance sponsor or your local R&D office.

Good Clinical Practice (GCP)
GCP is an international ethical and scientific quality standard for designing, conducting, recording and reporting trials that involve the participation of human subjects. It is the responsibility of all researchers who are carrying out a research project involving NHS patients and carers to complete GCP training and to update this every 2 years. All training certificates must be forwarded to the R&D department to comply with Trust permission. **Please note that student projects are exempt from this process.**

Risk and Incident Reporting
Much effort goes into designing and planning high quality research which reduces risk; however untoward incidents or unexpected events (i.e. not noted in the protocol) may occur in any research project. Where these events take place on trust premises, or involve trust service users, carers or staff, you must report the incident within 48 hours via the Trust incident reporting system. If you are in any doubt whatsoever whether an incident should be reported, please contact us for support and guidance.

Regardless of who your employer is when undertaking the research within Lancashire Care NHS Foundation Trust you must adhere to trust policies and procedures at all times.
APPENDIX E: Member checking and feedback.

Template of email sent to participants:

Date

Dear (Insert Name of Participant),

I would like to thank you again for your participation in the study entitled, A QUALITATIVE EXPLORATION OF BASIC EMOTIONS AND THE AFFECTIVE PHENOMENA OF POST-TRAUMATIC STRESS DISORDER. As a reminder, the purpose of this study was to explore the emotion and affective phenomena of post-traumatic stress disorder (PTSD) and produce themes that captured the essence of your experience using deductive-inductive thematic analysis.

I have attached a draft of the analysis and themes for you to review and feedback on. I welcome any and all feedback as I want to capture as accurately as possible your experiences at the time the interviews took place. Therefore, could you email your feedback by June 1st, 2015.

The data collected during interviews will contribute to a better understanding of emotions and PTSD, as well as how this may impact on support services. Please remember that any data pertaining to you as an individual participant will be kept confidential.

If you are interested in receiving the final report, please let me know and when the study is completed, anticipated I will send you the information. In the meantime, if you have any questions about the study, please do not hesitate to contact me by email or telephone as noted below.

Kind regards,

Mr Trevor Landry

Division of Clinical Psychology
Second Floor, Zochonis Building
Brunswick Street
Manchester M13 9PL
Tel: +44 (0)161 306 0404
Fax: +44 (0)161 306 0406
Email: trevor.landry@postgrad.manchester.ac.uk
<table>
<thead>
<tr>
<th># of responses</th>
<th>Suggested changes</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>None</td>
<td>Thanks Trevor, Very interesting information thank you for the interview I really enjoyed talking through my experiences and meeting you. Looks alright to me thank you, seems so long ago since the interview. Hope you are well… The interview helped me to consider new aspects of what happened to me, I can see how much I changed since the interviews but remember feeling all of those things. …It all seems accurate, thank you for the interview I hope it is helpful and I would like a copy of the results please. Thank you for the update, I would like a final copy please and no I wouldn’t change a thing. I have moved on since we met and am doing much better, I hope that the interview will help you and others who are going through similar circumstances.</td>
</tr>
</tbody>
</table>
APPENDIX F: Participant information and consent forms

Subjective accounts of the emotional experience of PTSD

Are you trauma survivor?

Have you been diagnosed with Post Traumatic Stress Disorder (PTSD)?

Do you want to help services to understand how best to treat and understand your experience of PTSD?

At the University of Manchester we are conducting research to look at individual emotional experiences of PTSD.

We would like to talk to people who have had a diagnosis of PTSD about emotions they may have found difficult or helpful before and after experiencing a traumatic event.

We hope that this information will help Mental Health Services understand the kind of support that survivors of PTSD would benefit from.

If you wanted to take part in the study, a researcher would arrange to come and talk to you for about one hour about your experiences. You would be paid £10 for taking part in the research.

If you are interested in taking part, or if you would like some more information about the study, please contact Trevor Landry on:

Phone: 07423 057349
Email: trevor.landry@postgrad.manchester.ac.uk
Subjective accounts of the emotional experience of PTSD.

If you choose to participate in the study please:

1. Read the included participation information sheet carefully.
2. Read and sign the included consent form.
3. Add your details below and return with the consent form in the prepaid addressed envelope or return the forms to the professional who discussed this research with you.

<table>
<thead>
<tr>
<th>Name</th>
<th>NHS #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone</td>
<td>Date of Diagnosis?</td>
</tr>
<tr>
<td>Email</td>
<td>Who gave you the diagnosis? (e.g. Psychiatrist/other mental health professional) Name of professional.</td>
</tr>
<tr>
<td>Date of birth</td>
<td>Where did you get the diagnosis? (e.g. Name of trust/service):</td>
</tr>
<tr>
<td>Can we leave a message? (Please circle)</td>
<td>YES/NO</td>
</tr>
</tbody>
</table>

If you have any questions about the study or with completing the forms please contact Trevor Landry on: trevor.landry@postgrad.manchester.ac.uk, Mobile: TBC.

Thank you for your interest.
Subjective accounts of the emotional experience of PTSD

We would like to invite you to take part in an interview research study. Before you decide whether to take part, please read why the research is being done and what it would involve for you. Please take time to read this information carefully and to speak to others about the study.

What does the study involve?
The study involves talking to a researcher for about 1 hour. We would like to talk to you about what emotions you may have found difficult or protective, before and after the diagnosis of PTSD. Also, what type of support or strategies you may have found helpful to manage any difficult emotions. This information will help us understand what support people need when they have received a diagnosis of PTSD.

Who is carrying out the research?
This research is being conducted by Trevor Landry who is a Trainee Clinical Psychologist at the University of Manchester for the purpose of an educational qualification. The project will be supervised by Dr John Fox and Dr Daniel Pratt, who are both qualified Clinical Psychologists working at the University of Manchester.

What happens if I take part? If you are interested in taking part, this is what will happen:

1. If you decide you would like to participate in this research you will be asked to provide contact details on the form provided and read and sign the attached consent form confirming you understand what the research involves and that you would like to take part.
2. The consent form and contact sheet can be returned to the research team in the prepaid envelope provided or it can be left securely with the mental health professional who has discussed this research with you for collection from a member of the research team.
3. Once the forms arrive, the research team will, with your informed consent, confirm the date that you were diagnosed with PTSD and when possible the diagnostic criteria used.
4. We would then arrange a place and time which is convenient for you to do the interview. The interview will be recorded on an audio recorder so that we can listen back to it and type up what was said. We would like to hear your experiences so we will ask some general questions that should help us focus on
Are there any potential risks?
It is hoped that the research will not lead to any risks for participants, however, some people may find it upsetting to talk about their experiences. The researcher will regularly check your distress and you will be able to stop the interview at any point or take a break if you need to. The researcher will also be able to guide you to further support if you feel that this would be helpful.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the North Lancashire Research Ethics Committee.

Who do I contact?
If you have any questions about the study or would like to take part please contact Trevor Landry on: trevor.landry@postgrad.manchester.ac.uk, Mobile: TBC.

If you have any concerns about the study that you prefer not to raise with the research team, please contact the University Research Office on 0161 275 7583.

How can I complain?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Co-ordinator on 0161 275 7583 or 0161 275 8093 or by email to research.complaints@manchester.ac.uk.
the parts of your experiences that you feel are most important. We will also ask you to fill out a short questionnaire asking for information like your age, gender and also about your PTSD symptoms.

5. When the research is finished we will send you a summary sheet of the findings (if you would like us to do so).

Payment and expenses
We will pay you £10 for taking part and to cover any travel expenses. You will be given this money at the end of the interview.

Participation in this study is entirely voluntary
You are free to withdraw from the study at any point without giving a reason. If you do not take part in this study it will not affect your care or treatment.

Will my information be kept confidential?
The questionnaire from the study and the typed-up version of your interview will not have your name or personal details on. Instead they will have a number on. Any names that you mention in the interview will be changed so they cannot be identified. All paperwork and recordings will be kept confidential. Only the research team will be able to see/hear them. Once the study is finished, the audio-recording of your interview will be destroyed. The results of this project will be written in a research report, which may be published in a scientific journal. We may use quotes from what you say in this report, but your details will be removed so nobody will know your identity. The study information might also be used in future research studies but would still remain anonymous.

We will not pass on anything that you talk about to your care coordinator, psychiatrist or anyone else involved in your care.

The only exception to this would be if you told us something that made us think that you or someone else could be at risk of harm. In this case, we would have to share that information with other relevant professionals such as your G.P. in order to keep you and others safe. However, we would talk to you about this first so that you knew who we would be sharing the information with and why.

Will the researcher be able to provide me with advice on my treatment?
No. Although the researcher is training to be a Clinical Psychologist, he will not be involved in your care for mental health difficulties and would therefore not be able to provide any advice or guidance on your treatment. However, he will be able to advise you on who you should speak to should you wish to discuss your treatment.

Are there any potential benefits to taking part?
It is hoped that the study will allow you an opportunity to share your experiences, and that in doing so, you will feel that you are part of a piece of research which aims to improve support for people with PTSD.
This scale is taken from Horowitz, Wilner et al. 1979. They scores the scale with 0, 1, 3 and 5 (p.211.). Subsequent researchers have scored the same scale 0, 1, 2, and 5. Even more recent publications score 0, 1, 3, 5 again! Despite there being only 7 items in the Intrusion scale as against 8 in the Avoidance scale, it has been suggested that one grades the PTSD as high if the score on either subscale is >19, medium for scores of 8.5 to 19, and low-level for scores of 1 to 8.5. Other work indicates total scores of between about 30 and about 60 are fairly typical for PTSD sufferers. Brewin’s work on intrusive images in depression has typical scores of 43 with higher scores for more expectedly traumatic experiences e.g. childhood abuse involving many occasions and full intercourse with a primary caregiver. Horowitz (the originator of the scale) has been quoted as recognising the usualness of intrusion, denial and upset following trauma. It is suggested that "It is through the process of communicating thoughts and feelings to others that people begin to understand and accept any consequences from an accident or injury." Working through and then being able to get on with life are seen as normal stages.

Demographic Questionnaire

Title of Project: Subjective accounts of the emotional experience of PTSD

This questionnaire is designed to gather some more information about you. Please ask the researcher if you would like anything explained further or you would like some help filling it out.

<table>
<thead>
<tr>
<th>Ethnicity: with which ethnic group do you identify? (please tick one)</th>
<th>Age:</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>Male □</td>
</tr>
<tr>
<td>White - British</td>
<td></td>
</tr>
<tr>
<td>White - Irish</td>
<td>Female □</td>
</tr>
<tr>
<td>White - Any other white background</td>
<td></td>
</tr>
<tr>
<td>Mixed</td>
<td></td>
</tr>
<tr>
<td>Mixed - White and Black Caribbean</td>
<td></td>
</tr>
<tr>
<td>Mixed - White and Black African</td>
<td></td>
</tr>
<tr>
<td>Mixed - White and Asian</td>
<td></td>
</tr>
<tr>
<td>Mixed - any other mixed background</td>
<td></td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td></td>
</tr>
<tr>
<td>Asian or Asian British – Indian</td>
<td></td>
</tr>
<tr>
<td>Asian or Asian British – Pakistani</td>
<td></td>
</tr>
<tr>
<td>Asian or Asian British – Bangladeshi</td>
<td></td>
</tr>
<tr>
<td>Asian or Asian British – Any other</td>
<td></td>
</tr>
<tr>
<td>Asian Background</td>
<td></td>
</tr>
<tr>
<td>Black or Black British</td>
<td></td>
</tr>
<tr>
<td>Black or Black British – Caribbean</td>
<td></td>
</tr>
<tr>
<td>Black or Black British – African</td>
<td></td>
</tr>
<tr>
<td>Black or Black British – any other black background</td>
<td></td>
</tr>
<tr>
<td>Other ethnic group</td>
<td></td>
</tr>
</tbody>
</table>
### Marital Status
(please tick one)
- Single
- Married
- Divorced
- Separated
- Other

### Who do you live with?
(please tick all that apply)
- Partner
- Parents
- Alone
- Children
- Other

### Employment
(please tick one)
- Full time
- Part time
- Unemployed
- Student
- Homemaker

### Highest level of educational attainment
(please tick one)
- GCSE (or equivalent)
- A-Level (or equivalent)
- Degree
- Masters
- PhD
<table>
<thead>
<tr>
<th>Have you received support or therapy after receiving a diagnosis of PTSD?</th>
<th>For how long?</th>
<th>What was helpful?</th>
<th>What was not helpful?</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES/NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Behavioural Therapy (CBT)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye movement desensitization and reprocessing (EMDR)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other psychological intervention. Please specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications. Please specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other support (ie Peer, Family etc) Please specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are you getting treatment now?  
If so, please describe?
APPENDIX H: Topic guide

Topic Guide December 2013 V 1.1

Study title: Subjective accounts of the emotional experience of PTSD.
This document is a topic guide which includes areas of questioning that are likely
to be explored during interviews with individuals who have had a diagnosis of
PTSD. Some areas of interest may emerge spontaneously, therefore, the
sequence and direction of questioning may alter in order to fully develop the
topic. Interview transcripts and data are analysed throughout the research and
these questions may develop or expand as the research progresses.

Participants will be briefed prior to interview that the interview is not a therapy
session and that they will not be required or asked to discuss traumatic events.

The following topics and prompts serve as an interview guide.

1. Current emotional experiences.
   a. Have you recently been experiencing any difficult emotions?
      i. Probe for fear, anger, sadness, guilt
   b. How do these emotions impact on your life? (psycho-social, affect)
   c. What can trigger the difficult emotions (primary emotions, hot
      emotions, sequencing)?
   d. When this happens are other emotions experienced that you may
      consider difficult (secondary emotions, coupling, appraisals)?
   e. Are you receiving support with managing these emotions?
      (coping)
   f. Does the support you received help you manage your emotions
      better?
   g. What elements of support have been helpful and what did you find
      unhelpful? (probe for strategies, family support, services, therapy,
      resilience, coping)

2. Emotional experiences immediately following the trauma
   a. What range of emotions did you experience around the time of the
      trauma/s? (probe for interactions and sequencing, affect, mood).
   b. What emotions were most difficult for you?
   c. How did these difficult emotions impact on your life? (psycho-
      social, affect)
   d. What triggered the difficult emotions (primary emotions, hot
      emotions, sequencing)?
   e. Does this also bring about other emotions that you may find
      consider difficult (secondary emotions, coupling, appraisals)?
   f. How did you cope initially? (coping, strategies, appraisals)
   g. Did you feel you needed support to manage these difficult
      emotions?
h. Just after the event what support did you find helpful and/or unhelpful?
   i. What strategies did you use to manage any difficult emotions?

3. Emotional experiences before trauma
   a. Did you have to deal with any difficult emotions before the incident? (Probe for resilience, coping strategies, social support, schema, appraisals)

4. Closing remarks
   a. Do you have any further points that you would like to make?
   b. Do you have any questions?
   c. How do you feel now that the interview has completed? (Probe for distress)
   d. Are you still happy to consent for the researcher to use the anonymised data derived from the interview for the research and analysis?
   e. Would you like to be forwarded the research findings when the analysis is completed?
   f. If I required any further clarification about what we talked about today would it be alright for me to contact you?
   g. Thank you for assisting with the research.
### APPENDIX I: Coding and process sample.

<table>
<thead>
<tr>
<th>Initial coding and notes</th>
<th>Participant sample</th>
<th>Themes and theory</th>
</tr>
</thead>
<tbody>
<tr>
<td>I: ok, .. here we go, thank you again</td>
<td>P: you’re welcome</td>
<td>Sensitised emotions, overwhelm?</td>
</tr>
<tr>
<td>I: erm, we’ll start again, I think we’ll start sort of around now, sort of in present time, we were talking off, off tape about a few difficult feelings and emotions, can you tell me a bit about what those are?</td>
<td>P: erm .. it’s, it’s feelings of worthlessness, I feel .. erm, a failure, I feel frightened, er .. angry .. frustrated, I could mention lots of different single words for how I feel inside on a daily basis and it isn’t just occasionally...</td>
<td>Fearing embarrassment? Emotions are shameful.</td>
</tr>
<tr>
<td>I: and what is that like for you?</td>
<td>P: erm .. it’s embarrassment, shame, erm, .. anger again, because there happening.</td>
<td>Overwhelming, tormenting emotions</td>
</tr>
<tr>
<td>I: do they, do they all happen at once, or does one sort of ..</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P: no, it’s all at once</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I: it just all hits you at once</td>
<td>P: yeah, all at once</td>
<td>Blaming self for emotions.</td>
</tr>
<tr>
<td>I: shame</td>
<td>P: yeah</td>
<td>Anger and shame coupling</td>
</tr>
<tr>
<td>I: and that feels</td>
<td>P: yeah</td>
<td></td>
</tr>
<tr>
<td>I: that just seems a very overwhelming</td>
<td>P: it’s a, a horrible</td>
<td></td>
</tr>
<tr>
<td>I: yeah</td>
<td>P: and it, it’s a fear of it happening even before it’s happened,</td>
<td>Fear and anxiety</td>
</tr>
<tr>
<td>Vulnerable, out of control</td>
<td>I: right, ok</td>
<td></td>
</tr>
<tr>
<td>I: so this burden, that’s a, that’s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoiding others</td>
<td>kind of a name for all those emotions for come</td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Considering others</td>
<td>P: yeah</td>
<td></td>
</tr>
<tr>
<td>Feeling responsible</td>
<td>I: there’s this burden</td>
<td></td>
</tr>
<tr>
<td>Expecting that others are negatively affected</td>
<td>P: yeah, it’s, it’s a constant thing with .. I mean I put a brave face on and anybody that would be at work wouldn’t have a clue that I feel the way I feel, because you walk in and, you know, people say, how, hiya, you ok, sort of thing, and I, yeah, fine, are you alright, and I, and I carry on as if everything is normal until I get in the car or you know and sometimes I’ll go and I’ll put the CD and I will do the three minutes, but it’s nicer to listen to it sometimes ‘cos then you can focus a bit more, and I’ll park on the side street and I will listen and try and calm down and, and think about it rationally, but, you know, erm, .. as I’ve just said, there’s people worse, far worse off than meself, and I’ve always been a very positive person, and I think that’s what upsets me in a way, because I’m not that positive person anymore. I want to be able to talk about it and I want to tell people how I feel, but there isn’t anybody, everybody else has moved on, we’ve all moved on, it’s in the past for everybody else, but it isn’t in the past for me. it’s there on a daily basis, and me husband as well, I mean, they went through probably far more, I went through the physical and the emotional afterwards, but what they had to face watching somebody they, they love, you know, on a life support for twenty four hours and then being told, you know, she may not pull through even then, and that I can’t imagine, I think it’s worse for me sons and me husband that way, and close friends, but .. they’ve, that’s, I’ve survived, I’m back to normal, (participant) is, the old (participant) is back again, because I laugh and I joke</td>
<td></td>
</tr>
<tr>
<td>Hiding emotions in front of others</td>
<td>P: no</td>
<td></td>
</tr>
<tr>
<td>Others do not/cannot understand?</td>
<td>I: you feel there is some, a lost part of yourself</td>
<td></td>
</tr>
<tr>
<td>Pretending everything is normal</td>
<td>P: oh yeah</td>
<td></td>
</tr>
<tr>
<td>Carrying on as usual</td>
<td>Using strategies to manage emotions</td>
<td></td>
</tr>
<tr>
<td>Thinking rationally</td>
<td>Trying to calm down</td>
<td></td>
</tr>
<tr>
<td>Contrasting problems.</td>
<td>Comparing to others</td>
<td></td>
</tr>
<tr>
<td>Comparing to others</td>
<td>Past positive person</td>
<td></td>
</tr>
<tr>
<td>Lossing that person?causing upset</td>
<td>Talking about change helps</td>
<td></td>
</tr>
<tr>
<td>Talking about change helps</td>
<td>Feeling isolated</td>
<td></td>
</tr>
<tr>
<td>Feeling isolated</td>
<td>Others have moved on but not me</td>
<td></td>
</tr>
<tr>
<td>Others have moved on but not me</td>
<td>Feeling overlooked?</td>
<td></td>
</tr>
<tr>
<td>Feeling overlooked?</td>
<td>Amidst difficulty daily</td>
<td></td>
</tr>
<tr>
<td>Amidst difficulty daily</td>
<td>Empathising with family</td>
<td></td>
</tr>
<tr>
<td>Empathising with family</td>
<td>Comparing experiences</td>
<td></td>
</tr>
<tr>
<td>Comparing experiences</td>
<td>Feeling a burden?</td>
<td></td>
</tr>
<tr>
<td>Feeling a burden?</td>
<td>Feeling close to death</td>
<td></td>
</tr>
<tr>
<td>Feeling close to death</td>
<td>Others feel like all is back to normal</td>
<td></td>
</tr>
<tr>
<td>Others feel like all is back to normal</td>
<td>Pretending to be normal</td>
<td></td>
</tr>
<tr>
<td>Pretending to be normal</td>
<td>Predicting others perceptions</td>
<td></td>
</tr>
<tr>
<td>Predicting others perceptions</td>
<td>Confirming loss of identity</td>
<td></td>
</tr>
<tr>
<td>Confirming loss of identity</td>
<td>Toxic emotions?</td>
<td></td>
</tr>
<tr>
<td>Toxic emotions?</td>
<td>Avoidance strategy</td>
<td></td>
</tr>
<tr>
<td>Avoidance strategy</td>
<td>Avoiding, suppressing</td>
<td></td>
</tr>
<tr>
<td>Avoiding, suppressing</td>
<td>Overlooked, burden of emotions, toxicity</td>
<td></td>
</tr>
<tr>
<td>Overlooked, burden of emotions, toxicity</td>
<td>Negative appraisals of emotions</td>
<td></td>
</tr>
<tr>
<td>Negative appraisals of emotions</td>
<td>Avoiding</td>
<td></td>
</tr>
<tr>
<td>Avoiding</td>
<td>Changed self-concept</td>
<td></td>
</tr>
<tr>
<td>Changed self-concept</td>
<td>Loss of self? Sadness</td>
<td></td>
</tr>
<tr>
<td>Loss of self? Sadness</td>
<td>Left behind, overlooked.</td>
<td></td>
</tr>
<tr>
<td>Left behind, overlooked.</td>
<td>Shame, avoidance</td>
<td></td>
</tr>
<tr>
<td>Shame, avoidance</td>
<td>Say nothing to family due to negative appraisals of emotions…toxic.</td>
<td></td>
</tr>
<tr>
<td>Say nothing to family due to negative appraisals of emotions…toxic.</td>
<td>Feeling toxic</td>
<td></td>
</tr>
<tr>
<td>Feeling toxic</td>
<td>Mismatched appraisals of recovery</td>
<td></td>
</tr>
<tr>
<td>Mismatched appraisals of recovery</td>
<td>Loss of self-concept</td>
<td></td>
</tr>
</tbody>
</table>
Background
Post-Traumatic Stress Disorder (PTSD) appeared first in DSM-III (APA, 1980) and until the recent publication of DSM-V (APA, 2013a), PTSD has been categorised as an anxiety disorder. The classification and assumption that PTSD is an anxiety related disorder has influenced treatment options and strategies which tend to favour exposure based Cognitive Behavioural Therapy (CBT) interventions (Power & Fyvie, 2012; NICE, 2005 and Ehlers & Clark, 2000). Although exposure based interventions such as TF-CBT have been found to be effective with reducing stress and anxiety (Bisson & Andrew, 2007) recent research has indicated that more than half of those with PTSD consider other emotions as problematic including sadness, disgust and anger (Power & Fyvie, 2012; Dalgleish & Power, 2004). Research has also found exposure based CBT unhelpful for non-anxious participants with PTSD (Power & Fyvie, 2012). These research findings highlight a need to revise current interventions to deem whether they are fit for purpose and explore new and better strategies for non-anxious PTSD presentations.

Also, changes in DSM-V suggest that PTSD should be categorised differently which is evident in the reclassification of PTSD away from anxiety and included as part of a new chapter on Trauma and Stress or other Related Disorders.

Aims
This study aims to explore, understand the emotional experience of PTSD.

The specific questions the research aims to explore are:

i) What emotions are experienced by survivors of PTSD?

ii) What emotions were difficult or protective?

iii) What triggers the difficult emotions (primary emotions)? Does this also bring about other emotions that the participants may find hard to manage (secondary emotions)?

iv) Were the participant’s emotions different before the incident? If so how?

v) How has the participant coped with these emotions?

vi) What strategies or interventions were helpful for managing these emotions?

Methods
Design
This is a qualitative study that will use thematic analysis. Qualitative methodology will be helpful to unpack and understand experiences from a service user perspective. Research has only recently started to consider the diverse range of emotional responses to trauma, however, this has been done using mostly quantitative methodologies which categorise emotions as fixed rather than considering the ‘lived’ experience of these emotions or how emotions may overlap. Also, the re-categorisation of PTSD in DSM-5 suggests that it would be an ideal time to stop and reflect on the experiences of service users in order to help services to consider and improve treatment interventions.

Grounded theory was chosen for the current study for the following reasons:

- Thematic analysis has been found to be useful for understanding psycho-social aspects of human behaviour
- Current accounts and understanding of PTSD are primarily diagnostically driven and manualised interventions are driven by outdated assumptions about the influence and presence of anxiety. Thematic analysis provides a framework from which to generate themes and understanding that can account for individual experiences of emotions following a diagnosis of PTSD.
- These subjective accounts will not only enrich psychological understanding of PTSD but may give glimpses into best practice which may help inform future adaptations to recovery and intervention strategies.
- Qualitative enquiry procedures are dynamic and therefore provide a flexible means for which to accommodate a patient directed exploration of the topic.

Inclusion criteria
All participants must be at least 18 years old; have sufficient oral English proficiency; community based and have capacity to consent. All participants will have had a diagnosis of PTSD.

Recruitment
Participants will be recruited with a range of experiences of trauma (Eg. Veterans, car accidents and survivors of abuse) and include those with or without experiences of treatment. Participants will be recruited via NHS trusts (MMHSCT; GMW; LCT) and relevant Third Sector organisations. In the first instance recruitment will be facilitated through liaison with clinical leads within relevant services and if necessary advertising within these services. This research will aim to recruit between 10-14 participants which is comparable with similar studies.

Outcomes
Confirmation of diagnosis will be facilitated by gaining consent to conduct a case file review. This will include confirmation of PTSD diagnosis, date of diagnosis and diagnostic criteria used (ie. DSM, ICD). This will form part of the inclusion criteria for the project and be clearly stated on the participant information sheet and consent forms. Confirmation of diagnosis will only be sought if written and informed consent is granted by the participant. Confirmation through a letter or professional conversation with a Mental Health Professional or GP affiliated with the participant will be sought. A demographic proforma will be used in order to help describe the sample. The demographic proforma will comprise of; age, gender, ethnicity and any treatment undertaken. The IES-R will also be used as a means to situate/describe the sample more fully and gain insight into symptom duration and severity (Weiss, 2007).

Semi-structured interviews will be conducted with all participants using a topic guide which will be used to facilitate the exploration of the research questions in an open and inductive manner. The topic guide will be devised from areas of interest highlighted in the literature but in line with its methodology, will be a flexible and dynamic instrument refined throughout the research by participant responses in order to extrapolate the most robust data for analysis. Both the topic guide and proforma have been reviewed by a survivor of PTSD and Mental Health Professional. This helped to refine the questions, order and time required for the interviews. These tools have also been scrutinised and reviewed as part of the researcher’s supervision. Supervision will also be a forum for on-going development, to assist with data analysis and interpretation.
Analysis plan
Procedure: Participants will be recruited in two ways:

1) Advertisements/posters detailing the study will be displayed in various NHS and independent mental health services as well as voluntary agencies, mental health charities, G.P practices etc.

2) Members of clinical teams or staff at the voluntary agencies accessed by potential participants will be asked to identify potential participants, provide them with some brief study information, and ask for their consent to be contacted by the researcher to allow the researcher to provide more detailed study information.

Once potential participants have been identified either through responding to advertisements/posters or via providing consent to staff to pass their details to the researcher, the researcher or the professional lead will provide study information via the participation information sheet (PIS) and also provide a copy of the consent forms for review and completion at least 24 hours prior to meeting with participants for an interview. The researcher will review the participants information and consent forms as an initial screening measure and if eligible the researcher will next, with the participants written informed consent, conduct a case file review to confirm diagnosis. This will consist of retrieving confirmation from a Mental Health Professional or GP of a PTSD diagnosis, date of diagnosis and method used for diagnosis (ie. DSM or ICD). This data will be coded and held anonymously. If deemed eligible the participants will be invited by the researcher to attend an interview. Participants will be briefed about the procedures of the study, consent will be reviewed to insure the participant wishes to continue. If they wish to continue, any questions the participant have about the study will be discussed. The interviews will take place at a location convenient to the participant. The participant will then be asked to complete a brief demographic questionnaire devised by the researchers followed by a brief measure of PTSD. This procedure will take approximately 15 minutes. After this procedure is complete, the audio recorder will be switched on and the interview will begin. The interview will be informed by a topic guide. The questions included in the topic guide aim to facilitate exploration of the participant’s experiences of emotions before and after a diagnosis of PTSD. It is anticipated that the interviews will last approximately 60 minutes. At the end of the interview, the audio recorder will be switched off and the participant will be fully debriefed. Participants will be provided with a copy of the debriefing sheet which will reiterate the specific aims of the study in lay language. Participants will be asked whether they have any questions about any aspect of the research and whether there is anything that was not adequately explained or anything that upset them or caused them to feel distressed. If participants reveal that they feel upset or become upset at any point during the interview, the distress and risk protocol will be invoked. They will be encouraged to speak to their G.P or care coordinator if their distress persists and will also be informed that they can contact the researcher should their distress persist using the contact details provided on the Participant Information Sheet. Participants will then be reimbursed for their study participation. This reimbursement is expected to cover travel expenses and no further expenses shall be provided Participants will also be asked whether they would like to be provided with a summary sheet of the study findings once analysis are complete.

Sponsor: University of Manchester
Date trial started: May 1st, 2014
Expected end date: June 1st, 2015
Expected submitted date of paper: June, 2015
APPENDIX K: Distress and risk protocol


SCHOOL OF PSYCHOLOGICAL SCIENCES
Zochonis Building, Oxford Road, Manchester, M13 9PL
Telephone: 0161 306 0400
Email: trevor.landry@postgrad.manchester.ac.uk
Mobile: TBC

Distress and Risk Protocol
Subjective accounts of the emotional experience of PTSD

During the course of the interview, it is possible that participants may become distressed as a result of discussing their experiences. Should this happen, the following action will be taken:

The research does not include any intervention component and thus the researcher would not provide any direct input for a participant who becomes distressed as a result of the research. However, as the researcher is a Trainee Clinical Psychologist who receives ongoing clinical supervision, it will be possible for the participant’s acute and chronic emotional distress to be assessed and for the researcher to use her clinical judgement as appropriate to ascertain potential further steps that may need to be considered in ensuring that the participant received appropriate support.

Participants who expressed feelings of distress during the research would be encouraged to contact their G.P or care co-ordinator (as detailed above) and would be assisted with this process if required but the ultimate decision regarding whether or not they access help would remain theirs. However, should a participant show a level of distress which rendered them a potential risk to themselves or others then the researcher would make appropriate contact with the participant’s G.P., care co-ordinator, social services or community mental health team. If immediate risk was apparent, an ambulance and/or the Police would be contacted as appropriate. Furthermore, the researcher would seek guidance on the appropriate course of action to take from her project supervisors, two of whom are experienced Clinical Psychologists and are trained to deal with risk situations.

Participants who revealed distress at the time of the interview, or who revealed distress following the interview by contacting the researcher and disclosing this would be telephoned 24 hours after revealing their distress by the researcher who would check on whether their distress levels were subsiding or not. Should distress levels remain or have worsened, the participant would be encouraged to seek support from their mental health team or from the support services detailed in their support services sheet. Should issues pertaining to risk be revealed, the appropriate agencies would be contacted (see previous paragraph). Please see attached Appendix 1, process map, for full details on pathway protocol.

Appendix 1: Process map.

Distress

- A participant indicates they are experiencing a high level of stress or emotional distress OR
- exhibit behaviours suggestive that the discussion/interview is too stressful such as uncontrolled crying, shaking etc.

Stage 1 Response

- Stop the interview/discussion
- The researcher will offer immediate support and assess mental status:
  - Tell me what thoughts you are having
  - Tell me what you are feeling right now?
  - Do you feel safe?
  - Do you feel you are able to continue with this interview?

Review

- If participant feels able to carry on; resume interview/discussion
- If participant is unable to carry on Go to stage 2.

Stage 2 Response

- Remove participant from discussion and accompany to quiet area or discontinue interview
- Encourage the participant to contact their GP or mental health provider OR
- Offer, with participant consent, for a member of the research team to do so OR
- With participant consent contact a member of the health care team treating them at for further advice/support

Follow up

- Follow participant up with courtesy call (if participant consents) OR
- Encourage the participant to call either if he/she experiences increased distress in the hours/days following the focus group

APPENDIX L: Participant debriefing form


SCHOOL OF PSYCHOLOGICAL SCIENCES
Zochonis Building, Oxford Road, Manchester, M13 9PL
Telephone: 0161 308 0400
Email: trevor.landry@postgrad.manchester.ac.uk
Mobile: TBC

Subjective accounts of the emotional experience of PTSD.

Overview of study
Thank you for taking part in this study and sharing your experiences. This study is an exploration of the emotions that people experience before and after a diagnosis of Post-Traumatic Stress Disorder (PTSD). The study seeks to understand what emotions were difficult or protective, how difficult emotions impacted on quality of life and how emotions were different before and after a traumatic incident. Also, key to this study was understanding what internal and external factors helped you to reduce PTSD symptoms.

What the study involves
In this study, we will interview 12 -14 people who have a diagnosis of PTSD. We will consider the experiences that are unique to individuals and look at themes that might be common to some or all of the people we interview. The study will be written up as a doctoral thesis and submitted to the University of Manchester. Papers from the thesis will also be submitted to research journals and the study may be presented at conferences.

The purpose of the study
It can be difficult to answer the types of questions we asked in this interview, and your generosity and willingness to participate in this study are greatly appreciated. Your input will help contribute to the advancement of the field of PTSD research. We hope that the study will provide the opportunity for the voices of those who experience PTSD to be heard. By listening to the voices of those who have this first-hand experience, we hope to provide professionals with information about ways in which they can best support individuals with their recovery from PTSD.

What to do if you were affected by the questions
Sometimes people find the subject matter of these interviews upsetting. If answering any of these questions led you to feel distressed and you would like to speak to someone about your thoughts there are a number of professional and voluntary organisations that you may find helpful. Similarly, if you have been affected in any other way by any of the issues we have discussed as part of this study, you may wish to contact these organisations. We have provided a list of some of these in your area. You may also find that your GP practice has useful suggestions and contact numbers.

Follow up contact
You have the option to receive a summary of the study’s findings and implications. If you would like to receive this information, please indicate your preference to the researcher for
follow up correspondence to be sent either via email or post and provide your email address/postal address. We anticipate that summaries of findings will be available in September 2015. If you need to change your contact details at any point, you can do so by contacting either Trevor Landry or John Fox on the numbers detailed at the top of this page.

What to do if you have questions or wish to withdraw
Similarly, if you have any questions regarding the study or you wish at any point to withdraw your involvement in the study, please contact Trevor Landry or John Fox on the numbers detailed at the top of this page.

If you have any concerns about the study that you prefer not to raise with the research team, please contact the University Research Office on 0161 275 7583.

Finally, thank you again for helping us with this research.