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Working with Trauma:
Interpersonal and process issues in therapy for people suffering from the effects of traumatic experience

by

Jacqui Farrants

Submitted in fulfilment of the requirements for the degree of

Doctor of Psychology

Department of Psychology

The City University

London

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Declaration of powers of discretion

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SECTION A:

INTRODUCTION TO THE PORTFOLIO

SECTION A: Introduction to the Portfolio

1 Overview

Awareness of the psychological effects of traumatic experience has been increasing over the last two decades, particularly since the inclusion of posttraumatic stress disorder as a diagnostic category in DSM-III for the first time in 1980. The issue of trauma is now something that almost all therapeutic practitioners will encounter in the course of their work, normally through either of two presentations. Clients may be referred for counselling and psychotherapeutic interventions overtly to address issues of recent traumatic experience, including road traffic accidents, industrial accidents and assault. Alternatively, they may enter therapy to address issues such as generalised anxiety or depression and then later on in therapy disclose traumatic past experience, often past histories of abuse.

There is now a variety of evidence-based therapeutic approaches designed to address either of these presentations of traumatic experience (for an overview see Hacker Hughes and Thompson, 1994). Working with people with histories of past trauma, however, frequently poses a number of difficulties for the therapist that are not addressed within the models of traumatic stress and the recommended therapeutic interventions. For example, while most theories of posttraumatic stress disorder (PTSD) incorporate the symptoms of avoidance and intrusion (for an overview see Section B of this thesis) therapies for PTSD rarely suggest interventions to address the immediate process of avoidance as it occurs during therapy. Therapists have to deal with the frustration and uncertainty of working with clients who, through fear or extreme anxiety, are reluctant to address their traumatic memories. Furthermore, with the emergence of the false memory debate, therapists may have to deal with their own and their client's ambivalence regarding the veracity of accounts of childhood sexual abuse. Working with traumatic material, therefore, places a huge burden on the therapist, who must learn to cope with his or her own feelings about the emotional material and the intense feelings of helplessness, rage, rescue or sadness which may be evoked in therapists by traumatised clients.

This thesis attempts to address and so illuminate these process issues through a variety of media, including an empirical research project, client material, and a review of the literature. The thesis, therefore, forms a portfolio of work on the area of interpersonal and process issues in therapy for people suffering from the effects of traumatic experience.

2 The research component

Section B comprises the research component of the thesis and is a two-part empirical study of avoidance in therapy for clients with posttraumatic stress disorder, combining quantitative and qualitative research methods. In my practice with clients who have suffered trauma I have been aware that, while some clients appear to benefit very rapidly from therapeutic interventions and experience significant symptom reduction, others appear to remain stuck and unable to work through the trauma and do not obtain relief from their symptoms. Efficacy studies of therapeutic approaches tend to focus on the extent to which clients' symptoms are alleviated by the approach under study and rarely address the sizeable proportion of those who do not appear to benefit from the interventions. Avoidance is one of the most important process issues involved in working with clients who have experienced trauma and, in the current study, it is hypothesised that avoidance may be one of the factors hindering progress. The purpose of the research, therefore, is to consider the impact of avoidance on the progress of a client during the course of therapy, both in terms of avoidant personality styles of clients, as in Part 1 of the research, and the process of avoidant discursive behaviours between client and therapist, addressed in Part 2.

The first part of the research uses a quantitative methodology to compare the coping styles of monitoring and blunting (Miller, 1980) with symptom severity pre- and post-therapy to illuminate the interaction of coping style on symptom reduction over the course of therapy. While personality styles have been explored in relation to the initial development of the disorder (for an overview see Chapter 1 of Section B of this thesis) these factors have not been addressed with regard to their impact upon the extent of progress during therapy. If it could be demonstrated that an avoidant, blunting coping style is associated with poor response to treatment for PTSD, then

this would have implications for the choice of therapy used, in that therapies which minimise avoidance may need to be considered with such clients.

The second part of the study uses discourse analysis of transcribed therapy sessions of clients in order to generate some of the discursive practices that function to enable an avoidance of painful emotional material. The purpose of the analysis is to identify some of the patterns of conversational behaviour that impact upon the therapeutic process in such a way as to facilitate or enable an avoidance of emotional material. If therapists are more aware of these processes, then they are less likely to blame clients for being resistant and instead focus on engendering alternative conversations with clients that are more helpful in terms of enabling them to address emotional material and reduce avoidance.

3 The client study component

Section C of the thesis comprises two accounts of therapeutic interventions with clients, "Penny" and "Jonathon".

The first account details work with "Penny" and demonstrates the use of Imagery Rescripting (Smucker, Dancu, Foa and Niederee, 1995) a relatively recent approach to working with survivors of childhood sexual abuse suffering from posttraumatic stress. The report describes the approach in relation to work with "Penny" and reflects critically upon the difficulties of its application. In particular, process issues are addressed, including the development of the therapeutic relationship and the client's concerns about false memory for abuse.

The second account describes work with "Jonathon", a client suffering from intrusive thoughts and traumatic grief following the death of his father. Despite the intrusive thoughts, that are part of the symptom presentation of clients with PTSD, and the fact that the client described a history of childhood neglect, he was not found to conform to the diagnostic category of PTSD, and so issues of differential diagnosis are examined. The development and course of the therapeutic alliance are again explored and, in particular, issues of dependency and attraction.

4 The literature review

Section D comprises a literature review of the false memory debate, and is a critical review of the research on recovered memories of childhood sexual abuse. All practitioners working in the field of trauma need to be aware of the evidence for and against the notion that memories of sexual abuse can be forgotten and later recovered. As highlighted in the client study of "Penny", this is a debate that, through wide coverage in the media, has now reached the awareness of clients as well as therapists, and it is vital that therapists are able to speak about this issue with intelligence and sensitivity. The importance of therapists having an informed view about this area led to the publication of this review in an abridged form in Counselling Psychology Quarterly (Farrants, 1998) see Appendix 16.

5 Personal statement

This portfolio reflects my academic and professional background as a Chartered Counselling Psychologist. My motivation for researching this area comes from my experience of working with clients with histories of childhood trauma, and with those suffering from PTSD for more recent events. I have experienced first hand the dilemmas, difficulties and emotional expenditure of working with severely traumatised people and have found the therapeutic approaches for working with trauma to fall short of addressing these process issues. I have here attempted, not only to reflect upon these processes, but also to provide empirical evidence of their impact upon therapy and to suggest implications for further research and practice. If we can find ways to improve upon our practice with regard to this client group, then we can begin in a small way to relieve the suffering of so many who currently find themselves unable to move on from a traumatic past.

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SECTION B:

RESEARCH

Avoidance in therapy for posttraumatic stress disorder: coping styles and process issues.

Abstract

While the issue of avoidance in PTSD is well-documented in terms of symptom presentation, little has been done to address the problem posed to therapists of clients engaging in an avoidance of traumatic material within therapy. The current study uses a two-part approach, combining quantitative and qualitative methods to address avoidance in therapy for PTSD.

In Part 1, a correlational design is used to compare clients' coping styles of "monitoring" and "blunting" (Miller, 1980) with change in symptoms over a course of therapy. The results indicate some support for the notion that coping style is relevant to symptom change over a course of therapy for PTSD. A blunting coping style was found to be significantly negatively correlated with degree of improvement in intrusive thoughts and a monitoring coping style significantly positively correlated with improvement in avoidance symptoms over the period. However, the possibility that these results are a function of significant correlations at the outset of therapy is considered. Furthermore, the low response rate resulted in the collection of insufficient data to fully test the hypotheses and, as a result, the study was treated as an exploratory, preliminary analysis and used to highlight research questions for a second phase of the research.

In Part 2 of the study, a discourse analytic approach was used to generate avoidant discursive practices in transcribed material from therapy sessions with clients with PTSD. Both clients and therapists were found to use a range of discursive practices which resulted in the conversation moving away from expressions of negative affect or an exploration of traumatic material. Putative explanations for the observed behaviours are discussed and the need for therapists to be aware of these processes and their own emotional reactions to client's traumatic memories is emphasised. Differences in presentation between clients with histories of sexual abuse and those experiencing non-abusive isolated experiences of trauma are raised. The nature of avoidance within therapy is discussed and the impact of the overarching discourse of the therapeutic setting and the associated roles and power dynamics within the dyad are explored. Implications for improving the effectiveness of therapy and suggestions for future research in the field of avoidance in PTSD are proposed and, in particular, a call made for a more process-focused and "dyad-orientated" approach to practice and research in this area.

Section B: Research

Part 1:

The relationship between the coping styles of monitoring and blunting and the change in symptoms over a course of therapy for clients with posttraumatic stress disorder.

Chapter 1: Introduction and Literature Review

1 Introduction to the area of research

1.1 Overview of the research

The aim of the present study is to address the extent to which the coping styles of monitoring and blunting are relevant to therapy outcomes of patients with posttraumatic stress disorder (PTSD) and, particularly, whether an avoidant blunting coping style is associated with poorer outcomes following therapy. This chapter develops the rationale for the study by demonstrating how the current theoretical models and treatment approaches to PTSD, while recognising avoidance as an important part of the symptom presentation, fail to adequately address the impact of avoidance on the effectiveness of therapy with this client group.

1.2 Historical context of PTSD

Despite cases consistent with a diagnosis of Posttraumatic stress disorder (PTSD) recorded as early as 490BC, the term PTSD was not officially recognised until 1980 when, as Trimble (1981) notes, "post-traumatic stress disorder (sprung) from the pages of the DSM-III like some newly found tropical flower" (p 152). Lay-people have long known that exposure to overwhelming events can lead to persistent fear, avoidance, anxiety and nightmares about the event. However, it was not until the wars earlier last century that this notion began to gain credibility amongst the psychiatric profession, following Abram Kardiner's (1941) pioneering work on *"The Traumatic Neuroses of War"*.

More recently, over the last decade, cases of PTSD have been widely reported in the media following several major tragedies, for example the Hillsborough disaster, the sinking of the Herald of Free Enterprise and the Jupiter cruise ship disaster. However,

with recognition of the disorder still in its infancy, many aspects of its definition remain controversial. These include issues concerning the diagnostic features of PTSD, problems of its categorisation and the extent to which PTSD "symptoms" can be regarded as a normal reaction to an abnormal stressor. Despite a rapidly increasing body of knowledge concerning factors influencing individual differences in response to traumatic events, it is still not possible to predict who will develop the disorder and who will not following exposure. Furthermore, work is still continuing to assess the effectiveness of a myriad treatments devised to combat the disorder. Each of these issues will be explored here.

2 Diagnostic features of PTSD

According to DSM-1V (APA, 1994) the essential feature of PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor. This must involve direct personal experience of an occurrence of actual or threatened death, serious injury or other threat to one's physical integrity; or witnessing an event that involves death, injury, violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The response to the event for adults must involve intense fear, helplessness, or horror.

The characteristic symptoms resulting from the exposure to the extreme trauma include:

- persistent re-experiencing of the traumatic event, in which the person may have recurrent and intrusive recollections or dreams of the event, and may experience these in a dissociative state. The person may experience intense psychological distress or physiological reactivity when exposed to triggering events that resemble an aspect of the traumatic event.

- persistent avoidance of activities, situations or people associated with the trauma.

This avoidance may include amnesia for important aspects of the event, numbing of emotions and reduced responsiveness to or interest in the external world, and a sense of a foreshortened future.

- persistent symptoms of increased arousal, which may include sleep disturbance due to recurrent nightmares, hypervigilance, an exaggerated startle response, irritability, anger outbursts or impairment in concentration.

The full symptom picture must be present for more than one month, and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The disorder is regarded as acute when symptom duration is less than three months, chronic if three months or longer, and with delayed onset if at least six months have passed between the event and symptom onset.

3 Problems of diagnostic categorisation

While the introduction of PTSD as a diagnostic category in DSM-III in 1980 has created a welcome framework for the scientific study of reaction to trauma, the notion of categorising psychological problems has not been without its critics. Categorisation has been regarded as encouraging the definition of people's problems as disorders without context, largely independent of the personal histories of the patients, their temperaments or their environments (van der Kolk and McFarlane, 1996). The issue of context is particularly relevant to PTSD because of the nature of the disorder which, as discussed below, combines biological, psychological and sociological aspects.

3.1 Complexity of the disorder

Nemiah (1995) criticises the current definition of PTSD for being based purely on surface manifestations, thus losing the focus on the workings of the mind. Shalev,

Canetti and Schreiber (1996) suggest that PTSD differs from other stress disorders in that it involves a unique combination of hyperarousal, conditioning, shattered meaning propositions and social avoidance, which makes a "biopsychosocial trap" in which one level of impairment prevents self-regulatory healing mechanisms from occurring on other levels (Shalev and Rogel-Fuchs, 1993; Shalev, Galai and Eth, 1993). For example, avoidance of internal cues reminiscent of the trauma may impair effective grief. The disorder is, therefore, complex. Listings of symptoms such as in DSM IV does not take into account the complexity of interconnections between symptoms, and so does little to help explain their maintenance (Shalev, 1996). The interrelation between symptoms is, therefore, important in PTSD and is not currently reflected in diagnostic categorisation of symptoms.

3.2 Generalisation

A further criticism of the DSM-IV definition of PTSD is that of generalisation. There appears to be significant variation among individuals, traumatic events and the contexts in which events occur, and individuals respond in a variety of ways to extreme stressors. It is, therefore dangerous to generalise about PTSD (Blank, 1993) and categorisation may cause the variety of traumatic responses to be overlooked, in favour of only those symptoms which are necessary criteria for a diagnosis of PTSD (Brett, 1996). Furthermore, there is an argument to suggest that diagnostic criteria for PTSD may need to be modified to include cases where the precipitating event is less than catastrophic, as in the example of Weaver (2000) who describes an adolescent girl who developed PTSD following repeated emotional bullying at school.

3.3 Symptoms as a result of PTSD

Furthermore, while DSM-IV lists symptoms associated with PTSD, it overlooks the fact that many symptoms may arise *as a result* of recurring traumatic memories. As McFarlane (1988) puts it, a patient is victimised by having memories of the event not by

the event itself. In fact, Kardiner (1941) postulated a two-stage model of the response to trauma, the first stage being what we now regard as the main symptoms of PTSD and the second being a manifestation of the person's adaptation to the trauma. It is well documented that depression and anxiety disorders, for example, are frequently found to be comorbid with PTSD (Barlow, 1993) and could be regarded as the individual's response to PTSD symptoms. The whole area of diagnostic classifications loses the complexity of these reactions. Approaches based on a counselling model, and the welcome recognition of Counselling Psychology as a division of the British Psychological Society (BPS) may be useful developments in the treatment of PTSD. Such approaches seek to move away from the traditional medical and diagnostic model of treatment and aim to work with people in an individual and collaborative way. The strength of holistic approaches lies in their emphasis on the individual and their reactions to events, rather than on making attempts to classify emotions, thoughts, behaviour and physiological reactions in terms of diagnostic categories.

3.4 Normal and abnormal reactions to extreme stressors

A further point to note with regard to diagnostic criteria of PTSD is the issue of whether observed symptoms can be considered to constitute an abnormal, pathological reaction, or merely a normal response to overwhelming events. Solomon, Laror and McFarlane (1996) suggest that it is normal to react with such symptoms in the immediate aftermath of a traumatic event, such as rape or combat, and that, initially, most people do react with intrusive thoughts. A study by Malt et al (1993) found that, immediately following railway accidents, over one half of train drivers reported moderate to high levels of intrusive memories. Not all went on to develop PTSD, suggesting that these responses are normal in the aftermath of a traumatic event, and should not be pathologised. It could be argued, therefore, that it is the persistence of these symptoms beyond a few weeks, and their intensity, which constitutes an abnormal reaction. Indeed, DSM-IV has provided a separate diagnostic category for Acute Stress Disorder (ASD) a short-term severe reaction to trauma, distinguished from PTSD in its duration, lasting less than four weeks.

It could be argued that, rather than a disorder, this cluster of "symptoms" may constitute a normal reaction to an extreme stressor.

Also, it appears that the relationships among the various symptoms following trauma change with the passage of time. It has been suggested that avoidance is not an integral part of the original response to a traumatic event, and that avoidance occurs later on only after the individual has been unable to work through the intrusive symptoms. For example, Shalev (1992) found, in a study of terrorist attack victims, that avoidance was not proportional to intrusions in the immediate post-attack period. This is further supported by the Malt et al (1993) study of post accident train drivers, in which intrusive memories were frequently reported, whereas avoidance was uncommon.

It would appear, therefore, that initial reaction to a traumatic stressor and initial levels of avoidance and intrusion do not predict the onset of PTSD. If this is so, it is likely that some other process may be responsible for the development of PTSD symptoms beyond the immediate aftermath of the trauma, turning an original normal response into a pathological and abnormal reaction. Shalev (1992) suggests that this factor may be the destabilisation of the individual's normal pattern of arousal, which may have a feedback effect on the processing of thoughts and feelings. McFarlane and Yehuda (1996) go as far as to postulate that the current emphasis on a cognitive processing model of PTSD may have actually hampered the investigation of what differentiates adaptive from maladaptive responses to trauma, and may have diverted attention away from the impact of trauma on personality. Theories of PTSD span a range of approaches and models, which are outlined below.

4 Theoretical models of PTSD

Several models have been proposed in an attempt to explain the aetiology of the disorder and to make sense of the development of the PTSD symptom pattern. Prior to official

recognition of the disorder and its inclusion in DSM-III, most theories of trauma response were psychoanalytical (Barlow, 1993). Freud had observed the characteristics of "repetition" and "denial" in veterans of World War I. These concepts were later incorporated into Horowitz' (1976) Information Processing Model of response to trauma, as "re-experiencing" and "avoidance". The model integrates psychodynamic ideas with cognitive-behavioural and information processing theories. According to the model, the trauma remains in active memory, but is kept from conscious awareness by the defences of denial and emotional numbing. These mechanisms serve to prevent the individual from being overwhelmed by the memory. However, intrusive, re-experiencing phenomena such as flashbacks and nightmares are repeated as part of an attempt to process and integrate the traumatic memories. The individual, therefore, oscillates between periods of intrusive thoughts and avoidance, the latter seen as a control process aimed at regulating overwhelming affect.

4.1 Information processing models

Information processing concepts provide frameworks for understanding PTSD (for example: Beck & Emery, 1985; Foa & Kozak, 1986; Foa, Steketee & Rothbaum, 1989; Litz & Keane, 1989). Most such theories involve the notion of a cognitive fear structure, which is activated at the time of emotional arousal (Williams, Watts, McLeod and Mathews, 1988) and which results in fear responses (Lang, 1977). The existence of a fear structure enhances attention and sensitivity to stimuli represented in the structure which are then perceived more readily and more resources are allocated to processing such information (Williams et al, 1988). Foa et al (1989) suggest that it is necessary in therapy to fully activate this fear structure in order for cognitive processing and restructuring to take place. While comprehensive, such models fail to account for individual differences in response to trauma.

4.2 Learning theory models

Proposed by Keane, Zimering and Caddell (1985) learning theory models of PTSD suggest that a conditioned response to any stimulus reminiscent of the traumatic event, is elicited via classical conditioning. Stimuli indirectly related to the trauma can become additional sources of anxiety via the processes of generalisation and higher-order conditioning. Avoidance behaviours to these stimuli are learned as a means of escape of the uncomfortable arousal state and are maintained via negative reinforcement. One advantage of this model is that it may account for delayed onset PTSD, the apparent delay occurring while ever increasing additional stimuli are added to the initial fear-evoking stimuli, and begin to elicit anxiety symptoms themselves until crisis point is reached.

4.3 Cognitive processing models

Cognitive processing models view emotional processing or integrating of the trauma as central to successful recovery, in order to transform fragmented, emotional images and sensations into meaningful narrative memories, for example Foa, Steketee and Rothbaum (1989). More recently, Creamer, Burgess and Pattison (1992) proposed a five-stage cognitive processing model incorporating stages of objective exposure, network formation, intrusion, avoidance and outcome and involving feedback loops between the stages. Cognitive and behavioural theories take some account of individual differences in the development of PTSD in that they highlight the role of subjective perception of the trauma, and not just the severity of objective exposure.

4.4 Biological models

Recent findings propose physiological evidence for the cognitive processing theories, which suggest that trauma memories are fragmented and nonverbal, and need to be incorporated into narrative memories in order for recovery to occur. Studies of

hippocampal volumes by Bremner, Southwick and Charney (1995); Stein et al (1994); and Gurvitz, Shenton and Pitman (1995) indicate that PTSD patients' difficulties putting feelings into words are reflected in actual changes in brain activity. Rauch et al (in press) found that, during the provocation of traumatic memories, there is a decrease in activation of Broca's area, the part of the brain most centrally involved in the transformation of subjective experience into speech. Simultaneously, the areas in the right hemisphere which are thought to process intense emotions and visual images show significantly increased activation. This may give rise to the "speechless terror" experienced by PTSD patients, as Broca's area is "turned off" while right hemisphere activity is heightened. This indicates that, in contrast to the way in which people seem to process ordinary information, traumatic memories are initially imprinted as sensations or feeling states, and are not collated and transcribed into personal narratives. Van der Kolk (1996) posits, therefore, that the very nature of a traumatic memory is to be dissociated and stored initially as sensory fragments which have no linguistic components. These findings are a very important recent development in the field of PTSD in that they provide evidence of biological mechanisms to explain the symptoms observed in the development of PTSD. They do not account, however, for individual differences in the development of PTSD, nor explain how mediating factors, such as social support, may influence the course of the disorder.

5 Individual differences in reaction to extreme stressors

Despite the range of theoretical models of PTSD, and despite the considerable work currently being undertaken to establish the mechanisms underlying PTSD, few theories provide comprehensive explanations to account for the very apparent individual reactions to traumatic events which, as has been discussed, cannot easily be predicted. Cases of PTSD have demonstrated very clearly the fact that, despite being exposed to the same traumatic event, individuals may react in a variety of ways, some going on to develop symptoms of PTSD and others remaining relatively psychologically unscathed. It is,

therefore, considered that mediating variables play their part in the onset of the disorder. Most traumatologists now agree that response to trauma is multiply determined (Figley, 1986; Gleser, Green and Winget, 1981; Green, Lindy and Grace, 1985; Raphael, 1986) and that the type of trauma experienced is less important than the trauma severity and individual reactions and vulnerabilities (Barlow, 1993). There is now an increasing body of evidence concerning the roles that objective and subjective factors play in the development of PTSD (Davidson and Foa, 1991).

Much of the research into the disorder, since its relatively recent recognition, therefore, has attempted to document the nature of these differences in response to trauma and to identify the nature of predisposing factors. While several determinants have been identified as predictive of PTSD, it is not possible to predict who will go on to develop the disorder, nor what constitutes a traumatic event. Exploration of individual differences between trauma survivors, has yielded a wealth of both situational, attributional and personality differences between those who develop post-trauma symptoms and those who do not.

5.1 Situational factors

Situational factors have been categorised as prestressors, peritraumatic factors and post-stressor factors (Amir, Kaplan, Efroni, Levine, Benjamin, and Kotler, 1997). Amir et al (1997) found that situational factors in the development of PTSD may include prestressors, such as family psychiatric or violent history, social support, education and age (Bremner, Southwich and Charney, 1995). Peritraumatic factors influencing the development of the disorder include the nature of the event, seeing a close friend killed (Solkoff, Gray and Keill, 1986; Chemtob, Bauer and Neller, 1990) the level of exposure to combat stress (Boyle, Decoufle and O'Brien, 1989; Kulka et al. 1990) the severity of the stressor (March, 1993) or violent and injurious trauma characteristics (Bownes, O'Gorman and Sayers, 1991; Green, Grace and Gleser, 1985) with sexual assault being associated with a worse prognosis than other types of crime (Kilpatrick, Saunders,

Amick-McMullan, Best, Veronen, and Resnick, 1989; Resick. 1988), fear of being injured or killed and actual injury (Resick, 1986). Post-stressor factors in the development of PTSD include being unmarried (Card, 1983), lack of social support (for example: Frank and Anderson, 1987; Kulka et al 1990) and alcohol and substance abuse (Foy and Card, 1987). Posttrauma variables found to negatively affect recovery include early post-victimisation reactions, such as high level of distress and immediate PTSD symptoms (Rothbaum, Foa, Murdock, Riggs and Walsh, 1990). Similarly, in studies of Vietnam veterans, Kolb (1987) and Ursano, Boydstun and Wheatley (1981) found being well-educated and having experience of coping with life stressors to aid in readjustment following trauma exposure. While much of the research focuses on war veterans, civilian studies have found reaction to trauma to be compounded by compensation issues, for example in survivors of motor vehicle accidents (Culpan and Taylor, 1973).

5.2 Personality factors

In addition to exploring relevant situational variables, the notion that an individual's personality and style of coping may be relevant to the development and the course of PTSD, and indeed may moderate between exposure to trauma and consequent mental health, needs to be explored. The research has drawn upon both personality theory, health psychology and attribution theory in its search for the factors predisposing individuals to PTSD.

McFarlane (1988) found premorbid personality to be an important factor in the development of PTSD. He found that a pattern of persistently chronic morbidity could be predicted when individuals displayed a pattern of adversity before the event, neuroticism, treated past psychiatric disorder, and a tendency to avoid thinking about problems. He found individuals without PTSD to have a greater tendency to forget about injuries sustained during the trauma than did those who developed PTSD. Bryant, Marosszeky, Crooks, Baguley and Gurka (2000) found avoidant coping style, behavioural coping style and a history of prior unemployment to be significant predictors of PTSD severity in a

sample of traumatically brain-injured patients with PTSD. Davis and Breslau (1994) found individuals prone to anxiety and/or depression, family history of psychiatric difficulties with behaviour problems of childhood, or other negative personality factors to have increased risk for PTSD.

In addition to examining individual differences in symptoms in response to trauma, it is useful to study those who remain well following a traumatic experience. Benezra (1996) assessed the personality factors of forty respondents who coped successfully with traumatic experiences without planned psychotherapeutic intervention. The recurrent themes included a healthy, secure upbringing, supportive relationships, a hardworking and productive life-style, self-determination, the ability to learn from the experience, personal faith, and not feeling embittered. This is reminiscent of work in the field of health psychology, for example Kobasa's (1979) model of the "hardy" personality, comprising a sense of control, commitment and meaningfulness in life. Bartone et al (1989) found individuals high in "hardiness" had better outcomes after exposure to disaster stress. A useful question is whether hardy individuals would have a better outcome following therapy, and whether hardiness characteristics could then be trained.

Bronisch (1997) found a genetic disposition, familial psychopathology and premorbid personality traits as background variables seem to have an influence on the development of PTSD, whereas coping strategies, as well as social support, modify the course of the disease. So it appears that, while some factors may predispose an individual to the development of PTSD, other factors may influence the progression of the disorder.

5.2.1 Attributions

The extent to which the individual takes responsibility or blame for what happened, and how far they regard the event as within their control may be a mediating factor in the development of PTSD symptoms. Attribution theorists in the field of PTSD, for example Brewin (1988) have found the nature of a person's construal of events to have consequences for how he or she will respond to that event.

Traditional theories have tended to focus on attributions and depression. There are several models which link negative construal of events with depression, for example the cognitive theories of Beck (1967) and Ellis (1962) and the learned helplessness models of Seligman (1974) and Abramson, Seligman and Teasdale (1978). More recently, work has been undertaken to identify the particular attributions which are involved in PTSD. For example, negative cognitive appraisals, and causal attributions which are associated with learned helplessness, have been found to affect recovery, (Gold, 1986).

In a study of survivors of the Herald of Free Enterprise, Joseph, Brewin, Yule and Williams (1991) investigated the evidence for the contribution of causal attribution and attributional style in the development of PTSD. Joseph et al (1991) found more internal and controllable attributions of experience to be related to intrusive thoughts, depression and anxiety at eight and nineteen months following the disaster. These findings are consistent with Weiner's (1986) cognitive theory of emotions which suggests that internal and controllable causal attributions for negative outcomes are related to feelings of guilt which in turn, it was suggested, may exacerbate symptoms. This finding is also consistent with Foa, Steketee and Rothbaum's (1989) assertion that symptoms of PTSD are enhanced by the perception of unexercised control. Similarly, Joseph, Yule and Williams (1993), in a study of the survivors of the Jupiter cruise ship disaster, found internal attributions to be related to greater depression and intrusive thoughts one year later. These two studies suggest that causal attributions for disaster-related events may be important in understanding individual differences in the severity and chronicity of symptoms. It is suggested that attributional style may be one cause of such differences.

Similarly, McCormick, Taber and Kruedelbach (1989) found the development of PTSD to be significantly related to a more internal, global and stable attributional style for negative events, and a less internal, stable and global attributional style for positive events. As has been discussed, current treatments for PTSD usually include a cognitive restructuring element which serves the function of enabling individuals to make more

accurate and realistic attributions concerning the event. The reported success of such treatments (for example, Smucker, Dancu, Foa and Niederee, 1995) supports the notion that attributions are a relevant factor in PTSD.

It is clear, therefore, that the severity of the stressor itself is not the only predictor of the development of PTSD, for the way in which the event is construed and attributions made by the individual concerning the part they played in it, are likely to influence subsequent symptom development. Individual differences in the way in which a traumatic stressor is perceived are an important factor in the development of the disorder, and Foa, Steketee and Rothbaum (1989) argue, therefore, that perceived threat is a better predictor of PTSD than actual threat. Similarly, subjective responses to trauma such as perception of trauma severity and level of threat are major determinants of PTSD (Green, Lindy and Grace, 1985; Kilpatrick, Saunders, Amick-McMullan, Best, Veronen and Resnick, 1989) Reaction to trauma, therefore, is mediated by individual differences in perception of the trauma (Horesh, Rolnick, Iancu, Dannon, Lepkifker, Apter and Kotler, 1996). However, as Bryant and Harvey (1995a) observe, many studies rely on self-report measures of trauma severity. In their studies of the survivors of motor vehicle accidents, Bryant and Harvey (1995b) found that, while it is clear that trauma severity was not linearly related to stress response, self-report measures of trauma severity may be a function of attributions which are influenced by posttraumatic symptomology and Feinstein and Dolan (1991), in a study of 48 accident patients, found that perceived severity of the accident did not relate to onset of PTSD. This raises the issue of how far personality factors are the *cause* or a *result* of PTSD symptoms, that is whether individuals' attributions precede the traumatic event, or are altered by the experience.

5.2.2 Locus of control

A notion related to attribution theory is that of locus of control (Rotter, 1966). There is some evidence for the fact that higher externality is associated with greater depression and is a possible vulnerability factor in adjustment to adverse life-events (Lefcourt, Martin, and Saleh, 1984; Benassi, Sweeney and Dufour, 1988). Attempts have been

made to apply the theory to PTSD. Vinokur, Caplan and Williams (1987) found external locus of control to be a personality factor relevant to the development of PTSD. In studies by Orr et al (1990) Vietnam veterans with PTSD displayed a trend towards a more external locus of control. These results are in accordance with attributional style research which shows greater externality for positive outcomes to be associated with PTSD (McCormick et al, 1989; Mikulincer and Solomon, 1988).

5.3 Coping styles

In addition to perceptions and attributions concerning the event, another area of personality research has focused on the extent to which individual differences in coping styles among those exposed to trauma are predictive of the development of PTSD following a traumatic experience (Amir et al, 1997). The coping styles of dissociation, suppression and avoidance have been found to be associated with PTSD.

5.3.1 Dissociation

Studies of a variety of traumatised populations have shown dissociation during the trauma to be a significant predictor of the subsequent development of PTSD (Holen, 1993; Koopman, Classen and Spiegal, 1994; Shalev, Peri, Canetti and Schreiber, 1996). Van der Kolk (1996) states that much of patients' symptomology can be explained as manifestations of adaptations to traumatic experiences appropriate to the developmental level at which the trauma occurred, such as splitting or dissociating. People who have earlier learned to use dissociative states to cope with threat seem vulnerable to using it again during acute distress (van der Kolk, 1996). This is particularly evident in cases of adult survivors of childhood sexual abuse. Dissociation is frequently the only means at a child's disposal with which to cope with the traumatic event. Indeed, while dissociation is commonly regarded as a maladaptive response to a stressor, it could be argued that different styles of coping can be useful under different conditions. For example, assertiveness may be dangerous in situations of torture, sexual abuse or witnessing violence. Passive coping is not always maladaptive and sometimes dissociating or

disengaging may aid survival.

Childhood sexual abuse seems to result in the highest degree of total amnesia prior to memory retrieval, with figures ranging from 19% (Loftus, Polenski and Fullilove, 1994) to 38% (Williams, 1994). Amnesias for emotional and cognitive material are related to age and duration - the younger a person at the time of trauma and the more prolonged the trauma, the greater the likelihood of significant amnesia (Briere and Conte, 1993; Herman and Shatzow, 1987; van der Kolk, 1996). It is possible that amnesia may relate to the extent to which an individual dissociated at the time of the trauma and, as has been discussed, young children who are physically or sexually abused may be likely to use dissociation as a coping strategy.

5.3.2 Suppression

Amir et al (1997) investigated the different coping styles of patients diagnosed with PTSD, comparing them with a healthy control and a non-PTSD anxiety disorders group. Furthermore, they assessed the relationship between coping styles and intrusion and avoidance, the core symptoms of PTSD. They found the PTSD patients to score significantly higher than both groups on the coping style of "suppression", via which individuals tend to avoid the problem or situation. Of eight coping styles categories, as identified using Plutchik's (1989) Coping Styles Questionnaire, Amir et al (1997) found only "suppression" to be significantly positively correlated with both intrusion and avoidance scores, from Horowitz, Wilner and Alvarez, Impact of Events Scale (1979). Amir et al concluded that the coping style of suppression plays a pivotal role in the psychological profile of PTSD patients, distinguishing such patients from those diagnosed with general anxiety disorders. Furthermore, the more the patient attempts to suppress the impact of the traumatic event, the more s/he suffers the symptoms of intrusion and avoidance. Work on attentional bias and anxiety has demonstrated that thought suppression leads paradoxically to preoccupation with the thought (Lavy and van den Hout 1990; Wegner et al, 1987) and so enhances anxiety rather then reduces it (Lavy and van den Hout, 1994). This supports the traditional conceptualisation of PTSD as a

manifestation of the failure to cope with the traumatic thoughts and memories via an inefficient *avoidant* coping style.

6 Avoidance

While suppression may sometimes provide an appropriate and effective approach to minor or short-term problems, the evidence suggests that it is an inefficient way in which to deal with PTSD. The area of avoidance and its relationship with PTSD symptoms needs to be fully explored.

6.1 Avoidance and the onset of PTSD

Research with combat veterans has suggested that avoidant coping styles may influence the development of PTSD symptoms following exposure to combat-related events. It has been found that greater PTSD severity is associated with more frequent use of escape-avoidance styles in coping with war memories (Solomon, Mikulincer and Arad, 1991; Wolfe, Keane, Kaloupek, Mora and Wine, 1993). In a study of older Vietnam combat veterans, Hyer and Boyd (1996) found those with a diagnosis of chronic PTSD to be most likely to use emotion-focused and avoidance coping strategies to cope with reactivated trauma memories in the present. From the fact that symptoms persisted, it is clear that these coping strategies were not effective in this context, and so proved an inefficient way of dealing with the trauma. It appears, therefore, that an avoidant coping style is related to PTSD symptoms in combat veterans. However war veterans are a specific and possibly atypical group, whose training may have had an impact on the coping strategies of preference, for example confrontative strategies being reinforced by exposure to combat, and so studies of civilian traumas also need to be taken into account.

Bryant and Harvey (1995b) investigated the factors that predict post-traumatic stress intrusions in civilians, following motor vehicle accidents (MVAs) and found an avoidant

coping style and compensation to be the best predictors of intrusion scores on the Impact of Events Scale (Horowitz et al, 1979), accounting for 41% of the variance, supporting the notion that an avoidant coping style is important in the development of negative emotional response to trauma (Schwartz and Kowalski, 1992; Solomon, Mikulincer and Flum, 1988). In a later study of burns patients, Bryant (1996) found concern over scarring and an avoidant coping style accounted for 61 per cent of the variance in post-traumatic stress symptomatology, reinforcing the importance of avoidance.

So studies on both combat and civilian trauma survivors highlight avoidance as an important factor mediating symptoms. It could even be argued that avoidance rates are higher than those reported, in that many studies rely on a self-selected sample and it is likely that those choosing not to respond to a survey may represent a greater proportion of avoiders than those responding. Avoidance is, therefore, clearly a large problem in relation to PTSD symptoms, as it may serve to inhibit recovery.

Attempts have been made to understand why it is that avoidance may mediate negative adjustment following trauma. Cognitive models of PTSD propose that avoidance behaviour is a primary reaction to intrusive thoughts and contributes to the persistence of intrusions (Creamer, Burgess and Pattison, 1992). It has been suggested that this is because, in the case of chronic PTSD, distressing and intrusive recollections of the traumatic event continue "to live on in the active memory of the survivor, posing an ongoing, chronic stressor which must be coped with in the present", (Green, Lindy and Grace, 1988, p 400,). Suppression in PTSD is, therefore, regarded as a way of not dealing with the stressor and of, therefore, not coping appropriately with it, leading to the maintenance of symptoms.

Foa et al (1989) describe a "fear network" and found strong response elements in structure may promote avoidance and lead to short inadequate activation of structure, preventing the opportunity for incorporation of new meanings and modification. "The 'super-avoiders' more successfully prevent activation of the fear structure and, therefore,

would be expected to show chronic PTSD symptoms." (p168). In cognitive processing theory terms, it is possible that avoidance will interfere with processing, in that avoidance may lead to the fear network not being sufficiently activated, so that recovery does not occur. Indeed it has been suggested that poor memory results from cognitive avoidance of threat-relevant material (Foa and Kozak, 1986; Mathews and McLeod, 1987) so that cognitive avoidance serves the function of aborting further processing of threatening material (Williams, 1988). Foa et al (1989) found degree of avoidance to discriminate acute from chronic cases of PTSD. Avoidance may be manifested by not talking about the event or avoiding reminders of it. Other avoidance tactics include depersonalisation, emotional numbness, distractibility and memory loss. These are not adaptive as they do not allow emotional processing to take place. If an emotional disturbance is not 'absorbed satisfactorily' some symptoms become evident, Rachman (1980). Immediate avoidance behaviour may serve an adaptive function in the immediate aftermath of a trauma. Further research is required that investigates adaptive and maladaptive use of avoidance in post-trauma response, and the utility of appropriate reduction of avoidance to facilitate positive adjustment.

Horowitz (1986) observed that post trauma adjustment is facilitated by habituation and so reducing avoidance behaviour may aid habituation and so reduce intrusive symptoms. It could be argued, therefore, that coping style is particularly of relevance to the field of PTSD, perhaps more so than in other disorders, as PTSD symptoms appear to be maintained by the extent to which the individual attempts to suppress disturbing and intrusive thoughts of the event. It could be argued that individuals with a generally avoidant coping style may be more at risk for chronic PTSD. If it could be found that some people have a premorbid avoidant coping style that interferes with cognitive processing of the event, this could perhaps be addressed before therapy takes place.

6.2 Avoidance leading to underreporting

So, avoidance may serve to prevent the event being processed in any meaningful or narrative way, thus precluding the opportunity for cognitive restructuring and altering of faulty attributions and cognitions. However, not only may avoidance interfere with cognitive processing of trauma, and so serve to maintain symptoms, but it has also been suggested that avoidance may prevent patients being recognised as having the disorder in the first place, so that avoidant symptoms of PTSD can interfere with diagnosis.

Epstein (1993) suggests that the "self-cloaking" nature of avoidant symptoms such as psychogenic amnesia and unconscious defensiveness could lead to a significant number of false negatives in the diagnosis of PTSD. In a study of accident injury patients, Epstein (1993) found some patients to deny any problematic psychological effects soon after injury, but to develop PTSD symptoms later on. He concluded that, without the process of psychiatric interviews at nine to ten week intervals, the diagnosis of PTSD might have been easily missed in two of the six cases studied, as the avoidant symptoms of PTSD can serve as a "self-cloaking" device that may hinder or prevent timely diagnosis. PTSD sufferers are naturally reluctant to recount their traumas, after all numbing and avoidance are key symptoms of the disorder. Weisaeth's (1989a; 1989b) study of a factory explosion found those with most severe posttraumatic reactions were the most reluctant to engage in treatment and to attend routine health checks. Sparr, Moffitt and Ward (1993) found PTSD and/or substance misuse clients in a psychiatric outpatient unit to be the most likely to miss appointments. Highly avoidant patients may need the support of more frequent contact and expression of interest on the part of an interviewer in order to overcome the painful affects that are aroused by thinking or talking about a highly traumatic event. The Impact of Events Scale (IES) is a useful screening instrument for detecting later outcome (Feinstein and Dolan, 1991). Bryant (1996), in a study of burns patients, observed that only half of the patients reporting PTSD had sought professional assistance and, more generally, that avoidance is associated with poor help-seeking behaviour (Schwartz and Kowalski, 1992).

Malt (1988) carried out the first longitudinal study of civilian accident victims, and concluded that PTSD seldom occurred after accidental injuries. However, approximately 14% of his patients had an avoidant subscale score of greater than 20 on the IES (Zilberg, Weiss and Horowitz, 1982) on initial examination and at follow-up. This suggests that avoidance may have led some of these patients to decline from discussing the full range of their symptomology. However, Shalev et al (1996) explained similar findings in their study by citing dissociation as the cause of underreporting of symptoms or affect.

An avoidant personality style, therefore, can be seen as an important personality factor in the maintenance of PTSD as it is associated with poor help-seeking behaviour. Diagnostic categories and theoretical models are, by their nature, generalised and so do not take account of individual differences in the symptom presentation, development or maintenance of the disorder. It is important that the findings from the research into such factors are considered and incorporated into the models, in order to provide a clearer and more complete picture of the nature and course of the disorder. This will aid the development of more precise treatments for the various and complex symptom presentations of PTSD. Accordingly, alongside attempts to establish the myriad factors underlying development of PTSD, a range of therapeutic interventions have been proposed to help those who suffer from the disorder.

7 Treatment approaches

Since the relatively recent recognition of the disorder, treatments for PTSD have included behavioural and cognitive-behavioural interventions, constructivist and systemic approaches, psychodynamic psychotherapy, pharmacological treatments and debriefing programmes.

7.1 Cognitive and behavioural therapies for PTSD

Cognitive theories propose that PTSD occurs because of a person's inability to process a traumatic experience adequately (Foa, Steketee and Rothbaum, 1989). If PTSD symptoms are a result of inadequate emotional processing, then therapy, aiming at the reduction of these symptoms, can be perceived as facilitating such processing (Rothbaum and Foa, 1996). A variety of cognitive-behavioural techniques have been used in the treatment of PTSD, including Prolonged Exposure (Foa et al, 1991), Stress Inoculation Training (Kilpatrick et al, 1982), Systematic Desensitisation (Wolpe, 1958) and Cognitive Processing Therapy (Resick and Schnicke, 1992). For an overview see Hacker Hughes and Thompson (1994). Other more recent cognitive-behavioural approaches include Eye Movement Desensitisation and Reprocessing (EMDR) (Shapiro,1989), Imagery Rescripting (Smucker et al, 1995) and Psychophysiology (Rothschild, 2000). Each shall be outlined here.

7.1.1 Prolonged exposure (PE)

PE (Foa et al, 1991) involves repeated reliving of the trauma in imagination, the aim being to promote the processing of the traumatic memory. Foa and Riggs (1993) found PE in a study of 96 rape victims to promote successful processing of the traumatic memory and to lead to a reduction in PTSD symptoms, especially those of intrusion and avoidance. Following treatment, Foa and Riggs reported that only 32% still had full PTSD.

7.1.2 Stress inoculation training (SIT)

SIT (Kilpatrick et al, 1982) teaches ways of coping with anxiety, which improves the individual's sense of control and of being an adequate coper. However, SIT does not directly address the processing of the trauma memory, unlike PE. An approach that integrates SIT and PE approaches, therefore, is more likely to address both the trauma memory and provide coping strategies to deal with the symptoms.

7.1.3 Systematic desensitisation (SD)

Originally proposed by Wolpe (1958) for use with anxiety disorders, SD has been used in the treatment of trauma. The successful outcome of SD, in which clients are exposed to fearful imagery in a state of relaxation, has been reported in two studies with war veterans (Peniston, 1986; Bowen and Lambert, 1986) however, the severity of PTSD and related pathology was not assessed, and so conclusions drawn can be only limited. Direct evidence for the success of SD in reducing PTSD symptoms comes from studies by Muse (1986) and Brom, Kleber and Defares (1989) who found SD more effective than for untreated controls. While several studies of the effectiveness of SD have shown beneficial results, lack of methodological rigour and the absence of PTSD diagnosis and measures in most of the studies limit the conclusions which can be drawn from them. Evidence for the inferiority of SD to flooding in complex anxiety disorders (Marks, Boulougouris and Marset, 1971) has resulted in SD for PTSD being abandoned in favour of other more reliable treatments.

7.1.4 Cognitive processing therapy (CPT)

Devised by Resick and Schnicke (1992), CPT is a therapy specifically for the treatment of PTSD in sexual assault survivors. A twelve session structured therapy programme, it combines exposure therapy with cognitive restructuring. In efficacy studies, clients improved significantly from pre- to post-treatment on PTSD and depression ratings, and maintained improvement throughout the six month follow-up period. A waiting list control group showed no significant improvement over the period (Resick and Schnicke, 1992).

7.1.5 Eye movement desensitization and reprocessing (EMDR)

EMDR (Shapiro,1989) is a form of imaginal exposure in which patients track the therapist's finger from side to side during imaginal exposure. According to Shapiro (1991) EMDR has had more published case reports to support it than either SD or flooding in the treatment of PTSD during a comparable time period. Silver, Brooks and Obenchain (1995) found that results show EMDR to be an effective technique in the

treatment of PTSD, producing positive incremental change in the PTSD programme for nightmares, intrusive thoughts, flashbacks, anxiety, anger, depression, and relationship problems. Boudewyns et al (1993) did not find differences on PTSD measures between EMDR and an eyes fixed exposure control. EMDR is surrounded by controversy, as there has, as yet, been no conclusive explanation as to the nature of the process or the mechanisms involved. Rothbaum and Foa (1996) have concluded from the outcome research to date that the efficacy of EMDR is equivocal. More recently, Shepherd, Stein and Milne (2000) summarised the results of 16 published randomised controlled trials assessing the efficacy of EMDR and found that, in most cases, EMDR was shown to be effective at reducing symptoms up to three months after treatment.

7.1.6 Imagery rescripting

Pioneered by Smucker, Dancu, Foa and Niederee (1995) as a "new treatment for survivors of childhood sexual abuse suffering from posttraumatic stress" (p3), imagery rescripting constitutes a nine-session programme combining imaginal exposure, mastery imagery and cognitive restructuring of the trauma. The advantage of this approach is that it goes beyond merely exposing the patient to the traumatic memory, but additionally attempts to restructure and reframe the meaning of the event in order to help the person not only process the memory, but process it with a more appropriate and realistic meaning. Exploring the details of the trauma allows the survivor to confront not just the emotion but also the meaning of the trauma. The therapist actively encourages a reframing of the trauma, especially in regard to such issues as apparent choice and subsequent guilt reactions. This cognitive element is likely to be at least as important as direct exposure in overall symptom reduction.

Indeed, Echeburua, Corral, Sarasua and Zubizaretta (1996) found cognitive restructuring with specific coping skills training to be superior in effectiveness to progressive relaxation training in victims of sexual aggression. This contradicts the conclusion reached in prior studies (for example: Foa, Rothbaum and Steketee, 1993) suggesting that there is no advantage of any one behavioural treatment over another. Echeburua et al

(1996) regarded cognitive restructuring to be useful in that it enables the individual to alter inappropriate and maladaptive attributions of guilt. However, therapies that involve reprocessing of earlier sexual abuse are subject to the criticism that they may promote false recall. For an overview of the "false memory" debate see Farrants (1998).

7.1.7 Psychophysiology

Recent approaches to working with trauma survivors are increasingly addressing the integration of treatment for the physical sequelae of the trauma with the psychological symptoms. Rothschild (2000) proposes a psychophysiological approach to trauma treatment, incorporating theories built upon neurobiology. The therapy she proposes attempts to bridge the gap between the increasing body of knowledge regarding the neurobiology of PTSD sufferers and the clinical practice of therapists. Founded on van der Kolk's (1994) article "The Body Keeps the Score", which presents a neurological, theoretical basis for understanding the mind-body connection, Rothschild (2000) proposes that trauma be regarded as a psychophysical experience. Treatment, therefore, involves addressing an understanding of the physical effects of trauma and their interaction with psychological symptoms. Due to the recency of this approach, no outcome studies are yet available.

7.2 Constructivist Approaches

Constructivist approaches to the treatment of trauma are concerned with bringing the trauma experience within the range of convenience of one's construct system (Sewell, 1996). Therapy, therefore, focuses on assisting the individual to understand trauma events by applying pre-existing constructs or developing new constructs with which they may understand the trauma and other events in their life (Cross and Watts, 1997). Klion and Pfenninger (1996) outline a three phase model of therapy for combat veterans, involving the development of the therapeutic alliance; interweaving the past, present and the future and active role reconstruction, including generating alternative life patterns. Ronan (1996) has developed the approach into a cognitive-constructivist model for use

with traumatised children and Viney (1996) has developed a personal model of crisis intervention counselling with adults. However, while constructivist approaches provide a useful way of conceptualising trauma responses and treatment, research into the effectiveness of constructivist approaches to trauma is in its infancy and both Ronan and Viney call for further controlled studies to develop the area.

7.3 Systemic approaches

Recent approaches to working with trauma include addressing the client's issues from a systemic perspective (West, 2000). In systemic therapy for PTSD, relevant relationships are explored. Firstly, the therapy involves broadening the perspective of who might reasonably be expected to be adversely affected by the traumatic event, other than the individual receiving the diagnosis, and thus who might fall within the treatment remit. Treatment, therefore, may involve families, couples or others affected by the event. Secondly, a broadening of the relationship between the protagonist of the precipitating event and the person expressing the disorder is advocated, so that therapy also addresses the dynamic between the client and the perpetrator of the event.

7.4 Psychoanalytic psychotherapy

Psychoanalytic therapy uses interpretations to elucidate the client's particular anxieties, and uses the nature of the therapeutic relationship, transference and countertransference to help the person come to terms with the trauma, Lindy (1996). Psychoanalytic psychotherapy aims to help the patient come to terms with the personal meaning of the event and the reasons for its psychological impact. While a useful way in which to consider trauma treatment, there is no evidence of controlled studies into the efficacy of psychoanalysis for the treatment of PTSD.

7.5 Pharmacological treatments

Medication has been used mainly to reduce anxiety symptoms in PTSD, and is usually used as an adjunct to psychotherapeutic approaches (Turnbull and McFarlane, 1996). Davidson and van der Kolk (1996) suggest that acute trauma is best treated with any of the drugs that reduce autonomic arousal, such as benzodiazepines or clonidine. They recommend prescription of either an SSRI or tricyclic antidepressant on initial diagnosis, to be followed with either an anticonvulsant, mood stabilizer or a benzodiazepine if the response to the initial treatment is only partial. Studies have shown that effective drug therapies, whilst not curing PTSD, can provide symptom relief enabling patients to move forward and to participate more effectively in other forms of therapy (Davidson and van der Kolk (1996). Drug treatments may also cut down on some of the attendant morbidity, and possibly mortality of PTSD.

7.6 Debriefing

Each of the above therapies are administered once a person has been diagnosed as suffering from PTSD. However, therapies have also been used to attempt to prevent the development of PTSD shortly after a traumatic event has occurred. For example, "debriefing" shortly after a disaster has been recognised by many as a way to alter faulty and unhelpful attributions and perceptions early on and to provide the opportunity for the individual to express their experience in narrative form (for example Tehrani, 1995). This, it is argued, may help buffer the individual from going on to develop the disorder and, until relatively recently, was assumed to be useful. However, the few controlled studies that examined the effect of debriefing immediately following exposure to trauma indicate a poorer outcome following debriefing than for no intervention (McFarlane, 1994). More recently, Bisson, Jenkins, Alexander and Bannister (1997) found burns victims who were debriefed to have more symptoms of PTSD at follow up than a non-debriefed control group. One possible reason for these surprising findings may be that, as discussed earlier, PTSD type symptoms may be initially a normal and natural part of the

aftermath of traumatic events, so that treatment is unnecessary at this stage, and may even interfere with the organism's natural processing of the trauma.

Hytten and Hasle (1989) report on the effects of debriefing on a group of fire-fighters who had dealt with a hotel fire. Of 39 participants, 38 stated that debriefing had been helpful, however there was no significant difference in scores on the Impact of Events Scale (Horowitz et al, 1979) between those receiving formal debriefing and those who only talked with colleagues. Morbidity levels were present for some of the sample, so it would appear that merely talking through processes, as in debriefing, was not sufficient to prevent them. Van der Kolk, McFarlane and van der Hart (1996) posit that merely allowing the person to put their thoughts and feelings about the event into words is not sufficient to deal with the symptoms, hence Foa et al's (1989) emphasis on cognitively restructuring the trauma meaning. Reiker and Carmen (1986) state that, "After abuse, the victim's view of self and world can never be the same again: it must be reconstructed to incorporate the abuse experience." (p367).

This may be why supportive counselling alone has not been found to be effective, and perhaps may explain some of the negative findings concerning debriefing, if debriefing has simply been enabling people to recount events without reframing them. For this reason, Raphael, Wilson, Meldrum and McFarlane (1996) state that it is necessary first to define the value of preventative interventions for individuals who are at high risk of developing chronic PTSD, in contrast to victims with a normative stress response for whom no benefit or even negative effects may be apparent, Raphael (1980).

It could be argued that personnel in occupations with a high risk of exposure to traumatic stressors, for example the emergency services, could be targeted with training to enhance their coping strategies. Carlier, Lamberts and Gersons (1997) suggest possible occupational health interventions for police officers, and Tehrani (1995) outlines a programme for Post Office workers, which begins with an introductory stage, involved in the selection and education of the workforce. However, such employee programmes do

not help the majority of people who may develop PTSD following traffic accidents or natural disasters. The fact remains that, despite understanding many of the factors predisposing individuals to PTSD following traumatic events, there is very little that can be done preventatively to avoid the diagnosis. A more productive way forward is to explore and increase the range of therapies that may help such individuals.

8 Issues for consideration in therapy

As with most descriptions of psychological therapies, individual differences in response to therapies and difficulties or resistance encountered are rarely mentioned. Therapies are frequently described as if they run according to a strict text-book pattern, for example the case study "scripts" of Barlow (1993). The reality is that it is not just the *content* of the treatment plan which is of interest, but rather that a variety of *process* factors concerning the individual client, and the therapeutic relationship frequently need to be addressed. This is especially true of those suffering from PTSD because PTSD has many different presentations, with people suffering from different symptoms (McFarlane and van der Kolk, 1996). These different presentations require different treatment approaches and sensitivity to individuals' interpretations of the event. and so should not be treated in text book fashion. Additional considerations may influence response to trauma and its treatment such as cultural and legal issues. For example, people from certain cultures may fear expressing "negative" emotions or crying in front of the therapist. Ongoing compensation claims may provide secondary gains to resisting recovery, and patients are also at risk of becoming retraumatised by the legal process. Such issues also form part of the work that has to be done within the therapeutic alliance.

8.1 The therapeutic relationship

Highly traumatised patients frequently evoke a variety of responses from potential caregivers. Survivors of sexual abuse, in particular, often re-enact their traumas during

therapy, putting the therapist in the role of abuser, and are most at risk of being abused by their therapist or the medical profession (Herman, 1992). Guilt and shame are frequently encountered in trauma survivors and, given the prominent role of such emotions and attributions, it is imperative to develop and evaluate techniques for guilt reduction. There is no evidence to suggest that exposure alone can deal with such attributions, and cognitive restructuring may be necessary to deal with this. The process occurring between the therapist and the client needs to be continually addressed. As Turner, McFarlane and van der Kolk (1996) point out, what occurs between a patient and a therapist is a function not only of the particular diagnosis of the patient but also of the unique and personal relationship between patient and therapist, factors which cannot be easily quantified, nor subjected to scientific study. If such process issues are not addressed, drop out rates can be high. If, for example, the therapist operates in a dogmatic or controlling manner, or persists inappropriately with any particular treatment method, abused clients may feel threatened, and regard therapy as a repeat of earlier trauma.

Clients may also express extreme anger, a symptom of the disorder, and Stevenson and Chemtob (2000) describe a client with combat-related posttraumatic stress disorder who directed his anger at the therapist during the course of treatment, which compromised the therapeutic alliance and resulted in premature termination of treatment. Stevenson and Chemtob conclude that including the spouse and other family members in the treatment engagement process may have prevented early termination. It is important that clinicians are reflective of their practice in this way, and they need to be open to examining the results of their interventions and adjust their methods without becoming paralysed by therapeutic nihilism. Furthermore, according to Turner, McFarlane and van der Kolk (1996) treatment success depends also upon the patient's ability to tolerate intimacy, and to trust another with their own helplessness and pain. There are individual differences in such tolerance of intimacy, which, they posit, is an important determinant of the success of treatment as well as the individual's initial reaction to the trauma, "Therapists who treat traumatised individuals need to have a range of therapeutic options at their disposal, and

to be able to tailor these to the needs of individual patients" (Turner et al, 1996, p545)

Approaches that place emphasis on the therapeutic alliance and on tailored and integrative approaches to individuals may be useful in addressing these process issues.

8.2 Avoidance

One of the most important process variables in the treatment of PTSD is that of avoidance. Avoidance is an integral part of PTSD, and patients are frequently reluctant to relive the trauma in the consulting room. Avoidance is, therefore, an issue which needs to be dealt with in therapy with understanding and sensitivity, and should not be regarded merely as an interference to "off the peg" treatments. McFarlane (1988) pointed out that it is the intrusive reliving of the trauma, not the event itself, which is responsible for PTSD symptoms, and that people's lives become organised around attempting to avoid the reliving experiences. This may include alcohol, other drugs or avoidance of therapy, "Avoidance should be understood as a legitimate choice of the survivor, but also as a form of adaptation with potentially long-term negative consequences." (Turner, McFarlane and van der Kolk, 1996, p545).

Unless a rationale is provided for asking the client to relive the trauma in therapy, and unless it is explained that short-term distress will lead to long-term benefit, drop out is likely to occur. Even with the rationale explained, some clients are still reluctant to relive the trauma, especially if dissociation is a problem (Rothbaum and Foa, 1996). Several sessions of anxiety management may help this reluctance, giving the client the coping measures to deal with the stress of reliving the trauma, and providing the time for the client to become acclimatised to the therapist and the surroundings. Patients with PTSD first need to be stabilised (Herman, 1992) in terms of anxiety reduction, sleeping, eating and social support before they can tolerate the extremes of anxiety caused by working through the trauma memories. Perhaps this initial stabilisation may reduce avoidance. It is necessary not to rush clients, and to allow them to gradually relate what they feel ready

to. Relaxation techniques may serve the dual purpose of relaxing the client and enabling them to visualise the trauma more effectively, as in Imagery Rescripting, (Smucker et al, 1995).

Rothbaum and Foa (1996) state that prolonged exposure treatment helps patients who exhibit pervasive anxiety and avoidance, however, for therapy to occur the avoidance has to be, in some part, overcome. Some patients may be so avoidant that they refuse to engage in exposure therapy in any meaningful way. Rothbaum and Foa recognise that, without emotional engagement, patients are less likely to improve, but also that the patient overwhelmed by anxiety will not process the memory properly. It is possible that lack of emotional engagement is related to avoidant styles, and that it is these avoidant individuals who do not respond so well to therapy. If a way could be found of identifying individuals with avoidant coping styles at the start of therapy, then outcome studies of therapy could compare the reduction of symptoms in avoidant individuals with those of others. So, one way forward in terms of research in this area would be to assess whether those who did not benefit from the treatment had a more avoidant coping style than those who engaged in treatment.

While research into the efficacy of treatments aids understanding about the disorder and the treatment approaches that are helpful in relieving symptoms, most of the research focuses on the proportion of patients who benefit from the treatment in question, and pay scant attention to the sizeable minority whose symptoms do not improve. Furthermore, throughout the research there is a tendency to treat PTSD sufferers as one generic group, despite evidence, as has been discussed, that this client group varies considerably in many respects, including response to therapy and levels of cognitive avoidance and intrusion. Indeed scales have been devised to measure both avoidance and intrusive thoughts, for example Horowitz' Impact of Events Scale (1979). It could, therefore, be argued that it is inappropriate to treat patients with a diagnosis of PTSD as one generic group. While individual differences in response to *traumatic events* have been the subject of considerable research projects, individual difference in response to *therapy* for PTSD has

not. It is well documented that the existing therapies for PTSD patients are not successful in all cases, for example Foa and Riggs (1993) described 32% of rape victims in their study to retain a diagnosis of PTSD following treatment. While they regarded the treatment as a success, as a majority clearly improved, those who did not improve form a sizeable minority. Research needs to evaluate the reasons for the failure of treatment in so many cases and to devise alternative ways in which to help such patients. The move toward working more holistically and individually with the process issues of therapy would be a step further in addressing this.

Some attempt has been made to tailor approaches to individuals. Falsetti (1997) presents a decision-making process for choosing treatment components that best match each patient's needs in civilian trauma-related PTSD. Falsetti attempts to address the fact that very few empirical studies have investigated matching clients' problems to treatments, particularly with regard to treatment of PTSD. However, Falsetti accepts that her approach involves assessing individual differences in symptom presentation, rather than matching therapy approach to other client variables. For example, Falsetti suggests that, if a patient is finding it difficult to talk about the trauma or is highly anxious, then an initial approach may be to teach the client coping skills rather than attempt exposure treatment at this stage. Falsetti, however, does not directly address the issue of the personality of the client or the preferred therapy approach, but rather advocates the use of an integrated approach to therapy, depending upon which symptoms are most prevalent at any given time. This is consistent with a Counselling Psychology approach that seeks to address the individual needs of the client in a tailored way, working integratively and holistically with clients.

So, the research has demonstrated a range of situational, attributional, personality and coping style factors predisposing an individual to the development of PTSD, which goes some way to accounting for individual differences in response to a traumatic event. Furthermore, for those individuals who do go on to develop PTSD after such an event,

these same factors may emerge as potential barriers to effective therapy, particularly that of avoidance. It is vital that the ongoing quest for effective therapies takes full account of the process issues which may prevent successful therapy outcome. The issue of avoidance is, arguably, the most prevalent process factor in PTSD treatment and, as such, should be given consideration in the development of new therapies.

Despite this, there is a dearth of process studies in the literature that address avoidance in treatment for PTSD. If an association could be found between individuals with avoidant personality styles and poor outcome in therapy for PTSD, relative to those with less avoidant coping styles, then this would have implications for the choice and implementation of treatments. Although no such studies are available for therapy for PTSD, research in this area has been undertaken with individuals suffering from simple phobias. The research focuses on the relationship between therapy outcome and coping styles, and utilises a valuable tool for the categorisation of individuals in terms of avoidance, the Monitoring-Blunting Style Scale (MBSS; Miller, 1987) which classifies individuals as either "monitors" or "blunters". These coping styles will be discussed, and this will be followed by an exploration of the application of the MBSS to therapy for phobic clients. A case will be made that these findings are of relevance to research in the field of PTSD.

9 The coping styles of monitoring and blunting

Monitoring and blunting refer to coping styles that can be observed in individuals who are confronted with threatening events. Monitoring is characterised by the tendency to seek out threat-relevant information, whereas blunting is characterised by avoiding threat-relevant cues (Miller, 1980). The devising of these coping styles originates predominantly from Miller's work with women in medical settings, in which she termed as blunters those whom she found to avoid information about their health-related problems, and monitors who sought out additional information concerning medical

procedures, (for example, Miller and Mangan, 1983). Miller et al (1996) found that, when threatened with an aversive event, some individuals typically monitor for information about it and amplify the threats cognitively and emotionally, whereas others avoid and psychologically blunt such cues (for example; Miller, 1990; 1992; 1995).

Miller found monitors to look for threats externally but also to attend more to their own bodily cues and to amplify them, (Miller, Brody and Summerton, 1988). Despite information seeking, they did not use this instrumentally, instead seeking a more passive role in decision making. (Miller et al, 1988) and did not take control. Carver, Scheier and Weintraub (1989) found monitors to try to elicit advice from others, or turn to religion, thus seeking information but using it to put themselves in the presence of safety signals. Monitors are more likely to engage in worry than blunters (Davey, 1993) and the relationship between monitoring and worry is found, independent of levels of trait anxiety.

Miller (1987) devised a self-report inventory, the Monitoring-Blunting Style Scale (MBSS) which measures these coping styles. Miller has largely used the scale in studies with people undergoing medical procedures (for example: Miller, 1995; Miller, Rodoletz, Shroeder, Mangan, and Sedlacek, 1996). For example, in a study of people facing medical threats, such as HIV (Miller et al, 1996) high monitors were found to be characterised by elevated levels of intrusive ideation in comparison with low monitors, with respect to their disease status. This increase in intrusive ideation indicates that high monitors are more likely to think about their disease status when they do not mean to, tend to dream about it, to have trouble falling asleep because of it, to be reminded of it, and to have strong feelings about it.

Miller found blunting and monitoring styles to be both stable and enduring personality characteristics (Miller, 1987). The MBSS has been found to be a reliable and valid measure of premorbid coping styles, in that coping style scores accurately predicted the informational strategy used in a performance task in which participants were invited

during the task to look at a light which indicated the level of their performance. (Miller, 1987). While there has been a suggestion that therapy itself may alter coping styles. Muris, Merckelback and de Jong (1995) found that MBSS scores did not differ significantly after a two year follow up period following exposure therapy. supporting Miller's (1987) assertion that the MBSS is a stable and reliable measure of coping style and that coping style is a trait rather than state variable.

The categorisation of individuals in terms of monitoring and blunting can be regarded as a useful solution to the problem of identifying those individuals who may have a tendency to avoid addressing threatening emotional material during therapy. The MBSS is therefore, potentially, a useful tool in research into the interaction between the effectiveness of therapy for PTSD and individual differences in terms of clients' avoidance. As has been discussed earlier, an important factor which is likely to maintain PTSD symptoms is the use of inappropriate avoidant coping mechanisms which prevent the activation of the fear network necessary for the trauma to be processed, (Foa and Kozak, 1986). The avoidant strategy of blunting can, therefore, be hypothesised to enable the individual to avoid meaningfully processing the traumatic event and so result in poor therapy outcomes.

While the MBSS has not yet been used with PTSD patients, there are significant points to be drawn from its use in the research into the relationship between individual differences in coping style and therapy outcome in animal phobics. A useful way forward for research into avoidance in PTSD is to begin by exploring the findings from the phobia research into these coping styles.

9.1 Monitoring and blunting in phobia outcome studies

Firstly, a study by Steketee, Bransfield, Miller and Foa (1989) tested the hypothesised relationship between coping style, type of information received prior to treatment and treatment outcome in a range of animal phobics. This was an attempt to replicate the

findings of Miller and Mangan (1983) who found monitors who received minimal information about a medical procedure, as well as blunters who were given detailed information, showed greater arousal, more pain and slower recovery than informed monitors and uninformed blunters. Twenty-seven animal phobics, recruited from advertisements in a local newspaper and who scored highly on measures of fear relevant to their phobia (fear of either snakes, cats, birds, spiders or dogs) were divided into monitors and blunters, on the basis of a median split on their scores on the MBSS. (The scoring version used in the study involved summing the number of monitoring items selected and the number of blunting items selected). Monitors and blunters were randomly assigned to two conditions regarding the type of information they received prior to treatment, namely highly relevant or irrelevant information regarding the procedures. No evidence was found of a relationship between coping style and type of information received, although evidence was found that monitors improved more on some outcome measures than blunters following two sessions of exposure therapy. Steketee et al concluded that monitoring or blunting coping style is an important moderating factor in determining exposure treatment outcome, but that there is no relationship between treatment outcome, coping style and the type of information received. They explained these findings by suggesting that monitors were more attentive to threat-relevant cues during exposure treatment and so processed more fully corrective information. According to Foa and Kozak's (1986) fear network theory, activation of the fear network is a prerequisite for the extinction of phobic fear, and so it could be reasoned that a habitual monitoring style would be likely to result in a stronger fear network activation than the blunting style, and that monitoring should be positively related to therapy outcome. However, Muris et al (1993a) criticise this study for the fact that results were based entirely on heart rate data obtained during therapy sessions, which has not been demonstrated to be predictive of longer term therapy outcome.

Muris et al (1993a), therefore, replicated Steketee et al's study with 40 female spider phobics who had applied for treatment at a university spider phobia project and met the DSM- III-R criteria for simple phobia. Using just one session of exposure therapy, they

extended the study to examine the relationship between monitoring and blunting coping styles and long-term treatment outcome, rather than just the short-term measures taken in the Steketee study. Rather than rely on heart-rate data, outcome measures included improvements in assessment of spider phobia and in avoidant behaviour. Muris et al hypothesised that therapy success would be better consolidated in monitors than blunters, as they considered monitors to be more likely to continue to attend to rather than avoid the phobic stimulus beyond therapy, thus reinforcing the effects of the earlier exposure therapy. Eighteen months after treatment, participants were administered a five-point version of the MBSS, in which participants indicate the extent to which each item is applicable to him or her on a scale of one to five. The results did not support their hypothesis and Muris et al (1993a) found coping style to have no influence on short-term nor long-term therapy outcome. These findings may be explained by the fact that successful therapy may influence reported coping style, particularly as the measures were taken only after treatment. However, as Muris et al observe, monitoring and blunting are considered to be trait variables, (for example: Miller, 1987) and furthermore, a later study by the same authors (Muris et al, 1995) found that coping style did not change significantly over a two-year period, before and after therapy. Muris et al conclude that their study did not confirm the suggestion of Steketee et al (1989) that monitoring/blunting coping style is an important factor affecting exposure treatment outcome, although they suggest that it is possible that different results may be obtained for individuals with other types of phobia.

However, it could be argued that rather than the *type of phobia* being of relevance, a more pertinent issue might be the *type of therapy* offered, and that different therapies may produce different results. For example, both the Steketee et al and the Muris et al study used in vivo exposure treatment. The very nature of exposure therapy is to confront the patient with the phobic object in a way that limits avoidance. Blunting may, therefore, be less of an option in exposure therapy than in cognitive treatments involving imaginal exposure, in which the patient can more readily choose to block thoughts and images. As Steketee et al (1989) observe, with continued exposure, cognitive avoidance may become

increasingly difficult. It could be argued that this may result in the behaviour of monitors and blunters converging and masking any habitual differences in avoidant behaviour between the two groups. It is possible, therefore, that the use of imaginal exposure treatments may produce more variability in blunting and monitoring behaviour by enabling individuals to respond to therapy in a way which is more consistent with their habitual coping style. If this is the case, then future studies using imaginal exposure may yield more significant differences in outcome between the two groups than those using in vivo exposure treatments. Such studies are relevant to treatment for PTSD as, although some treatments might involve the client being exposed to the site of the traumatic event, PTSD therapy normally involves an element of imaginal exposure away from the site of the trauma.

Muris et al (1993b) conducted a second study with spider phobics, this time finding, contrary to their hypothesis, monitoring to be significantly related to a *less* favourable treatment outcome. They explained these findings by suggesting that the in vivo exposure treatment may have produced anxiety in monitors to such an extent that this interfered with their ability to process corrective information. However, it is unclear why these results were not found in Muris et al's first study. One difference involved the point at which the MBSS was administered. In the first study (Muris et al, 1993a) the MBSS was completed only at the eighteen month follow-up, whereas in the second study (Muris et al, 1993b) the MBSS was completed prior to treatment. While MBSS scores are found to have good test-retest reliability (Miller, 1987) and so can be regarded as stable personality characteristics, it is conceivable that a radical life event, such as one-session treatment in the case of a phobic, alters coping style. Muris et al conducted a further follow-up study (Muris, Merckelback and de Jong, 1995) in which the stability of coping style was assessed and the relationship between monitoring, blunting and therapy outcome was examined in more detail. Participants from the 1993b study were contacted and asked to complete a follow-up measurement of spider fear and MBSS two years after treatment. Once again they found a monitoring style to be associated with a less favourable therapy outcome, and this time they found a blunting style to be related to

better treatment results. They also found no significant change in MBSS scores over the period. These findings run counter to the expectations of Steketee et al (1989) and to Foa and Kozak's (1986) fear network theory.

To explain these findings, Muris et al cite the information processing theory of Williams, Watts, McLeod and Mathews (1988) which has produced studies showing phobic subjects to exhibit an attentional bias towards threatening information. Several studies have shown that successful behavioural treatments reduce attentional bias (Watts. McKenna, Sharrock and Tresize, 1986; Lavy, van den Hout and Arntz, 1993). It has been speculated that individuals with an intensive and resistant attentional bias towards threatening information display more severe symptoms and/or recover less after therapy (Eysenck, 1992; Eysenck and Mathews, 1987; Mineka and Sutton, 1992). As the concept of monitoring strongly resembles attentional bias, information processing theory is consistent with Muris et al's suggestion that extremes of anxiety may be elicited in monitors, more so than in blunters, in *in vivo* exposure situations. This may explain the current findings, but does not account for the fact that blunting seemed to be associated with positive outcomes. The findings that blunting is associated with improved treatment outcomes runs contrary to the theories of Williams et al (1988) who state that cognitive avoidance may disrupt the beneficial effects of exposure treatments, especially long-term benefit. Evidence is accumulating that distraction strategies interfere with the efficacy of exposure treatments, whereas instructing patients to give more detailed attention to the stimulus improves it. (for example, Watts 1974). However, perhaps blunting simply refers to the absence of attentional bias. The marginally significant negative relationship between monitoring and blunting at pre-treatment in this study may support this. Further studies are called for to investigate the effects of monitoring and blunting on exposure therapy outcome, and to assess whether monitoring and blunting are, indeed, related to attentional bias.

So, the findings with regard to the specific effects of different coping styles on therapy outcome are, therefore, inconsistent. However, there is enough evidence from the field of

phobia treatment to suggest that the hypothesised relationship between coping style and progress in therapy may be a useful area of exploration in therapy for PTSD. In particular, the MBSS has been demonstrated to be a useful and reliable tool for the measurement of an information avoiding coping style, "blunting" and so is an important resource in research to explore avoidance in therapy for PTSD.

10 Summary of the literature

In summary, the work on PTSD has focused largely on individual differences in the development and maintenance of symptoms of the disorder, and on the efficacy of therapies in reducing symptoms. So far, little has been done to assess individual differences in PTSD patients' responses to therapy, despite the fact that many patients do not improve in therapy. There is a large body of evidence to suggest that one of the most important factors influencing the treatment of PTSD is the extent to which individuals avoid addressing traumatic material. This suggests that it is important to understand more about the nature of such avoidance in order to consider how it can be worked with within the therapy in order to improve therapy outcomes.

One possibility is that the tendency to avoid threatening material is a predispositional trait, and that some individuals tend to avoid threatening material, whereas others tend to seek out information and attend to threat, as suggested by the studies of the coping styles of monitoring and blunting in treatment for phobia. If individuals with PTSD, for whom therapy has been of limited effectiveness were found to have a predisposition to a blunting coping style, consistent with Foa and Kozak's (1986) fear network theory, then this would have implications for the choice of therapy used. If it could be demonstrated that an avoidant, blunting coping style is associated with poor response to treatment for PTSD, therapies that minimise avoidance may need to be considered with such clients. For example, it might be the case that, for blunters, in vivo exposure treatments are more successful than imaginal exposure, as they limit the capacity for cognitive avoidance.

11 The rationale for the present study

The present study, therefore, aims to address the extent to which monitoring and blunting coping styles are relevant to therapy outcomes in patients with PTSD, and particularly whether a blunting coping style is associated with poorer outcomes following therapy. Participants were tested for the coping styles of monitoring and blunting before treatment and measures of PTSD symptoms, and comorbid depression and anxiety were taken before and after therapy.

An attempt was made to correlate symptom reduction with levels of monitoring and blunting. It was hypothesised that (a) a significant negative correlation would be found between a blunting coping style and improvement following therapy, that is that the higher the score for blunting, the smaller the reduction of symptoms following therapy; and that (b) a significant positive correlation would be found between a monitoring coping style and improvement following therapy, that is that a high monitoring score would be associated with greater improvement in therapy.

Chapter 2: Method

1 Design

A correlational design was used, the independent variables being coping style, measured in terms of participants' scores on "blunting" and "monitoring" from the Monitoring-Blunting Style Scale (MBSS). The dependent variables were means of change in symptoms following a course of therapy for PTSD. These include change in anxiety and depression symptoms measured by the Hospital Anxiety and Depression Scale (HADS); levels of intrusive and avoidant symptoms from the Impact of Events Scale (IES); and levels of a variety of PTSD symptoms, measured by the Posttraumatic Diagnostic Scale (PDS). It was predicted that:

Hypothesis 1: A significant negative correlation would be found between a blunting coping style and improvement following therapy, that is that a high blunting score would be associated with a smaller reduction of symptoms following therapy.

Hypothesis 2: A significant positive correlation would be found between monitoring coping style and improvement following therapy, that is that a high monitoring score would be associated with greater improvement in therapy.

2 Participants

All participants were mental health patients who had been referred for treatment within the NHS and who met DSM-IV criteria for PTSD.

Psychologists working with clients with PTSD were recruited personally by the researcher, who contacted specialist PTSD units and generic mental health services around the London and Essex areas to request their assistance with the study. Fifteen psychologists agreed to recruit participants for the study and all worked for the National Health Service in either Primary or Secondary care. A total of 63 questionnaire packs,

including researchers' instructions on how to take part in the study (see Appendix 1) was distributed to these psychologists for administration to their clients. Completed questionnaire packs from 9 clients were returned by the psychologists (a return rate of 14.3%). The return rate was disappointingly low, resulting in a very small sample size. However, a decision was made to report the results here due to the large, significant correlations observed, justifying exploration and explanation. Three participants were female and 6 were male. The participants varied in age from 28 to 61, with a mean of 46.33 years.

3 Psychological Variables

3.1 The Monitoring-Blunting Style Scale (MBSS; Miller, 1987)

The MBSS (see Appendix 2) is a self-report scale designed to assess individual differences in monitoring and blunting processing styles (Miller, 1995, 1996). Specifically, the scale asks individuals to imagine four hypothetical stress-evoking scenes of a largely uncontrollable nature (for example: "Imagine that you are afraid of flying and you have to go somewhere by plane"). Each scene is followed by eight statements that represent different attentional strategies for dealing with the stressful event. Four statements following each scene are of a monitoring or information-seeking variety (for example: "I would read and reread the safety instruction booklet") and four are of a blunting or distracting variety (for example: "I would watch the in-flight film, even if I had seen it before"). Two scores are derived from this scale: (a) the total monitoring score, which is obtained by summing the number of monitoring options endorsed across the four situations (higher score equals more monitoring) and (b) the total blunting score, which is obtained by summing the number of blunting options endorsed across the four situations (higher score equals more blunting). The range of possible scores for blunting, therefore, is 0 - 16, and for monitoring is 0 - 16. Test-retest analyses with a sample of 110 subjects show the MBSS subscales to be highly stable over a four month period: for the monitoring subscale, $r(98) = .72$, $p < .01$; for the blunting subscale, $r(98) = .75$, $p <$

.01 (Miller and Mischel, 1986).

The version of the MBSS provided for the current study by the scale's author was that used in the Steketee et al (1989) study in which the number of blunting and monitoring items selected were each summed to produce a total monitoring score and a total blunting score. This is distinct from the version used in the Muris et al studies in which a five-point Likert type scale was used. Each participant yielded one score for monitoring and one score for blunting. A decision was made not to re-administer the MBSS after treatment because, on the basis of the previous research findings, it was regarded as a reliable measurement of traits, and it was felt that its unnecessary inclusion would significantly add to the time taken to complete the post-treatment measures and so might reduce participants' co-operation with the study.

3.2 The Impact of Events Scale (IES; Horowitz et al, 1979)

The IES (see Appendix 3) is a 15-item self-report scale that measures two of the cardinal symptoms of PTSD; intrusive and avoidant threat-related ideation (Horowitz et al, 1979). Respondents are asked to rate the extent to which a list of 15 items had applied to them over the course of the previous seven days, on a four column Likert scale; "Not at all" (0); "Rarely" (1); "Sometimes" (2); "Often" (3). Two scores are derived from the scale: (a) the total intrusion score, which is obtained by summing the scores on each of the 7 intrusive ideation subset items, and (b) the total avoidance score, which is obtained by summing the scores on each of the 8 avoidance subset items. The range of possible scores are, therefore 0 - 21 on the intrusive ideation subset and 0 - 24 on the avoidance subset (higher scores equal more intrusive ideation and more avoidance, respectively. Test re-test analyses with a sample of 25 subjects show the IES subsets to be highly stable over a two week period; for the intrusion subset r = .89; for the avoidance subset r = .79 and for the total stress score overall, r = .87. (Horowitz, 1979). The correlation between the Intrusion and Avoidance subscales (.42; Horowitz et al, 1979) indicates that the two factors are strongly associated but do not measure identical constructs. Internal consistency of the Intrusion and Avoidance subscales, using Cronbach's alpha, has been

shown to be .78 for Intrusion and .82 for Avoidance (Horowitz et al. 1979). Some researchers have used the total score on the IES to define significant posttraumatic stress. for example McFarlane (1988) and Bryant and Harvey (1995) who defined significant posttraumatic stress as a total IES score of greater than or equal to 30.

3.3 The Posttraumatic Stress Diagnostic Scale (PDS; Foa, 1985)

The PDS (see Appendix 4) is a 49 item screening and diagnostic instrument that helps assess the presence and symptom severity of posttraumatic stress disorder. It parallels DSM-IV criteria for a PTSD diagnosis and may be administered repeatedly over time to monitor changes in symptoms. It is divided into four parts, measuring the nature of the traumatic event(s) experienced (Part 1 and Part 2); symptoms experienced (Part 3) and impairment in functioning following the trauma (Part 4). The scoring is somewhat complex and is outlined below. See also see the PDS Hand Scoring Directions (Appendix 5).

Parts 1 and 2 consist of 21 items about the nature of the client's experience of the event and the onset of symptoms. The individual is required to check any of the 21 options which relate to their experience (items 1-21) and this is scored by comparing the responses with those required for a diagnosis of PTSD. Part 3 (Items 22-38) requires respondents to complete a 4-point Likert scale (range 0 - 3) of the frequency of their experience of a list of 17 symptoms. Items 39 and 40 relate to the duration and onset of the symptoms, respectively, and the respondent is invited to check one of a list of 3 options for item 39 and one of two options for item 40. Part 3 is scored by summing the responses to items 22-38 (range 0-51) and checking the responses to items 39-40 against diagnostic criteria. Part 4 offers up to 9 options (items 41-49) of areas of life affected since the trauma, and this is scored by totalling the number of areas affected (range 0-9).

The scores are further organised into six sub-scales, labelled A to F as follows: A) exposure to traumatic event (items 16-21); B) re-experiencing (items 22-26); C) avoidance (items 27-33): D) arousal (items 34-38); E) symptom duration/ delayed onset

(items 39-40); F) significant distress or impairment in daily functioning (items 41 - 49). Each sub-scale score is compared with a score required for a diagnosis of PTSD to be met, and an overall level of impairment in functioning, total number of symptoms endorsed, symptom severity score and symptom severity rating are calculated.

Foa (1985) measured test-retest reliability using kappa, a chance-corrected measure of agreement, and a kappa of .74 was obtained, indicating good agreement. The Pearson correlation coefficient between Symptom Severity Scores for the two administrations was .83. A Cronbach alpha of .92 was calculated for the 17 items (Items 22-38) on which the Symptoms Severity Score is based, indicating that the Symptom Severity Score is internally consistent. The diagnostic performance of the PDS was assessed by comparing a PDS diagnosis with a diagnosis from the PTSD module of the SCID (Structured Clinical Interview for DSM-III-R, Williams et al, 1992). A kappa of .59 between the PDS and the SCID was obtained with 79.4% agreement between the two measures. The sensitivity of the PDS was 82% and its specificity was 76.7%. These results suggest that the PDS has a good overall level of diagnostic agreement with the SCID. In the absence of any other published self-report tests of PTSD, measures of convergent validity were taken by comparing the PDS Symptom Severity Score with other scales associated with the symptoms of PTSD. Higher PDS scale scores were associated with greater depression on the BDI, higher state and trait anxiety on the STAI, and higher scores on the IES intrusion and avoidance scales (all $p < .001$). Pearsons correlations are as follows: BDI .79; , STAI-S .73; STAI-T .74; IES-I .80; IES-A .66. (Foa, 1985).

3.4 The Hospital Anxiety and Depression Scale (HADS; Zigmond and Snaith, 1983)

The HADS (see Appendix 6) is a 14 item instrument for screening for clinically significant anxiety and depression, and is also a measure of severity of these mood disorders. Respondents are asked to rate the extent to which a list of 14 items had applied to them over the course of the previous seven days, on a four option Likert scale, for example: "Not at all" (0); "Not often" (1); "Sometimes" (2); "Most of the time" (3). Two scores are derived from the scale: (a) the total anxiety score, which is obtained by

summing the scores on each of the 7 anxiety subscale items, and (b) the total depression score, which is obtained by summing the scores on each of the 7 depression subscale items. The range of scores, therefore, is from 0 - 21 for each subscale (higher scores equal more anxiety and more depression respectively). In a sample of 50 patients, subscale scores were significantly correlated with psychiatric ratings; for depression, $r = .70$ ($p < .001$) and for anxiety, $r = .74$ ($p < .0001$).

4 Assessment and procedure

Participants for the study were recruited at initial assessment by the psychologist who was to carry out their therapy. The psychologist was provided with a set of instructions (see Appendix 1) and a pack of the above psychological tests to administer to their client. Before treatment began, patients who had been referred for treatment for PTSD were invited, by the psychologist due to carry out their therapy, to take part in the study. Clients were provided with a Participant Consent Form (see Appendix 7) outlining the purpose of the study, the way in which the information gathered would be used, and assuring the participant of anonymity and of their right to withdraw from the study at any time. Once signed consent had been obtained, participants were asked to record their symptoms and coping style before the start of therapy by completing the following four psychological tests:

- Posttraumatic-stress Diagnostic Scale; (PDS) (Foa, 1995)

- Impact of Events Scale; (IES) (Horowitz, 1979)

- Monitor-Blunter Style Scale; (MBSS) (Miller, 1987)

- Hospital Anxiety and Depression Scale; (HADS) (Zigmond and Snaith, 1983)

At the end of treatment or following eight sessions, whichever was the sooner,

participants again recorded their symptoms by completing the PDS, IES and HADS. Therapists were asked to record on the Patient Details and Researcher Observations Sheet (see Appendix 8) details of the participants' age, gender, number of therapy sessions and duration of therapy and, for the purposes of triangulation, their overall impression concerning the extent to which they regarded the client as having engaged in the therapy, and their view concerning the extent of her/his improvement over the period.

The completed pack of information, including questionnaire responses before and after therapy, were returned to the researcher by hand or by post. Where appropriate, respondents were debriefed, their comments noted and any outstanding questions answered.

Chapter 3: Results

1 Treatment of the data

Of the 15 psychologists who agreed to participate, completed questionnaire packs were returned from only 4 of them, comprising 4 packs from one therapist, 1 from another and 2 each from the other 2. Data was, therefore, gathered from a total of 9 participants, and formed only 14.3 % of the total packs distributed. This was considered to be too few for a full analysis to be undertaken and so the study at this stage was regarded as a preliminary analysis, potentially useful in terms of highlighting areas of interest for a further research project.

The data collected from the 9 participants consisted of quantitative data from each respondent from each of the four questionnaires administered, together with personal covariates such as age and gender, and information about the therapy period and number of sessions. See Appendix 9 for a list of variables used in the analysis and Appendix 10 for the raw quantitative data from the questionnaires. In addition, a small amount of qualitative data was gathered in the form of a brief outline of the therapist's perception of the progress of therapy with the client. The completed questionnaire packs have not been included in the appendices and are available from the researcher on request.

All questionnaires were scored. Scoring of the PDS enabled the researcher to assess whether the participant met the criteria for a diagnosis of PTSD, as those without such a diagnosis were to be excluded from the study. All 9 participants were found to fulfil the criteria for such a diagnosis, so all were included in the analysis.

Although therapists had been asked to take the second measure of symptoms following the end of therapy or after 8 sessions, whichever was the sooner, one participant had received 12 sessions of therapy at the time of the second measurement and another had received 9 sessions. A decision was made to include these cases in the analysis on the basis that the initial specification of 8 sessions had been an arbitrary figure. It was considered that these cases may help provide useful

information at this preliminary stage of analysis, regardless of the number of therapy sessions between the two measures taken.

The statistical package SPSS for Windows, Version 8 was used throughout the analysis.

2 Screening and cleaning data

2.1 Accuracy of the data

A preliminary "eyeball" check of the data ensured that discrete variables were appropriately coded and that each value and the means and standard deviations were within range.

2.2 Missing data

Of the nine completed questionnaire packs returned, one pack (case number 5) contained missing data on one of the post-therapy measures, namely the two subscales of the IES. The missing data was regarded as random with no systematic bias in that it comprised data from only one participant from only one questionnaire. The data was treated according to the SPSS default for missing data, that is that the case was omitted from all analyses involving the variable in question. There were no spoils. Data from 9 participants was, therefore, used in the analysis.

2.3 Outliers

Box plots were generated for each variable to detect univariate outliers. Of the 41 variables, 8 were found to have outliers on at least one case. Of these 8, 4 cases comprised scores on discrete variables, with ranges of either 0 – 1 or 1 – 3 and had been classified as outliers because each was the only case to achieve a value at either end of the scale. As these detected outliers were within the appropriate range and the sample size small, a decision was made not to treat these as extreme cases.

Of the remaining four cases, three were from variables with a low range and the

extreme values identified reflected the small sample size. For example, the variable recording the number of re-experiencing symptoms *(pdsrexna)* had a value of 5 for all but one of the total nine cases, with a value of 4 for the remaining case, which had been detected as an outlier. A decision was made not to regard such instances as extreme cases.

The remaining outlier was the variable showing the number of days over which therapy had taken place (*period*). Case 9 recorded a total of 264 days, the range for the remaining eight cases for this variable being 56-126. This case was regarded as an outlier and treated as follows:

Once all inferential statistics had been conducted on the data, the value for this case was reduced to a non-extreme case by adopting the value of the next highest case + 1, that is 127, and the intercorrelational analysis re-run. An eyeball check of the two outputs was made to identify any differences before and after this value change. No differences in significance levels were found and, therefore, it was concluded that the significance levels obtained in the original analysis had not been unduly influenced by this extreme case.

2.4 Normality, Linearity and Homoscedascity

Due to the small sample size it was not considered appropriate to ensure that each variable was normally distributed, linearly related nor homoscedastic. The parametric statistical tests used were considered to be sufficiently robust for the analysis of data that departed from these assumptions.

3 Descriptive statistics

See Appendix 10 for raw questionnaire scores from each participant. Summary details of participants and therapy received are as follows:

Table 3.1 Participant and therapy details

Case	Ref	Age	Gender	Period of therapy (days)	Number of therapy sessions
1	R003	42	M	96	8
2	R014	50	M	264	8
3	R016	61	F	126	8
4	R028	32	M	91	7
5	R031	44	M	68	8
6	R036	50	M	63	8
7	R037	58	F	71	8
8	R041	28	M	56	9
9	R042	52	F	102	12
Means		46.33		104.11	8.44

With regard to the traumatic event cited, 4 participants reported accidents, including road traffic accidents, 2 had been subject to a non-sexual assault by a stranger, 2 had witnessed a traumatic death and 1 had been the victim of torture. The two coping styles of monitoring and blunting, for N = 9, were comprised as follows:

Table 3.2 Descriptive statistics for the blunting and monitoring variables

Variable	Mean	Median	Mode	Range	Standard deviation	Variance
blunting	3.89	4	5	3	1.27	1.61
monitoring	9.22	9	11	12	3.73	13.94

From the table, it would appear that the two coping styles of monitoring and blunting, with which the study is concerned, vary considerably in terms of measures of central tendency and measures of dispersion, with monitoring scores being on average higher with a broader distribution than blunting scores.

3.1 Computation of variables

Further variables were computed by subtracting the "after" scores from the "before" scores on all measures, in order to evaluate the change in symptoms over the period of

therapy. In addition, the blunting score (*mbssb*) from the MBSS scale was subtracted from the monitoring score (*mbssm*) to produce an overall MBSS score (*mbssdiff*) in accordance with data treatment in earlier studies (see Steketee, Bransfield, Miller and Foa, 1989). See Appendix 11 for the data from the computed variables.

4 Quantitative data analysis - inferential statistics

4.1 Intercorrelations

Firstly, bivariate, Pearson correlation coefficients were calculated for the monitoring and blunting variables (*mbssm, mbssb* and *mbssdiff*) and all computed change variables, together with the covariates of age, gender, number of sessions and period of therapy. See Appendix 12 for intercorrelations. The purpose of this was to assess the extent to which blunting and monitoring were associated with reduction in symptoms, in accordance with the hypotheses for the study. Furthermore, the extent to which other variables were correlated with each other was explored.

Significant correlations were found between several symptoms within the same scale, for example several of the variables from the PDS scale were correlated with one another. This was to be expected as some subscales of this test are scored by combining some of the others, and because symptoms within such scales are known to be associated. The anxiety subscale of the HADS correlated with the depression subscale, a well-documented finding, and also with several of the symptom measures from the PDS. The change in the depression subscale of the HADS correlated positively with the change in chronicity of symptoms from the PDS. Additional intercorrelations are summarised in table 3.3 and the means of the changes in these variables before and after therapy are summarised in table 3.4.

Table 3.3 Summary of significant correlations

Variable	gender (coded male = 1, female = 2)	sessions	monitoring
Age	.724*		
change in intrusion (IES)	.746*		
change in avoidance (IES)			.722*
change in no. arousal symptoms (PDS)		.871**	
change in impairment in functioning (PDS)	.756*		
change in no. symptoms (PDS)		.848**	
change in PTSD diagnosis (PDS)		.936**	

* *Correlation is significant at the 0.05 level (2-tailed)*

** *Correlation is significant at the 0.01 level (2-tailed)*

Table 3.4 Means of changes in significant variables before and after therapy

	before therapy	after therapy	change
intrusion (IES)	16.13	11.00	5.13
avoidance (IES)	14.88	10.00	4.88
arousal (PDS)	4.33	3.78	0.55
Impairment in functioning (PDS)	4.00	3.78	0.22
number of symptoms (PDS)	15.11	13.44	1.67
PTSD diagnosis (PDS)	1.00	0.89	0.11

4.2 Testing Hypothesis 1

4.2.1 Correlations between blunting and change in symptoms

Blunting (*mbssb*) was not significantly correlated with any change variables. Therefore, at this stage of the analysis, no support was found for hypothesis 1 which predicted a blunting coping style to be significantly negatively correlated with degree of improvement in symptoms over the course of therapy.

The possibility that restriction of range of the blunting variable (*mbssb)* (scores ranging from 2 to 5) may be responsible for this finding was considered. In order to test this, a further correlational analysis was performed, this time including some variables from the "before" measures instead of the measures of change, as follows:

4.2.2 Intercorrelations between symptom measures taken before therapy and participant characteristics.

Blunting (*mbssb)* was found to be significantly negatively correlated with intrusion scores before therapy from the IES (*iesintra)* $p<0.05$, suggesting that a blunting coping style is associated with low levels of intrusive thoughts before therapy. See table 3.5:

Table 3.5: Correlations between blunting and intrusion symptoms before therapy.

		pre-therapy intrusion (IES)
blunting	Pearson Correlation	-0.772
	Sig. (2-tailed)	0.015
	N	9

The fact that a strong correlation was found suggests that restriction of range was not responsible for the lack of significant correlations found between blunting and the change variables. Alternative reasons for these findings were therefore considered, including the fact that gender, which was significantly correlated with change in intrusive thoughts from the IES (*iesintrc*) may be acting as a suppressor variable, masking any relationship between change in intrusive thoughts *(iesintrc)* and blunting (*mbssb*). (The correlation between gender and the change in levels of intrusion is fully addressed in the Section 4.4 *Other Relevant Correlations*). Partial correlation coefficients were, therefore, calculated for the above "before" and "after" variables, this time controlling for the variable, *gender,* see Appendix 13.

4.2.3 Partial correlation coefficients, controlling for gender

When *gender* was controlled for, blunting was still found to be significantly negatively correlated with intrusion scores before therapy from the IES (*iestintra)* $p<0.05$, but, in addition, was very highly negatively correlated with change in

intrusion scores from the IES (*iesintrc*), see table 3.6:

Table 3.6: Correlations between blunting and intrusion symptoms before therapy, and change in intrusion symptoms, when controlled for gender.

		pre-therapy intrusion (IES)	change in intrusion (IES)
blunting	Pearson Correlation	-0.8126	-0.8914
	Sig. (2-tailed)	0.026	0.007
	N	9	8

These findings suggest that the reason that no association was found initially between blunting and change in intrusive thoughts was that *gender* was acting as a suppressor variable. This provides support for Hypothesis 1 in that a blunting coping style is strongly associated with low improvement in levels of intrusive thoughts over the course of therapy. However, the fact that a negative correlation was also found between blunting and intrusion scores at the start of therapy suggests that the correlation between blunting and change in intrusion may simply reflect the initial correlation, rather than a relationship between blunting and change per se.

4.3 Testing Hypothesis 2

4.3.1 Correlations between monitoring and change in symptoms

Monitoring (*mbssm)* was found to be significantly positively correlated with change in avoidance symptoms from the IES (*iesavc),* $p<0.05$, see table 3.7.

Table 3.7: Correlations between monitoring and change in avoidance symptoms

		change in avoidance (IES)
monitoring	Pearson Correlation	0.772
	Sig. (2-tailed)	0.025
	N	8

An association, therefore, was found, between a monitoring coping style and reduced

avoidance symptoms over the course of therapy. This supports Hypothesis 2 in that monitoring is associated with greater improvement in some symptoms following therapy.

4.4 Other relevant correlations:

Gender and number of sessions were found to be significantly correlated with several of the change variables, as follows:

4.4.1 Gender

The covariate *gender* was found to be significantly positively correlated with change in intrusion from the IES (*iesintrc),* $p<0.05$, and with change in impairment of functioning from the PDS (*pdsimpc),* $p<0.05$, suggesting that, in this sample, women were more likely than men to have reduced levels of intrusive thoughts and overall improvement in functioning over the course of therapy. Gender was also significantly positively correlated with age, $p<0.05$, indicating that the women in the sample were on average older than the men, see Table 3.8:

Table 3.8: Correlations between gender and age, change in intrusion levels and overall change in impairment in functioning.

		age	change in intrusion (IES)	change in impairment in function (IES)
gender	Pearson Correlation	0.724	0.746	0.756
	Sig. (2-tailed)	0.027	0.034	0.018
	N	9	8	9

4.4.2 Number of Sessions

The number of therapy sessions was very highly positively correlated with change in number of arousal symptoms from the PDS *(pdsarnc),* $p<0.01$, change in overall number of symptoms endorsed from the PDS (*pdssynoc)*, $p<0.01$, and change in a diagnosis of PTSD from the PDS (*pdsdiagc)*, $p<0.01$. See table 3.9:

Table 3.9: Correlations between number of sessions and change in number of arousal symptoms, change in overall number of symptoms and change in a full diagnosis of PTSD.

		change in no. arousal symptoms (IES)	change in no. symptoms (IES)	change in diagnosis of PTSD (IES)
sessions	Pearson Corr.	0.871	0.848	0.936
	Sig. (2-tailed)	0.002	0.004	0.001
	N	9	9	9

No association was found between the period over which therapy occurred and any change in symptoms.

4.5 Summary of the quantitative results

In summary, despite the small sample, some significant results were obtained. The preliminary study indicated some support for both hypotheses. Hypothesis 1 was supported in that a blunting coping style was found to be significantly negatively correlated with degree of improvement in intrusive thoughts following therapy. Hypothesis 2 was supported in that a monitoring coping style was found to be significantly positively correlated with the degree of improvement in avoidance symptoms over the period. Furthermore, it would appear that there is an initial association between a blunting coping style and degree of intrusive thoughts before therapy, not predicted by the hypotheses.

In addition, other significant correlations were found, which had not been predicted by either hypothesis, namely the impact of gender and the number of therapy sessions on the degree of change in symptoms over the course of treatment. However, with such a small sample, care needs to be taken with regard to the interpretation of non-significant correlations.

5 Qualitative data analysis

Following the end of treatment, or eight sessions, whichever was the sooner, therapists were asked to note their overall impression concerning the extent to which they regarded the client as having engaged in the therapy, and their view concerning the extent of her/his improvement over the period. There was one case of missing data, for case number 2, with 8 of the 9 therapists completing this part of the study. A full transcript of the therapists' comments are available on request. While the comments provided only a very brief and general resume of the clients' response to therapy, the data can be regarded as covering three main themes:

- The attitude of the client to the therapy, including issues of trust or initial scepticism about the process.

- The extent of engagement or avoidance during the course of therapy.

- The response to therapy and the degree of symptom change over the period.

A majority of the sample, both men and women, were reported to have engaged well in the therapy, and to have experienced some improvement in their symptoms. However, 3 men and no women were described as being initially sceptical about the extent to which they believed that therapy could help them, and 2 men and no women were described as avoidant. This indicates an interesting gender difference in attitude to therapy, with men being reported as less ready to engage in the process of psychological treatment than women, in this small sample. This is consistent with the quantitative findings which also indicated gender differences (see above) in that intrusive thoughts in women reduced significantly over the course of therapy and that their overall functioning significantly improved over the course of therapy, whereas this was not the case for the men in the study.

The findings from both the qualitative and quantitative aspects of the study are explored further in Chapter 4.

Chapter 4: Discussion

1 Summary of the results

Insufficient data was gathered to fully test the hypotheses of the study. Inspection of the 9 data sets collected, therefore, formed an exploratory, preliminary analysis. and was used to highlight research questions for a second phase of the research. The findings from the preliminary study indicate some support for the fact that coping style is relevant to symptom change over a course of therapy for PTSD. A monitoring coping style was found to be significantly positively correlated with improvement in avoidance symptoms over the period, supporting Hypothesis 2 which states that a higher monitoring score would be associated with greater improvement in therapy. A blunting coping style was found to be significantly negatively correlated with degree of improvement in intrusive thoughts, supporting Hypothesis 1 which states that a significant negative correlation would be found between a blunting coping style and improvement following therapy, that is that the higher the score for blunting, the smaller the reduction of symptoms following therapy. However, the observed correlation may simply be a function of the correlation found between blunting and intrusive thoughts at the start of therapy, so it is not possible to regard these findings as unequivocally supporting Hypothesis 1.

In addition, the impact of gender on attitude to therapy, engagement in the process and improvement of symptoms over the course of treatment was in evidence. The number of therapy sessions was found to be associated with improvement in some symptoms, and the period over which therapy took place was not associated with such changes. However, any findings must be considered within the context of the small sample size from which they arose, and it is important that these are not overstated nor over-interpreted.

2 The Relationships between Coping Style, Intrusion and Avoidance

2.1 The relationship between blunting and intrusive thoughts.

A blunting coping style was found to be significantly negatively correlated with degree of intrusive thought before therapy (see Table 3.5) and, when *gender* was controlled for, blunting was found also to be very highly negatively correlated with the degree of change in intrusive thoughts by the end of therapy (see Table 3.6). While the latter finding appears to support the hypothesis that blunting is related to low improvement in symptoms over the course of therapy, it is possible that this finding is a function of the negative correlation before therapy, with low blunters having higher levels of intrusion. So, while this provides support for the notion that blunting is related to low levels of intrusive thoughts, this is only in relation to the affect of blunting on the pre-therapy state rather than during the progress of therapy, and so does not provide evidence of avoidance during therapy.

2.2 The relationship between blunting and avoidance

The above arguments are based on the assumption that blunting is akin to avoidance and that blunting is an avoidant coping style. However, the current findings raise the question of how far it is appropriate to view blunting as an avoidant strategy. If blunting is akin to avoidance, a significant positive correlation would be expected between blunting and the measures of avoidance from the other scales, namely the PDS and IES. However, no such correlations were found, with no avoidance measures from either the PDS or the IES being significantly correlated with blunting, either at the start of therapy or with their change over the period. This is contrary to the rationale of the study, which regards blunting as an avoidant coping style, which would be expected to be associated with other avoidance measures. However, the absence of such a correlation must be understood within the context of the small sample size and so must be treated with caution.

2.3 The relationship between monitoring and avoidance.

Interestingly, although no relationship was found between avoidance and blunting, monitoring was significantly positively correlated with change in avoidance, with a monitoring coping style being associated with a reduction in avoidance symptoms over the course of therapy (see Table 3.7). Monitoring, however, was not found to be associated with avoidance levels at the start of therapy. This suggests that high monitors became less avoidant over the course of therapy than low monitors, regardless of their avoidance levels at the start, and that monitoring influences development of avoidance during therapy. This supports the findings of Steketee, Bransfield, Miller and Foa (1989) who found that monitors improved more than blunters following two sessions of exposure therapy for animal phobia.

2.4 A comparison of outcomes between blunters and monitors

Several studies showed monitors to have better outcomes than blunters (Steketee et al 1989). This is consistent with the current study in which monitoring was associated with reduction in avoidance levels and, therefore, with better outcomes. However, earlier research is inconclusive. Muris et al (1993b; 1995) found a positive effect of a premorbid blunting coping style in comparison with a monitoring style. They suggested that this was consistent with Williams et al's (1988) information processing model, in that too much attentional bias leads to extremes of anxiety which interferes with cognitive processing and so is detrimental to effectiveness of treatment. The information processing model, therefore, regards the reduction of extremes of attentional bias to aid therapy. If blunters are those with low levels of attentional bias, then the fact that they improved less in therapy than the monitors is not consistent with this model. However, the model also proposes that distraction disrupts the benefits of exposure treatment, and that a certain amount of attention to the stimulus is necessary for phobic extinction to occur. According to the model, therefore, neither extreme monitors nor extreme blunters would be expected to do as well in therapy as those with more moderate scores on each measure. Further studies might aim to test this.

One difference between the present study and the earlier phobia studies is that the

therapy used in the current study involved imaginal exposure to the traumatic event, whereas the earlier studies used in vivo exposure techniques. As has been observed earlier, the extent to which one's natural tendency to blunt a stimulus may vary according to whether it is being imagined or is physically present in the room, so cannot be avoided or blunted. It would be interesting to assess whether different results would be obtained for in vivo exposure therapy for PTSD.

In summary, a wealth of questions are raised by the results of the preliminary study, concerning the extent to which monitoring and blunting coping styles are related to avoidance and intrusive thoughts. However, in addition to these areas which test the two hypotheses, correlations were found with variables other than blunting and monitoring, upon which attention will now be focused, beginning with the relevance of gender to PTSD outcomes.

3 The Relationship between Gender and Therapy Outcome

The women in the sample were, on average, older than the men, and women were found to be more likely than men to have reduced levels of intrusive thoughts and increased overall improvement in functioning over the course of therapy (see Table 3.8).

This suggests that the women's response to the therapy exceeded that of the men in the sample. Most current treatments for PTSD involve the client speaking in detail about the traumatic event that they experienced, regardless of the therapeutic approach taken. These findings would suggest that women were able to engage more fully in the process of speaking meaningfully about the event and their feelings about it, and so benefit from the process of therapy. This is supported by the qualitative information provided by therapists at the follow up measurement. The three female clients who took part in the study were all described by their therapists as engaging well in the process, whereas all the male clients reported on (5 of a total of 6 male clients, 1 having missing data on this measure) were described by their therapists either as sceptical of therapy, avoidant, slow to engage or trust, or changing little throughout the course of therapy.

Matching of clients with therapists, for example in terms of gender, may be relevant to engagement in therapy and therapeutic outcome, due to rapport and trust being more easily built. (Fenton et al, 1987; Jones et al, 1987). If the clients who were reported to engage, that is the female clients, were receiving therapy from female therapists, and those who were reported not to engage, that is the male therapists, were receiving therapy from female therapists, then it may be the gender of the client-therapist pair which is responsible for the engagement rather than the gender of the client per se. However, on examining the data, there is no systematic bias in the gender of the therapist, both male and female clients working with same and different gender therapists.

This raises the issue of whether this sample is typical of a population of clients seeking therapy for PTSD in that men are more avoidant than women and engage less easily in the therapy. Alternatively it may be that this sample is typical of a population of clients using the mental health service in general, regardless of their particular diagnosis. This would support the stereotypical view of women being more able to talk about their feelings than men, and comes at a time when male suicides have been found to have increased by 60%, having now overtaken the suicide rate for women (Samaritans, 1999). Further research might focus on whether women with PTSD fare better following therapy than men with PTSD, and whether there is a difference between the outcomes of men and women in general, that is those presenting to the mental health service with a range of disorders.

The degree of improvement in the levels of intrusive thought was significantly greater for the women in the sample than for the men. No gender differences were found between the levels of intrusive thought, nor any other symptoms, before therapy, which suggests that the women began from the same start point as the men, but progressed in therapy differently to and more effectively than the men. Similarly, no gender differences were found for coping style, indicating that coping style is relevant to symptom change, regardless of gender.

One possible explanation for these findings is that these apparent gender-specific responses to therapy for PTSD reflect differences in the type of traumatic event

experienced. For example, more men than women are likely to have experienced combat trauma and more women than men are more likely to have experienced rape or sexual assault. However, in the current sample, there was no systematic bias in the range of traumatic events experienced, with men and women being randomly spread across the four events cited, namely non-sexual assault, witnessing a traumatic death, involvement in an accident and being the subject of torture.

Further research might consider the possible explanations for the apparent gender differences in PTSD outcomes and the extent to which they are consistent with a population of mental health service users as a whole, or are specific to those with PTSD.

4 The Relationship between Number of Therapy Sessions and Outcome

The number of therapy sessions was very highly positively correlated with several measures of symptom change from the PDS, namely change in number of arousal symptoms, change in overall number of symptoms reported and overall change in diagnosis of PTSD (from Yes to No) (see Table 3.9) although no association was found between the period over which therapy occurred and any change in symptoms. This indicates the effectiveness of therapy for PTSD, as symptom reduction can be attributed to the therapy as opposed to being merely a function of the passage of time since the traumatic event. However, there are methodological limitations in the current study which need to be considered when interpreting any of the above findings.

5 Limitations of the study

5.1 Inconsistencies in the measurement of monitoring and blunting coping styles.

Miller's original concept of monitoring and blunting has been criticised for its inconsistencies and shortcomings (Muris et al, 1994). One problem is that of defining monitors and blunters, with different studies measuring these styles in different ways.

Originally, the MBSS employed a dichotomous format, as in the current study, in which participants are asked to mark the options which are applicable to them of a range of possible responses to each scenario (Miller, 1987). More recent studies, however, have used a 5-point format on which the participants indicate to what extent each option is applicable (for example: Muris, van Zuuren and Merckelbach, 1993). The new measurement has arisen due to a weakness in the research pertaining to the internal consistency of the dichotomous scale. For a discussion on this topic, see Parker and Endler (1992). The dichotomous scale was used in the current study, because this was the format of the questionnaire with which its author provided the researcher, and for which permission was granted for usage.

Furthermore, some of the earlier research has treated the data from the monitoring and blunting subscales by subtracting one subscale score from the other to derive one overall score for each person, and categorising them as either a monitor or a blunter on the basis of a median split, for example, Miller (1987). One problem with this is that some individuals may not fall very easily into either category, having similar scores on each of the subscales, and so may render comparisons between the two "types" of people less relevant. In the present study each participant has one score for monitoring and one for blunting, so that it was possible for one person to score equally high or equally low on both measures. People were, therefore, not categorised either as monitors or blunters, both styles being recognised within each person. It could be argued that this is a more appropriate way in which to treat such data, rather than to divide individuals into discrete groups, reflecting the complexity and variety of coping resources that each individual may use concurrently. Treating monitoring and blunting as two continuous variables, as in the present study, enables this complexity to be incorporated in the data analysis. This attitude to coping styles is more consistent with modern views of personality and counselling theories, which regard people as individuals rather than a cluster of diagnostic labels or categories. Caution should, therefore, be exercised when interpreting the results of the current study and it should be noted that, whenever monitoring and blunting is referred to, this relates to the scores of individuals on either of the subscales and not to a classification of an individual as either a monitor or a blunter, as may be the case in some of the other studies which used a median split.

Furthermore, the variety of ways in which MBSS scores are treated throughout the coping styles research renders comparisons between studies problematic and may partly account for some of the apparently conflicting results in the literature on monitoring and blunting. For example, the Muris et al studies used a 5 point Likert scale as opposed to the current dichotomous scale. In another study, Miller (1987) identified four coping styles, namely high monitor / high blunter; high monitor / low blunter; high blunter / low monitor and low blunter / low monitor. It would be interesting, in future research, to consider how far these four coping styles might be predictive of therapy outcome in PTSD. However, it was not possible to group the data in this way in the present study, again due to the limited number of participants. The low response rate is an issue of interest in itself.

5.2 The low response rate

One limitation of the study is the small amount of data, due to the low response rate. Initially, many of the organisations and individuals who were approached to take part in the study declined, on the grounds that they did not have the time, that they rarely saw clients with PTSD or that they considered their clients to be already "over-researched". Of the 15 psychologists who agreed to participate, completed questionnaire packs were returned from only 4 of them, comprising 4 packs from one therapist, 1 from another and 2 each from the other 2. Data collected formed only 14.3 % of the total packs distributed.

Therapists cited a variety of reasons for the lack of response:

- clients had dropped out of therapy, and so follow-up data could not be gathered.
- therapists forgot about the study
- a lack of referrals of clients with PTSD
- therapists' discomfort with researching clients in distress.

This last reason is significant and requires further exploration. Some therapists did

not feel comfortable recruiting to the study clients whom they felt were in considerable distress, or for whom they felt trust in the therapist may be an issue. Gathering data for research from clients may be seen to conflict with the tasks of therapy, and may be seen as a barrier to the therapeutic relationship (Barker, Pistrang and Elliott, 1996). It is important when gathering data to be sensitive to the needs of the client, in preference to the demands of the research. Although the client's signed, informed consent is established before any of the study procedures are administered, it could be argued that the power imbalance inherent in the therapeutic relationship, particularly initially, before a working alliance has been established, may be sufficient to leave the client feeling pressurised or obliged to take part. Some therapists may be very sensitive to this and so be reluctant to ask the client to take part in the study. This is consistent with Barker et al's (1996) nine reasons for clinical and counselling psychologists sometimes failing to become involved in research, namely the issue of "intrusiveness", in which therapists regard the intrusion of research procedures into the therapeutic relationship to be damaging to the relationship. Studying the client may be considered to distort the psychological atmosphere, for example by making the client anxious about confidentiality.

It is possible that reasons other than those cited by the therapists may also be responsible for the lack of response from those initially agreeing to take part. Barker et al (1996) suggest that research is time consuming and often takes a low priority compared to service demands, and is not often supported or valued by managers or colleagues. Furthermore, it may be that, due to the "before and after" nature of the study, some therapists may have felt that their therapeutic competence and effectiveness with clients was being measured, and so may have found the study threatening. Barker et al (1996) suggest that research may produce findings that lead to a painful re-examination of one's ideas and challenge one's assumptions and ways of working. This, they suggest, may lead to therapists feeling threatened, and so citing other reasons for not being able to carry out the research, for example time pressures.

Feelings of threat, therefore, coupled with the pressure of work traditionally associated with professionals working within the NHS, may have produced a reluctance to engage in any procedure that involved additional time, thought or

perceived pressure or anxiety. This has highlighted the difficulties inherent in relying on busy professionals to help gather data from their clients.

5.3 The disadvantages associated with self-report methods

A further limitation of the study is that it relies almost entirely on clients' self-reporting of their symptoms, feelings and behaviour. It is the clients, themselves, who completed the questionnaires and, as with all self-report measures, this provides a subjective view of the person, from the client's own perspective. In current psychological practices, this may be considered an advantage. Many psychologists, for example Harre (1974) and Kelly (1955) have argued that researchers should ask the participant for his or her own view unless there are compelling reasons not to do so. Humanistic counselling approaches are based on the philosophy that the client's perceptions of themselves and their world are paramount and that it is important to enter and remain within the client's frame of reference in order to begin to fully empathise with their experience and so facilitate their progress (see for example, Rogers, 1951). Furthermore, the recent rise in Counselling Psychology in the UK has led to a "growing acceptance of the humanistic value system...reflected in reactions against the medical model of professional-client relationships" (Woolfe, 1996, p5). The self-report methods used in the current research, therefore, can be said to be consistent with modern counselling and Counselling Psychology philosophy.

The disadvantage of self-report methods, however, is that respondents are not always truthful, they may deceive themselves or others due to the denying of the problem to themselves, or because they do not want others to know about certain of their thoughts, feelings or behaviour for fear of judgement or ridicule.

In the present study, the self-report measures were supplemented by a small amount of information from the therapist. The study, therefore, is not entirely dependent upon the clients' own perception of their symptoms. As seen earlier, in the discussion of the gender of the participants, the qualitative information provided by therapists at the follow up measurement was consistent with the quantitative outcome measures taken, in that the female clients were reported to have engaged well, whereas the male clients were described as more sceptical. This suggests that the therapists'

observations of the level of improvement in symptoms over the course of therapy was consistent with the quantitative outcome measures taken, and so goes some way to address the potential validity problems often associated with self-report measures. The gathering of further qualitative data to investigate some of the issues raised by this preliminary study would not only help to triangulate the current research findings, but also go some way toward exploring and clarifying in greater depth some of the processes involved in the symptom profile of those with PTSD.

6 Concluding Remarks and further research

The data from this preliminary study are not sufficient for firm conclusions to be drawn in relation to the hypotheses put forward due to the small return rate of completed questionnaires, however they highlight several interesting areas for further exploration of avoidance in PTSD. The fact that the information-avoidant coping style of blunting was found to be associated with symptoms of intrusion suggests that avoidance may play a role in PTSD presentation, although it is less certain whether it influences the course of therapy.

However, focusing on the issue of personality and coping styles is only one of many ways of addressing the problem of avoidance. Considering avoidance in therapy solely in terms of personality and coping styles may be regarded as over-simplistic in that there may be many factors associated with clients not addressing emotional material in therapy other than trait components. For example, situational variables may be as important as individual differences in avoidance in therapy. In view of the increasing body of research that shows one of the most overriding and influential factors in the outcome of psychological therapy to be the relationship between therapist and client (Frank, 1979) one area of importance in avoidance research is to consider avoidance in terms of the interaction between client and therapist. The ongoing quest for effective therapies needs to take full account of such situational and process issues that may prevent successful therapy outcome.

A second study, therefore, was conducted in order to build on the findings of the first study and to consider the ways in which avoidance manifests within the therapy

session itself, exploring the dialogue within the therapeutic dyad.

7 Rationale for Part 2 of the study

Part 2 of the study used a qualitative approach to further explore the process of avoidance. The overall result is a two-part study using both quantitative and qualitative methods to explore the problem of avoidance in PTSD. Research which combines both quantitative and qualitative methods can provide a useful way forward in terms of examining a research question (Barker et al, 1996) and the two approaches can often complement each other. The rationale for combining the two approaches in the current study is in order to use qualitative data to elucidate and explore the quantitative findings and as an adjunct to and a follow-up investigation of a primarily quantitative study (Barker et al, 1996). If the nature of avoidance within the therapeutic dyad can be better understood, then strategies to overcome it could be recommended.

Section B: Research

Part 2:

The discursive practices facilitating an avoidance of emotional material in therapy for clients with posttraumatic stress disorder.

Chapter 5: Method

1 Research design

Discourse analysis, a qualitative approach for the study of written and spoken text (Billig, 1992; Edwards and Potter, 1992; Gilbert and Mulkay, 1984; Potter and Wetherell, 1987) was used. It is a method increasingly deployed in the field of psychology and psychotherapy, as it enables communications to be analysed in detail in terms of their social functioning. In the current study, the method is applied to written text in the form of transcriptions of therapy sessions with clients with PTSD, in order to generate some of the discursive practices which function to enable an avoidance of the expression of negative affect. The purpose of the analysis is to identify some of the patterns of conversational behaviour which impact upon the therapeutic process in such a way as to facilitate or enable an avoidance of the expression of emotional material.

1.1 Choice of methodology

A qualitative method was chosen because it enables closer contact with the clinical material, consistent with its increasing use in the field of applied social sciences, (Barker et al, 1996). Using a qualitative method enables the subject of avoidance to be studied in depth and detail, avoiding the simplifications imposed by the quantification associated with quantitative methods, and providing a useful alternative and augmentation to the quantitative design in Part 1 of the study. Furthermore, such designs have the practical advantage of requiring fewer participants than quantitative designs, addressing the problems of data collection experienced in Part 1, and the data collected is very rich, providing a wide scope for qualitative analysis, consistent with current philosophy on therapeutic research in the field of Counselling Psychology.

An exploration of the ways in which avoidance is manifest within therapeutic conversation requires an analysis at the level of the dialogue used. A discourse analysis methodology was chosen as it lends itself to an exploration of therapeutic dialogue in that

it is concerned with the study of written and spoken text (Potter and Wetherell. 1987). Its applicability to research on process with clients in therapeutic situations has been demonstrated (e.g. Dimity, 2000; Harper, 1995) and so it is regarded as the most appropriate method for illuminating the complex process of avoidance in therapy for PTSD. Alternative qualitative methodologies, such as phenomenological methods. grounded theory and narrative approaches were considered, however such approaches rely on an exploration of the subjective *meaning* of utterances and focus on the *content* of the text. The purpose of the current research was more to explore the *process* of the therapeutic conversation, rather address the content of utterances. Discourse analysis. being concerned with meaning in terms of the social function of utterances rather than in terms of their content, lends itself more readily to the subject under investigation.

1.2 Research Method

There is very little agreement as to the usage of the term "discourse analysis" and there are many variants of the approach (Robson, 1993). The method considered most appropriate for the current study is social-psychological and is concerned with text and talk in social practices. (Billig, 1992; Edwards and Potter, 1992; Gilbert and Mulkay, 1984; Potter and Wetherell, 1987). This approach takes a functional perspective on language, focusing on the way in which language is used to do things such as describe, persuade or blame (Madill and Barkham, 1997). The current study is concerned with the way in which language is used to avoid and specifically the way in which it enables an avoidance of the expression of negative affect or an exploration of painful emotional material in therapy for PTSD. Descriptions are treated as constructed versions of reality, rather than as neutral accounts of states of affairs or as a medium for accessing underlying attitudes or beliefs. The focus of the analysis is the impact upon the therapeutic process of the various discursive patterns generated rather than an interpretative account of any underlying motivations of the participants.

2 Data collection

2.1 The data

Data comprised six transcripts of sections of therapy sessions. Four transcripts were transcribed by the researcher from audio tapes. Of these, two were from the researcher's own work with clients and two were from the work of one other therapist. The two remaining transcripts were from two other therapists and were presented to the researcher in transcribed form, comprising part of the assessed written process report component of a course of postgraduate study in Counselling Psychology. In summary, the transcribed materials comprised the work of four therapists and six clients, with two of the four therapists providing material from two clients each, and the remaining two therapists producing material from one client each.

2.2 Recruitment of participants

A mailshot was sent to all postgraduate Counselling Psychology students at a major university in London, requesting transcribed material of therapy sessions with clients with PTSD (see Appendix 14). Three students responded, two of whom each provided a ten-minute transcript that they had submitted as part of the assessed written process report component of their course of study. The third student provided two 40 minute audio tapes of work with two different clients. The researcher provided two transcripts of her own work with two different clients of 45 minutes each.

2.3 Inclusion criteria

Only transcripts or tapes from therapy sessions with clients who were suffering from PTSD were included. A client was regarded as suffering from PTSD if, in the professional opinion of the therapist providing the transcript, he or she met the criteria for this diagnosis. This inclusion criterion was stated in the mailshot, thus selecting out transcripts of those whom the therapists deemed as not suffering from PTSD. Therapists

demonstrated, within accompanying case study work or case note material and subsequent conversations with the researcher, that DSM-IV criteria for PTSD had been met. The researcher was satisfied that the therapists' accounts of clients' symptoms broadly satisfied the DSM-IV criteria for a diagnosis of PTSD in each case. All data provided met these inclusion criteria, and no data was excluded.

Due to the archive nature of the material, it was not possible to require each therapist to apply the same therapeutic tool for the measurement of PTSD, unlike the previous quantitative part of the study. It must, therefore, be accepted that, despite the steps taken to standardise inclusion criteria and ensure that only clients with symptoms consistent with the DSM-IV criteria for PTSD be included in the study, there will inevitably be some subjectivity in the diagnosis applied. The negligible risk of including material from those not conforming to all the DSM-IV criteria for PTSD was balanced against the usefulness of including material from clients who had in common, at the very least, that they were all receiving therapy for the psychological effects of a traumatic experience. This was considered sufficient for the exploration of the process of avoidance in traumatised individuals, and is consistent with a social constructivist perspective with regard to the inevitability of subjectivity in research (Gergen, 1985). More specifically, it is consistent with calls for a more discursive approach to diagnosis in preference to the cognitive model, currently dominating approaches to diagnosis (Edwards, 1991).

2.4 Participants

One therapist was male and three were female and one client was male and five were female. Three clients were survivors of childhood sexual abuse, one was the survivor of a sexual assault in adulthood, one had survived an industrial accident and the other had witnessed a road traffic accident and had issues of traumatic grief following the death of a relative. Three were receiving therapy within NHS agencies and three were attending voluntary counselling services. The therapist who is also the researcher is denoted as "A", the therapist who provided the two tapes as "B" and the therapists who provided the transcribed material as "C" and "D". The distribution of these variables is summarised in

table 5.1.

Table 5.1 The distribution of clients across therapists

Client ref.	Client's gender	Therapist	Therapist's gender	Nature of trauma	Session number	Agency	Transcript time (mins)
AD	M	A	F	Industrial accident	1	NHS CMHT	45
HP	F	A	F	Bereavement / witness accident	1	NHS CMHT	45
NL	F	B	M	Childhood sexual abuse	48	Voluntary sector alcohol service	40
RH	F	B	M	Childhood sexual abuse	28	Voluntary sector alcohol service	40
RW	F	C	F	Childhood sexual abuse	12	Voluntary sector rape service	10
HG	F	D	F	Sexual assault	5	Trauma service	10

2.5 Sample size

Because the researcher is interested in language use rather than the people generating the language and because a large number of linguistic patterns were expected to emerge from a few people, the sample size was considered adequate for investigating the current research question. The area of interest with which the study was concerned was the ways in which avoidance is used within therapy for PTSD. This is distinct from the type of research which explores incidents of a specific event that may occur on only a few occasions within each transcript, in which case a larger number of transcripts might be required in order to encompass sufficient of these events to provide a reliable analysis (Perakyla 1997). The current research was concerned with the avoidant processes occurring within the transcripts, rather than focusing on a specific predefined event and so the number of transcripts was considered appropriate for this purpose.

The possibility of using a single text to explore this question was considered, and indeed there are many precedents for using a single text to demonstrate how certain effects can

be achieved (e.g. Dimity, 2000; Potter et al, 1984; Woolgar, 1980). However, it was hypothesised that analysing a selection of transcripts might elicit a broader range of avoidant strategies, and so better illuminate the process of avoidance in therapy for clients with PTSD.

3 Ethical considerations

3.1 Consent

Written permission was obtained from all clients for the taping of therapy sessions and their subsequent use by the university of the transcribed material. In addition, for the four clients whose tapes were used by the researcher (as opposed to just the transcribed material without the tapes) additional consent was obtained for the use of the tapes for research purposes. The signed taping consent forms are not included in the appendices for reasons of confidentiality, but are available from the researcher on request. Clients were informed of the purpose of the study, the way in which the information gathered would be used, and assured of anonymity and of their right to withdraw from the study at any time.

3.2 Confidentiality

For reasons of anonymity, a minimum amount of background information about each client is included. Within the written transcripts themselves, all identifiers, including the names of people and places have been omitted. The tapes, which may contain such identifiers, have been kept separate from the transcripts and stored securely.

Following analysis of the transcripts, one therapist requested that the transcribed material not be directly quoted from, because of concerns for the anonymity of the client. This transcript was one of the two that had been submitted without the tape (HG) and was the property of the university. However, following discussion with the university, a decision

was made to comply with the request and only refer to the contents of the transcript in general terms without directly quoting from it.

Each transcript is identified by a two letter reference code that was generated randomly and does not relate to the initials of any of the participants. The sections of transcripts cited in the Analysis Section as examples are each labelled with an identifier made up of this two letter code and a number denoting the lines of transcript from which the quotation is drawn, for example "RW54-9".

4 Transcription

4.1 Transcription process

Four of the taped therapy sessions were transcribed by the researcher, and two were provided already transcribed by the therapists who provided them. As the material was transcribed by different people, variability is expected in terms both of what information is included and in the notation used. However, such subjectivity is an accepted part of discourse analysis and, indeed, it is accepted that it is not possible in transcription to reach complete "accuracy" of what was said. "Transcription is a constructive and conventional activity" (Potter and Wetherell, 1987, p165). The transcriber is struggling to make clear decisions about what exactly is said, and then to represent those words in a conventional orthographic system (Stubbs, 1983). While some variability has to be accepted and worked with, attempts were made as far as possible to standardise the notation and produce "truthful" accounts of what was said, by adopting the following procedures:

For the four tapes that were transcribed by the researcher, once the tape had been initially transcribed, it was played through again and the transcription checked and alterations made. This procedure was repeated until the transcription was considered to be as fair a representation of the taped material as practically possible. However, the inevitability of subjectivity in the process is acknowledged, and it is recognised that the dialogue is

transcribed through the medium of the researcher and can never be regarded as the only true interpretation of the taped material.

The researcher chose to record a variety of paralinguistic features in the transcripts, namely pausing, lowered voice, overlapping speech, emphasis and non-verbal noises such as coughing, sniffing and sighing. Pauses of less than three seconds' duration occurred extremely frequently in the dialogue and their transcription was regarded as onerous and potentially interfering with the readability of the transcript. Following the recommendations of Potter and Wetherell (1987), consideration was given as to whether this information was necessary in terms of the level at which the analysis would proceed. As short pauses were not considered to add anything potentially useful to the analysis, a decision was made to include only those pauses of 3 seconds or more. Furthermore, where pauses occurred between the turns, it is arbitrary whether the pause should be attributed to the turn of the therapist or client, regarded by Sacks, Schegloff and Jefferson (1974) as a "gap" which belongs to no-one. These gaps were recorded as pauses and, for the purpose of the consistency of the transcription, always arbitrarily attributed to the person who spoke following the pause.

Attention was paid to adding punctuation in a way that was as faithful as practical to the delivery of the dialogue and that maintained the speaker's expression or enhanced readability. All turns were prefixed with *C* or *T* to denote the speaker, client and therapist respectively, and each line of the transcript was numbered for ease of reference.

The remaining two transcripts which were provided already transcribed by the therapists were re-typed in order to include them in the researcher's computer files, for ease of analysis, and were modified by the researcher in two ways. Firstly the turns were prefixed with *C* or *T* to indicate the speaker, and the lines numbered for ease of reference. Secondly, where pauses had been indicated by the word "pause" or by dotted lines, this was replaced by a full-stop in brackets *(.)* to indicate an untimed pause. This was considered to aid readability and to make the notation consistent with the standard notation used in the other transcripts. These two transcripts payed little attention to

pause-length, hesitations, overlapping speech, lowered voice or emphasis. It is not possible to conclude that these paralinguistic features were not present in the original tapes, but only that any that were present were not transcribed. The six transcripts, labelled AD, HG, HP, NL, RH and RW respectively are available on request, in disk form or in hard copy.

4.2 Technical quality of recordings

Reliability was enhanced by paying attention to the technical quality of the recordings. For the two transcripts that had been recorded by the researcher, herself, the quality of the tapes was maximised by paying attention to the quality of the recording equipment, the setting in which the recording took place, the arrangement of the seating and the positioning of the microphone. Despite this, there remained some utterances which were unintelligible on transcription, denoted "(inaudible)" in the transcripts.

The remaining four transcripts had been recorded by others. Although the researcher, therefore, had no control over the quality of these recordings, the two tapes received were considered to be of high technical quality. The final two transcripts were received already transcribed without the tapes. However, the tapes had previously been deemed of adequate quality and audibility for assessment purposes by the university, and so were considered to meet the technical quality requirements for the research.

4.3 Transcription Adequacy

Reliability was enhanced by paying attention to the adequacy of the transcription. The form of notation throughout the transcripts is based on that developed by Gail Jefferson as described in Potter and Wetherell (1987). Due to limitations of the computer word-processing package used for the transcription, some of Jefferson's symbols have been replaced with others. For example overlapping speech is indicated by a square bracket before each line of overlapping speech, as used by Wood and Kroger (2000) and not by one square bracket bridging the two lines as suggested by Potter and Wetherell (1987).

A rich transcript is a resource of analysis and at the time of transcribing, the researcher cannot know which of the details will turn out to be important for the analysis (Perakyla 1997) and so an attempt was made to record as many aspects of vocal interaction as practicable. The transcription conventions used emphasise readability at some expense of detailed nuances of stress, pronunciation and timing. See Appendix 15 for the transcription notation convention used.

Furthermore, it is recognised that transcriptions of audio recordings may entail a loss of some aspects of social interaction (Perakyla, 1997), for example non-verbal behaviour and temporal processes. However, the purpose of the present study is not to provide an all-encompassing account of the social behaviour of clients and therapists over a protracted period of time, but rather to consider verbal behaviour within a section of the specific time-limited context of the therapy session. As Perakyla (1997) observes, analyses of discourse, amongst other methods, do not aim at describing all aspects of social organisation. It is the organisation of verbal interaction in conversations which is the particular domain of such analysis, whereas other methods may be more suitable for focusing on other aspects of social organisation.

5 Coding and Analysis

The transcribed materials were approached using a systematic analysis of discourse (Potter and Wetherell, 1987). This was made up of two stages: coding and analysis.

5.1 Coding

The discursive practices used by the speakers were explored in detail and utterances were grouped to generate a list of discursive practices used. An understanding of the discursive practices observed developed with the analysis of each transcript. Each transcript was, therefore, returned to for analysis several times and reassessed and recoded in the light of the discursive practices that had been generated by the other

transcripts. At this stage an attempt was made to produce a body of instances of each discursive practice generated. The coding stage did not restrict itself to practices in which avoidance was hypothesised as, at this pre-analysis stage, no definition of what constituted avoidant discursive practices had been constructed. This is consistent with a qualitative approach in that data collection should not be constrained by pre-existing hypotheses (Barker et al, 1994).

5.2 Analysis

Analysis was concerned with the function and consequence of each of the discursive practices that had been generated at the coding stage. The effects on the conversation of the clients' accounts, including paralinguistic features of talk, were examined in detail and each piece of talk was considered with regard to the way in which it influenced the process of the therapy session.

It was observed, at this stage, that certain of the discursive practices resulted in the conversation moving away from emotional descriptions of the trauma or from expressions of affect. This observation provided a working definition of avoidance and, for the purposes of the analysis, discursive practices that resulted in the conversation moving away from an exploration of emotional material were regarded as constituting avoidance. It should be noted that the use of this term does not imply interpretations of any underlying motivation of the participants but rather the social effect of these practices in terms of the process of the dialogue. This approach is consistent with the discourse analytic framework in which individuals' utterances are regarded not as an indication of underlying attitudes or beliefs as in quantitative research, but rather as phenomena in their own right (Schegloff, 1992). Each discursive practice was, therefore, considered in the light of how it functioned to influence the process of the therapy session with regard to the extent to which it enabled the conversation to move away from expressions of emotional material.

5.3 Enhancing validity

The emerging patterns and proposed functions of the various utterances were subject to review by the researcher's research supervisor. Regular discussion and feedback took place between the researcher and supervisor, resulting in revisions to the hypotheses.

Further measures were taken to enhance the validity of claims, using criteria developed by Potter and Wetherell (1987) specifically for discourse-analytic research, together with those used in related methods such as conversation analysis that Perakyla (1997) suggests may also be adapted for the purpose. Accordingly, the current analysis concerns itself with *validation through "next turn"*, *deviant case analysis*, *transparency of analytic claims, new problems* and *fruitfulness.*

5.3.1 Validation through "next turn"

The examples cited in the current study are concerned with the responses of each of the dyads to each other's utterances and so in each case the next turn is available for inspection. The researcher's hypotheses can, therefore, each be subjected to the "proof procedure" (Sacks et al, 1974) that is that the next turn will show whether the interactants themselves treat the utterance in ways that are in accordance with the analyst's interpretation. Potter and Wetherell (1987) refer to this as "participants' orientation" and, in the current study, an attempt has been made to demonstrate how the responses provide support for the function of the preceding discursive practice.

5.3.2 Deviant case analysis

Deviant cases refer to those cases for which things go differently and do not immediately fit the pattern or support the emerging hypothesis. The meticulous analysis of deviant cases, sometimes referred to as "coherence" (Potter and Wetherell, 1987), gives impetus, strength and rigour to the development of the analytic arguments (Perakyla, 1997) and so, having established patterns of interaction, the researcher took pains to search for and examine any apparently deviant cases.

Each of these cases was dealt with according to the three steps proposed by Clayman and Maynard (1994). Firstly the deviant case was examined to see whether the participants, themselves, treated it as deviant, in which case the example would be regarded as providing additional support for the pattern. If there was no evidence for the participants treating the case in this way, a consideration was given to the appropriateness of reconceptualising the pattern to incorporate the deviant case. If there was no justification for either of these approaches, then an explanation was sought from the individual contingencies of the case, and an examination made of the ways in which the particular circumstances of the case differed to the ones that fit the pattern. If none of the three above criteria applied, the pattern was regarded as invalid and either discarded or reworked. The same process for the analysis of deviant cases was then applied to the new pattern.

5.3.3 Transparency of analytic claims

An attempt was made to ensure the adequacy, relevance and comprehensiveness of the sections of the transcripts cited. In this way the reader was provided with sufficient and persuasive evidence for the hypotheses and arguments proposed in order to make a judgement with regard to "apparent validity" (Kirk and Miller, 1986), the notion that once you have read the results of good analysis, you are convinced they are transparently true.

5.3.4 New problems

Inconsistencies in clients' accounts or new problems where they occurred were highlighted and explored within the context of the hypothesis proposed. Such incidents were used to provide further confirmation that discursive devices were being used as hypothesised (Potter and Wetherell, 1987) and the ways in which the clients sought to reconcile inconsistencies used to validate the hypothesis with regard to their function. An example of this in the current study is the ways in which disagreement between client and therapist is managed (see Chapter 6, Section 5.1).

5.3.5 Fruitfulness

The current study sets out to achieve a novel way of exploring and analysing avoidance in

therapy for those with PTSD and so fulfils the criteria of fruitfulness in terms of providing a new way of looking at a subject and increasing understanding of the subject matter (Madill and Barkham, 1997). Its fruitfulness in terms of its capacity to make sense of new kinds of discourse and to generate novel explanations (Potter and Wetherell, 1987) will be argued in Chapter 7.

Chapter 6: Analysis

1 Overview of findings

The analysis of the transcripts elicited three important findings that can be summarised as follows:

- therapists, as well as clients, avoid addressing emotional material in therapy.

- clients and therapists use different strategies from each other to achieve avoidance, and these are a function of the disparate roles and expectations within the therapeutic dyad.

- the ways in which avoidance is achieved are mediated by the power dynamics associated with the therapeutic context.

The analysis will focus firstly on those discursive practices used by clients and then move on to consider those used by therapists. Clients' responses to therapists' avoidant practices will be used to illuminate the extent to which avoidant strategies are a function of the disparate roles and expectations within the therapeutic dyad. Finally, the mediating factor of the therapeutic setting will be demonstrated through a consideration of the ways in which disagreement is managed. Examples of each of these areas will be presented and, in each case, an argument will be put forward that each discursive practice serves an avoidant function, that is that the utterance results in the conversation moving away from expressions of negative affect or painful emotional material. Validation of the claims will include issues of transparency, fruitfulness, deviant case and next turn analysis.

2 Avoidant discursive practices used by clients

There is evidence that clients avoid an exploration of painful emotional material in therapy by speaking about difficult events or feelings in such a way as to present them

as of little impact or consequence. Clients construct traumatic events and feelings as of minor importance and so reduce the affect expressed in the therapy session. This is achieved through three main discursive practices: understatement, normalising discursive constructions, and paralinguistic devices. Examples of each will be presented and a case made that each discursive practice serves an avoidant function.

2.1 Understatement

The first way in which clients attempt to reduce an expression of the affect associated with their symptoms is by using low-impact words or descriptions of their experience. Consider the following examples in which clients "correct" the therapist's use of stronger adjectives:

Example AD790-5

790 T: And, did you feel terrified ?

791 C: Don't know if terrified is the right word

792 T: Erm, what would be ?

793 C: erm (10.4) uneasy I think would be more, more descriptive of how I felt
794 really. I wasn't terrified. I was just, like, when I realised that I could have
795 died, it was just like I, you know, stepped back

Example AD518-20

518 T: So you don't [feel quite as safe as

519 C: [comfortable

520 T: [might have been used to feel

Example RW148-56

148 T: You can feel the pressure of him (.) of his knees or (.)

149 C: Of just being (.)of just the sensation of (.) of (.) sort of being (.) like locked

150 T: Mmhm mmhm

151 C: My legs not being able to move (.) but that' no (.) (inaudible)

152T:(inaudible)Where are you knees (.) are they sort (.)jammed together, or are they
153 jammed apart?

154 C: No they're sort of apart, cos he' s gone like that

155 T: He's got his knees in between yours

156 C: Don't know (.) um (.)

In each of these examples, the clients react as if the therapist has overstated their experience, in the first two examples in terms of the client's feelings and in the second with regard to the level of violence of the rape, with the client rejecting words with the connotation of force. This results in a negotiation of the words appropriate to the situation, and so the meaning of the experience. In the following two examples, the client uses low-key descriptors of thoughts and feelings:

Example AD386-8

386 C: and I, you know, that, that gives me a little reminder of you know what
387 happened, but apart from that I just, I say I just, try and get on with it and

388 T: Sure....

389 C: I just get a little bit nervous cos they come in on the lorry and you have to

390 pick them up on the crane

391 T: Um

Example AD246-8

246 T: How did you feel when you went out ?

247 C: (3.0) Uncomfortable

248 T: Um-hum

So the ways in which clients use and negotiate the language of their feelings enables them to construct their experience as less than traumatic. As seen from the above examples, in each case the therapist accepts these constructions and responds by not challenging them and so tacitly accepts the less affect-laden language. Use of understatement can, therefore, be regarded as a successful strategy by which clients move the therapeutic conversation away from an exploration of distressing feelings, thus constituting what is described here as an avoidant strategy.

2.2 Normalising discursive constructions

Normalising discursive constructions refer to particular constructions of events in which clients seek to position their behaviour or reaction to events as normal, thus avoiding an expression of the affect associated with construing their behaviour in terms of the pathological sequelae of traumatic events. Clients sought to normalise through any of three normalising constructions, those of "luck", "caution" and "being glad". Two examples of each of the first two constructions are given here. The third, "being glad" construction pertains to the transcript of HG (from which direct quotations from this transcript are not included due to issues of confidentiality - see Chapter 5).

In the construction of "caution", the client describes his slower and more tentative behaviour at work since his industrial accident as an appropriate and sensible precaution:

Example AD395-400

395 C: And when it gets to that part I'm like, OK, be <u>really</u> careful here and it's like
396 it's, it's I don't suppose it's a bad thing that I'm more careful now because the
397 way I was before, I was like, I suppose you'd say I was quite blasé about the
398 job I'm doing

399 T: Um

400 C: But after an accident I suppose it's the way you are, you're twice as careful

Example AD438-441

438 C: Well at work it's like, oh come on give us a lift with this and like come on,
439 you know, you're taking too long, get over here

440 T: Um

441 C: and it's like I'm being that little bit extra careful

In the above examples, the client positions himself as a safe and cautious worker since the accident, rather than as nervous or fearful. Similarly, in his lucky" construction, the client describes himself as "lucky" with regard to the accident he experienced. Using this "lucky" construction, the client positions himself as a person who has experienced extreme luck, rather than someone who has undergone a terrifying and traumatic ordeal. This construction is used when he is speaking of his close shave with death, as in the following two examples:

Example AD318-21

318 C: And it was, it was lucky that I was holding the steel frame that had mesh on
319 it, really otherwise I'd have, you know

320 T: That protected you from a lot of it

321 C: Yeah. Yeah, otherwise I don't think I would have been here, but

Example AD78-85

78 C: I enjoy the work I do,

79 T: Um

80 C: Otherwise I, I wouldn't still be there. It's, I mean, day to day you're reminded
81 of how lucky I was, working with the heavy weights that I am it's, so day to
82 day, I'm, like I'm, you know, just glad I'm here really. It's er, but it's er, some
83 days are better than others. It's, you do get days when you think why am I
84 here, cos, you know no-one seems to care what happened to you. It's like you
85 should be doing this easily and it's, it's not like that, it's, I dunno, I suppose
86 they don't really know what it's like,

The constructions of luck and caution each enable the client to construct realities in which he positions himself as both lucky with regard to the outcome of the traumatic incident and appropriately cautious with regard to his changed behaviour following the event. These constructions serve to normalise his behaviour and feelings following the traumatic event and so reduce the expression of affect associated with memories of it. While these two constructions were particular to one client, a second client HG also deployed a similar "glad" discursive construction in which negative events and feelings were construed positively, normalising distressing events and feelings and so serving the same function, namely that of reducing the expression of negative affect.

The validity of the claim that these normalising constructions serve an avoidant function can be tested by "validation through next turn". In each of these cases the therapist becomes engaged in the clients' positioning. This is illustrated in the following example of the therapist's response to the construction of luck, in which the therapist reinforces the client's normalising of his injuries and close brush with death:

Example AD320

320 T: That protected you from a lot of it

and in the following examples of the therapist's responses to the discourse of caution:

Example AD401

401 T: Sure, and there's nothing wrong with being careful of course

Example AD445-8

445 T: So it sounds like you're telling me look, obviously it's difficult for you being
446 at work because of what happened

447 C: Um

448 T: and one way you deal with it is just to be a bit careful now,

Example AD552-4

552 T: You're taking the precautions that you need

553 C: Um

554 T: to be able to cope with being there

The above examples demonstrate the effectiveness of these constructions in engaging the therapist in normalising the clients' experience. The therapists respond by reinforcing the constructions rather than pursuing any feelings of distress. The conversation is, therefore, diverted away from painful emotional material, and so this process provides support for the fact that the clients' normalising discursive constructions constitute an avoidant strategy.

However, there are some occasions on which the therapist does not respond by engaging in the construction and it is important to consider these deviant cases, which at first appear to disconfirm the claim. Consider the following two examples in which, in response to the client's introduction of the construction of luck, the therapist, rather than engaging in the discourse, instead focuses on painful thoughts and feelings:

Example AD777-81

777 C: Before the accident, no. When I, while I was in hospital and when I saw
778 myself I, I realised how lucky I was and I could have

779 T: There was, there was a point at which you realised

780 C: Yeah

781 T: your life had been in danger if you like

Example AD148-56

148 C: (3.2) I have, have feelings like I'm, I'm so lucky because when I went back to
149 work they they (laughs) they still had where I was crushed chalked on the
150 floor because they had, they had to have an investigation team

151 T: Um, [(inaudible)

152 C: [so when I walked in I came and I see on the floor, and it was like, and
153 when I see what fell on me as well, I was just amazed that I'm still here really,
154 it's just, um

155 T: What did you feel, physically, when you saw that, you know, chalk mark on
156 the floor?

In each of the above examples, the therapist focuses on the client's feelings or thoughts which may "lie behind" the normalising. So, in these cases, the discourses are not effective in engaging the therapist in a normalising of the experience and a moving away from expressions of affect. This initially appears to provide disconfirmatory evidence that the normalising constructions serve an avoidant function. However, the above two examples differ from the earlier examples in one main respect. There is evidence that, in these examples, "luck" is being used specifically as a euphemism for the way the client felt at particularly distressing points after the accident, namely when confronted with his mortality and his closeness to death. In the above examples, the client's descriptions of his realisation of how lucky he had been to survive the accident occur at the points at which he might be expected to be experiencing fear or distress. As it is used at these particular points in his account, it is possible that "luck" is used to describe a sense of distress at the realisation of his proximity to death. This results in the therapist attempting to reflect the painful feelings behind the euphemism, as illustrated in the following example:

Example AD163-7

163 T: So a mixture of feelings. Feeling relieved that, you know, you're here

164 C: That's right

165 T: But also, that horrible feeling "oh my god, I could have died"

166 C: Um (3.4) and what if I wasn't there I'd be my normal self and, you know, it's a
167 lot of things

In the other examples the client is using the normalising constructions in a more general manner at various points in the account, which may more easily engage the therapist, whereas in the above examples the client is referring to his feelings at particular points of realisation which may alert the therapist to the possibility that it is used as a euphemism, hence the reflection of affect.

Clients, therefore, use normalising constructions to avoid exploration of painful emotional material and are effective in engaging the therapist in these discursive practices until they use them more specifically, as a euphemism for painful feelings relating to specific events, in which case the therapist addresses the feelings behind the euphemism.

2.3 Paralinguistic devices

The third way in which clients seek to "lighten" their experience is by their use of laughter, overlapping speech and lowered voice utterances.

2.3.1 Use of laughter

Laughter is used at points of the expression of painful emotional material to reduce the expression of affect and so move away from a conversation about the painful emotions. Consider the following examples in which clients laugh when they are speaking of distressing past experiences.

Example RW54-9

54 C: He's (.)sort of like getting on the bed (.)sort of like mmm sort of getting over me

55 sort of

56 T: mmmm

57 C: (.) but again, again not threatening there' s no (.) there' s no threat

58 T: mmhmm

59 C: (.) It's bizarre (laughter) arr

Example HP653-5

653 C: so my girlfriends go up and down that road all the time. When they saw that,
654 they hadn't heard about the accident, they thought something had happened
655 (laughs) to my dad. It was just all a nightmare.

Example AD288-9

288 C: and my face was just a mess really, you know it's, it's, it wasn't me, it's, and
289 my mum said how much of a mess I looked (laughs) I looked and er,

Example AD774-5

774 T: Did you think that your life was in danger ?

775 C: (laughs) What, before the accident or

In each of the above examples, the laughter occurs at the specific points at which clients refer to difficult and distressing events associated with their traumatic experiences, including death, injury and abuse. It can be assumed, due to the nature of the events described, that the explanation for laughter at these points is not a result of the client finding amusement in the subject under discussion. This suggests that the laughter is a device by which clients seek to "lighten" the discussion and avoid exploration of "heavier" distressing feelings, albeit spontaneous rather than considered.

2.3.2 Overlapping speech

Overlapping speech is used to mask words related to the trauma. For example, clients

interrupt the therapist when the issue of death or life-threatening illness is raised:

Example HP838-42

838 T: Yes. So she may have found out quite late in the day. Um, how long before
839 she died did they make the diagnosis that [(inaudible)

840 C: [Well, they couldn't find the
841 diagnosis. She'd been for months and months. In the end they had to give her
842 a biopsy,

Example HP480-1

480 T: So you got the phone call did you, telling you [(inaudible)

481 C: [From my dad

In the above examples, the clients talk over the therapist as he or she begins to mention distressing events. This has two effects. Firstly, the therapists' words become inaudible, enabling the client to avoid hearing the words associated with death. Secondly the therapist stops talking while the client takes over the dialogue. The interruption, therefore, gives the control of the conversation back to the client, who can then proceed at his or her own pace and choice of language and agenda.

2.3.3 Lowered voiced utterances

Similarly, clients lower their voice (denoted by speech contained within °°) when referring to death or serious illness:

Example HP455-8

455 C: And I just feel that you know like you get phone calls about death or
456 whatever, um you hear on the telephone or something, °oh so and so's died

457 or whatever, I'm just always in the front, in the front line of everything
458 happening.

Example HP511-3

511 C: here, we've only just got to be with [name of GP], we changed and er, he'd
512 been gone, evidently he'd been going to the doctors saying °I've had these chest
513 pains really bad and um they were doing all the tests°

Example HP515-8

515 C: °said there's nothing wrong with him°

516 T: Um

517 C: °And then he had a heart attack. Everything (inaudible) he went there six
518 times°

In the above examples, the clients lower their voice when speaking of death and serious illness. Although they do not, in these instances, entirely avoid speaking of the painful material, they refer to it in such a way as to keep it "low key", a sort of "half saying", and so a way of avoiding expressing fully the memories and associated feelings of distress, through lack of emphasis.

However, it could be argued that lowering the voice in this way draws attention to what is being said, as in the commonly used dramatic device of lowering the voice to command an audience's attention. It is possible that clients are seeking to ensure the attention of the listener. However, if this were the case, it would be expected that clients would lower their voice at various points throughout the transcript and not only when speaking of death or illness. A more likely explanation is that the clients speak of these distressing incidents more quietly than normal in order to soften and so minimise their impact on the conversation.

So, although the devices of laughter, overlapping speech and lowered voice utterances may not always directly constitute complete avoidance of painful material, they may enable the client to "soften" or reduce the expression of affect associated with the traumatic experience and so enable the client to gain some control over the pace of the conversation and the direction of the agenda. The use of overlapping speech and lowered voice utterances is summarised in the following example in which the client uses both in combination in response to the therapist's introduction of the subject of self-harm:

Example NL419-24

419 T: So you didn't have a temper before, all you used to do was

420 C: [(coughs)

421 T: [Hurt yourself

422 C: (sniffs) °Cut°

423 T: Cut yourself

424 C: °Yeah°

The client effectively controls the pace of the conversation through a combination of interruption and lowered voice utterances.

3 Avoidant discursive practices used by therapists

So far, the discussion has centred on the strategies adopted by clients that result in an avoidance of an exploration of painful material. However, what is of particular interest is that there are numerous occasions on which it is the therapist who seeks to reduce the negative affect expressed. In fact, many of the avoidant discursive

practices identified pertained to the ways in which the therapist moves the conversation away from the clients' emotional material. These include negotiating the language of traumatic experience, changing the subject away from feelings, oblique reference to trauma and focusing on the positive, including solicitation of expressions of the effectiveness of therapy.

3.1 Negotiating the language of traumatic experience

There are occasions on which the therapist uses less powerful descriptions of feelings than those of the client, and the client reacts as if the therapist has understated his or her feelings. Consider the following examples:

Example HP557-9

557 C: Ahh, just all nerves, everything was just [everything

558 T: [Really jittery

559 C: Ahh, more than that

Example HP302-10

302 C: [I had
303 continuous heart-rate, a terrible heart-rate. Um, it felt like my body was going
304 all day long with heart. What is that, I don't know.

305 T: Erm yes (inaudible) like your heart was fluttering

306 C: Not fluttering, it was just moving too fast, you know like you've just done a
307 mad run

308 T: (inaudible) just pounding

309 C: All the time. Never calm down in the day. I was laying on the settee, please
310 try and relax. Relaxing's worse for it.

In the above examples, the clients respond with stronger descriptions of symptoms than those used by the therapist, substituting more graphic accounts for the therapists' words and so reacting as if the therapist has understated their experience. In this way, the level of affect expressed is regulated via the construction of the language and the descriptors used with regard to the client's experience.

One explanation for this process is that the therapist has genuinely underestimated the extent of the client's distress, rather than is seeking to minimise it. However, even if this is the case, it is clear that the therapist uses language that has lower impact than that of the client. It is, therefore, the therapist who is moving away from an expression of strong emotions, with the client responding with stronger descriptions of negative feelings and so this can be regarded as an avoidant strategy on the part of the therapist, albeit unwitting. However, this practice was observed only on these two occasions, with clients' understatement occurring more frequently. Therapists' avoidance tended to involve alternative discursive practices as follows:

3.2 Changing the subject away from feelings

Another way in which the therapist attempts to move the conversation away from the client's emotion is by changing the subject when the client expresses distress, as illustrated in the following examples:

Example RH17-23

17 C: Um he spoke to [name of Social Worker] when I was on the phone to her, erm
18 snatched the phone, pushed me off the bed, um and yeah I just had to call the
19 police cos he was going to kill me.

20 T: So this is [name of Social Worker] your social worker

21 C: Yeah, she is now, cos she wasn't before. She was just somebody that was, I

22 could talk to

23 T: Um

Example RH237-44

237 C: Um (5.7) these last few weeks have just been pure hell really

238 T: So are you saying the [client's name] of, of the past would have wanted to go
239 out, would want to do things, would want to socialise,

240 C: Um

241 T: be with people

242 C: Um

243 T: And now it's different

244 C: Um (5.7) yeah

Example RH263-6

263 C: [Um. (5.7) I don't know, [therapist's name], perhaps I'm just going mad
264 (inaudible)

265 T: Um, you mention there about feeling safe

266 C: Um

In each of the above examples, the therapist responds to expressions of the clients' distress by focusing on some other aspect of the situation and so moving away from

the distress, avoiding the clients' affect-laden material. The therapist's changing of the subject functions to enable him or her to avoid dealing with the client's distressing accounts and serves to reduce the affect expressed in the session. In terms of "validation through next turn", the fact that the clients respond monosyllabically, not actively engaging in the therapists' discourse, provides evidence for the fact that the clients' agenda has been moved away from. Clients may also respond to the therapists' change of subject by reasserting their distress, resulting in resuming control of the agenda, as in the following example:

Example RH37-42

37 C: Yeah and um he was going to prepared to do, to do life for me, which I have
38 heard before

39 T: Um

40 C: but he was, no I don't know whether he'd been drinking. What I know is that it
41 was awful, it was really awful and [Social Worker], well she just couldn't
42 believe what I have been subjected to. She's had first hand from my mum,

The responses of the clients to the therapists' change of subject provides support for the notion that the function of the therapists' discursive behaviour is to move away from the clients' affect-laden material.

However, there is one occasion on which the therapist changes the subject after having actively elicited an emotional response from the client. This would seem to contradict the claim that therapists are avoiding addressing the clients' emotion:

Example AD298-308

298 T: So you're saying that one of the things that's been most difficult for you is
299 actually that period in hospital where you saw the damage that had been

300 C: Um

301 T: done to your face and it felt well that's not me. it felt

302 C: Um

303 T: strange

304 C: Yeah

305 T: So can you tell me, I know you've described this probably a million times for
306 the insurance people and everything.

307 C: Um

308 T: Can you tell me what actually happened in the accident ?

The fact that the therapist has attempted to initiate an exploration of feelings about the client's facial injuries, suggests that she is not attempting to avoid expressions of affect and this is inconsistent with her moving away from subject subsequently. While this may seem an apparently deviant case, the fact that the client responds monosyllabically to the therapist's attempted exploration supports the notion that the therapist has introduced an area which the client is unwilling to explore and so the therapist's change of subject can be understood as a response to the client's lack of engagement. Evidence for this process is provided by the client's comments immediately prior to the above passage:

Example AD291-7

291 C: [No, that's right and er, I'm glad they didn't, cos they was
292 going to take photos for the, um, for the um insurance and

293 T: Yes, yes

294 C: And I'm glad they didn't in the end because, I think I would have been

295 tempted to look at them and I think that would have made it worse actually

296 T: Um

297 C: looking back at er what I looked like but

The client describes his desire at the time not to think about how his face looked after the accident, and this is consistent with his lack of elaboration about it when the therapist attempts to pursue his past injuries. The client is, therefore, avoiding exploring this area, and the therapist's change of subject may be seen as a sensitive reaction to this. This initially apparently deviant case can, therefore, be incorporated into a revised hypothesis that the therapist changes the subject to avoid affect *when it is the client who has introduced the emotional material.*

3.3 Oblique reference to trauma

A process was identified in which both the client and therapist engaged together in an avoidance of the traumatic material. Several occasions were identified in which clients and therapists refer obliquely to the trauma and the clients' traumatic memories, without mentioning them directly, hinting at underlying worries or concerns, as follows.

Example RH187-97

187 C: I could be anywhere I could now be anywhere and something will come back
188 to me

189 T: (9.1) And this is a memory that you haven't

190 C: Um, these are, these are things that I have remembered but then I remember
191 something that goes with it

192 T: Right

193 C: or it could be something new or, I know, I know it's not in my mind.

194 T: Um

195 C: um

196 T: (6.7) So it's like the memory comes back, or a more de', more detail of a
197 memory and then because of that coming back it's so distressing you start crying.

Example NL140-9

140 C: Well blotting, erm blotting everything out again, that's all I can make of it
141 anyway (sniffs)

142 T: So when you say blotting it all out again it's almost as if you're saying well
143 that's why I first started drinking six years ago

144 C: (sniffs) Yeah

145 T: To blot things out

146 C: Yeah

147 T: Right (3.6) So the the alcohol serves that purpose of blotting out

148 C: Yeah everything

149 T: Right

Example RH290-9

290 C: (3.5) I don't know, um (4.2). It was like having a friend there really I

291 suppose, it was a painkiller

292 T: Yes

293 C: Cos er it was oblivion I suppose, it's a way of er shutting everything off

294 T: Right

295 C: Which is what I was doing, shutting everything away

296 T: It's almost as if, today you're talking about

297 C: (Coughs)

298 T: Determined not to drink

299 C: Um

In the above examples clients refer obliquely to the trauma, through reference to difficult memories or to dysfunctional coping strategies to deal with them, without actually disclosing the content of the memories. Rather than explore the content of the memories, the therapist talks around the issue, addressing the fact of the memories and the dreams and the function of the drinking, rather than the content of the memories, themselves. In this way the actual content of the distressing memories is not addressed directly, with the focus on the surrounding issues rather than the trauma itself. The client and therapist appear to be engaged jointly in a dialogue in which a full exploration of the past trauma is avoided.

However, an alternative explanation is that it is the therapist who is being avoidant because it is the client who has introduced the traumatic material to the conversation, albeit obliquely, as illustrated in the following example in which the client introduces her worrying dreams:

Example NL30-8

30 C: (3.4) And I think I'm dreaming about everything that's worrying me

31 T: Right

32 C: I think

33 T: So everything that's on your mind that's worrying you

34 C: Yeah

35 T: You're dreaming about that

36 C: Yeah (sniffs) it's er

37 T: (6.9) Has the dreaming recently started or

38 C: Yeah

It is possible that the client is seeking permission to speak of the abuse, indeed hinting at the content of her dreams, while the therapist continues to refer obliquely to the trauma, rather than facilitate an exploration of it. As it is the client who has introduced the subject, albeit indirectly, it is the reaction of the therapist that shapes the subsequent dialogue, enabling the content of the trauma to be circumlocuted. The therapist chooses to pursue the symptoms of the trauma, rather than the traumatic material itself and so directs the conversation away from the emotional material. The notion that it is the therapist who is avoiding exploring the abuse is supported by examples in which the client directly introduces the content of the traumatic material:

Example RH138-53

138 C: There was an incident when we were abroad and um I was (3.2) I suppose I
139 was about seven and my father tied my hands together to the back of the bed

140 T: Yes

141 C: Um. I don't know whether that's got anything to do with it

142 T: Right

143 C: (3.7) But the more, the more things that are coming out the more I feel like
144 drinking

145 T: Yes

146 C: because it's er, um, pain, pain

147 T: So it's painful

148 C: Yeah

149 T: to have these

150 C: Um

151 T: traumatic [horrible

152 C: [um

153 T: memories

This supports the view that oblique reference to the abuse facilitates avoidance and that this avoidance is on the part of the therapist and not the client. This circumlocution on the part of the therapist is more marked when contrasted with examples in which the therapist encourages the client to explore the content of the abuse, as in the following example:

Example RW103-10

103 T: He he's more over you on the bed he's sort of

104 C: Yah, um over me but sort of back here because he' s (her voice lowers)undoing
105 my trousers

106 T: mmhmm

107 C: But I've go my top on (.) he doesn't do anything with that it's not lifted up or
108 taken off or anything it' s left on, it's just trousers and (.) ah (.) (lowers voice)(.)
109 knickers down and I've still got my shoes on (laughter)

110 T: So ca can you actually feel him doing this?

In the above example, the therapist prompts the client to continue describing the content of the traumatic memories, resulting in a detailed exploration of the episode of abuse. It is the client who then terminates the discussion:

Example RW187-90

187 T: He said that? (.) Is that what he said to you, it won't hurt?

188 C: This is not going to hurt, this won't hurt (.) Whoo (laughs)

189 T: Are you alright?

190 C: (.) Can we stop there for a minute

So when the therapist encourages the client to speak directly of the content of the abuse, moving away from oblique referencing, it is the client who regulates the expression of affect by eventually seeking a break from describing the memories. Focusing directly on abuse leads the client to express affect, whereas oblique reference to abuse prevents this. This supports the claim that oblique reference to

trauma is a way in which therapists seek to avoid affect, as the extent of the clients' exploration of the trauma can be influenced by the response of the therapist.

Furthermore, in terms of "validation through next turn", there is some evidence to suggest that, where therapists have referred only obliquely to the trauma, clients react as if the therapist has discouraged them from exploring it. Consider the following responses to the therapists' oblique reference to the past trauma:

Example RH156-64

156 T: (7.4) So, how do you think you're going to be able to deal with these horrible
157 memories

158 C: Don't know

159 T: °Right°

160 C: I don't know, [therapist's name] (3.7) I can't just say to myself oh it was in
161 the past, it was years ago, um and forget about it because I can't do that which
162 is what some people have said, but then others have said well no you can't
163 forget it

164 T: Um

Example RH321-5

321 T: and now you're saying, but why did it happen

322 C: Yeah

323 T: °Yes°

324 C: And I don't see how anybody can forget things like that. Perhaps they can,

In each case, the clients respond as if the therapist has attempted to minimise the pain of their distressing memories and their associated negative thoughts and emotions by suggesting that they forget the past trauma. This provides further support that the therapist is avoidant with regard to addressing the trauma, as the clients appear to be inviting the therapist to allow them to explore it by introducing the subject, albeit tentatively and indirectly, and speak as if they experience the therapists' response as not enabling them to do so.

So, the oblique references to the abuse serve to enable an avoidance of an exploration of the content of the trauma, resulting in circumlocution of the traumatic material and so an avoidance of the associated expressions of affect. This process was observed only in relation to those clients who had experienced childhood sexual abuse, and so may be a discursive strategy particular to therapy sessions with survivors of abuse, rather than to clients with PTSD in general.

3.4 Focusing on the positive

Therapists frequently respond to their clients' expression of negative affect by focusing on the positive aspects of the client's situation or by construing the clients' distressing accounts in positive terms, thus moving away from the clients' agenda and avoiding the expression of negative affect in the session. Consider the therapist's response to the assertion that " *it has been horrendous*" *(485)*:

Example RH497-504

497 T: (7.5) But it almost sounds a (inaudible) it almost sounds as if you now
498 experience life [without alcohol

499 C: [Um hum

500 T: and thinking back to what you were saying earlier on you're determined not to
501 drink, it's almost as if you started

502 C: Um

503 T: along the path as it were

504 C: Um

and a description of a panic attack experienced on a train home from work:

Example HP285-91

285 C: and I did, erm all the journeys and on Friday night, the tenth journey home
286 last week, I had a panic attack (laughs).

287 T: OK and was that something that went on for a long time, like the, the earlier
288 panic attacks you described or was that shorter ?

289 C: Oh, they're shorter, and they've, as I say, they, they've, once a week maybe,
290 not three a day

291 T: OK so that's quite a lot [better

In response to the clients' expressions of distress, the therapist chooses to focus on positive aspects of the situation, rather than explore the distressing feelings themselves. In this way, the therapists' positive focus serves to move the discourse away from the client's pain and onto less affect-laden areas, enabling the therapist to pursue his or her own agenda rather than stay with that of the client.

3.4.1 Therapist's solicitation of expression of effectiveness of therapy

A specific way in which the therapist seeks to focus on the positive aspects of the client's situation is by soliciting positive expressions from the client with regard to his or her progress, as in the following examples:

Example NL333-42

333 T: (12.6) So you were saying to my question about what has created this change
334 in you, you said coming here and talking about the issues presumably

335 C: Yeah

336 T: and er also attending the group as well

337 C: Yeah (11.0) the support's helped me

338 T: Right

339 C: (6.5) because when I'm drinking now, I don't drink to the extent of what I did
340 before

341 T: Right

342 C: apart from that day, I smashed the bedroom

Example HP318-23

318 C: When I'm trying to relax and it's going so fast I'm like this, all the time, trying
319 to slow down, cos they gave me that Diazepam, for a little while

320 T: Um. Did that help ?

321 C: Yeah, but then I started panicking through them. They did when I was really
322 desperate because I'd never had any tablets before, um, that first one was like
323 heaven because it made me actually have, er, you know, lay down and sleep

It would appear that the therapist is seeking positive strokes for his effectiveness, moving away from the client's agenda to his own, thus avoiding the clients'

expressions of distress. It could be argued that the therapist is simply reflecting what the client has said and seeking clarification, rather than attempting to avoid emotional material. However, the reaction of the clients, namely reiterating their distress, suggests that the therapist has moved away from their agenda. Furthermore, one occasion was identified in which the client reacted as if a particular response to the positive focus was expected:

Example NL443-51

443 T: So you started to come here and you started reducing the number of times you
444 harmed yourself

445 C: Yeah

446 T: (8.9) So what does that tell you

447 C: (5.0) finding myself, I don't know, what do you mean ?

448 T: No no, so you you're saying that you're finding yourself

449 C: Yeah

450 T: °Um-hum°

451 C: Though, sometimes it's, erm, when I drink, I'm not myself

The client's reaction to the therapist's question provides support for the notion that the function of the therapist's utterance is to seek a specific response of progress, as this is the way in which the client appears to understand it. After replying tentatively, the client goes on to remind him of her current drinking behaviour. In this way she resists a positive admission of the helpfulness of the therapy, while reasserting her ongoing distress, and so regains control of the agenda

The therapists' positive focus can, therefore, be regarded as an avoidant strategy on

the part of the therapist in that an attempt is made to move the conversation to a more optimistic and upbeat tone. Furthermore, the therapist's solicitations of expression of progress function to elicit "strokes" from the client with regard to their professional effectiveness, and so serve to move away from the client's needs in order to address those of the therapist, again avoiding expressions of negative affect.

An alternative explanation is that the positive focus, rather than being an avoidant strategy is, in fact, a function of the therapists' more solution focused approach to work with the client, and so may reflect the particular orientation of the therapist rather than an attempt to avoid painful material. However, the notion that focusing in this way serves the function of moving away from the clients' agenda and thus constitutes an avoidant strategy is evident from the variety of responses that this discursive practice elicits from the clients. These responses will be discussed here.

4 Clients' responses to therapists' avoidant strategies

Clients respond to this re-focusing in either of two ways, namely disengaging or reasserting negative affect. Each of these responses will be dealt with in turn and used to provide support for the claim that therapists avoid clients' negative affect.

4.1 Clients' "disengaging" response to therapists' positive focus

One way in which clients respond to therapists' positive focus is to answer briefly and monosyllabically, as illustrated by the following examples:

Example RH370-80

370 C: It's a bit sad, really, that I should be having to go through this at thirty-two
371 and I've nothing else better to think about

372 T: Um, and I'm just thinking back to our session today and it's almost as if the
373 emotions and feelings that were there are now coming to the fore and you are
374 now thinking about them, if you like, in detail

375 C: Um

376 T: for the first time

377 C: Yeah, um

378 T: and so that's why I'm questioning what you're saying about it's really pathetic
379 isn't it, because maybe for the first time (4.6) feelings are coming out

380 C: Um

Example HP429-37

429 T: Well, we can certainly talk some more about the physical symptoms you get
430 when you get panic attacks.

431 C: Yeah

432 T: and the good news is that there are things we can do to help you, get you
433 know, reduce those panic attacks or, or you know, actually get rid of them

434 C: Yeah

435 T: and I'd certainly be prepared to explain to you what's going on, work through
436 those things.

437 C: Yeah

Example NL307-16

307 C: Only critical comments (sniffs) to try to put me, you know (9.2) but I go

308 against that

309 T: Right

310 C: For my own benefit

311 T: So it almost sounds as if you're now thinking about your needs

312 C: Yeah

313 T: And perhaps in the past you haven't

314 C: °Um°

315 T: thought about them.

316 C: (sniffs)

The clients, in effect, resist an engagement with the therapists' up-beat agenda by responding monosyllabically and not taking up the optimistic discourse. In this way monosyllables such as "um" or "yeah", although implying agreement, when used in succession, function as "disengagers", enabling the client to avoid entering into the therapist's agenda. This may, therefore, reflect a passive going along with the therapist by the client rather than an active agreement and provides support for the notion that the clients' agenda has been moved away from and so is being avoided by the therapist.

However, the passive nature of this response enables the therapist to control the conversation, moving away from the clients' expression of distress and pursuing his or her own agenda. The impact on the therapy of this process is that an exploration of negative emotions is effectively curtailed. So, one way in which the therapist's positive focus impacts on the therapy is that it results in the client deploying monosyllabic "disengagers" which, while allowing the client to disengage from the therapists' discourse, also effectively enable the therapist to control the agenda and to

move away from the client's expression of affect. So the clients' responses to the therapists' positive focus provide support for the notion that the process of introducing an optimistic discourse serves an avoidant function on the part of the therapist.

4.2 Clients' reassertion of affect in response to therapists' positive focus

The second of the two responses to the therapist's positive focus involves a reassertion by the client of his or her distress and enables the client to return to his or her own agenda. Clients initially report agreement with the therapist, as in the above examples, but then, unlike the above examples, revert to an exploration of their pain and distress. This enables the clients to regain control of the agenda and to continue exploring their distress. Consider the following examples, the first of which follows the therapist's solicitation of progress from the client, from example *NL307-16* above:

Example NL328-32

328 C: (7.3) and I'm only going to waste if I don't do something

329 T: You said that in a very determined way

330 C: °Yeah°. (6.9) but I still cannot cannot pack anything,

331 T: No

332 C: Silly thing like that, you know (4.8) (sniffs) (sighs)

Example HP291-6

291 T: OK so that's quite a lot [better

292 C: [Oh yeah I know it's, I know I'm much better. I mean I
293 was completely, everybody just couldn't look at me I was so ill looking, and I
294 went down to under eight stone

295 T: So you've lost weight

296 C: Couldn't eat over Christmas. Food, having a bath caused me panic.

Example RH505-9

505 T: and as you said earlier on that you're not going to drink

506 C: Um

507 T: What do you think that's about

508 C: (9.0) I don't know (9.7) °don't know° (9.4) it's just been sheer torture really
509 and I can't see a light at the end of the tunnel at the moment

In the above examples, the clients respond to the therapists' focus on the positive aspects of their situation by actively reasserting the extent of their distress, countering or indeed balancing the therapists' positivity with an account of their negative emotions. The client reacts as if the therapist is minimising his or her distress. This is a frequently observed pattern in the transcripts and suggests that the therapist is positively reframing the experience of the client and so reducing the expression of negative emotions in the session. This can result in a conversational "tussle" between the client and the therapist in which each attempts to frame the situation in their own terms, with the therapist focusing on the positive aspects of the client's situation and the client re-emphasising the negative aspects and his or her ongoing distress. This "discursive wrestling" is neatly illustrated in the following example:

Example NL356-64

356 C: No. I didn't self harm

357 T: Right

358 C: But I threw away all my stuff, all my possessions (inaudible) another form of
359 hurt I suppose

360 T: but is it, it's different isn't it because it's not damaging your body

361 C: Um, no

362 T: (4.1) And it was just <u>your</u> possessions was it

363 C: Yep

364 T: That you threw about, yes

However, one occasion was found in which the client responded to the therapist's positive reframing by elaborating her positive feelings:

<u>Example RH570-3</u>

570 C: Um. Oh yes, and I <u>will</u> do it, I will get there

571 T: You sound really determined

572 C: Oh I am now, yeah, but I have got to get stronger um, but I will get there (4.2)
573 because I actually think now I will be good

Although this apparently deviant case initially appears to run counter to the pattern of responses described, it differs from the earlier examples in respect of the client's initial statement of the future. In the above example, the statement which the therapist reflects as "determined" can, in fact, be regarded as a positive statement, which is in contrast to the more negative statements in the other examples. Therefore, the therapist's positive construal of the client's statement in example RH570-3 is consistent with her construal of events and so does not lead to a re-assertion of her distress. The therapist's reflection of her optimistic statement results in positive

engagement from the client.

So, while the above example initially appears to challenge the claim that clients respond to therapists' positive focusing by not engaging with the positive discourse, it differs in respect of the therapist reflecting a positive statement from the client rather than framing statements of clients' distress in positive ways. So, although this example initially appears to contradict the claim, it can be considered as providing support for the pattern of responding.

In summary, the clients' responses support the hypothesis that, when therapists attempt to reframe clients' negative feelings by focusing on the positive aspects of the situation, the client does not engage in the positive discourse and either responds monosyllabically, resulting in a curtailing of an exploration of his or her distress, or else reasserts his or her distress, enabling the negative discourse to continue. Indeed in some cases they might do both, as illustrated in the following example:

Example RH171-83

171 T: I say that because you you you had a period of er of drinking over a few years

172 and then you stopped drinking

173 C: Um

174 T: over two and a half years ago

175 C: Um

176 T: And now you're saying you're determined that not to drink again

177 C: Um

178 T: But what's happening is that all these memories are coming to the fore

179 C: Um

180 T: again and I'm just wondering how

181 C: How I'm dealing with it

182 T: Yeah

183 C: Not very well because all I do, really is I sit there and cr', all I do is cry

The above example neatly summarises the way in which the two strategies can be combined, with the client deploying the disengager, "Um", until the therapist provides her with an opportunity to reassert her negative emotions. In this way, the clients' responses to the therapists' positive focus provide support for it's function, that is to move away from the clients' distressing or negative agenda, thus attempting to avoid an exploration of affect.

5 The mediating factor in avoidance of the therapeutic setting.

The way in which clients and therapists negotiate the agenda in order to avoid affect differs as a function of their disparate roles within the therapeutic dyad. This is most in evidence in the way in which disagreement is managed in the session.

5.1 The management of disagreement

It is notable that in none of the above examples do the clients directly disagree with the therapist's positive construction of events. Rather they either respond passively or seek to balance them with an alternative negative construction, without actually stating that they do not agree with what the therapist has said. Each of these responses operates as a more "acceptable" alternative to directly disagreeing with or confronting the therapist. When disagreement does occur, clients seek to "correct" or assuage their contradiction in order to restore equilibrium. This may be a way in which the client is able to regain control of the agenda without directly challenging the therapist and so without "breaking the rules" of the therapy session, reflecting the

power imbalance inherent in the roles. Consider the following examples in which the clients' disagreement with the therapist is immediately followed by a correction of the disagreement :

Example RH79-87

79 T: and um at the moment you're in a flat that you don't feel safe in

80 C: No. It's not that I don't feel safe in it, it's um (4.3) I suppose just being on your
81 own having all this, I'm still looking over my shoulder

82 T: Yes

83 C: I know that he can't go in there

84 T: Yes

85 C: Um

86 T: Yes

87 C: but I think wherever I'm going to be I'm going to be anxious

Example RH252-4

252 T: And er, and and perhaps maybe coming here is in a way is quite exhausting

253 C: No because I feel safe here, I do, I do feel safe here, um I haven't done in the
254 last few, few meetings, but you weren't there then, um

In the above examples, the clients mollify their initial disagreement with the therapist. In the first case the client softens the disagreement by distinguishing between the *knowledge* that she is safe and the *feeling* of safety, providing a way in which she is

simultaneously able to agree with the therapist. in this case in terms of the latter definition of feelings of safety. In the second example, the client's initial disagreement is softened with a suggestion that the therapist is right with regard to some occasions of therapy. Furthermore, this enables her to attribute any negative effects of therapy to other facilitators and not to the current therapist, thus preserving the equilibrium of the therapeutic relationship. So, having broken the rules of therapy, clients seek to restore equilibrium by turning their disagreement into agreement, and behave as if they have deviated from the expected response by correcting the disagreement with an alleviating follow-up response.

However, two instances were identified in which clients' disagreement with therapists' interpretations do not conform to this pattern of correction following disagreement. Each of these deviant cases will be dealt with in turn. In the first example, the therapist refers to the client's understanding of the onset of her symptoms:

Example HP390-6

390 T: It was a week afterwards, what makes you say ah-ha it must have been to do
391 with the bike um accident

392 C: Well I don't

393 T: But, you know, when I, when I asked you this you said well [this

394 C: [Cos everybody told
395 me

396 T: Oh, OK then,

Unlike the cases discussed above, there is no immediate attempt to soften the initial disagreement. However. the client follows this by continuing to explain:

Example HP397-401

397 C: Everyone told me that was it, the doctors, everybody was droning on about it,
398 no it's not.

399 T: Um, but you're saying now it is or not sure,

400 C: Well, I said to [GP's name] I hold my hands up after all the tests had come
401 back, you win I said to him, you know

So the client goes on to accept reluctantly the doctors' diagnosis and, in this way, eventually corrects her initial disagreement with the therapist, thus restoring equilibrium. This case, therefore, conforms to the pattern. However, the second deviant case appears to contradict the hypothesis:

Example HP442-6

442 T: I'm just wondering, can you say a bit about the thoughts that you had when
443 this accident happened, when this, crash happened [outside your house

444 C: [Well, I don't think it was, I
445 mean I was so brave with my mum, because she was like, she went like a bit
446 like a child, you know

There is no obvious attempt to correct the disagreement as in all the other cases, and so explanation needs to be sought from the individual contingencies of the case. The client does, in fact, go on to qualify her disagreement, following it with the words, "I mean" and going on to justify and explain her position, thus softening the disagreement to some extent. Furthermore, a lengthy discussion of her mother's illness ensues (448-505), moving the conversation away from the direct area of disagreement, thus avoiding confrontation over this issue, and so effectively "softening" any disagreement. Interestingly, later, the client implies she now agrees that the death of the "boy" in the accident affected her emotionally:

Example HP943-5

943 C: Well, I mean I can see it now because erm, I didn't think that had affected me
944 cos I didn't know that boy erm and I thought with my personality I can't
945 believe that would affect me

and:

Example HP958-60

958 C: I remember when I was really really bad there maybe was it because I was
959 panicking and I didn't want to stay in the house, but it was definitely after that
960 boy died

So eventually, the client reaches convergence with the therapist's view, thus restoring equilibrium, and so fitting the pattern of the way in which clients deal with disagreement. The fact that a longer time elapses before correction may be particular to this client. Nevertheless, agreement is ultimately achieved and so this initially apparently deviant case can in fact be regarded as supporting the notion that disagreement with the therapist is avoided or corrected.

Therefore, the management of disagreement clearly illustrates the way in which avoidance is mediated through the roles and power imbalances within the therapeutic dyad. Clients and therapists use different strategies in order to control the agenda, and the ways in which avoidance is achieved is a function of role expectations. The operation of this process highlights the power imbalance implicit in the therapy session, in which the participants function according to the social expectations inherent within the therapeutic discourse. Avoidance of expression of negative affect in the session is, therefore, mediated by the context of the therapy session in terms of its social expectations and, in particular, the power imbalance inherent between the client and therapist.

6 Summary of findings

In summary, a range of processes between client and therapist, which serve to reduce or avoid the expression of affect during therapy, has been presented. The ways in which each of these function within the therapeutic conversations has been outlined and, in each case, an argument made that their deployment serves to enable either or both of the dyad to reduce or avoid expressions of strong negative affect in the session. Three important findings emerge from the analysis.

Firstly, both clients and therapists seek to avoid expressions of emotion in the session. Discursive practices used by clients include understatement, normalising discursive constructions and the paralinguistic devices of laughter, overlapping speech and lowered voice utterances. Therapists deploy different avoidant discursive strategies from clients. These include negotiating the language of the traumatic experience, changing the subject away from feelings, oblique reference to sexual abuse and focusing on the positive aspects of the clients' experience, including the solicitation of expressions of the effectiveness of therapy.

Secondly, the discursive practices used by clients and therapists are a function of the different roles of each within the therapeutic context. The "tussle" between clients and therapists to control the agenda, including the ways in which clients respond to therapists' avoidance, has been used to demonstrate this process.

Thirdly, the ways in which avoidance is achieved are mediated by the power imbalances associated with the therapeutic context. This has been illustrated in particular by the way disagreement between the client and therapist is managed, and will be explored further in Chapter 7.

Chapter 7: Discussion

1 Introduction

The findings indicate that both clients and therapists engage in avoidant discursive practices within therapy for PTSD, and that the nature of these practices is a function of the different roles adopted by each of the participants within the dyad. Each of these areas will be discussed with a focus on possible explanations for avoidant discursive behaviours and on the implications for therapeutic practice. A case will be made that the avoidant discursive behaviours in clients and therapists are associated with fear of being overwhelmed by emotional material. Furthermore, it will be argued that the disparate avoidant behaviours between client and therapist are a function of roles adopted by the participants that reflect the overarching therapy discourse and the power dynamics inherent within it. The interactive nature of avoidance will be explored, with a focus on implications for future research in the area. Methodological concerns will be addressed, including the interaction of the person of the researcher on the research process. Finally, conclusions will be drawn and consideration given to future directions for research and implications for practitioners working within the field of trauma.

2 The avoidant discursive practices of clients

Clients adopted strategies that resulted in a moving away from negative affect in the therapy session, through three main discursive practices: understatement, normalising discursive constructions, and paralinguistic devices.

Consistent with the discourse analytic method used, the analysis focused on the ways in which avoidance was achieved in therapy, rather than on any supposed underlying motivations of the participants. It is nevertheless useful and appropriate at this stage, however, to consider the possible explanations for the behaviours observed.

2.1 Social expectation

One possible explanation for the observed tendency of clients to move away from emotional material is that clients were responding to the social expectation that it is inappropriate to discuss intimate feelings or experiences with a stranger. Two transcripts were from clients' first sessions and it is possible that new clients may have been reluctant to speak about intimate or deep feelings because of these social demands. However, avoidant discursive practices were found across transcripts, including the remaining four transcripts that were taken from later sessions. Most of the clients in the study, therefore, had some experience of the therapeutic situation and so would be expected to be familiar with the expectation of speaking of personal issues in this context. While it is possible that social expectations account for reluctance to explore negative emotional material at the initial stages of therapy, it is unlikely that this is the case for those who have attended therapy for longer. In any case, most people are aware that therapy involves speaking about feelings even if only through media depictions of the therapist stereotype or from accounts from friends, regardless of any personal experience of therapy. Social expectation is not, therefore, a plausible explanation for the avoidant discursive practices observed, which were found across transcripts.

2.2 Fear of being overwhelmed by affect

A second possible reason for the discursive practices observed is that clients are afraid of being overwhelmed by strong negative affect. This is consistent with the well-documented findings regarding avoidance in clients with PTSD. For example, Horowitz' (1976) Information Processing Model of response to trauma proposes that the trauma remains in active memory, but is kept from conscious awareness by the defences of denial and emotional numbing. These mechanisms serve to prevent the individual from being overwhelmed by the memory. However, intrusive, re-experiencing phenomena such as flashbacks and nightmares are repeated as part of an attempt to process and integrate the traumatic memories. The individual, therefore, oscillates between periods of intrusive thoughts and avoidance, the "hallmarks" of PTSD. In Horowitz' model, therefore, avoidance is seen as a control process aimed at

regulating overwhelming affect. This provides a possible explanation for the avoidant discursive strategies observed in the study, *"clients will often resist the therapist's attempts to touch the emotional core of their conflicts, although they long for this contact as well"* (Teyber, 1992, p91).

2.3 Feelings of vulnerability

More particularly, the normalising discursive constructions identified suggest that some practices used by clients may function to distance them from a sense of vulnerability. For example, the discursive construction of luck can be regarded as a defence against a realisation of the client's own mortality, an acceptance of the ultimate vulnerability. The discursive construction of caution provides an alternative construction to the notion that the client is behaving in a more tentative and less confident manner than before the accident. Substitutions of words such as "uneasy" in place of "terrified" reframe the experience as less threatening and the clients as less vulnerable. This is consistent with the findings regarding increased feelings of vulnerability in those suffering from PTSD as "c*onfrontations with violence challenge one's most basic assumptions about the self as invulnerable and intrinsically worthy, and about the world as orderly and just"* (Reiker and Carmen, 1986 p367). It is, therefore, understandable that people who have experienced trauma may take great pains to distance themselves from the feelings of vulnerability that such adverse experiences can engender, and so provides a plausible explanation for the avoidant discursive practices observed in clients.

Furthermore, feelings of vulnerability may be compounded by the tendency of traumatised clients to view these feelings as global and enduring. Horowitz and Epstein (1991) posit that, in many people with PTSD, trauma-related conceptions of themselves and the world come to dominate their everyday existence, and they may believe that they are weak, helpless or unworthy. This is because they may generalise from the experience of the trauma to the totality of existence, rather than view the traumatic event merely as one terrible incident that has occurred at a particular place at a particular time (Epstein, 1991: Janoff-Bulman, 1992). This therefore enhances the perceived need for such clients to disclaim feelings of vulnerability, as they perceive them as global and enduring. This may be tantamount to an admission, for

example, that "I am a weak person and a coward and will always be so". They may not understand their feelings in terms of a specific and transitory experience from which recovery is possible, in other words regarding their anxiety as a trait rather than a state. The tendency of clients in the present study to reconstruct negative feelings or symptoms as normal and functional is consistent with the view that feelings are regarded as global and enduring characteristics and so pose a threat to a positive and healthy self concept. In order to maintain a positive self-identity, clients seek to distance themselves from feelings of vulnerability and emphasise positive aspects of themselves and events, construing them in more normalising and positive ways. The body of literature associating feelings of pervasive, global and enduring vulnerability with PTSD provide a further plausible explanation for the avoidant behaviours observed in the current study, in that certain discursive practices may be functioning to move the conversation away from an exploration of vulnerability.

2.4 Implications for effective therapy

However, whatever the explanation for the avoidant practices observed, it is important that practitioners are aware of them, as they may obstruct progress in therapy. In therapy for PTSD, it is important to help people to begin to address and so accept the feelings of personal vulnerability that the trauma has engendered. The key element of therapy for people with PTSD is the integration of the alien, unacceptable, terrifying and incomprehensible into their self-concepts. Most models of PTSD regard an exploration of the distressing feelings associated with the trauma to be crucial to effective therapy. For example, Foa and Kozak's (1986) fear network theory posits that activation of the fear network is a prerequisite for the extinction of phobic fear. For this to occur, the client, at the very least, needs to be able to maintain a conversation about the emotional impact of the traumatic event.

Thus an important part of therapy is to help clients to understand their feelings of vulnerability within the context of PTSD, to help them to view distressing and negative emotions as the temporary result of the traumatic experience and, therefore, amenable to change. Life events initially experienced as alien and imposed from outside upon passive victims, must come to be personalised as integrated aspects of the individuals' history and life experiences (van der Kolk and Ducey, 1989). If

clients can understand their symptoms as temporary and amenable to change, rather than construe their vulnerability as global and enduring, then they may be more prepared to address these feelings in therapy and this may pave the way for a positive outcome.

The current study highlights that avoidance of emotion does occur in therapy for PTSD and, whatever reason is put forward for this process, it needs to be addressed in order for effective therapy to proceed. The therapist needs to be sensitive to any feelings of vulnerability in clients and to allow them time to begin to trust him or her before expecting them to expose these feelings. All too often we hear clients described as resistant or avoidant without any apparent sensitivity to these issues, and therapists should be respectfully aware of this behaviour and sensitive to it, rather than dismissing clients as resistant.

2.5 Discursive practices particular to presentations of childhood sexual abuse

A further point of interest with respect to the discursive practices used by clients is that certain practices were found to be particular to those clients who had experienced sexual abuse as children. The discursive practice of oblique reference to trauma was particular to therapeutic conversations with clients who had experienced childhood sexual abuse and there was no evidence that therapists referred obliquely to traumatic experiences other than sexual abuse. This suggests a particular dynamic between therapists working with clients with histories of sexual abuse. The nature of the traumatic event experienced may influence the discursive practices used within therapy and therapeutic conversations around childhood abuse may differ qualitatively from those around other trauma.

One possible explanation for oblique reference to trauma being associated only with childhood sexual abuse is that there are certain symptoms and characteristics in presentations of childhood abuse that are distinct from those of traumatised clients who have not experienced sexual abuse. These symptoms are not acknowledged within the DSM-IV criteria for PTSD. The long-term consequences of childhood abuse are very different from those of a natural disaster or other circumscribed trauma in adult life (Herman, 1992). Victims of childhood abuse are more likely to have

amnesias of the trauma and a range of dissociative symptoms (Saxe, van der Kolk, Berkowitz, Chinman, Hall, Lieberg and Schwartz, 1993). Other distinguishing features of childhood abuse include low self-esteem and a sense of shame, guilt and responsibility for what happened. As has been discussed, one important aspect of PTSD is that experiencing a traumatic event challenges basic assumptions about the self and the world, in terms of no longer seeing oneself as invulnerable and worthy and the world as a safe and just place (Reiker and Carmen, 1986). The assumption in this statement is that, prior to the traumatic event, the individual regarded him or herself as invulnerable and the world as a safe place. This may be true of those with secure and loving family backgrounds who have experienced a singular traumatic event in adult life. However, this is unlikely to be true of survivors of repeated childhood trauma, who have learned that the world is unsafe and unjust. Traumatic experiences are not only processed by means of currently existing mental schemas, they may also activate latent self-concepts and views of relationships that were formed earlier in life (Van der Kolk, 1996). This is particularly relevant for people with prior histories of trauma, as earlier self-schemata may be activated. The notion of "learned helplessness" (Seligman, 1974) which refers to the learned state produced by exposure to noxious, unpleasant situations in which there is no possibility of escape or avoidance (Reber, 1985) can be readily applied to the presentation of symptoms of survivors of childhood abuse. It is possible, therefore, that survivors of repeated childhood sexual abuse may differ qualitatively from those with unproblematic childhoods who have experienced an isolated traumatic event as an adult, resulting in the different discursive practices observed in this client group.

Furthermore, the suggestion that a certain symptom presentation is particular to those with sexually abusive backgrounds calls for different and distinct therapeutic strategies from those presenting with other types of trauma. It highlights the importance of not treating trauma survivors as one generic group, when in fact the nature of the trauma experienced may be one of many factors differentiating the symptoms and particular presentations of individuals. This calls for a separate diagnostic category to accommodate the particular presentation and symptoms resulting from childhood sexual abuse and to separate these from the symptoms of other adult traumatic experiences. Further research might address the ways in which these two client groups differ in order to consider appropriate strategies for building

the relationship and providing effective therapies.

3 The avoidant discursive practices of therapists

So, a case has been made that the avoidant behaviours observed in clients can be accounted for in terms of clients' fear of being overwhelmed by affect or a sense of vulnerability, and that this is consistent with existing theory of PTSD. However, one of the most surprising findings from the present study is that it is not only the clients who avoid addressing affect-laden material, but also the therapists.

Therapists frequently engage in the clients' avoidant discourses and serve to maintain and reinforce them. Furthermore, the therapist initiates much of the avoidance during sessions. Therapists use a range of discursive strategies to move away from their clients' emotional material, including focusing on the positive, changing the subject away from feelings and referring indirectly to the traumatic experience. This finding is an interesting addition to the models of avoidance in PTSD, which are inevitably one-sided, taking into account only the behaviour of the client within the therapeutic dyad.

One of the roles of therapists is to enable their clients to address their pain and encourage them to explore the sources of their distress. As Teyber (1992) observes, while there are many ways in which therapists can respond to clients, for example information seeking, clarifying or relating the clients' material to other issues the client has mentioned, as a general guideline, *"the most productive response is to respond to the feeling that the client is currently experiencing ... the therapist's first priority is to acknowledge and approach the affective component of the client's response."* (p91). As discussed earlier with regard to clients' avoidance, most models of PTSD recognise that it is important for the client to speak about feelings in order to begin to address the trauma and to so reduce symptoms (see for example Foa and Kozak, 1986). It is initially counterintuitive, therefore, to consider that therapists may be responsible for facilitating avoidance of emotional material. Therapists' capacity to help clients change is in direct relation to how the therapist responds to their emotions (Teyber, 1992) and the reaction of the therapists in the study appears to run counter to

this understanding.

3.1 Formulation and assessment

One possible explanation for the observed discursive behaviour is that therapists are avoiding emotional explorations in order to establish certain facts, including being clear about the ways in which the person is suffering, in order to compile a formulation of the problem. This is likely to be the case in an initial session and, it could be argued that, it may not be appropriate to begin to address the client's feelings in any depth at the assessment stage. However, avoidant discursive behaviours were observed across all transcripts and not just in the two that were from initial sessions. Furthermore, it could be argued that, even in the case of initial sessions, a comprehensive formulation must involve an investigation of the person's feelings and thoughts as well as their behaviour and symptoms. Indeed, establishing safety is an integral part of the assessment process and this requires a thorough assessment of PTSD in which the client must describe traumatic memories, feelings and symptoms which are often accompanied by strong emotional reactions (Newman, Kaloupek and Keane, 1996). Some exploration of feelings would, therefore, be expected even in initial sessions, and so the exigencies of formulation and assessment do not provide a compelling explanation for the avoidant practices observed in therapists.

3.2 Fear of being overwhelmed by the clients' traumatic material

A further explanation for this behaviour is that it is the result of a fear on the part of the therapist that the client's distress is too overwhelming for them to bear. This is consistent with the wave of denial towards the end of the nineteenth century with regard to sexual abuse, when trauma symptoms were regarded as the result of children's sexual fantasies (Brown, 1961). Trauma-related thoughts and feelings bring back the intolerable affects that patients so carefully avoid which may prove to be almost unbearable for therapists as well (Turner, McFarlane and Van der Kolk, 1996). Hearing clients' traumatic experiences may be shocking and lead to lasting alterations in assumptions and expectations, which in turn impact therapists' feelings and relationships (Barlow, 1993). Therapists' reactions to clients' traumatic material can be understood as comprising three main factors, namely vicarious traumatisation,

countertransference and compassion fatigue (Leo, 1999). each of which will be discussed in turn.

3.2.1 Vicarious traumatisation

While empathic engagement with trauma survivors is necessary for effective psychotherapeutic intervention, such engagement also makes therapists vulnerable to the detrimental effects of vicarious trauma, with consequent negative effects on individual counsellor effectiveness and organisational dynamics in the workplace (Leo, 1999). Therapists have to cope with the challenge of being constantly confronted with the horrendous experiences that can befall people, and with the sense of disintegration and despair that these experiences can bring. This is summarised eloquently by Turner, McFarlane and Van der Kolk (1996) who state that:

"Working with people who have been traumatised confronts therapists as well as patients with intense emotional experiences; it forces them to explore the darkest corners of the mind and to face the entire spectrum of human glory and degradation. Sooner or later, those experiences have the potential to overwhelm therapists. The repeated exposure to their own vulnerability becomes too intense, the display of the infinite human capacity for cruelty too unbearable, the enactment of the trauma within the therapeutic relationship too terrifying" (p552).

The notion of vicarious traumatisation, therefore, provides a persuasive explanation for the observed tendency of therapists within the study to avoid directly addressing the clients' pain and attempting to move the conversation away from the traumatic material.

3.2.2 Countertransference

Similarly, therapists' avoidance may be understood in terms of countertransference, the therapist's emotional involvement in the therapeutic interaction (Reber, 1985). While the term is taken from the psychodynamic literature, it is becoming increasingly used within a range of approaches to counselling and the transference-countertransference relationship is now considered within the integrative paradigm (Woolfe and Dryden, 1996).

The pressure of working with traumatised clients may be heightened by the fact that clients with traumatic histories frequently idealise their therapists, because of a need to replace the sources of security that were destroyed by the trauma (Turner. McFarlane and Van der Kolk, 1996). Intense feelings of helplessness, rage, rescue or sadness may be evoked in therapists by traumatised clients and can leave therapists feeling powerless and incompetent. The therapist is in a helping role in relation to the client and so there is some expectancy from both parties in the dyad that the therapist will be able to help and to alleviate the client's pain. The therapist assumes responsibility for the client's feelings, *"therapists tend to avoid their clients' feelings because they do not want to hurt them or make them feel bad"* (Teyber, 1992, p113). This sense of responsibility places an additional pressure upon the therapist. Being frequently confronted by the intensity of the clients' distress is a reminder to the therapist that she/he has not been effective in alleviating the pain, which may result in the therapist feeling deskilled and so threaten her/his view of her/himself as effective. Turner, McFarlane and van der Kolk (1996) warn therapists working with traumatised clients to beware of their own needs to be comforted by their patients. Indeed, the current study found evidence of therapists attempting to solicit positive admissions of progress from clients and reassurance of the effectiveness of the therapy. If a positive admission is received, the therapist may feel more comfortable, however, a negative response from the client regarding progress in therapy may increase the therapist's feelings of inefficacy, helplessness and powerlessness. As Teyber (1992) observes, *"therapists must also be aware that their biggest obstacle to providing clients with a relationship that can produce change will be their own discomfort with certain client feelings"* (1992, p119). Issues of countertransference, therefore, provide a plausible explanation for the avoidant discursive practices observed.

Interestingly, the behaviour of the therapists initially involved in Part 1 of the study is consistent with these avoidant reactions to traumatic material observed in Part 2. The Part 1 quantitative design required therapists to administer before and after therapy questionnaires to clients with PTSD. As outlined earlier in the report. therapists cited their discomfort with researching clients in distress as one reason for failing to provide data that they had initially agreed to gather. Gathering data for research from clients may be seen to conflict with the tasks of therapy, and may be seen as intrusive and a barrier to the therapeutic relationship (Barker et al. 1996). While this argument

suggests a reluctance to research a range of client presenting problems. it may be even more the case for those with traumatic histories in view of the strong feelings of helplessness and the need to rescue the client, often evoked in therapists by this client group.

Secondly, due to the "before and after" nature of the study, some therapists may have felt that their therapeutic competence and effectiveness with clients was being measured. This may have resulted in them finding the study threatening in terms of the perception of their professional, therapeutic effectiveness if their clients' symptoms were seen not to improve significantly. Barker et al (1996) suggest that research may produce findings that lead to a painful re-examination of one's ideas and challenge one's assumptions and ways of working. This is consistent with the notion that therapists may feel a threat to their efficacy as therapists and a threat to their professional identity, perhaps fearing that the outcome of therapy may not be as positive as they would hope and perhaps fearing the judgement of their peers. It would be interesting to compare the extent to which therapists engaged in similar studies with a different client group.

3.2.3 Compassion fatigue

Furthermore, therapists may feel less compassionate towards those expressing negativity than those expressing positivity. In a recent study, Capps and Bonnano (2000) found readers presented with the narratives of recently bereaved people to report feeling more frustrated and more inclined to avoid and less inclined to comfort individuals who more often expressed negatively valenced thoughts and emotions and diminished agency. It is conceivable that this process was present in the current study as it would account for the observation that therapists focus on the positive aspects of the situation and invite clients to express positivity.

3.3 Implications for effective therapy

If it is the case that the avoidant behaviours observed in therapists are the result of their own feelings that make working with clients with PTSD difficult, it is essential that therapists take steps to buffer themselves against any negative effects of clients' emotional material. Working with trauma survivors impacts on the whole person and

the effects pervade many areas of the therapist's life, and not just the therapeutic relationship. In an exploration of the narratives of trauma counsellors regarding their struggle with secondary traumatic stress, Arvay (1999) identified seven main themes. including struggling with changing beliefs, therapeutic relationship, social support and power issues. Due to the serious effects of secondary traumatisation on the counsellor, client and organisation, prevention and management of this phenomenon must be taken seriously by all concerned (Leo, 1999). McCann and Pearlman (1990b) make several recommendations for the effective buffering of therapists from the effects of secondary traumatic stress. These include the use of one's professional network for support, avoiding isolation, talking to others in the field who can recognise vicarious traumatisation, balancing victim and non-victim cases, engaging in other professional and personal activities, recognising one's own limitations, working for social change, and focusing on the positive personal impact of this work and ways in which it can enrich one's life.

Whatever the explanation for the discursive behaviours identified, it is vital that therapists are aware of these processes when they occur, as therapy will inevitably be less effective and therapists less useful to their clients if they cannot tolerate the emotions expressed or are unable, for whatever reason, to hear their clients' pain. Avoidant reactions to clients' material will be mediated by the therapists' own issues and the way in which they regard themselves, *"therapists' own personalities, needs, and current life situations will often keep them from responding to the strong emotions that clients present"* (Teyber, 1992, p90). Therapists' own reactions to their clients are the biggest obstacles to responding effectively to their clients' emotions and, as Teyber (1992) observes, *"If therapists are not prepared to work with their own emotional reactions to the feelings that clients present, ... they will tend to avoid or intellectually explain their clients' feelings"* (p111).

It is, therefore, vital that therapists work at developing greater self-awareness of their own material that may impact upon the therapeutic encounter, as recommended by professional guidelines for therapists (see for example, BPS guidelines 2001-2002). Indeed, this is one of the main reasons for the inclusion of the requirement of personal therapy in most counselling and counselling psychology training. It enables the therapist to develop awareness of his or her own issues and personal ways of

interacting which may come into play within the therapeutic process (Legg, 1999). Guidano and Liotti (1983) found that the therapist's own self-awareness is enhanced as he or she attends to the emotions accompanying his or her perceptions of the client. The process occurring between the therapist and the client needs to be continually addressed. The requirement in most therapy disciplines for trainees to undergo their own personal therapy has hitherto been largely one of unsubstantiated belief in its necessity, and the supposed benefit to clients of therapists undergoing their own therapy has not been subject to empirical test. The current findings go some way towards providing a more scientific rationale for requiring therapists to increase their self-awareness and to address their own feelings in relation to clients' material as it demonstrates the impact of therapists' avoidance within the therapeutic process.

3.3.1 Implications for the training and supervision of therapists

So whatever the underlying motivation of the participants with regard to moving the conversation away from emotional material, it is important that therapists develop insight into the way in which their discursive behaviour influences the course of therapy. As highlighted by the present study, many of the interpersonal dynamics in therapy are not immediately obvious to either party. It is only through detailed analysis of the transcripts that the reactions of the therapist and the client to each other can be fully elucidated and explored. This suggests a useful way forward in the training of therapists. Close analysis of transcribed material will enable therapists to gain further insight and self-awareness of the ways in which their reactions impact upon those of the client. This is partly addressed within Counselling Psychology training with the use of process reports to illuminate the interpersonal processes occurring within a brief sample of a transcribed session. However such reports tend to focus more on the demonstration of the competence with which the therapeutic approach is used, and less on the deeper processes, such as avoidance that may occur. Such a detailed analysis may lend itself more to exploration within clinical supervision, in which the supervisor is in a position more suited to highlighting the blind spots of the therapist and so enhancing the effectiveness of their practice in order to benefit clients. Indeed, Capps and Bonnano (2000) emphasise the importance of the potential of others' evaluations of narrative to illuminate relevant interpersonal dynamics. It is important that difficulties in working with certain clients are not merely dismissed as the result of transference, which implies that the problem lies

solely with the client. Indeed, Shlien (1984) argues that "*transference is a fiction invented and maintained by the therapist to protect himself (sic) from the consequences of his own behaviour*" (p153). Whether one agrees with this view, it is clearly the case that therapists need to take responsibility for what occurs within the dyad, and not attribute difficulties solely to the client, however tempting this may seem in terms of relieving the feelings of inadequacy frequently evoked in therapists working in this field.

The findings from the current research are important as they offer a plausible demonstration of the ways in which the therapist's feelings regarding the client's traumatic experience may be played out in the therapy. It reveals the impact of this behaviour on the therapy session itself, and so ultimately on the well-being of the client. Hitherto, such effects were only supposed or else noticed in cases of extreme therapist traumatisation or unprofessionalism, for example when therapists are considered too unwell or too stressed to work. The importance of these findings is that avoidance in therapy applies to "well" therapists and not just to therapists who are aware of experiencing the effects of burnout or acknowledge vicarious traumatisation. Therapists who are functioning well are also subject to the influence of clients' painful material in powerful, albeit subtle, ways which may affect the engagement of the client with the therapy and with the painful material and so the outcome of the therapy.

Qualitative research into the lived experience of counsellors working in the field of trauma is largely absent from the literature (Arvay, 1999). The current study can be regarded as a useful addition to this poorly researched area in terms of highlighting the actual discursive practices that construct avoidance in the therapy session, and so provides empirical evidence of therapists' avoidance. The current study, therefore, highlights an exciting way forward for enhancing the effectiveness of therapy. The extent to which the therapist is able to stay with the client's emotional pain, for whatever reason, may differentiate an effective from an ineffective therapist. This may illuminate one factor in the failure of some clients to engage in therapy in any meaningful way, never overcoming their avoidance and so not improving in terms of their symptoms.

4 Client and therapist roles within the therapy discourse

A further important finding is that clients and therapists use different avoidant discursive practices from each other and that these practices reflect the disparate roles of each participant within the dyad.

4.1 Agenda regulators and mode regulators

Therapists' discursive practices largely relate to the control of the agenda in that they determine *what* is discussed. Four of the five therapist practices generated function to control the agenda, namely changing the subject, positive focus, solicitation of effectiveness of therapy and oblique reference to abuse. As has been seen, through these discursive behaviours, the therapist actively changes the agenda by imposing new material on the conversation or by asking direct questions about another area, or alternatively avoids the client's agenda by circumlocution of the topic introduced. In this way the therapist dictates the content of the conversation in terms of what is spoken about. The only exception to this is the practice of therapists negotiating the language of trauma. However, as the practice of negotiating the language constituted only two examples, the overwhelming majority of therapists' avoidance can be regarded as controlling the agenda. Therapists' discursive practices can, therefore, largely be termed *agenda regulators*.

In contrast, clients' discursive practices, on the other hand, relate to *the way* in which emotional material is spoken about. The practices of understatement, normalising and the use of paralinguistic devices enable clients to choose the way in which the trauma is discussed by either understating it, normalising it, minimising it or enabling it to be spoken of quietly, or with certain words not heard or spoken at all. In this way, the discursive practices used by clients are all concerned with the ways in which the emotional material is expressed. Client practices can, therefore, be regarded as *mode regulators* in that they are concerned with *how* the traumatic material is expressed.

The division of strategies in this way indicates that clients and therapists achieve different things through their avoidant practices which, in turn, illuminates the different roles adopted by the participants in the dyad. The therapists' role enables

them to determine the agenda and take control over what is discussed. The clients, on the other hand, operate within the therapists' agenda, taking control only over the ways in which they speak about their experience rather than over the agenda or the direction of the conversation itself.

Interestingly, however, the findings demonstrate that clients do, in fact, influence the agenda through other means, namely through the use of reassertion of affect in response to the therapists' avoidance. Clients were found to initially report agreement with the therapist's positive focus but then revert to an exploration of their pain and distress, enabling them to regain control of the agenda and to continue exploring their distress. However, the use of this particular, more passive, strategy for gaining control of the agenda, as opposed to the more active practices used by the therapists for the same purpose, demonstrates that the participants are positioning themselves in a more subordinate role and therapists in a more dominant role. These findings are consistent with Tracey and Miars (1986) who found therapists to have high levels of control over what was discussed during sessions, and clients to achieve control in more submissive ways. In this way, participants are operating within the overarching discourse of "therapy", conforming to perceived roles and expectations of "the client" and "the therapist" respectively.

This overarching "therapy" discourse is further illuminated by the management of disagreement in the session, the observed tendency of clients to avoid direct confrontation or challenge of the therapist, ultimately expressing convergence with the therapists' view. The way in which clients manage disagreement with the therapist, therefore, reflects the subordinate role of the client within the dyad. This is consistent with the view that clients may find the positioning of themselves within a therapy discourse as disempowering (Harper, 1995), which may account for the more passive and subordinate discursive behaviour observed.

4.2 Overarching discourses and power dynamics

So, the current study illuminates the specific discursive practices that both reflect and construct the power dynamics within the therapeutic relationship, demonstrating that therapy can never be entirely free of context, operating as it does within certain

predefined parameters, in this case within the "therapy" discourse. However, much of the literature assumes that it is the therapist who holds the power within the therapeutic dyad. For example, traditional approaches to therapy, such as the psychoanalytic tradition, have been criticised for infantilising the patient, and that. far from helping clients to overcome infantile problems, the analyst resubmerges them in an infantile relationship in which it is the analyst who emerges as all-powerful (Spinelli, 1994). Masson (1988) does not draw a distinction between this inevitable use of power and its abuse, advocating the abolition of therapy on the grounds that an unequal power relationship is, in and of itself, abusive and that *"the therapeutic relationship is inherently power-imbalanced in favour of the therapist and to the detriment of clients"* (Spinelli, 1994, p117).

As a result of such criticisms, more recent therapeutic traditions have attempted to address the power imbalance within the therapeutic relationship. The social philosophy or politics implicit in the humanistic paradigm has influenced adherents of this approach to work to reduce the status and power differences existing between client and helper (McLeod, 1996). Counselling Psychology approaches concern themselves with emphasising equality and respect within the counselling relationship (BPS, 2001). However, these accounts tend to be optimistic regarding the extent to which equality can be achieved within this context. It is naive to suggest that therapists can create an environment that is totally free of context. The words of Bob Dylan quoted by Spinelli (1994) to illustrate freedom of choice are particularly pertinent to the issue of freedom of context: *"Are birds free from the chains of the sky?"* (Dylan, 1964).

Also, throughout the debate on power, an assumption is made that the power imbalance always favours the therapist. However, it is important to recognise that clients too hold power that they can misuse or abuse within the same relationship,

"Just as therapists may exert their power by setting the time, duration and cost of sessions, or may attempt to impose unwanted and destructive viewpoints or interpretations on their clients, so too may clients seek to deviate from the agreed-on frame, or withhold payments, or simply not show up to sessions, or not return to therapy without providing notice, or heap undeserved verbal or even physical abuse

on the therapist" (Spinelli, 1994, p122)

The current study goes beyond these power behaviours on the part of the client by demonstrating how the client's discursive practices within the session enable them to subtly take control of the way in which the trauma is spoken about. They achieve this either by use of certain discursive practices or else by disengaging with the therapist's agenda or by reasserting their distress. Clients' tendency not to overtly disagree or confront therapists on areas of contention suggests that they are operating within a perceived power imbalance weighted in favour of the therapist. The fact that they do sometimes achieve control of the agenda, albeit through passive means, and effectively regulate the expressed affect in the session suggests that they are able to gain power within and despite the overarching expectations of the therapy session and despite their positioning in a less powerful role in relation to the therapist, while at the same time adapting to the demand characteristics of the session.

As Spinelli (1994) suggests, all relationships are unequal in power, indeed "relationship *is* power in flux" (p121), and the imbalance of power is neither necessarily good nor bad, merely unavoidable. Discursive practices, therefore, can be explored at different levels, namely at the level of the utterances and what they achieve and at the level of the overarching discourses which address the relationship of the protagonists in the dialogue. Widdicombe and Wooffitt (1990) refer to these two levels of discursive psychology respectively as that which offers a fine grain analysis of the action orientation of talk, and as that involving investigations concerned with the imbrication of discourse, power and subjectification. The current analysis has focused largely on the former approach, that of a fine grain analysis of the utterances, however it is not possible to divorce these utterances from the context of the therapeutic relationship and what is being achieved by the discursive practices within this context. One is dependent upon the other and a division between the two approaches is opposed in favour of a synthesis of the two approaches, consistent with the view of Wetherell (1998).

4.3 Implications for effective therapy

The discourses of clients and therapists cannot be divorced from the context of therapy, therefore, and both the therapist and the researcher need to acknowledge that

they are engaged in a discourse in which certain boundaries are assumed. They must recognise that the therapy session is a particular piece of social interaction, which is an overriding discourse in itself, with its inherent boundaries, time-limitations, "scripts" and power imbalances. "*Discourses are embedded in power relations and, therefore, have political effects...representations of people can serve to support power inequalities between them, while passing off such inequalities as fair or somehow natural*" (Burr, 1995, p64). Future research might attempt to replicate the current findings for clients with PTSD, particularly with regard to the different discursive practices generated. Consideration may be given in future research to the extent to which the functions of *agenda regulation* and *mode regulation* proposed here can be generated in other transcripts of PTSD therapy and, if so, whether they are specific to therapy for PTSD or are relevant to therapy for a range of presenting problems.

In their attempt to reduce inequality as far as possible, it is vital that therapists do not lose sight of the fact that power imbalances will necessarily exist, regardless of their attempt to promote collaboration and self-efficacy of clients. Biaggio (1996) clearly illustrates this point in her account of the way in which her own therapy helped her understand how she was influenced by the therapy experience, and how this, in turn, led to her shaping her professional views about the therapist's power and responsibility with regard to the client. She asserts that it is important at the training stage to instil in students an understanding of the power they have over clients and the incredible burden of responsibility that their professional role carries with it. The current study highlights the ways in which therapists use their power, albeit unwittingly, within the therapeutic relationship and provides a useful lesson to those in training, who may otherwise believe that it is only deliberately abusive therapists who need to be aware of power issues.

As Parker (1992) suggests, greater awareness of these overarching power discourses may be achieved by exploring which categories of person gain and lose from the employment of the discourse and by looking at who would want to promote and who would want to dissolve the discourse. In the present study, the therapists' solicitation of an admission of positive progress from the client and reassurance of the usefulness of therapy serves the need of the therapist rather than that of the client and so it is the

therapist who serves to benefit from the discourse.

5 Towards a "dyad-orientated" discourse of therapy

Although the discussion has been organised around the discursive practices of clients as distinct from those of therapists, avoidance in therapy can be largely considered an interactive process between client and therapist, with both participants co-constructing the discourse of trauma. In particular, such interactive processes identified include a tendency for the client to reiterate distress in reaction to therapists' avoidance, and for the therapist to react to the clients' introduction of sexual abuse by circumlocution of the issue and addressing it indirectly.

Viewing avoidance in this way contrasts with the view taken in most quantitative research on PTSD, including Part 1 of the current study, in which there is the tacit assumption that the client acts autonomously, and that the therapist is merely an impartial observer. This is an old-fashioned view of therapy, based upon the traditional medical model of treatment. Collaboration between the client and counsellor is a hallmark of current approaches to Counselling Psychology. (Bor, Legg and Scher, 1996). The counsellor is no longer considered as the "expert" and the counsellor's experience and knowledge is no longer privileged over the validity of the client's experience and knowledge. Indeed, as Turner et al (1996) suggest, therapy is an intensely intimate process. The word "process" is important here. It implies that therapy is not something done to the client by the therapist, but is a collaborative interaction between both parties in the dyad. While psychodynamic approaches to counselling in particular stress the importance of attending to transference and countertransference issues, more integrative approaches to counselling now recognise the importance of the interaction between client and therapist (Woolfe and Dryden, 1996). It may be the case that particular therapist-client dyads together are more avoidant than others, with each responding in avoidant ways to the other. Turner et al (1996) point out that what occurs between a patient and a therapist is a function not only of the particular diagnosis of the patient but also of the unique and personal relationship between patient and therapist. Although they state that these factors cannot be easily quantified, nor subjected to scientific study, the current study has

attempted to subject these processes to study and so illuminate the ways in which avoidance is achieved.

Moreover, the process between therapist and client mirrors the understanding in qualitative research of the process between researcher and researched. Qualitative research takes account of the fact that the researcher is not an invisible nor impartial observer, but instead is instrumental in creating the realities he or she is investigating, inevitably shaping the object of inquiry (Henwood and Pidgeon, 1992). The current study reveals the importance of the interactions between client and therapist and shows how avoidant discourses can be co-constructed between the therapist and client. Considering avoidance in this way is a move away from regarding avoidance as an entity which is the result of certain personality traits of the client, and a move towards considering avoidance as a process occurring through the medium of the interaction between the client and the therapist. Avoidant discursive practices were found across all the transcripts, that is across all clients and therapists studied, and suggests that avoidance is not a function of any particular coping style or personality trait, but rather is situational and an important constituent within the therapeutic dyad. It then makes more sense to regard avoidance as an unstable and social process and therapists need to be educated to deal with the avoidance as it occurs in the here and now, within the social context and to address it accordingly, exploring the particular function it is serving at a particular time. The apparent complexity of avoidance in terms of its interactional nature within the dyad renders it elusive to quantitative methods of analysis alone, which may oversimplify the issue. Further qualitative research would be a more appropriate way forward in the exploration of avoidant processes in therapy, and help move away from the traditional "client-orientated" discourse of therapy to an emerging discourse of a "dyad-orientated" therapy.

The discussion thus far has focused on the avoidance of the client and therapist, demonstrating how avoidance is an interactive process that cannot be divorced from the overarching framework of the therapeutic session, with its inherent expectations, roles and power differentials. Similarly, in a parallel process, the writing of this report and the interpretations made must be understood within the overarching framework of the research activity and the person of the researcher. I turn now to consider these methodological issues.

6 Methodological concerns

Chapter 5 demonstrated the measures taken to enhance the validity and reliability of claims, in terms of the methods of transcription and analysis used. This section will assess the findings in terms of their trustworthiness, transferability and fruitfulness, and provide a reflexive account of the researcher's part in the process. In each case an attempt will be made to ensure the transparency of the process of assessing the findings against these criteria.

6.1 Transferability

6.1.1 Transferability to other therapeutic dyads

As an alternative to "generalisation", qualitative research relies on "transferability" of findings, the application of findings in contexts similar to the context in which they were first derived (Lincoln and Guba, 1985). Therefore, in the present study, the avoidant strategies identified might be expected to occur in other transcripts from clients receiving therapy for PTSD. Replication of the study in similar settings would be required in order to assess the extent to which the discursive practices generated are consistent with those for other therapeutic dyads.

Some discursive practices occurred more frequently in some transcripts than others. The practice of oblique reference to trauma being specific to sexual abuse transcripts has been discussed, however most behaviours generated were not common to all transcripts. This may be partly due to the difference in length in transcripts, with smaller transcripts offering less opportunity for observation of patterns. However, the purpose of the analysis was not to achieve consistency across transcripts but rather to generate a range of avoidant discursive practices that may play a role in therapy for PTSD.

The patterns identified in the current analysis can be considered in terms of the extent to which they are social practices that are *possible* in similar settings as, in the analysis of dialogue, it is the possibilities of language use that are the central objects

of generalisability (Perakyla, 1997). While the results cannot be said to be generalisable as descriptions of what other counsellors or other professionals do with their clients, they can be regarded as generalisable as descriptions of what any counsellor or other professional with his or her clients *can* do, given that he or she has the same array of interactional competencies as the participants under study have (Perakyla, 1997). As possibilities, the processes identified in the six transcripts in the current study can be said to be generalisable to other therapeutic conversations and to other therapist and client dyads.

6.1.2 Discursive practices and PTSD

It is not possible to know whether the avoidant discourses generated are particular to clients with PTSD or whether they might be found in transcripts of clients who present with other psychological problems, or indeed in a non-clinical sample. It could be the case that such avoidance is a critical factor in all mental health problems. Avoidant discourses might be found in the transcripts of a variety of clients with a variety of presenting problems and not just in those with PTSD. In order to assess how far the discourses found are particular to clients with PTSD, similar studies would need to be undertaken with samples of other clinical populations and with non-clinical samples. However, the current study is concerned only with social behaviour within the therapy session. Analysis of the discourses of a non-clinical population who are not receiving therapy, does not tell us anything about therapeutic discourses. The study can only be seen as lacking validity if it is purporting to measure something which it is not. In this case the study does not suggest that avoidance is only to be found in this particular client group to the exclusion of all others. Instead it is concerned with the question of how avoidant discourses are used within the transcripts analysed. However, an interesting area of research might be to assess the importance of avoidance in PTSD by comparing the discourses identified here with those from clients with mental health problems other than PTSD. This would determine the extent to which the avoidant discourses can be applied across different presenting problems, or whether different diagnoses might generate different presentations of avoidance. It might be the case that certain discursive practices are more prevalent or receive greater emphasis for some presenting problems than others. For example, as has been discussed, the discursive practice of oblique reference to trauma is in evidence only in the transcripts of those who had experienced childhood

sexual abuse rather than individuals suffering from PTSD as a result of other adult trauma. It might be the case that certain discourses are particular to certain client presenting problems. However, unlike most other presenting problems, avoidance is a part of the diagnostic make-up of PTSD, and it was this fact that prompted the current study. An exploration of avoidance in other presenting problems, therefore, may be less relevant.

In any case, if therapists are aware of the range of discursive practices used and the ways in which they function to achieve avoidance, then they can consider strategies to address them. They can be on their guard with regard to their own need to collude, rescue, victimise or whatever particular response is provoked when working with traumatised clients, thus enabling them to achieve greater effectiveness by attending to the processes at work within the therapy session.

6.1.3 Diagnostic categories

Another issue regarding the transferability of findings relates to the diagnostic category of PTSD. DSM-IV categories can be regarded as constructs that are useful in order to help professionals working with people with psychological difficulties. The issue of diagnostic categorisation, itself, is of interest to discourse analysts in that categories cannot be assumed to represent disorders in an objective fashion, but rather are constructed and accomplished within psychiatric discourse (Harper, 1995). The criteria listed for inclusion or exclusion of a category can, in many cases, be regarded as arbitrary and subject to revision as knowledge of the disorder increases or with social and political changes. Clients do not always fit neatly into the currently used category and may sometimes span several. While the introduction in 1980 of PTSD as a diagnostic category is welcome in that it has generated more research in the area, scientific categorisation tends to regard people's problems as discrete psychological disorders, divorced from context and largely independent of the person or their particular history (van der Kolk and McFarlane, 1996). As has been seen, this has been illustrated regarding the particular presentations of those traumatised by childhood abuse and how they may differ from those with non-abusive traumatic experiences. The decision in the current study to use a DSM-IV diagnosis of PTSD as an inclusion criterion was one of convenience. What is of interest is the experience of clients in general who have been traumatised. It might be more valid, therefore, to

broaden future studies to consider all clients who have been traumatised, rather than only those conforming to the current DSM criteria for PTSD. This is consistent with the notion that validity should be regarded as a process of checking. questioning and theorising, and not an attempt to achieve correspondence between the research findings and the "real" world, but rather choosing among competing and falsifiable explanations (Kvale, 1989) as in the current study.

6.2 Trustworthiness

6.2.1 Discursive practices

A similar criticism concerning trustworthiness may be made with regard to the discursive practices generated within the transcripts. Qualitative research is frequently criticised for its lack of objectivity, and the tendency for researchers to "see faces in the fire". While many qualitative research methods attempt to address this perceived shortcoming by deploying independent judges to validate categories or coding generated, this criticism is particularly pertinent to discourse analytic methods in which independent judges are not normally used. As suggested by Miles and Huberman (1994), it is difficult to avoid seeing what you expect to see without using careful procedures. In the current study, an attempt was made to employ careful procedures, outlined in the Method Section, and to be transparent with regard to the way in which each discourse was generated. The rationale and justification for each has been clearly argued, with several examples of each to illustrate the practice proposed. Furthermore, the research supervisor served as an independent judge in order to validate the findings. An attempt has also been made to adhere to Miles and Huberman's (1994) seven criteria for considering external reliability in qualitative research. These include providing a clear, detailed and explicit description of the procedures used, the collection, processing and condensing of the data and the explicit linking of conclusions with examples from the data.

While reliability can be increased by seeking to construct a negotiated joint reality with participants (Westkott, 1983) it was considered neither practicable nor ethical to discuss the generated meanings with participants. Firstly, in some of the cases, archive data was used and so the respondents are not available. In the cases of those clients who provided data concurrently, they may have now completed their therapy.

There are ethical reasons for not re-approaching these clients once therapy has ended. Observations regarding their process need to be carefully timed and sensitively delivered with the sole reason of facilitating the progress of therapy. To confront individuals with a number of researcher observations which have not been fully addressed with the client in therapy may be seen as counter-therapeutic and even, in some cases, harmful or unethical. A further obstacle with regard to negotiating meaning with the participants is that this negotiation of meaning would take place within a relationship of power and so is not a free and democratic process, and therefore, it could be argued, not a valid nor reliable one.

6.3 Fruitfulness

Qualitative research can be judged in terms of its fruitfulness, "the scope of an analytic scheme to make sense of new kinds of discourse and to generate novel explanations" (Potter and Wetherell, 1987, p171) and by its ability to create fresh solutions to problems. The current study has provided important observations regarding the ways in which avoidance is constructed within therapy for PTSD, particularly with regard to the avoidant discursive practices of therapists and has proposed new notions of *agenda regulation* and *mode regulation* in the discursive behaviours of therapists and clients respectively. The implications for practitioners of these findings and directions for future research have been discussed.

6.4 Reflexivity

Qualitative research acknowledges the ways in which research activity inevitably shapes and constitutes the object of inquiry. The researcher and researched are characterised as interdependent in the social process of research (Hammersley and Atkinson, 1983). In this way, qualitative research challenges the dualistic distinction between knower and known, leading to the realisation that the personal is always present in research (Polanyi, 1958; Stanley and Wise, 1983).

The notion of reflexivity is particularly important in this study as the idea that researcher and researched are interdependent is analogous to the notion of therapist and client being interdependent. In both cases there is a move away from the notion

that clients may have certain characteristics that predispose them to behaving in a certain way. Any such characteristics must be seen in the context of the interaction of the dyad and also within the overarching framework of the therapy session with the expectations and power dynamics that this implies. Therefore, there is a parallel process between the undertaking of this research and working with a client in therapy. Just as there is an interactive process between the therapist's and the client's responses, so in my analysis of the texts, I used what I had learned from one text to analyse another. Through this process, I reshaped my conceptualisation of events, approaching each stage of the process within a different frame of mind, with evolving attitudes and understandings as my knowledge base expanded. These understandings are likely to be influenced by my role as a practitioner and my role as a scientist, and I shall address each of these in turn.

6.4.1 The practitioner

As a counselling psychologist, myself, working with clients with PTSD it would be naive to assume that I can divorce myself from thinking as I would as a practitioner, to become merely the "objective" observer and describer of social processes. I already possess a preconceived model of PTSD and how symptoms are triggered and maintained, operating within a discourse of mental health and more specifically, a cognitive discourse of diagnosis and therapy.

Two of the six transcripts were from my own work with clients. It is possible that the way in which I interpreted and described the two transcripts from my own counselling work differed from the transcripts supplied by other therapists. As the therapist working with two of the clients in the study, my knowledge of the clients in a context outside of the immediate transcript will have influenced my understanding of their utterances as I had preconceived ideas about these clients in advance of analysing the transcripts. This is likely to have influenced my understanding of the internal world of the clients that may have impacted on my conceptualisation of the social processes occurring in the session. It is also likely that I have blind spots in relation to my work with these two clients, and that I may have found it easier to notice avoidant processes at work with the other therapists in the study rather than my own. A different researcher is likely to have proposed alternative processes that lie beyond my field of vision.

While I learned a considerable amount about my own practice in terms of the ways in which I contributed to avoidance of the clients' emotional material, I felt somewhat constrained from discussing the work of the other therapists in the same terms. While it felt acceptable to describe my own responses to clients' material as avoidant, to highlight similar processes in the other therapists in the study felt as if I was being critical of others' practice. Avoidance was common to all transcripts. This suggests that it is a normal part of the therapeutic encounter and does not imply bad practice, and so no criticism of any therapist's work should be inferred.

In these ways, the findings from the analysis are likely to be influenced by my identity as a therapist and, more specifically, as one of the therapists in the study. This may have affected consistency with regard to my understanding of each of the transcripts and with regard to the way in which I described and expressed my observations and interpretations.

6.4.2 The scientist

It is not only the analysis of the transcripts which must be regarded as a reflexive process, but also the way in which the analysis is reported and described. The language, expressions and indeed discourses I choose to use in conveying my points are influenced by my own understandings, personal attitudes, biases and knowledge bases, and what I am attempting to achieve. As Stringer (1985) suggests, the reporting of research is not merely a record of events but a complex, multifaceted social achievement (Stringer 1985).

As with therapy, research is not a neutral process in terms of being value- and context-free. Nor is it neutral in terms of feelings and mood, the research being influenced by the researcher's affective states at the various points during the process. I was aware of feeling frustrated and anxious at various stages in the process. The research is part of a doctoral study and so the desire to enhance the body of knowledge about avoidance in PTSD must be understood within the context of my motivation to achieve a qualification. Frustrations with regard to the slow pace of the research and other process factors will have impacted on my mood at the time of writing and may have influenced my rationale for completing the research.

The realisation that I was not going to be able to gather sufficient data for Part 1 of the study led me to consider alternative ways to explore the problem of avoidance. I ultimately decided to use a qualitative approach in the second part of the study. While this felt initially liberating, I was also aware of a problem at the other end of the spectrum to that of the quantitative study, that was a feeling of being overwhelmed by the sheer amount of data. Furthermore, the content of the data was such that it involved accounts of clients' distress and pain. Just as the findings suggest that therapists may feel overwhelmed by the client's affect, as a researcher I felt overwhelmed by the amount of distress contained within the utterances I was analysing. Using a discourse analytic approach did not enable me to behave as a distant and impartial observer, but rather I needed to immerse myself in the accounts, and so in the pain of the clients whose utterances made up the transcripts. As Rennie et al (1988) suggest, such methods require commitment and hard work and getting "close to the bone" (p145) of the data. The research was hard work and painstaking and I was aware of feeling tired and drained. The content and nature of the transcripts may have affected my mood, which in turn may have influenced my understanding and interpretation of the material. However, by remaining "close to the bone" of the transcripts and by grounding my findings within the context of established research, I attempted to ensure that my mood did not adversely nor inappropriately affect my arguments or conclusions.

In summary, my identities of scientist and practitioner are likely to have influenced the analysis and reporting of the study in a variety of ways, including ways in which I can never be consciously aware. One practical implication of accepting the inevitable role of the researcher in the research process is that this should be highlighted and revealed in the documentation of qualitative studies. In this way an attempt is made not so much to reduce researcher bias but rather to be more honest and transparent about it. As Miles and Huberman (1994) suggest, the researcher must be as explicit and self-aware as possible about personal assumptions, values, biases and affective states and how each of these may have come into play during the study. I have here attempted to ensure that such influences are not detrimental to the research, realising the futility of the belief that such influences can ever be eradicated. Instead I have attempted to be transparent and honest about their likely impact, and to accept that

part of the process is inevitably a critical interrogation of my own presuppositions and my unexamined techniques of sense making (Ashmore, 1985).

6.5 The "truth" of claims

So an attempt has been made to demonstrate the transferability, trustworthiness and fruitfulness of the findings and to provide a transparent and reflexive account of the process of the research undertaken, in order to increase the persuasiveness of the claims made. However, it is not claimed that what has been arrived at has any objective "truth". The naturalistic view is that relying upon correspondence with the empirical world as the ultimate arbiter of truth is both impractical and untenable, and that we need to move away from the notion that there is a universal truth against which findings can be compared. The outcome of qualitative research is understanding rather than explanation, being based on principles of social constructionism (Gergen 1985) which assume that there is no fixed external reality to be objectively known but a fluid social reality that is co-constructed. The researcher, therefore, does not claim to generate universal truths. The findings from the current study must be regarded as one "reality" constructed by the researcher. Claims should be judged not so much against any empirical truth but rather in terms of their helpfulness and applicability to understanding the process within the therapy session. Accordingly, the conclusions drawn with respect to implications for effective therapy rely on the observed practices of avoidance themselves rather than on any interpretations made of participants' motivations for the avoidance. Further research is needed to explore the extent to which the motivations of therapists and clients proposed here are responsible for the avoidant discursive practices observed, and such research may generate alternative "truths". *"An advantage of qualitative research is that theory is generated which is contextually sensitive, persuasive, and relevant"* (Henwood and Pidgeon, 1992, p97). The more pragmatic argument can be made that the outcomes of research will be evaluated in terms of their persuasiveness and power to inspire an audience (Feyerabend, 1975).

7 Summary and conclusions

The discussion has addressed the avoidance of emotional material by clients and related it to issues of fear of overwhelming affect and vulnerability. highlighting the particular presentations of those with a history of childhood sexual abuse. The avoidance of therapists has been addressed and related to issues of vicarious traumatisation, countertransference and compassion fatigue. Recommendations made for therapists to ensure their own well-being and to develop self-awareness of their own emotional issues that may impact upon the therapeutic encounter and the implications for the training of therapists has been considered. A case has been made that the discursive practices engaged in by the participants are a function of role differences and power dynamics within the overarching context of the therapeutic setting. The interactive and inconsistent nature of avoidance within therapy has been highlighted, and contrasted with the traditional understanding of stable avoidant personality traits, and the value of qualitative research to address these complex processes has been highlighted. Finally, methodological issues, including the transferability of the findings, the trustworthiness of the process, the fruitfulness of the research and the impact of the researcher on the process have been explored and addressed. Throughout, an attempt has been made to ensure the applicability of findings by considering the implications for improving the effectiveness of therapy and suggestions for future research in the field of avoidance in PTSD.

Perhaps the most important finding of the research is the extent to which avoidance in therapy is an interactive process between client and therapist, rather than just the responsibility of the client. An awareness of this process forces us to move away from a preoccupation with the development of new techniques and methods for the treatment of PTSD that focus solely on the behaviour of the client. Instead the focus must shift to the avoidant behaviours of therapists and the ways in which they interact with those of the client, with a view to facilitating the client's addressing of the painful emotional material and evoke the affect necessary for an alleviation of PTSD symptoms. As van der Kolk (1996) states, the issue of avoidance is, arguably, the most prevalent process factor in PTSD treatment and, as such, should be given consideration in the development of new therapies.

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SECTION C:

CLIENT WORK

Section C: Client Work

Part 1:

A case study of an intervention for the treatment of survivors of childhood sexual abuse suffering from posttraumatic stress.

A case study of an intervention for the treatment of survivors of childhood sexual abuse suffering from posttraumatic stress

In the interests of confidentiality, all names and identifiers have been changed.

1 The referral and context

Penny was referred by her GP to the Psychology Department of the NHS Trust in which I work. The only information I received at this stage was that Penny, aged twenty-six, had described suffering from flashbacks of sexual abuse that she had suffered as a child, perpetrated by her parents.

2 The assessment session

2.1 First impressions - appearance and behaviour

Penny was tall and thickset, with short, spiky hair dyed orange. She wore thick, heavy denim clothes, which made her appear very large and strong. When I went to meet her in the waiting room, she was sitting hunched over with her head in her hands, and I was initially taken aback as I thought she was a man. When she spoke, Penny presented as a confident and articulate person.

2.2 Biographical information and family history

Penny has two married parents who run a successful removal business. She has a younger brother and sister, aged twenty-one and nineteen respectively who both live at home with their parents. Penny left home two years ago. She is a lesbian and for the last year she has been living with her partner, whom she describes as supportive. She is employed as a youth worker for lesbian and gay adolescents, which involves providing some counselling and group work. She described an adolescent history of alcohol and drug abuse and overeating.

2.3 The client's definition of the problem

Penny reported that she had been suffering from flashbacks and nightmares of the abuse she had suffered. These symptoms began four years previously when she first became aware that abuse had occurred. She had received some counselling at that time, which she described as helping her to become more aware of her feelings, however the flashbacks continued, being triggered particularly during sex with her partner, and she reported that she had never allowed any partner to bring her to orgasm, although she was able to do so herself. She felt she was not functioning well at work as she was having difficulty concentrating and that she often felt numb and detached.

2.4 The counsellor's definition of the problem

I felt that Penny was suffering from the symptoms of Post Traumatic Stress Disorder (PTSD) with delayed onset (DSM-IV) following the abuse, namely flashbacks, distressing dreams, extreme headaches, dissociation and avoiding activities or places which reminded her of the abuse. Her history of drug and alcohol abuse and overeating is typical of survivors of sexual abuse, for "victims often develop antisocial and self-abusive behaviours" (Foreward and Buck, p23). Her current lack of concentration and numbness is consistent with this formulation, for survivors often suffer from "continued shock and disbelief, perceptual dissonance, numbed detachment and psychic pain" (Mayr and Price, 1989, p38). Memories of the abuse may be triggered off unconsciously in situations akin to the abusive situations (van der Kolk and van der Hart, 1991; Ainscough and Toon, 1993) and I felt that Penny's difficulty allowing her partner to stimulate her to orgasm was a result of memories of the abuse being reactivated during sex. Penny felt that all aspects of her life were currently being affected by these symptoms. She described feeling low and depressed, though not suicidal. I obtained a measure of her symptoms by asking her to complete a PTSD symptom questionnaire, the Impact of Events Scale (Horowitz et al, 1979), with a view to repeating the test at the end of therapy as a measure of change. I explained the nature of PTSD and provided Penny with an information leaflet about it.

2.5 The approach taken, rationale and goals

In my experience, when survivors of child sexual abuse display PTSD symptoms such as flashbacks, humanistic counselling alone, while supportive, seems to have little impact on the symptoms. I have been able to help people most by using a specific cognitive-behavioural approach called "Imagery Rescripting". This is an approach pioneered by Smucker, Dancu, Foa and Niederee (1995), which they describe as a "new treatment for survivors of childhood sexual abuse suffering from posttraumatic stress" (p3). It constitutes a nine session programme, including assessment, combining imaginal exposure, mastery imagery and cognitive restructuring of the abuse. I outlined this approach to Penny and she seemed initially sceptical. Penny's counselling experience had led her to believe that she should spend at least two years in therapy working on these issues, and she was disappointed when I explained that I was initially only able to work with her on a short-term basis, due to the NHS Trust limitations. However, when I reassured her that we would continually review progress and that we would not end therapy until she felt ready, she was more positive and ready to engage in the process. She recognised that it would be a painful experience, and I reassured her that I would go at her pace so that the control was with her, and that I would not push her to talk before she felt ready.

2.5.1 The contract and structure of the sessions

Consistent with the Smucker programme, we contracted initially for eight further weekly sessions, which would vary from one to one and a half hours' duration, followed by a review of progress and the option of further sessions to be negotiated. These were to take place within the Community Mental Health Team.

2.5.2 Goals

The main goal at this stage was to relieve Penny of her PTSD symptoms and to begin to work through her feelings about the abuse, with a view to enabling her to function more effectively in her relationships and in her work. The therapy was not directed at encouraging Penny to confront her parents about the abuse unless she chose to do so

(Smucker et al, 1995).

2.5.3 Confidentiality

I explained to Penny that what we discussed was between ourselves, with the exception that there may be aspects of her case which I would discuss with a supervisor within the Department, in order to be able to help her as best I can. I informed her that I would contact her GP when we finished seeing each other, and that I would contact her GP before that time only if I considered her to be at risk of harming herself, and that in that event I would make all possible efforts to let her know of my action before I did so.

3 The content and process of the sessions

3.1 The overall content of the sessions

3.1.1 Building the relationship

Over the next eight sessions we worked through the Smucker programme, with some modifications. While Smucker suggests that the client should begin to relive her/his experiences in the second session, I feel that this is too early and my initial concern was to build a good working relationship with Penny before the painful material was worked through. Penny had already told me that she did not trust her GP, who had made some apparently homophobic remarks to her and had pathologised her sexuality, and so I felt that trusting another professional may be an issue for her. I was particularly careful not to pathologise her sexual identity and to show her acceptance and warmth. This was not difficult as she had a warm and open manner, was insightful about the abuse and appeared highly motivated to work on her issues. I was optimistic about being able to help her because of this and because of the good client-therapist match in terms of age and gender (for example: Berzins, 1977).

In the first session I adopted an almost purely Rogerian stance, employing the core conditions of empathy, genuineness and unconditional positive regard (Rogers, 1990) and

by listening reflecting and not offering any interpretations at this stage, on the basis cited by Dryden (1992) that "if the counsellor believes it is important for the client to trust her, she may set for herself the goal of being especially accepting of the client's ambivalent feelings" (p8). At this stage I felt it was important for Penny to realise that I would continue to accept her, regardless of what she may disclose.

We used the second session to practise relaxation techniques, which were to be used to aid imaginal exposure in forthcoming sessions, and visualising a "safe place" where she could return in her imagination if the abuse imagery became too painful.

3.1.2 The memories

From the third session onwards, Penny related several incidents of sexual abuse by her parents, either individually or together, including having objects inserted into her vagina and rectum or being forced to have oral sex or intercourse. The memories began at about age three. Despite Penny's initial concern that she would be able to recall the events in only a fragmentary form, she was able to visualise the abuse quite vividly and began to fill in some of the gaps in her memory to form coherent scenarios. I was careful to adhere to the clinical guidelines for dealing with recovered memories (Bloom, 1994) on the basis that the way in which the therapist facilitates recall "may profoundly shape the recalled memory" (p 174). Reliving these events was clearly very painful for Penny, and she was frequently tearful as she spoke. It was clear from her account that she had frequently dissociated from the events as they occurred which is consistent with her forgetting the abuse for so long and with her current flashbacks (Mayr and Price, 1989). I felt moved as I listened to her pain, however I was able to remain focused as I had faith in the therapy and believed that only by processing the events consciously and experiencing the emotions attached to them would Penny be able to move on (Smucker et al, 1995). Penny reported relief that I had been able to stay with her pain and that I did not react with shock or disgust, which had previously been a barrier to her disclosing her abuse to others.

3.1.3 Expressing anger

Part of the therapy involved helping Penny to express anger and outrage toward the abusers and to be able to feel warmth and nurturing to herself as a child. To start with, Penny expressed these emotions readily and dramatically, being able to visualise cuddling and rescuing the child and destroying the abuser. However, as therapy progressed, it became harder for her to experience and express this anger, particularly towards her father, as she continued to see him as all-powerful. Despite attempts at cognitive restructuring, including homework in which she wrote unposted letters to him, her ability to express her anger seemed to fluctuate. On exploring her reluctance, she said she felt that the setting was inhibiting and that she felt that if she were to become angry she would like the scope to be able to throw cushions around and be destructive which was implicitly inappropriate in this NHS setting. I wondered whether she was afraid of what might happen if she were to give full vent to her anger. Furthermore, I am aware that I find it hard to express anger myself, having come from a family in which "negative" emotions were not sanctioned, and I wondered to what extent my unconscious non-verbal communication might have inhibited her from full expression. However, subsequent events led me to an alternative hypothesis for this resistance: -

3.1.4 Resistance

As Penny's expression of anger fluctuated, so did her defences. When the memories became too painful, her defences grew stronger. She cancelled one session, arrived twenty minutes late for another, and began to question how far her recollections of the events were accurate. She had seen a chat show about false memory of abuse and wondered how far her memories could be false. Penny was insightful and aware of this avoidance, so we were able to explore this openly in the sessions. She said that her relationship with her partner was currently unstable. Her partner was finding it hard to deal with Penny's apparent increasing emotional dependency upon her during this vulnerable time. The impact of this insecurity was that Penny felt less inclined to feel anger toward her parents for the abuse, as she felt she may need to rely on them more, should her relationship with her partner break up. It is common for survivors of sexual abuse to crave love from the aggressor and from the family (Mayr and Price, 1989) and

they "will go to almost any length to reverse that feeling of being unloved" (Foreward & Buck, 1978, p20), particularly at such times of emotional vulnerability. Penny's partner ended their relationship and Penny moved out to live alone for the first time. Some sessions were, therefore, spent exploring this and her insecurity at being able to maintain an identity as a "single dike" (Penny's expression) out of the context of a sexual relationship. She had also begun to have some dreams and sexual fantasies about men, which she perceived also as a threat to her sexual identity. She began to express some concern about the ending of therapy as we approached session eight, as she could potentially lose partner, sexual identity, parents and therapist at the same time. We contracted for a further six sessions to provide space to continue to work on the abuse issues, together with exploring her current relationship problems so that she felt supported over this time.

3.1.5 One foot in the present

Smucker et al's programme provides little space for addressing current issues. In order to work on Penny's relationship with her partner and parents we deviated from the programme and extended our contract. I believe with abused clients that it is important to keep "one foot in the present" as not only does it provide some sense of normality and a respite from the past, but it also enables evaluation of the impact of the therapy on the client's current relationships. Jones (1992) suggests that, as all abuse occurs within a wider context than that of the individual, all sexual abuse counselling should occur within a family framework, even if that work is with the individual, on the basis cited by White and Epston (1990) that family therapy is more to do with the framework in which therapy operates than the number of people attending.

3.1.6 The continued development of the therapeutic relationship

During Penny's reliving of her experiences, I became aware that I felt very close and warm toward her. On one occasion, as she spoke of an abusive episode when she was three years of age concerning her mother, she described feeling unable to articulate what she was visualising. I felt that these early memories may have been primarily encoded through the sensori-motor and visual modes of representation, and therefore not likely to

be accessible through linguistic or verbal means (Staten, 1990). I asked her if she would like a pencil and paper to draw what she was experiencing. When she agreed, I sat in a chair beside her, closer than I would usually, in order to follow what she was drawing. As she became tearful I felt moved and impulsively placed my hand on her arm by way of reassurance and encouragement. I very rarely touch clients as I believe it can be perceived as intrusive, particularly in the case of survivors of sexual abuse, however it felt entirely appropriate at the time, and had the effect of encouraging her to continue. I failed to address this with her afterwards, but the fact that when we ended therapy she asked if she could hug me suggested that she had not found my action intrusive.

4 Evaluation

4.1 The client's report of the outcome

Over the last two or three sessions, despite moving out from her partner and expressing some anxiety about maintaining an identity as a "single dike", Penny described feeling strong and surprised at how well she had handled the split. Later she reported that, despite living separately, she had resumed her relationship with her partner. I saw this as a reflection of Penny's renewed strength, as it had been her emotional dependency that her partner had previously found hard to cope with. She was also able to allow her partner to stimulate her to orgasm for the first time. Penny was doing extremely well at work, had acquired some new work, and had appeared on local radio to promote her youth project. She no longer suffered from flashbacks, headaches or other somatic symptoms and I was somewhat surprised by this dramatic change in her mood so soon after the apparent pain of revelation. However, this rapid improvement is something I have observed previously with people suffering from PTSD symptoms (both survivors of sexual abuse and others). I asked Penny to complete a second Impact of Events Scale, and together we compared her responses with her earlier ones. This showed dramatic improvements in all areas and Penny found it encouraging to see in black and white just how far she had come over the months. We explored relapse prevention, while recognising that often survivors need

several sessions of therapy at different points in their life, and that Penny was welcome to return should she feel the need. Penny gave me some useful feedback, describing the work we had done together as "superb" and, as we ended, she asked for a hug. I felt it would be counter-therapeutic to refuse, and we hugged warmly. It felt like a good ending.

4.2 Professional dilemmas and concerns experienced.

4.2.1 Expressing anger

An issue raised by my work with this client is the extent to which there is a fine line between being accepting of the client, listening to her story without expressing shock or disgust and showing acceptance or complacence about the abuse she has suffered. There were times when I felt that a stronger reaction from me would have helped Penny to experience a sense of outrage towards her abusers, and we addressed this issue during therapy.

4.2.2 The recovered memory debate

This case brought up the whole issue and ongoing debate of recovered memories (see for example, Brown 1995; Farrants, 1998). Penny had come to therapy aware of abuse, these memories had emerged before our sessions, and I ensured that I adhered strictly to the guidelines on false memory (Bloom, 1994). It is, nevertheless, a matter of ongoing debate whether people can remain unaware for many years that they have suffered abuse, in the way that Penny did. Penny described feeling certain that the abuse had occurred, and that her questions about false memories were a way of "clutching at straws" so that she could deny the reality of the painful experience.

5 Summary and conclusion

In summary, this client report illustrates the use of Smucker's Imagery Rescripting therapy with one client. It highlights the need to incorporate into the approach time for addressing current issues that may impact upon the exploration of past trauma. The importance of attending to process variables is raised. Such processes might include the

feelings of the therapist toward the client and the therapist's discomfort with expressing certain emotions such as anger. In particular, the extent to which the interaction between client and therapist impacts upon the therapy is discussed. Finally, the client study illustrates one way in which the false memory debate may influence therapy, now that it has entered the consciousness of clients as well as therapists, and emphasises the importance of therapists to not only be aware of the issues regarding false memory of abuse but to be able to communicate these issues clearly and sensitively to clients where appropriate.

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Section C: Client Work

Part 2:

A case study of an intervention with a client suffering from intrusive thoughts and traumatic grief.

A case study of an intervention with a client suffering from intrusive thoughts and traumatic grief.

In the interests of confidentiality, all names and identifiers have been changed.

1 The referral and context

Jonathan was referred to me by one of the Community Psychiatric Nurses (CPNs) within the Community Mental Health Team (CMHT) in which I work. The CPN had supported him over a period in which Jonathan had been admitted to a psychiatric ward as an in-patient following a depressive and suicidal episode six months previously. Jonathan's depression had lifted after a few months of medication and CPN support, however, he was experiencing obsessional, disturbing and graphic thoughts of dismembered bodies and other gruesome images. He reported having suffered from these thoughts since his teens, but that they had reached a peak during his depression. Despite his depression lifting, they had remained and the CPN felt that Jonathan may benefit from seeing a psychologist.

2 The assessment session

2.1 First impressions - appearance and behaviour

Jonathan was a small, casually but neatly dressed, twenty-nine year old man. Although visibly nervous, he was warm and polite. He was tearful for part of the session and regarded therapy as his final chance of what he referred to as "peace of mind". Although pessimistic that anything would change, he was anxious for reassurance that he was a "deserving case" for treatment. This led me to believe that he wished me to adopt the role of nurturer and I expected that he may become dependent upon me (Dryden, 1989). Jonathan's demeanour did indeed evoke in me a strong desire to take care of him, and so I was careful from the start to monitor this countertransference.

2.2 Biographical information and family history

Jonathan is single and shares a house with his mother and older brother. His father died suddenly eight years ago in a mental hospital following a psychiatric illness. Jonathan runs his own gardening business. He has a history of adolescent drug and solvent abuse and self-mutilation (cutting his arms with glass), however, he has done none of these things since adolescence.

2.3 The client's definition of the problem

Jonathan reported that he felt he was no longer depressed but that he was finding his disturbing thoughts overpowering and difficult to cope with. He was becoming irritable with his family and found it hard to concentrate on his work.

2.4 The counsellor's definition of the problem

Initially, I wondered whether Jonathan was suffering from Posttraumatic Stress Disorder (PTSD) following some distressing events actually experienced (DSM IV). For example, he described witnessing two road accidents during adolescence and seeing dismembered bodies in the wreckage, and also that his aunt had been robbed at knife-point when he was aged eleven. His symptoms shared some of the characteristics of PTSD, for example the vivid images accompanying the thoughts, the fact that they were frequently triggered by news stories relating to death or injury and his irritability with his family (DSM IV). Following assessment, which included completion of the Impact of Events Scale (Horowitz et al, 1979), it was clear that Jonathan's disturbing thoughts did not relate directly to any of the events he had witnessed, a requirement for a diagnosis of PTSD (DSM IV).

Jonathan referred to other obsessional thoughts and behaviour, including positioning of household objects and a fear of contamination leading to excessive hand-washing and I formed the hypothesis that his disturbing and intrusive thoughts were obsessions, defined

by DSM IV as "Persistent thoughts, impulses, or images that are experienced, at least initially, as intrusive and senseless" (p 245).

Furthermore, Jonathan became distressed and tearful when he spoke of his father who had died eight years previously and I hypothesised that this prolonged grief was a result of some unresolved bereavement tasks (Worden, 1995).

It has been suggested that obsessional behaviour is frequently underpinned by extreme underlying anxiety, of which the client may not be consciously aware (for example: Ehlers and Steil, 1995; Wells, 1995) and I wondered whether there was some further underlying anxiety which Jonathan had not yet articulated. Also, I planned to explore the events surrounding the onset of his depression, which had begun only six months previously.

2.5 The approach taken, rationale and goals

2.5.1 The contract and structure of the sessions

We contracted initially for eight further weekly sessions, each of one hour's duration followed by a review of progress and the option of further sessions to be negotiated. These were to take place within the Community Mental Health Team. Because of Jonathan's tendency for dependence, I was acutely aware of the importance of structure and boundaries and of a need to be consistent and open with him. (Dryden, 1989).

2.5.2 Goals

The main goals agreed at this stage were to relieve Jonathan of his intrusive thoughts and to begin to work through his feelings about his father's death, with a view to enabling him to function more effectively in his relationships and in his work.

2.5.3 Confidentiality

I explained to Jonathan that what we discussed was between ourselves, with the exception that there may be aspects of what he told me which I would discuss with a

supervisor within the Department, in order to be able to help him as best I could. I informed him that I would contact his GP when we finished seeing each other. In view of his previous suicide attempt, I was careful to explain that I would contact his GP before that time only if I considered him to be at risk of harming himself or others, and that in that event I should let him know of my action before I did so.

2.5.4 The approach taken

In the first session I adopted an almost purely Rogerian stance, employing the core conditions of empathy, genuineness and unconditional positive regard (Rogers, 1990). At this stage I felt it was vital for Jonathan to realise that I would continue to accept him, regardless of what he may disclose. In later sessions I adopted a cognitive behavioural approach to explore the cognitions related to his intrusive thoughts (Beck, 1976; Rachman and DeSilva, 1978) and followed Worden's (1995) approach to the treatment of traumatic grief.

3 The content and process of the sessions

3.1 Bereavement work

The early sessions were spent working through Jonathan's confused feelings about the death of his father eight years previously, following Worden's (1995) approach to traumatic grief. Jonathan described his father as a distant, shy and withdrawn man and that he did not feel as if he had ever had a relationship with him. His father had developed a mental illness two years before his death, which resulted in aggressive, unpredictable and sometimes violent outbursts toward the family. Jonathan was tearful when he spoke of his father's death and described relief that his father's terrorisation of the family had ended, while also expressing regret at the lost chance for a closer relationship with him. Worden states that "The most frequent type of relationship that hinders people from adequately grieving is the highly ambivalent one with unexpressed hostility" (Worden, 1995, p65) and I felt that Jonathan may be suffering from a traumatic grief reaction as a

result of his ambivalence to the death.

As part of the therapy, I asked him to write a letter to his father expressing his feelings, and this appeared to provoke a cathartic reaction. Following this, Jonathan reported that his intrusive thoughts had been fewer and less intense than at any time since the onset of his depression six months ago, and I felt that we had established a good working relationship. I was encouraged by his early improvement, particularly in view of the fact that patient ratings of their counsellor after the third session have been found to be predictive of the outcome of therapy better than any other variable (Winefield, 1992).

3.2 The nature and content of the intrusive thoughts

Through a cognitive exploration of the nature and content of Jonathan's intrusive thoughts (Beck, 1976) a deep sense of Jonathan's feelings of worthlessness and self-loathing emerged. The vivid images which accompanied the thoughts followed either of two themes, namely images of himself being humiliated, for example being stamped or spat upon, or otherwise of himself carrying out acts of "depravity" (his word) for example eating the entrails of a dead friend. Jonathan regarded the fact that he had these thoughts as evidence that he was bad and depraved. He believed himself to be capable of carrying out these actions in reality. This negative view of himself as a result of the thoughts served to perpetuate the thoughts and so maintain a circular feedback loop (Penn, 1982) of self-loathing. This is consistent with Salkovskis' (1985; 1989) findings that intrusive thoughts result in distress according to the extent to which their occurrence and/or content is interpreted in a particular type of negative way. It may also account for his obsessional behaviour as, according to Salkovskis, Richards and Forrester (1995), obsessional behaviour is likely to occur if the intrusive thoughts are interpreted as an indication that the person may be responsible for harm to others. I explained to Jonathan the difference between fantasy and reality and reassured him that the thoughts did not mean that he was likely to carry out these actions. (Salkovskis et al, 1995). Jonathan found it particularly difficult to talk about the content of his thoughts as he feared that I too might despise and reject him.

The act of voicing the thoughts for the first time enabled Jonathan to experience that he could be listened to with warmth and empathy and that I would continue to accept him regardless of his disclosures. The whole issue of acceptance and approval became a theme in itself and underpinned all the work that followed, and I believe was the single most important factor in Jonathan's progress. I reflected to Jonathan these themes of worthlessness and self-loathing and used immediacy (Egan, 1994) to reflect his desire for approval. Together we explored how he may have come to feel this way and it became clear that he had suffered from emotional neglect as a child by both his mother and father and had never felt loved or approved of. This may account for his low self-esteem, feelings of worthlessness and his dependency, particularly upon older women (Kenward and Hevey 1989). We explored his childhood experiences which led to his deep sense of worthlessness, in order to identify negative schemas which he had carried into adulthood (Salkovskis et al, 1995) and their impact on his current relationships.

3.3 Relationships with women

From what Jonathan told me of his relationships with women, I formed the impression that he was searching for the care and mothering that he had lacked. He had had only two sexual relationships, both with older women in their fifties. The first relationship lasted over one year and was with a woman who had commissioned him for some gardening work. The relationship became sexual after he sought sympathy from her following an accidental cut to his finger while gardening. Jonathan was currently in his second relationship, the onset of which he associated with the onset of his depression six months previously. He had arranged a first date with the woman for which she had been over two hours late. He describes the time while he was waiting for her as a 'spiralling into a black depression. On exploring during the session his cognitions at this time, it was clear that her lateness had reinforced his notion that he was unimportant, worthless and deeply unlovable, mirroring his feelings during childhood, and this seemed to precipitate his depressive episode. Although the relationship had continued, he worried about the fact that his partner was over twenty years older than himself. and he felt a sense of the

relationship having no future. His partner was inconsistent and conditional in her feelings for him and frequently threatened to end the relationship at some prearranged date. When the time came, she would agree to see him for a further period.

3.4 The therapeutic relationship

I was aware that my contract with Jonathan very much mirrored the relationship with his girlfriend. We had a fixed contract, following which further sessions would be negotiated. He began to express anxiety at the impending ending of our contract, despite my reassurance that we would stagger the ending and that we would not stop suddenly or without warning or until he felt ready, as advocated by Ward (1984) for dependent clients. On the penultimate session of our initial contract, Jonathan disclosed that he had strong sexual feelings for me. I was not surprised by this disclosure and I regarded his feelings as an extreme form of transference to the therapist as nurturer (Watkins, 1983). I explained to him that his attraction to me was understandable in that our relationship had been the first unconditional relationship he had experienced with a woman. I explained to Jonathan that I cared about his well-being and felt that we had a good working relationship and reinforced that it was to remain on a purely professional footing. He was fearful that I would reject him on account of this disclosure and I reassured him that my respect for him was unchanged, which I demonstrated by continuing to behave consistently towards him and by not terminating our contract early, which he had feared. I feel that his disclosure may have been a way to test whether I would continue to accept him unconditionally and seemed to me to be an attempt to elicit a declaration of my feelings for him. Jonathan had clearly become dependent upon our sessions and his need for the love and approval that had so clearly been absent from his early life manifested itself in both the content and process of therapy, namely in his sexual relationships and in his relationship with me. We continued to work on this theme throughout the therapy and I was careful to be consistent, to maintain firm boundaries and to continue to accept him unconditionally. We extended our contract and, on the advice of my supervisor, did not have a fixed end date so that Jonathan would continue to feel safe and accepted.

3.5 Factors maintaining current anxiety

Jonathan's current living circumstances were a source of anxiety. He was living with his mother who expressed no emotion toward him and a brother who was out of work and becoming reclusive, and occasionally abusive, violent and unpredictable. Jonathan feared that his brother was becoming like his father and he believed that his own intrusive thoughts were evidence that he too was becoming unstable, like his father. Also, his gardening business was not thriving as well as he would have liked and he therefore had a sense of a foreshortened future, devoid of hope or happiness.

Having expressed these anxieties during therapy, Jonathan's intrusive thoughts changed from involving fictional gruesome and disturbing images to more realistic anxieties concerning his future. He agreed that the intrusive thoughts had perhaps previously been effective in allowing him to avoid responsibility for changing the realities of his present life, which he felt helpless to alter. I suspected that his depression may have served a similar function and that he had become stuck in a negative "rut" of learned helplessness (Seligman and Maier, 1967), believing he was powerless to change his circumstances.

Through therapy Jonathan was able to begin to take responsibility for change. He began working towards moving into a home of his own, he became more relaxed about the future of his relationship with his partner and was able to enjoy the time they spent together on a day-to-day basis. He increased his advertising for his gardening business and began to cycle occasionally instead of driving, as he enjoyed the exercise. He accepted that his mental health was improving and no longer believed he would degenerate as his father had done. He planned to widen his social circle by joining a conservation action group.

Once Jonathan's sense of helplessness had begun to diminish, we began to work on his specific OCD symptoms, using exposure and response prevention (Meyer, 1966). Almost as soon as he had begun to monitor his obsessional behaviour he was largely able to resist the compulsion to wash his hands inappropriately and to place objects symmetrically.

Similarly, he reported that for many years he had suffered from panic attacks in supermarkets, which we were then able to deal with using a biopsychosocial approach (Barlow, 1988) and which he was then able to control with relative ease. I was surprised at the speed of these improvements. It appears that the very fact of gaining mastery over his compulsions and anxieties promoted a sense of control over his life. This in turn reduced his need to carry out the compulsions for the illusory sense of control which they had afforded (Reed, 1985) and so formed a circular self-reinforcing feedback loop (Penn 1982). As a consequence, Jonathan seemed to attach less importance to his intrusive thoughts which, although still present, were considerably less frequent and, when they occurred, briefer. He took the responsibility himself for beginning to end therapy, suggesting that we reduce our meetings to fortnightly and a few weeks later he suggested that we change this to every three weeks, which indicated that his dependency upon me was diminishing as his sense of control and self-efficacy increased. I reflected this to him, and he was able to see a change from his earlier anxiety about ending. I felt that it was important that it was he who was able to begin to "reject" me.

4 Evaluation

4.1 A critical assessment of the effectiveness of the therapy

Jonathan's progress was considerably more extensive and rapid than I expected at the start. It appears that my interventions helped him to reframe his situation and to alter his negative beliefs about himself and his life, and to begin to believe that he could change. However, I suspect that most change was caused not so much by the content of the cognitive interventions, but more by the process between us. Strupp (1989) refers to the "overriding significance of the interpersonal relationship between patient and therapist as the vehicle for therapeutic change." Jonathan learned that he could feel accepted and cared for unconditionally. I feel that the relationship between us was the most productive factor during therapy.

4.2 The client's report of the outcome

Jonathan reported feeling considerably less distressed than he had done for several years, and was able to begin to take action to improve his circumstances, once he overcame his belief that he was helpless. He described feeling that, although he enjoyed our sessions, he no longer felt he *needed* them so frequently as he felt he was managing well between sessions.

4.3 Professional dilemmas and concerns experienced.

It was vital to Jonathan's progress that I dealt in an objective and professional manner with regard to the transference and countertransference issues, namely his sexual feelings toward me and my strong caring feelings toward him. I was able to remain warm and accepting without revealing the depth of my feelings and without encouraging his dependency, as is evidenced by his ability to take the initiative to make changes in his life and to take control of reducing the frequency of our sessions.

5 Summary and conclusion

The work with Jonathan clearly illustrates how dealing with symptoms such as OCD or panic attacks can be considerably more effective when underlying anxiety about other factors has been worked through. For example, once Jonathan had worked on his anxieties concerning his current life and his lack of hope for his future, his obsessional behaviour ceased with relative ease and rapidity in a way in which dealing with clients' symptoms alone does not always appear to. It seems as if once the underlying anxiety has been addressed there is no longer anything to maintain the behaviour. I have found this to be the case with several clients and, although my findings are admittedly anecdotal, it may be interesting to attempt to quantify these results in some way in future empirical research.

Furthermore, this client study demonstrates the importance of the development and management of the therapeutic alliance with clients who may have a tendency to become dependent upon the therapist. A solid collaborative working alliance, in which the therapist relates to the client with genuineness and as an equal partner in the dyad, allows the client to experience validation of their feelings from a person they respect. This, in turn, increases their perception of self-efficacy as they no longer regard themselves as "the mental patient", and this shift occurs when therapists are able to validate clients and to encourage them to take responsibility themselves for change. This is consistent with the approach of Counselling Psychology which promotes the "working alliance" (Dryden, 1992) between psychologist and client, in contrast to traditional approaches which operate according to the medical model, with the therapist as expert (Cunningham and Davis, 1985).

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SECTION D:

LITERATURE REVIEW

The "False Memory" Debate: A critical review of the research on recovered memory of child sexual abuse.

The "False Memory" Debate: A Critical Review of the Research on Recovered Memories of Child Sexual Abuse.

1 Introduction

Few issues within psychology have been so hotly debated as that of "false memory syndrome", the notion that illusory and untrue memories of earlier childhood sexual abuse can be implanted by therapists in adult clients. The issue is of increasing relevance to any professional involved in therapy, particularly in view of the wealth of publicity and media attention afforded to cases of alleged false recall. The reputation of the therapy professions is at stake, as clients begin to sue therapists for the implantation of false memories. In an increasingly polarised and emotive debate, extreme positions have been adopted, on the one side by those believing that recovered memories nearly always represent actual traumatic experiences and, on the other side, by those describing a growing epidemic of false "memories" of abuse which never occurred. Proponents of the latter position draw upon findings from laboratory studies of the fallibility of memory and are critical of the methods used by therapists, which they believe to promote the creation of false memories. In response, those who believe that recovered memories are likely to be genuine provide evidence from research on those known to have suffered earlier sexual abuse and propose putative mechanisms which may account for any subsequent delay in recall of the abuse. The following is an evaluation of the evidence put forward by both sides of the controversy in order to assess the extent to which either of the two stances is viable.

2 Laboratory studies demonstrating the fallibility of memory

Firstly, proponents of false memory syndrome have utilised the findings from laboratory studies of the suggestibility of memory to support their stance.

2.1 The suggestibility of memory

A long history of research on human memory documents the extent to which misleading suggestions can distort recall of events (Lindsay and Read, 1994). In a classic study, Loftus (1993) led five subjects to believe over a period, with the use of misleading and suggestive questioning, that a particular event had occurred, for example that they had been lost in a shopping mall as a child. Loftus concluded that it is indeed possible to implant false memories that can be as vivid, internally coherent and detailed as true memories, and that repetition of erroneous suggestions can lead to an acceptance by the subject of their truth. This they referred to as the "misinformation effect" and Ceci and Loftus (1994) found such memory for non-events and the subjects' staunch belief in their reality to be far from rare. However, this study is not without its critics.

It has been argued that studies such as these reveal nothing helpful to the study of memories of abuse (Pezdek, 1994). Firstly, in Loftus' study, the events were implanted by a relative, who could in theory have witnessed the event, thus giving it credence, and secondly it could be argued that individuals may be operating according to a pre-existing script for common events such as being lost while shopping, rendering such a memory easy to construct. Pezdek (1994) argues that individuals, especially children, are unlikely to possess such a script for sexual abuse, unless it is something which they have directly experienced. However, Pezdek's point fails to recognise that most adults in the present culture, with all its publicity about abuse, may in fact possess such a script. Admittedly, children may be less likely than adults to possess this script, however, the debate concerns the recall of adults and not children. Furthermore, Read and Lindsay (1994) report findings by Holst and Pezdek (1992) that subjects shared common scripts for three types of robberies which affected their memory of events, despite no direct of experience of them. These studies, therefore, suggest that personal experience of sexual abuse is not essential for the recovery of such "memories", as the possibility remains that pre-existing scripts arc being deployed.

However, caution needs to be exercised in generalising the Loftus study to other situations, as it has been criticised for manifold methodological flaws (Brown, 1995). Only five subjects took part in the experiment, all of whom were friends or relatives of the researcher, and no control subjects were used. This may introduce a confirmatory bias, something of which Loftus, herself, accuses memory recovery therapists. While the misinformation effect may provide some support for the notion that memory can be distorted through suggestive questioning, the extent to which entirely new memories can be created has been questioned (Toon, Fraise, McFetridge and Alwin, 1996).

Consequently, Toon et al (1996) dismiss the shopping mall study as irrelevant to the understanding of recovered abuse memories. A case for the inappropriateness of attempting to generalise the findings from laboratory research to real situations has been made by several commentators. Watkins (1995) warns against discounting anecdotal, observational data in favour of laboratory studies, stating that new phenomena are frequently found first in this way, and Olive (1996) regards anecdotal case study evidence as more valid than laboratory studies. Brown (1995) states that overgeneralisation from one area of enquiry to another eliminates the complexity of variables involved.

2.2 The effect of social influence

Others have argued that the subjects involved in the laboratory studies are subject not so much to memory distortions as to the effect of social influence and that it is the *reporting* of events and not the *memory* of them which changes. Brown (1995) cites the studies of Zaragoza (1991) in which the Loftus study was replicated, and found that the tendency to recall according to the misleading suggestion was more a function of social influence, namely a desire to agree with the experimenter, than an impaired memory. If this is in fact the case, then it is an overstatement to say that memories can be transformed by misinformation, if it is merely the *reporting* of them which is transformed (Brown, 1995). A distinction should be made between post-event misinformation and interrogatory

suggestion, involving interpersonal pressure and which is more likely to result in false recall (Gudjonsson, 1992). There is little evidence then that the occasional misleading question by a therapist can create false memories of abuse.

2.3 Memory for trauma

A further criticism of laboratory studies is that they do not deal with traumatic stimuli in the way that recall of child sexual abuse does (Brown, 1995) and that individuals are more suggestible to the relatively trivial subject matter used in laboratory research than they are to important events (Sherif, 1979). However, it is clearly simpler and more ethically sound to demonstrate memory distortion in controlled laboratory conditions using trivial information than in real situations using traumatic stimuli (Spector, 1996) provided that generalisations are made only cautiously. Traumatic memories should, therefore, be distinguished from narrative memories (Van der Hart and Nijenhuis, 1995). Recovery of sexual abuse memories often results in Post-traumatic stress disorder (PTSD) symptoms (Vardi, 1994; Smucker, Dancu, Foa, and Niederee, 1995). If the memories recovered are indeed false, this raises the question of what caused the PTSD symptoms. Furthermore, Watkins (1995) regards the apparent terror of some clients when recounting traumatic memories to be unexplainable if the memories recounted are indeed false. Brown (1995) suggests that to generalise, therefore, "from normal to traumatised individuals with PTSD symptoms may be like comparing apples and oranges in terms of encoding, retention, or retrieval" (p13). Some go as far as to posit that emotional and traumatic experiences are processed differently in the brain from intellectual experiences (Le Doux, 1989; Metcalfe and Jacobs, 1996) as trauma implies the disruption of normal memory processes (Horowitz and Reidbord, 1992). Memories of sexual abuse may be encoded, stored and retrieved differently from other memories (Van der Kolk, 1994), particularly if the abuse occurred under circumstances of high arousal, terror or ambivalence, where escape was impossible or when the meaning of abuse, if confronted, could be devastating. This, they argue, may lead to repression or dissociation, psychologically motivated defences, which may not be demonstrable in the laboratory.

While Ceci and Loftus (1994) acknowledge some of the criticisms of laboratory research, they counter these by citing examples of memory distortion not only for mundane and trivial memories but also for intensely painful memories. For example, they refer to the findings of Wright (1993) which demonstrate that individuals' recall of the distressing Hillsborough disaster, became distorted over time. They argue that if memory of such traumatic events can become distorted, so too could memories of abuse. However, the distortion of an existing memory should be regarded as distinct from a total fabrication of an event that did not occur at all. Furthermore, alternative findings support the notion that traumatic memory is no more likely to be distorted than normal memory. For example, Terr's (1990) study of twenty children who suffered from trauma following being kidnapped from a California school bus, found their recollection of events at twelve years' follow up to be more accurate, clearer, more detailed and longer-lived than ordinary memory. However, this sample may not be typical of trauma victims, as the kidnap was not a solitary experience, occurring as it did with other children and being in the public eye. This may have resulted in the children sharing their experiences with each other, their parents and the media repeatedly since the event. This may have provided greater opportunity for rehearsal and cognitive processing and for making sense of the event, which is frequently not the case for many abused children who may not have spoken of the abuse at all during childhood. Further evidence from therapy for trauma victims suggests that repetition of the event and exposure to the intrusive images helps alter the emotional reaction to the memory although not the memory itself (Foa, Feske, Murdock, Kozac, and McCarthy, 1991; Resick and Schnicke, 1992). However, the Hillsborough victims in Wright's study had a similar experience to the California children in terms of sharing their memories with others and the media and yet, according to Wright, their memories revealed distortions. It cannot be ruled out that the discrepancies in these findings may be the result of the misinformation effect, with the extent to which memories were recalled accurately being a function of the way in which individuals had been questioned about the event previously.

So, the research findings are mixed, with some evidence for the fact that the misleading or suggestive questioning can result in memory distortion, although the extent to which entirely new memories of traumatic incidents can be created from nothing, the claim of the false memory proponents, has yet to be demonstrated. False memory proponents have argued that it is the way in which the therapist operates which leads the client to recover false memories. Indeed it has been reported that over two thirds of alleged abusees stated that their first suspicion that abuse had occurred arose during a therapy session (Roe, Schwarz, and Peterson, 1994) and it is therefore, necessary to examine both the evidence that pseudomemories have been recovered during therapy, and the methods used by the therapists.

3 The evidence that false memories have been recovered during therapy

In a critique of Lindsay and Read's (1994) article outlining the risk of false memories being created in therapy, Pezdek (1994) argues that evidence for therapist implanted memory is weak, as do Baker-Ward, Gordon, Ornstein, Larus and Clubb (1993). Lindsay and Read (1994) have been criticised for asserting the possibility that false memories can be created while providing no evidence for the phenomenon (Pezdek 1994). As Pezdek reflects, "it is illogical to infer the existence of a phenomenon from the possibility of explaining it" (p 340). In order to support the view that it is possible for pseudomemories to be created, Read and Lindsay (1994) cite examples of bizarre and unlikely memories which have been recovered during therapy, some of which were in press at the time of Lindsay and Read's article. For example, Bass and Davis (1988) write of recovered memories of entire cities of satanic ritual abusers, Wagenaar (in press) described a woman who recalled giving birth at the age of eight, and Loftus (in press) writes of therapist-aided memories of life in the womb, the bizarre nature of which lead Read and Lindsay to conclude them to be highly unlikely to be true. They also refer to Piper (in press) who reports a therapist-assisted memory of molestation by a man who was later found to have been out of the country at the time. Far from regarding this fact as evidence

that the abuse did not occur, the client reported that she must, therefore, have been abused by a different man. While this example does not in any way *prove* that abuse did not occur, it does provide an example of a client altering the story to fit the facts and grants some credence to the notion that it is possible to recall events inaccurately. Ceci and Loftus (1994) cite the example of Laura Pasley who sued her therapist for incompetence, having recovered memories which Laura later retracted, believing them to be false. Unfortunately, it is not clear whether Laura had any corroborating evidence that the abuse did not occur, and so this cannot be regarded as evidence of false recall. In fact it is almost impossible to prove that abuse did not occur, with the retraction of earlier statements alone constituting insufficient evidence (Pezdek, 1994). Read and Lindsay (1994) conclude that even their critics now concede that false memories can be implanted by therapists, and maintain that the debate has shifted from the possibility of therapy-induced false beliefs to their prevalence. The specific attitudes and behaviour of therapists has been cited by false memory proponents as a factor contributing to this prevalence.

3.1 The contribution of therapists to the recovery of false memories

Watkins (1995) states that "Certainly part of the controversy today is the fault of overeager therapists who have too suggestively championed the possibility of child abuse" (p178). Some have blamed poorly trained therapists for inadvertently implanting false memories of abuse in their clients, or therapists who practise without an understanding of psychological theories of normal memory. However, it is not only the inexperienced and incompetent who are accused of eliciting false memories during therapy. Scotford (1994) the director of the British False Memory Society (BFMS) claims that, while therapists "palm off blame" (p 5) onto poorly trained hypnotherapists, in fact the BFMS also receives complaints about fully trained professionals such as psychiatrists and psychologists. Ceci and Loftus (1994) state that even eminent, experienced therapists use techniques likely to create false memories. They cite the example of Fredrickson (1992) who states that survivors will have a series of realisations of the abuse without a

sense of having experienced it, and that they will refer to this as memory not because they recall the experience but more because the pieces fit into their sense of reality. Ceci and Loftus (1994) criticise Fredrickson for his apparent lack of concern that such "realisations" may indeed not be true memories. Similarly, Rogers (1995) found a significant number of doctoral therapists to regularly apply methods involving leading suggestions which may have potential risk, and Andrews, Morton, Bekerian, Brewin, Davies, and Mollon's (1995) survey of the beliefs of British Psychological Society (BPS) practitioners revealed that many psychologists believe their clients' reports of ritual satanic abuse, despite the La Fontaine report (1994) which found no evidence of satanic abuse and despite any lack of police or other corroborative evidence for the practice. It has been argued, therefore, that recovery of false memories is a function of suggestive probing by the therapist or the influence of popular culture (for example Lindsay and Read, 1994; Loftus, 1993). However, such claims are not supported by any systematic, empirical or ecologically valid evidence (Berliner and Williams, 1994). Indeed Elliott (1994) found only 15 per cent of subjects recalling abuse to have done so during psychotherapy, contrary to Roe et al's (1994) figure of two thirds, suggesting that more often than not factors other than therapy or the therapist are triggering the recall. False memory proponents ignore the fact that there is a standard of care in psychotherapy literature, and unfairly deploy selective references to anecdotal accounts of bad practice to support their stance (Brown, 1995). The suggestion that therapists deliberately plant false memories has been criticised by McKissack (1993) on the basis that, if false memories are created by unscrupulous therapists, their motives are, at the least, puzzling (Withers and Mitchell, 1995). Indeed, most professionally trained therapists are aware of the dangers. The fact that the BPS have issued guidelines to help prevent the creation of false memories in therapy is an indication of the awareness within the psychology profession of such risks (BPS, 1995). While the BPS guidelines suggest ways in which practitioners can minimise the risk of false memory production, it has been argued that it is the nature of certain memory recovery therapies, rather than specific therapist interactions, which may inadvertently lead some adults to create illusory memories (Lindsay and Read, 1994) and that the BPS guidelines do not go far enough in warning

against these methods (McCullough, 1996).

4 The contribution of memory recovery methods to the recovery of false memories

4.1 Hypnosis

In particular, the use of hypnotic procedures has come under some criticism for producing false recall, as a result of the suggestibility of clients under hypnosis. As Bloom (1994) reflects, "Every clinician using hypnosis is asked on occasion to facilitate recall of past memories of trauma including sexual abuse. The response to these requests by therapist and patient may profoundly shape the recalled memory itself and how it is subsequently used." (p173-4). Furthermore, Campbell (1995) states that "It has long been known that the effects of hypnosis are to increase productivity, most of which is error, and to increase confidence for both correct and incorrect material" (p 190). Campbell also warns against "disguised hypnotic procedures", such as regression work, dream analysis and guided imagery, and Lindsay and Read (1994) also cite a range of techniques which they regard as likely to increase the incidence of false recall.

On the other hand, Brown (1995) cites studies which have found the high hypnotisability of clients, rather than the specific use of hypnosis, to be associated with the creation of false memories, for example Laurence and Perry (1983) and Orne (1979). Pseudomemories were found to reduce when free recall was used as opposed to forced choice retrieval strategies, and Sheehan, Statham and Jamieson (1991) conclude an interaction between hypnotisability and social influence in the creation of false memories. While Andrews et al (1995) regard as acceptable the direct questioning of a client concerning whether they have been abused, this in itself could be regarded as a loaded suggestion with which the client may feel socially influenced to comply, and the very use of the question implies plausibility of earlier abuse as an explanation of current symptoms. Contrary to the fact that therapists using hypnosis may be responsible for

inadvertently creating false memories, Andrews et al (1995) found therapists using hypnotic regression to be more alert than others to the possibility that their own clients' memories could be false. Another therapy frequently criticised is bibliotherapy, involving popular books.

4.2 Popular books

Several authors have expressed concern at the rise of popular books about abuse, particularly that of Bass and Davis (1988) "The Courage to Heal", fearing that such books may inadvertently lead some readers to create illusory memories or beliefs of childhood sexual abuse (Lindsay and Read, 1994). Indeed, Campbell (1995) goes as far as to suggest that the most common way in which false memories enter conscious is through reading this book. According to Campbell (1995) the book encourages suing without external corroboration, and refers to ritual satanic abuse despite the fact that so far no evidence has been found for such practices (La Fontaine, 1994; Lanning, 1992). However, despite the concern expressed by some authors, there is as yet no hard evidence that reading the book has led to the creation of false memories of abuse, and indeed it is questionable whether such evidence could ever be found, although the Independent on Sunday, 15 May (1994) reported that Laura Davis, who wrote a companion book, "The Courage to Heal Workbook" is being sued for professional negligence and misrepresentation by a reader for advice given in the book.

There is, as yet, no evidence that any particular therapeutic approach may produce false memories (Mollon, 1996). Recovered memory is not limited to sexual abuse, nor to the therapeutic context, nor to untrained therapists and is a robust and frequent phenomenon (Andrews et al, 1995) and so neither therapists nor therapies can take the full responsibility for the recovery of such memories. If this is the case and if recovered memories are not generally implanted by therapists, then the onus is on those believing such memories to be genuine to provide evidence that experiences of abuse can be forgotten and subsequently recovered. It is necessary to explore the evidence suggesting

that childhood sexual abuse can be forgotten for a period and later recovered.

5 The evidence that childhood sexual abuse can be forgotten and later recovered

Proponents of genuine recovered memory have cited a wealth of studies documenting that people who have been sexually abused as children have, at some time, forgotten the experience. Elliott and Briere (1995) found 42 per cent of a sample of sexually abused subjects to report some level of amnesia for the abuse, with 20 per cent describing a period of complete amnesia. However, as Elliott and Briere acknowledge, one weakness of this study is its reliance on uncorroborated, retrospective data. Similarly, Herman and Schatzow (1987) found 64 per cent of the 53 clients in a twelve week group therapy programme to have some degree of memory impairment and 28 per cent to have severe lacunae in memories of the abuse. However, once again the study places reliance on clients' retrospective reports, assessed by memory recovery therapists (Lindsay and Read, 1994). Herman and Schatzow (1987) claim that 74 per cent of their patients obtained independent corroboration of the abuse, although the nature of this corroboration is not detailed in the report (Williams, 1995). Furthermore, the term "impairment" is not defined and could presumably range from forgetting minor details of the abuse to being unable to recall it at all for a period of time. Further retrospective studies by Feldman-Summers and Pope (1994) and Loftus et al (1994) reported similar findings with regard to subjects' forgetting and recall of abuse.

The problems of retrospective studies are overcome by Widom and Morris (1993) in a longitudinal study in which they found a substantial proportion of a sample of documented child abuse cases to fail to recall at follow-up, although it is not clear whether the "substantial proportion" referred to is significant. Williams (1994) attempted to overcome the methodological weakness of lack of external corroboration of abuse by interviewing a sample of women for whom earlier childhood sexual abuse was well documented in medical records (Williams. 1994). She found that 38 per cent of 129

women with documented abuse histories did not recall the abuse on re-interview seventeen years later. Of those recounting the abuse, 47 per cent claimed that there had been a time when they had not remembered the abuse. Unlike most other retrospective studies, Williams' study provides clear corroborative evidence that abuse did occur. The shortcoming of the study is that it relies on subjects' retrospective reports of the *forgetting* of the abuse. It is unclear how reliable are the individuals' retrospective reports that they had not remembered the event for a period, and there may be alternative reasons for those not recalling at the time of the interview. Failure to recount the memory to a researcher does not imply forgetting, and may instead reflect deliberate avoidance (Ceci and Loftus, 1994). Furthermore, Della Femina, Yeager and Lewis (1990) in a study documenting severe physical abuse, found apparent lack of memory to do with underreporting rather than amnesia for a variety of reasons, including being too painful to discuss, a desire to protect parents, a belief that they deserved the abuse, a dislike of the interviewer or a desire to forget. This raises the issue of how far it is possible to distinguish between amnesia or underreporting for abuse and also of the extent to which it may be unhelpful to remind people of events which they may have good reason to wish to forget.

Furthermore, some of the subjects in these studies reported always having been aware of the abuse and that there had never been a period during which they had forgotten. Research has found forgetting to be related to the degree of intensity, severity and duration of the trauma, and to the age of abuse onset, with less recall for those for whom abuse began at a younger age (Van der Hart and Nijenhuis, 1995; Van der Kolk and Van der Hart, 1989; Herman and Schatzow, 1987). Williams (1994) also found the "forgetters" in her study to be younger at the time of the abuse and were less likely to have received support from their mothers or any counselling at the time. This may suggest that the opportunity for support provides the individual with a way of making sense of what occurred, making it less likely that they would forget the abuse and supports the findings detailed earlier of Terr (1990) amongst others, in which opportunity for expressing and sharing traumatic experiences may enhance memory. There are clearly individual differences in the extent to which traumatic memories may be forgotten.

In order to support the notion that some individuals may forget an experience of abuse for a period of time, the proponents of recovered memory have outlined the mechanisms that may account for such forgetting. Cognitive researchers have differing views about the mechanisms underlying loss of memory, including repression, dissociation and childhood amnesia (Lindsay and Read, 1994).

6 The putative mechanisms involved in the forgetting of early traumatic experiences

6.1 Repression

One mechanism used to explain forgetting of childhood sexual abuse is that of repression. In the classic Freudian model, repression is regarded as an unconscious defence mechanism which can function to protect the individual from memories which would produce anxiety, apprehension or guilt were they to become conscious (Reber, 1987). This mechanism would, therefore, provide a possible explanation for the forgetting associated with childhood sexual abuse were it not for the fact that the concept of repression itself is controversial. Repression has been defined as merely "a hypothesised mental process" (Reber, 1987 p640) and a "fuzzy concept" (Van der Hart and Nijenhuis, 1995) for which there is no evidence (Holmes, 1990) and which even some psychoanalytic authors would like abolished (Giora, 1989, Shapiro, 1965). However, Watkins (1995) states that the process of repression is well supported contrary to the assertions of researchers such as Loftus (1993) and that there is some evidence for the concept (Davis, 1987; Weinberger, Schwartz, and Davidson, 1979).

If we accept that the concept of repression is, as some suggest, the mechanism by which memories of sexual abuse are not recalled, it would follow that medical procedures such as catheterisation, which are just as traumatic to children, would also be subject to

repression (Ceci and Loftus, 1994) yet such memories are rarely recovered in therapy. Similarly, Gardner (1992) compares forgetting of abuse with forgetting of time spent in a concentration camp, alleging that, if trauma was to be forgotten, then so would experience of the concentration camps. However, the two experiences are incomparable as one may be an isolated incident, the other a considerable and prolonged change of life circumstances, witnessed and experienced by others. This suggests that a failure to recall may have nothing to do with repression.

Furthermore, different authors within the recovered memory debate appear to use a variety of definitions for "repression". Technically, if an experience has been repressed it is not available for conscious retrieval, and so, by this definition, repression could not account for memories of abuse recovered in therapy (Cohler, 1994). Ceci and Loftus (1994) therefore, regard repression as an overused explanation for memory failure. Ofshe and Watters (1993) regard repression to be an invalid construct, concluding that all memories based on repression are necessarily false. However, it is not a logical conclusion to suggest that all recovered memories are false because of problems with the concept of repression, as they could arguably be a function of less controversial mechanisms such as infantile amnesia or dissociation. Indeed sceptics of recovered memory, for example Loftus (1993), frequently selectively focus their attacks on the concept of repression while ignoring the vast literature on total amnesia for traumatic events (Van der Hart and Nijenhuis, 1995).

6.2 Dissociation

A further mechanism which may explain the forgetting of childhood sexual abuse is that of dissociation, the process whereby thoughts or memories that produce anxiety are cut off from consciousness (Reber, 1987). Williams (1995) suggests that "If the young child has limited resources to cope with the abuse, she may rely on dissociation as a means for dealing with overwhelming trauma, or she may become adept at altering her state of consciousness" (Williams, 1995, p 668). This is consistent with the findings suggesting

that duration of abuse is important in forgetting (for example: Van der Hart and Nijenhuis, 1995; Van der Kolk and Van der Hart, 1989; Herman and Schatzow, 1987) as the longer the duration of the abuse, the more likely is the individual to acquire the defence of dissociation. However, dissociation may be regarded more as a description of observable behaviour than an explanation of it, which has encouraged researchers to seek alternative explanations for forgetting of early abuse.

6.3 Infantile amnesia

Several researchers have turned to the concept of infantile amnesia in response to a traumatic event as a possible explanation for forgetting. The research evidence suggests that earliest recall for events is rarely before the ages of three to four (Pillemer and White, 1989; Sheingold and Tenney, 1982; Wetzler and Sweeney, 1986). This would account for the findings suggesting that age of onset of abuse affects recall (Van der Hart and Nijenhuis, 1995; Van der Kolk and Van der Hart, 1989; Herman and Schatzow, 1987) and may account for very early abuse experiences not being available for recall. However, by the same token, it is unlikely that these early memories would be later recalled in adulthood (Williams, 1995) on the basis that what has not been encoded in the first place cannot be recalled (Ornstein, 1995). However, contemporary cognitive psychology argues that the mode of encoding memories changes with the acquisition of language, rendering the earlier memories irretrievable (Reber, 1987). If early information is encoded non-verbally then it may be retrievable if triggered by nonverbal stimuli, for example another victimisation experience or certain types of therapy (Pillemer and White, 1989), for example imagery or hypnosis. It is not uncommon to experience as a therapist clients for whom a traumatic experience in adulthood has triggered an emotional response to earlier abuse. Events may be recalled once they fit the adult schemata, whereas they were not understood by the child at the time and therefore not incorporated (Harvey and Herman, 1994; Usher and Neisser, 1993) This is consistent with the findings of Williams (1995) that maternal support or counselling for the child may aid memory by enabling the child to make sense of the event and so enabling the memory to be

incorporated and so reduce stress. Indeed, fewer stress symptoms have been found in children receiving maternal support (Everson, Hunter, Runyan, Edelson, and Coulter, 1989; Waterman, 1993) although this may be a spurious correlation, in that in those families where mothers were speaking openly to their children about the abuse, the child may be more likely to be removed from the abuse.

So, those seeking to demonstrate that recovered memories can be genuine have provided some possible explanations of the ways in which childhood sexual abuse may be forgotten, then subsequently recalled in adulthood. However, most explanations of forgetting seem more descriptive of the fact that traumatic events may be forgotten than they are explanatory of the way in which this occurs. Understanding of memory mechanisms generally tends to be theoretical and the mechanisms which underpin observable memory phenomena are arguably mere constructions accounting for what is observed rather than a factual account of what is known about the way in which memory operates. A further complication that needs to be addressed by both sides of the controversy is the apparent difficulty of distinguishing between false and true memories.

6.4 The discrimination between accurate and inaccurate memories of sexual abuse

Before a resolution of the controversy, both sides of the debate need to recognise that true and false memories of child sexual abuse are not always easily differentiated (Gardner, 1995). The discrimination of true from inaccurate recall of memories for clients who have undergone extensive memory recovery therapy is problematic, as "illusory memories can look, feel, and sound like real memories." (Lindsay and Read, 1994, p325). Roe et al (1994) found abuse memories to become more vivid and patients to became more confident in them over time. However, these findings are consistent with both genuine improved recall and with mistaken recall (Ceci, Huffman, Smith and Loftus, 1994) and so do not aid in the search for discriminatory criteria.

It has been suggested that there may be some means of distinguishing true from false

memories, for example with the use of EEG (Campbell, 1995) or with training, as has been used for psychotic patients (Watkins, 1995), although it could be argued that the delusions of psychotic patients bear no relation to false recall of abuse. There is some evidence that people tend to use different language when describing illusory memories than when describing memories of events actually experienced (Schooler, Gerhard and Loftus, 1986; Johnson and Suengas, 1989) and work is currently proceeding on expanding content validity analysis to address the problem of differentiation (Lindsay and Read, 1994). However, at present there are clearly no criteria for discriminating between false and accurate recall of abuse and, indeed, some therapists regard the ability to discriminate in this way as immaterial, with the exception of cases in which litigation may be involved. Rather than focusing on the validity of clients' memories, perhaps it would be more pertinent to address the secondary gains involved with clients who produce such memories, if indeed they do, and to avoid confirming or denying clients' memories, working instead on their underlying motivations (Spector, 1996).

7 Is memory recovery necessary and therapeutic?

One concern of those who argue against the concept of false memory is that genuine survivors of sexual abuse may not be taken seriously, and so may not receive adequate help. This highlights the fact that throughout the debate there has been an assumption that all those who have genuinely suffered from abuse should be made aware of the fact and receive some form of therapy. However, several authors have questioned the therapeutic value of uncovering events, even if they genuinely did occur, and of the extent to which a past experience of abuse can lead to present day symptoms.

The belief of some therapists that all symptoms have trauma as their primary aetiology may be a possible factor which can lead to false recall (Brown, 1995). Berliner and Williams (1994) state that "some therapists make the mistake of attributing far too many current problems to a sexual abuse history" (p384) and that "the importance of the factor

of sexual experience in the causation of disease has been greatly overestimated by Freud" (Moll, 1913 p279). For example multiple personality disorder (MPD) is said to have an aetiology of child sexual abuse (Coons and Milstein, 1986) and DSM-IV lists traumatic childhood abuse as the sole predisposing factor in MPD. however "So firmly is child abuse linked with the theory of MPD pathogenesis that some investigators have used abuse as the criterion for diagnosis", Piper (in press, p26) and so diagnosis becomes circular. Furthermore, Piper states that "sexual abuse does not appear to predispose to any one diagnosis" (p27).

It is well documented that people who have experienced trauma do not all react in the same way, for example not everyone who experiences a traumatic event develops PTSD symptoms. Perhaps it is because child sexual abuse is considered so abhorrent that it is difficult for therapists to accept that individuals can survive abuse without developing psychological problems. This may also be a function of the fact that therapists may only see those survivors who have developed psychological problems and have little experience of those who do not develop symptoms, as they do not present for therapy. However, it is the case that several of the recent studies have not involved a clinical population (for example: Feldman-Summers and Pope, 1994) and so should help to redress any bias. If not all abuse leads to symptoms, it could be argued that not all those abused require therapy. It is possible that defences such as denial, repression or dissociation may have enabled some survivors to continue to function without developing pathological symptoms. If this is the case, it may be useful to leave these defences intact, rather than to assume that such defences are always more damaging to the individual than the uncovering of the trauma. Ceci and Loftus (1994) argue that if unconscious past memories lead to symptoms, so may consciously dwelling on them. Campbell (1995) blames "New Age ideology that insight into symptoms leads to their alleviation, and that a relentless search for 'confirmatory' imagery is therapeutic" (p 196). Moll (1913) asks whether "interminable digging" into a client's past is necessary to achieve a positive mental health outcome and the possibility has been raised that an approach dealing with past trauma may detract from other important therapeutic issues (Haaken and Schlaps,

1991). However, several have disagreed with this, regarding dealing with past issues to be therapeutic. Herman (1992) states that directly addressing the feelings and beliefs related to prior traumatic events can be helpful in reducing symptoms, and Herman and Schatzow (1987) liken the treatment of a client without excavating their past to the planting of a garden on a toxic waste site, although they do not provide any evidence that this is the case (Briere, 1989). Indeed Spiegal (1994) found no difference in the outcomes between treatments involving dealing with current symptoms and those involving working on past experiences. For this reason, Ceci and Loftus (1994) ask whether it is worth the risk of using memory recovery methods until the base rates for false recall are known, however, it is unlikely that this can ever be known for certain, given the frequent lack of external corroboration and the fact that false and true memories are indistinguishable in their nature (for example: Lindsay and Read, 1994). The fact remains that the actual number of those adults who have been sexually abused as children is not known and nor is the number of those who have developed psychological problems as a result. It is, therefore, important not to assume that memory recovery therapies always provide the most beneficial approach, regardless of one's stance on whether such memories are accurate or not, particularly in view of the resulting upheaval in family systems when abuse, either accurately or inaccurately is recovered.

8 The False Memory Societies

Much concern centres around the damage to families of false accusations. "False allegations cause a huge amount of distress in the relatively small number of families where this occurs and these families should be identified and supported (Toon et al, 1996). False Memory Societies have been founded in several countries to support parents who claim to have been wrongly accused of abuse. The False Memory Society Foundation (FMSF) was established in America, founded by Pamela and Peter Freyd in 1992, who were themselves accused of abusing their daughter after she had undergone two sessions of psychotherapy (Fried, 1994). They do little to add credence to their

claims, however, by producing emotive and misleading publications, and by some of the extreme views held by their founder members.

The false memory societies maintain that it is not possible for true memories of traumatic events to be forgotten, regarding any recollection of abuse from previous amnesia to be false. However, by adopting such a rigid stance, they disregard the evidence to the contrary, for example, Herman and Schatzow (1987), Briere and Conte (1993) and Williams (1992), and the studies of those traumatised by war (Archibald and Tuddenham, 1965; Grinker and Spiegal, 1945; Kolb, 1984). Following from this extreme viewpoint is the assumption by the false memory societies that all those who deny abuse are innocent and they make no attempt to screen out genuine abusers, accepting that all those who contact their society have been wrongly accused (Watkins, 1995). The language in the false memory society publications is emotive and provocative. The FMSF publish newsletters, in which they claim that false accusations of child sexual abuse are "running rampant" and that "an epidemic is emerging ...[which is] the mental health crisis of the decade - if not the century!" (FMS Foundation Newsletter, November1991). The Director of the British counterpart to the FMSF, the BFMS, himself accused of sexually abusing his two daughters, likens the false memory phenomenon to the Salem witch hunt of 1692 (Scotford, 1994). In a paper to the British Society of Experimental Hypnosis (BSEH) (1994) Scotford states that the deep cultural anxiety concerning child sexual abuse may be leading to overexaggeration of its incidence, and asks "has the pendulum of concern swung too far the other way?"(p 2).

In his address to the BSEH, Scotford dismisses therapeutic methods such as the empty chair technique as "necromancy". He states that police regard hypnosis as a "truth serum" and that juries convict in spite of the lack of corroborative evidence, although he does not provide any support for this claim. As information gleaned during hypnosis is not admissible as hard evidence in court, this suggests that the law does, in fact, recognise the fallibility of memories recalled under hypnosis, rendering Scotford's claim untenable. He then lists a catalogue of myths about recovered memory, including that memories

retrieved under hypnosis are more accurate than other memories and that it is possible to regress clients to a former life. Scotford does not make it clear, however. who he regards as believing such myths. Trained professionals, particularly those who practise hypnosis are all too aware of the suggestibility of those under hypnosis (for example: Andrews et al, 1995). Such emotive language and unsupported claims do little to assist a reasoned debate.

Furthermore, the case of the false memory societies is not assisted by the views held by some of its founder members regarding child sexuality. Early advocates of false memories, Paul and Shirley Eberle, have been regarded by some as proponents of child pornography, being described by one police child abuse expert as "the most prolific publishers of child pornography in the USA". Similarly, Watkins (1993) reports that Ralph Underwager, an early founder and director of the FMSF was quoted approving paedophilia as "a responsible choice" in family relations and "a part of God's will". Also worrying is the assertion by Gardner (1992) that not all sexual activities between adults and children are psychologically damaging. While this may be true in the sense that not all those abused develop symptoms, this should not, however, condone the practice. Such views undermine the claims of the false memory societies and have rendered others sceptical of their motives. It is unfortunate that much of the current controversy appears to centre around the firmly-held beliefs of those involved in the debate, as this polarisation of views is unhelpful to both genuine survivors and to those falsely accused (Withers and Mitchell, 1995).

9 Summary and conclusion

Despite mixed research findings, there is clearly some evidence to support both sides of the debate. In light of the evidence of the fallibility and suggestibility of memory. it is conceivable that there are occasions when individuals develop false memories of childhood sexual abuse. However. the evidence suggesting that it is also possible to

forget and later recall sexual abuse indicates that recovered memory for real events is also a genuine phenomenon. The extreme positions adopted are, therefore, not tenable and to claim either that false memories are never created, or that genuine abuse is never forgotten cannot be justified in view of the evidence. A more rational position is to accept that both may be possible. A more productive way forward, therefore, would be to explore the factors likely to produce false memories and to draw up guidelines to aid practitioners (for example BPS, 1996; Bloom, 1994) in order to reduce the incidence of false memory creation. This will help to protect therapists from accusations of bad practice and to prevent the growing scepticism for child sexual abuse which this emotive and polarised debate has engendered. The reality is that child sexual abuse does occur in all too many cases, and, as Toon et al (1996) put it, "This reality and its distressing effects on victims and their families must not be lost in the current uproar." (p77).

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Appendix 1: Instructions for researchers.

Research into the effects of traumatic experience

Instructions for researchers

Dear Colleague

Thank you for agreeing to help with this research into the coping styles of patients with Posttraumatic Stress Disorder, (PTSD). It is hoped that the results of this research may lead to the design of more appropriate therapies for those clients who do not benefit from the currently available therapies.

This pack contains two sets of papers, **Pack A** and **Pack B.**

Pack A contains:

- 1 x Participant consent form
- 1 x Posttraumatic-stress Diagnostic Scale (PDS)
- 1 x Impact of Events Scale (IES)
- 1 x Monitor-Blunter Style Scale (MBSS)
- 1 x Hospital Anxiety and Depression Scale (HADS)

Pack B contains:

- 1 x Posttraumatic-stress Diagnostic Scale (PDS)
- 1 x Impact of Events Scale (IES)
- 1 x Hospital Anxiety and Depression Scale (HADS)
- 1 x Patient Details and Researcher Observation Sheet

Instructions

- Please explain the nature of the study as outlined in the ***Participant Consent Form*** (from Pack A) to all those patients who present with symptoms of PTSD.

- Ask those who agree to take part to complete the ***Participant Consent Form***, and provide them with a copy.

- Please ensure that you inform the patient's GP of the study before the start of the research (required for ethical reasons, and can be done by adding a line on your standard letter to the GP)

- Administer **Pack A** before the start of therapy to all those patients who have given their written consent to participate in the study.

- Do not write the participant's name on any of the papers - a unique reference code has been allocated by the researcher instead.

- At the end of therapy or after 8 sessions, whichever is sooner, you should complete, yourself, the ***Patient Details and Researcher Observations Sheet*** from **Pack B**.

- Administer the remainder of **Pack B** to the participant.

- You are not required to score any of the tests yourself, unless you wish to do so for your own purposes.

- Please return all completed paperwork to:

Jacqui Farrants, Chartered Counselling Psychologist, Community Mental Health Team, Victoria Centre, Pettits Lane, Romford, Essex, RM1 4HL

If you have any queries, please telephone me at the Victoria Centre on 01708 724416, or e-mail me at J.R.Farrants@city.ac.uk. Thank you for your co-operation

Yours sincerely,

Jacqui Farrants, BSc (Hons), MSc, CPsychol.
Chartered Counselling Psychologist

Appendix 2: The Monitor-Blunter Style Scale (MBSS)

Subject #: _____ Date:__ / __ / __

MONITOR-BLUNTER STYLE SCALE (MBSS)

1. Vividly imagine that you are **afraid** of the dentist and have to get some dental work done. Which of the following would you do ? Check **all** of the statements that might apply to you.

___ I would ask the dentist exactly what he was going to do.

___ I would take a tranquilizer or have a drink before going.

___ I would try to think about pleasant memories

___ I would want the dentist to tell me when I would feel pain.

___ I would try to sleep.

___ I would watch all the dentist's movements and listen for the sound of the drill.

___ I would watch the flow of water from my mouth to see if it contained blood.

___ I would do mental puzzles in my mind.

2. Vividly imagine that you are being held hostage by a group of armed terrorists in a public building. Which of the following would you do? Check **all** of the statements that might apply to you.

___ I would sit by myself and have as many daydreams and fantasies as I could.

___ I would stay alert and try to keep myself from falling asleep.

___ I would exchange life stories with the other hostages.

___ If there was a radio present, I would stay near it and listen to the bulletins about what the police were doing.

___ I would watch every movement of my captors and keep an eye on their weapons.

___ I would try to sleep as much as possible.

___ I would think about how nice it's going to be when I get home.

___ I would make sure I knew where every possible exit was.

3. Vividly imagine that, due to a large drop in sales, it is rumoured that several people in your department at work will be laid off. Your supervisor has turned in an evaluation of your work for the past year. The decision about lay-offs has been made and will be announced in several days. Check **all** of the statements that might apply to you.

___ I would talk to my fellow workers to see if they knew anything about what the supervisor's evaluation of me said.

___ I would review the list of duties for my present job and try to figure out if I had fulfilled them all.

___ I would go to the movies to take my mind off things.

___ I would try to remember any arguments or disagreements I might have had with the supervisor that would have lowered his opinion of me.

___ I would push all thoughts of being laid off out of my mind.

___ I would tell my spouse that I'd rather not discuss my chances of being laid off.

___ I would try to think which employees in my department the supervisor might have thought had done the worst job.

___ I would continue doing my work as if nothing was happening.

4. Vividly imagine that you are on an airplane, thirty minutes from your destination, when the plane unexpectedly goes into a deep dive and then suddenly levels off. After a short time, the pilot announces that nothing is wrong, although the rest of the ride may be rough. You, however, are not convinced that all is well. Check **all** of the statements that might apply to you.

___ I would carefully read the information provided about safety features in the plane and make sure I knew where the emergency exits were.

___ I would make small talk with the passenger beside me.

___ I would watch the end of the movie, even if I had seen it before.

___ I would call for the flight attendant and ask her exactly what the problem was.

___ I would order a drink or tranquilizer from the flight attendant.

___ I would listen carefully to the engines for unusual noises and would watch the crew to see if their behavior was out of the ordinary.

___ I would talk to the passenger beside me about what might be wrong.

___ I would settle down and read a book or magazine or read a letter.

Impact of Events Scale

On .....(date) you experienced .... (life event)

Below is a list of comments made by people after stressful life events. Please check each item, indicating how frequently these comments were true for you DURING THE PAST SEVEN DAYS. If they did not occur during that time, please mark the "not at all" column.

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

Horowitz et al (1979)

Appendix 4: The Posttraumatic Stress Diagnostic Scale, (PDS)

Part 1

Many people have lived through or witnessed a very stressful and traumatic event at some point in their lives. Below is a list of traumatic events. Put a checkmark in the box next to ALL of the events that have happened to you or that you have witnessed.

(1) ☐ Serious accident, fire, or explosion (for example, an industrial, farm, car, plane, or boating accident)

(2) ☐ Natural disaster (for example, tornado, hurricane, flood, or major earthquake)

(3) ☐ Non-sexual assault by a family member or someone you know (for example, being mugged, physically attacked, shot, stabbed, or held at gunpoint)

(4) ☐ Non-sexual assault by a stranger (for example, being mugged, physically attacked, shot, stabbed, or held at gunpoint)

(5) ☐ Sexual assault by a family member or someone you know (for example, rape or attempted rape)

(6) ☐ Sexual assault by a stranger (for example, rape or attempted rape)

(7) ☐ Military combat or a war zone

(8) ☐ Sexual contact when you were younger than 18 with someone who was 5 or more years older than you (for example, contact with genitals, breasts)

(9) ☐ Imprisonment (for example, prison inmate, prisoner of war, hostage)

10) ☐ Torture

11) ☐ Life-threatening illness

12) ☐ Other traumatic event

13) If you marked Item 12, specify the traumatic event below.

_____

IF YOU MARKED ANY OF THE ITEMS ABOVE, CONTINUE. IF NOT, STOP HERE.

Part 2

(14) If you marked more than one traumatic event in Part 1, put a checkmark in the box below next to the event *that bothers you the most.* If you marked only one traumatic event in Part 1, mark the same one below.

☐ Accident
☐ Disaster
☐ Non-sexual assault/someone you know
☐ Non-sexual assault/stranger
☐ Sexual assault/someone you know
☐ Sexual assault/stranger
☐ Combat
☐ Sexual contact under 18 with someone 5 or more years older
☐ Imprisonment
☐ Torture
☐ Life-threatening illness
☐ Other

In the box below, briefly describe the traumatic event you marked above.

_____
_____
_____
_____
_____
_____

Below are several questions about the traumatic event you just described above.

(15) How long ago did the traumatic event happen? (circle ONE)

1 Less than 1 month
2 1 to 3 months
3 3 to 6 months
4 6 months to 3 years
5 3 to 5 years
6 More than 5 years

For the following questions, circle Y for Yes or N for No.

During this traumatic event:

(16) **Y N** Were you physically injured?

(17) **Y N** Was someone else physically injured?

(18) **Y N** Did you think that your life was in danger?

(19) **Y N** Did you think that someone else's life was in danger?

(20) **Y N** Did you feel helpless?

(21) **Y N** Did you feel terrified?

Part 3

Below is a list of problems that people sometimes have after experiencing a traumatic event. Read each one carefully and circle the number (0–3) that best describes how often that problem has bothered you IN THE PAST MONTH. Rate each problem with respect to the traumatic event you described in Item 14.

0 Not at all or only one time
1 Once a week or less/once in a while
2 2 to 4 times a week/half the time
3 5 or more times a week/almost always

(22) **0 1 2 3** Having upsetting thoughts or images about the traumatic event that came into your head when you didn't want them to

(23) **0 1 2 3** Having bad dreams or nightmares about the traumatic event

(24) **0 1 2 3** Reliving the traumatic event, acting or feeling as if it was happening again

(25) **0 1 2 3** Feeling emotionally upset when you were reminded of the traumatic event (for example, feeling scared, angry, sad, guilty, etc.)

(26) **0 1 2 3** Experiencing physical reactions when you were reminded of the traumatic event (for example, breaking out in a sweat, heart beating fast)

---

(27) **0 1 2 3** Trying not to think about, talk about, or have feelings about the traumatic event

(28) **0 1 2 3** Trying to avoid activities, people, or places that remind you of the traumatic event

(29) **0 1 2 3** Not being able to remember an important part of the traumatic event

(30) **0 1 2 3** Having much less interest or participating much less often in important activities

(31) **0 1 2 3** Feeling distant or cut off from people around you

(32) **0 1 2 3** Feeling emotionally numb (for example, being unable to cry or unable to have loving feelings)

(33) **0 1 2 3** Feeling as if your future plans or hopes will not come true (for example, you will not have a career, marriage, children, or a long life)

(34) **0 1 2 3** Having trouble falling or staying asleep

(35) **0 1 2 3** Feeling irritable or having fits of anger

(36) **0 1 2 3** Having trouble concentrating (for example, drifting in and out of conversations, losing track of a story on television, forgetting what you read)

(37) **0 1 2 3** Being overly alert (for example, checking to see who is around you, being uncomfortable with your back to a door, etc.)

(38) **0 1 2 3** Being jumpy or easily startled (for example, when someone walks up behind you)

---

(39) How long have you experienced the problems that you reported above? (circle ONE)
1 Less than 1 month
2 1 to 3 months
3 More than 3 months

(40) How long after the traumatic event did these problems begin? (circle ONE)
1 Less than 6 months
2 6 or more months

Part 4

Indicate below if the problems you rated in Part 3 have interfered with any of the following areas of your life DURING THE PAST MONTH. Circle Y for Yes or N for No.

(41) **Y N** Work

(42) **Y N** Household chores and duties

(43) **Y N** Relationships with friends

(44) **Y N** Fun and leisure activities

(45) **Y N** Schoolwork

(46) **Y N** Relationships with your family

(47) **Y N** Sex life

(48) **Y N** General satisfaction with life

(49) **Y N** Overall level of functioning in all areas of your life

Appendix 5: PDS Hand Scoring Directions

Posttraumatic Stress™ Diagnostic Scale

Edna B. Foa, PhD

PDS™ Hand-Scoring Directions

Validity

1. **Items 1–12:** If the client marked at least one item, go to Step 2. If the client did not mark at least one item and did not respond to Items 13 and 14, put an X in the No box under "Criteria A–F Met?" at the bottom of the PDS Hand-Scoring Worksheet. This client does **not** meet *DSM-IV* criteria for posttraumatic stress disorder (PTSD), and the rest of the test should not be scored.

2. **Item 13:** If the client put a checkmark next to at least one item from 1–11, go to Step 3. If the client put a checkmark next to Item 12 **only**, the clinician must read the client's responses to Items 13 and 14 to determine if the event meets *DSM-IV* criteria for a "traumatic event." If it does, go to Step 3. Otherwise, put an X in the No box under "Criterion A–F Met?" at the bottom of the worksheet. This client does **not** meet *DSM-IV* criteria for posttraumatic stress disorder (PTSD). You can stop scoring at this point or continue scoring to determine the client's Level of Impairment in Functioning, Number of Symptoms Endorsed, Symptom Severity Score, and Symptom Severity Rating.

3. **Item 14:** Determine which traumatic event the client marked and write it on the Traumatic Event line at the bottom of the worksheet. (If the client chose "Other," refer to Item 13 and the box below Item 14 for a description of the event.) If Item 14 has no response or multiple responses, the clinician should determine what event the client based his or her answers on.

   Note: Item 15 is not included in any score calculations.

Worksheet Section A

4. **Items 16–19:** Record the number of Yes and No responses for Items 16–19. If the client omitted all four items, put an X in the Incomplete Information box under "Criterion A Met?" and go to Step 6 (skip Step 5). If the No total is 4, put an X in the No box under "Criterion A Met?" and go to Step 6 (skip Step 5). Otherwise, go to Step 5.

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ABCD

Product Number
51621

5. **Items 20–21:** On the worksheet, record the client's responses to Items 20 and 21. Fill in the appropriate box under "Criterion A Met?" according to the table below.

Client's Responses to Items 20 and 21	Criterion A Met?
One or two Yes	Yes
Both No	No
Any other combination	Incomplete Information

Worksheet Sections B, C, and D (Items 22–38)

6. In the first column of boxes in Sections B, C, and D, write the number of 0, 1, 2, and 3 responses the client chose. Add up the numbers in the boxes labeled 1's, 2's, and 3's and record the total in the Number of Symptoms box. (Do **not** count the number in the box labeled 0's.) If the client omitted all of the items in a section (B, C, or D), put an X in the Incomplete Information box **for that section.** Skip Step 7 **for that section.**

   Then multiply the number in each box (except the 0's box) by the number that appears to the right of the box (multiply the number of 1 responses by 1, the number of 2 responses by 2, etc.). Write the results in the boxes in the second column. Add up these numbers and write the total in the Symptom Severity box. Follow the above steps for Sections B, C, and D.

7. Using the tables below, put an X in the appropriate box for "Criterion Met?" for Sections B, C, and D.

	Number of 0 Responses	Criterion Met?
B	5	No (go to Step 8)
C	7	No (go to Step 8)
D	5	No (go to Step 8)

	Number of Symptoms	Criterion Met?
B	0	Incomplete Information
	1 or greater	Yes
C	Less than 3	Incomplete Information
	3 or greater	Yes
D	Less than 2	Incomplete Information
	2 or greater	Yes

Worksheet Section E

8. **Item 39:** Record the client's response to Item 39 on the worksheet. Find the client's response in the table below and put an X in the appropriate box for

"Criterion E Met?" in Section E and "Symptom Duration" at the bottom of the worksheet.

	Criterion E Met?	Symptom Duration (Specifier 1)
Response 1	No	Does Not Apply
Response 2	Yes	Acute
Response 3	Yes	Chronic
Omitted	Incomplete Information	Incomplete Information

9. **Item 40:** Record the client's response to Item 40 on the worksheet. If the client chose response 1, put an X in the No box under "Delayed Onset" at the bottom of the worksheet. If the client chose response 2, put an X in the Yes box under "Delayed Onset." If the client omitted the item, put an X in the Incomplete Information box under "Delayed Onset." (Note: The Symptom Duration and Delayed Onset specifiers are used only to identify onset and duration of PTSD symptoms. They are not used for determining whether or not a diagnosis of PTSD is appropriate.)

Worksheet Section F

10. **Item 49:** Record the client's response to Item 49 on the worksheet. If the client chose the Yes response, put a 9 in the Number of Areas Affected box and an X in the Yes box under "Criterion F Met?" Otherwise, count the number of Yes responses for **Items 41–48** and write the total in the Number of Areas Affected box. If this total is 2 or greater, put an X in the Yes box under "Criterion F Met?" If the number of No responses is 7 or greater, put an X in the No box. Otherwise, put an X in the Incomplete Information box.

PTSD Diagnosis

11. If you put an X in the Yes box under "Criterion Met?" in Sections A, B, C, D, E, **and** F, put an X in the Yes box under "Criteria A–F Met?" at the bottom of the worksheet. If you put an X in the No box for one or more of the criteria, put an X in the No box under "Criteria A–F Met?" Otherwise, put an X in the Incomplete Information box.

Level of Impairment in Functioning

12. Find the client's Number of Areas Affected for Criterion F in the table below and write the corresponding label on the Level of Impairment in Functioning line at the bottom of the worksheet.

Criterion F—Number of Areas Affected	Level of Impairment in Functioning
All omits	Unknown
0	No Impairment
1–2	Mild
3–6	Moderate
7–9	Severe

Number of Symptoms Endorsed

13. Add up the Number of Symptoms for Criteria B, C, and D. Write the total on the line labeled Number of Symptoms Endorsed at the bottom of the worksheet.

Symptom Severity Score and Rating

14. Add up the numbers in the Symptom Severity boxes for Criteria B, C, and D. Write the total on the line labeled Symptom Severity Score. Find the client's score in the table below and write the appropriate label on the Symptom Severity Rating line at the bottom of the worksheet.

Symptom Severity Score	Symptom Severity Rating
0	No Rating
1–10	Mild
11–20	Moderate
21–35	Moderate to Severe
36–51	Severe

Number of Omitted Items

15. For Items 14–49, look at the client's answer sheet and count the number of items he or she omitted. Write the total on the line labeled Number of Omitted Items at the bottom of the worksheet. Find the total in the table below and put an X in the appropriate box next to "Excessive Omits?" on the worksheet.

Number of Omitted Items	Excessive Omits?
0–5	No
6–12	Yes, symptoms may be understated
13–36	Yes, results are questionable

Appendix 6: The Hospital Anxiety and Depression Scale (HADS)

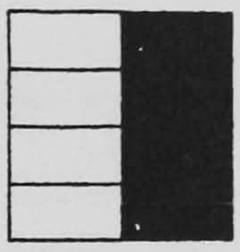
HAD Scale

Name: Date:

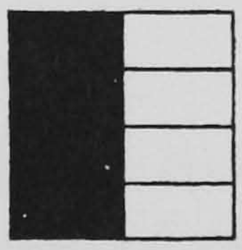
Doctors are aware that emotions play an important part in most illnesses. If your doctor knows about these feelings he will be able to help you more.
This questionnaire is designed to help your doctor to know how you feel. Read each item and place a firm tick in the box opposite the reply which comes closest to how you have been feeling in the past week.
Don't take too long over your replies: your immediate reaction to each item will probably be more accurate than a long thought-out response.

Tick only one box in each section

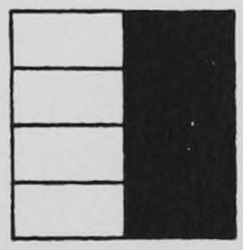
I feel tense or 'wound up':
- Most of the time .....
- A lot of the time .....
- Time to time, Occasionally .....
- Not at all .....



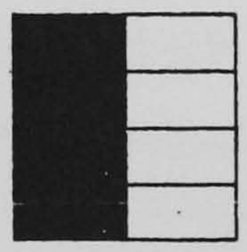
I still enjoy the things I used to enjoy:
- Definitely as much .....
- Not quite so much .....
- Only a little .....
- Hardly at all .....



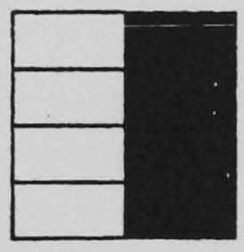
I get a sort of frightened feeling as if something awful is about to happen:
- Very definitely and quite badly .....
- Yes, but not too badly .....
- A little, but it doesn't worry me .....
- Not at all .....



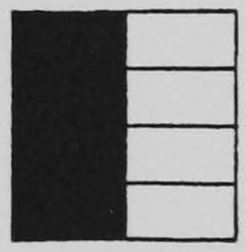
I can laugh and see the funny side of things:
- As much as I always could .....
- Not quite so much now .....
- Definitely not so much now .....
- Not at all .....



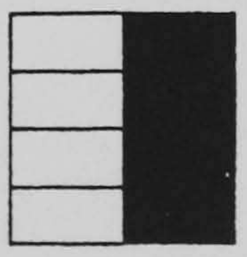
Worrying thoughts go through my mind:
- A great deal of the time .....
- A lot of the time .....
- From time to time but not too often ...
- Only occasionally .....



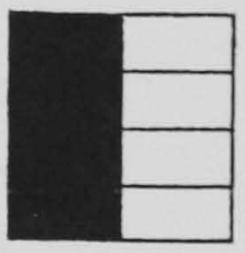
I feel cheerful:
- Not at all .....
- Not often .....
- Sometimes .....
- Most of the time .....



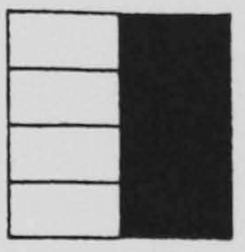
I can sit at ease and feel relaxed:
- Definitely .....
- Usually .....
- Not often .....
- Not at all .....



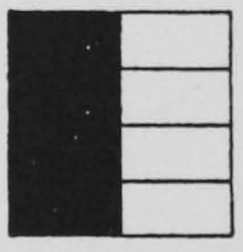
I feel as if I am slowed down:
- Nearly all the time .....
- Very often .....
- Sometimes .....
- Not at all .....



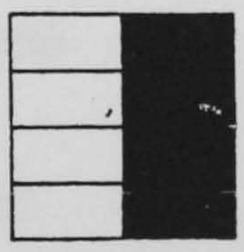
I get a sort of frightened feeling like 'butterflies' in the stomach:
- Not at all .....
- Occasionally .....
- Quite often .....
- Very often .....



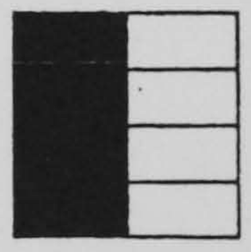
I have lost interest in my appearance:
- Definitely .....
- I don't take so much care as I should.....
- I may not take quite as much care .....
- I take just as much care as ever .....



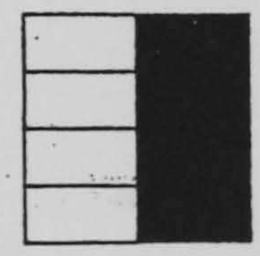
I feel restless as if I have to be on the move:
- Very much indeed .....
- Quite a lot .....
- Not very much .....
- Not at all .....



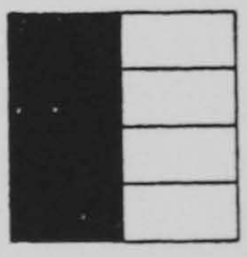
I look forward with enjoyment to things:
- As much as ever I did .....
- Rather less than I used to .....
- Definitely less than I used to .....
- Hardly at all .....



I get sudden feelings of panic:
- Very often indeed .....
- Quite often .....
- Not very often .....
- Not at all .....



I can enjoy a good book or radio or TV programme:
- Often .....
- Sometimes .....
- Not often .....
- Very seldom .....



Do not write below this line

Appendix 7: Participant Consent Form

Reference code……

Participant Consent Form

Research into the effects of traumatic experience

Information for the participant

I am conducting a research study in order to help people suffering from the effects of a traumatic experience. I am asking you to participate in the study, which will entail completing two very brief questionnaires about how you feel.

Only your therapist and myself will see the completed questionnaires. Your name will not appear on any of the questionnaires so that confidentiality will be maintained at all times.

Participant's consent:

I agree to participate in the above study. The purpose of the research has been explained to me by my therapist, and I have been given the opportunity to ask questions. I understand that I can withdraw from the study at any time, and this will not affect my therapy in any way.

Signature

Name Date

Address

Witnessed by:

Signature

Name Date

Appendix 8: Patient details and researcher observations sheet.

Reference code .....

Patient Details and Researcher Observations Sheet

Patient's age

Patient's gender

Date of first therapy session

Date of most recent therapy session

Total number of sessions attended

Researcher's name

Please state **briefly** your overall impression concerning the extent to which the patient engaged in therapy, and the extent of his/her improvement over the period. (continue overleaf if necessary).

Appendix 9: List of variables used in the analysis

Variable code names are denoted in **bold** *type. Numbers denote the codings for each of the responses where appropriate.*

Subject ref:.....**ref**

Period over which therapy took place, between before and after measures taken:.....**period**

Age .....**age**

Gender.....**gender** (male = 1; female = 2)

Number of therapy sessions between before and after measures taken:.....**sessions**

	Before	After
HADS		
Depression	**hadsdepa**	**hadsdepb**
Anxiety	**hadsanxa**	**hadsanxb**
IES		
Intrusion	**iesintra**	**iesintrb**
Avoidance	**iesava**	**iesavb**
MBSS		
Monitoring	**mbssm**	
Blunting	**mbssb**	

PDS

Reexperiencing		
Number of symptoms	**pdsrexna**	**pdsrexnb**
Severity of symptoms	**pdsrexsa**	**pdsrexsb**
Avoidance		
Number of symptoms	**pdsavna**	**pdsavnb**
Severity of symptoms	**pdsavsa**	**pdsavsb**
Arousal		
Number of symptoms	**pdsarna**	**pdsarnb**
Severity of symptoms	**pdsarsa**	**pdsarsb**
Level of impairment in functioning */Mod /Severe*	**pdsimpa** *No /Mild /Mod /Severe* **1 2 3 4**	**pdsimpb** *No /Mild* **1 2 3 4**
Number symptoms endorsed	**pdssynoa**	**pdssynob**
Symptom severity score	**pdssysea**	**pdssyseb**
Symptom severity rating *Mod-Severe /Severe*	**pdssyra** *Mild /Mod/ Mod-Severe /Severe* **1 2 3 4**	**pdssyrb** *Mild /Mod/* **1 2 3 4**
Symptom duration */Chronic*	**pdsdura** *NA /Acute /Chronic* **1 2 3**	**pdsdurb** *NA /Acute* **1 2 3**
Delayed onset	**pdsdela** *Yes /No* **1 0**	**pdsdelb** *Yes /No* **1 0**
Full diagnosis of PTSD	**pdsdiaga** *Yes /No* **1 0**	**pdsdiagb** *Yes /No* **1 0**
Therapist's comments	Qualitative data.	

Appendix 10: Raw data from questionnaires

	ref	age	gender	period	sessions	hadsdepa	hadsanxa
1	003	42	m	96	8	11	12
2	016	61	f	126	8	11	20
3	028	32	m	91	7	8	18
4	031	44	m	68	8	10	9
5	036	50	m	63	8	12	16
6	037	58	f	71	8	7	7
7	041	28	m	56	9	12	16
8	042	52	f	102	12	9	9
9	014	50	m	264	8	16	19

Stage 1

	iesintra	iesava	mbssm	mbssb	pdsrexna	pdsrexsa	pdsavna
1	12	8	8	5	5	9	3
2	16	23	11	5	4	10	7
3	12	15	9	4	5	7	4
4	16	19	7	5	5	13	7
5	20	17	16	2	5	6	7
6	18	13	11	4	5	14	7
7	21	17	12	2	5	14	7
8	15	13	5	5	5	8	4
9	19	11	4	3	5	11	7

Stage 1

	pdsavsa	pdsarna	pdsarsa	pdsimpa	pdssynoa	pdssysea	pdssyra
1	7	3	6	4	11	22	3
2	20	5	14	4	16	44	4
3	6	5	8	4	14	21	3
4	18	3	8	4	15	39	4
5	13	5	14	4	17	33	3
6	15	4	10	4	16	39	4
7	17	5	13	4	17	44	4
8	9	4	6	4	13	23	3
9	19	5	13	4	17	43	4

Stage 1

	pdssdura	pdsdela	pdsdiaga	hadsdepb	hadsanxb	iesintrb	iesavb
1	3	0	1	2	4	10	4
2	3	0	1	9	10	7	7
3	3	0	1	9	13	11	8
4	2	0	1	17	14	18	18
5	3	0	1	15	17	.	.
6	3	0	1	3	2	6	7
7	3	0	1	7	11	13	11
8	3	1	1	6	3	8	12
9	3	0	1	15	14	15	13

Stage 1

	pdsrexnb	pdsrexsb	pdsavnb	pdsavsb	pdsarnb	pdsarsb	pdsimpb
1	3	3	3	6	2	2	4
2	4	4	5	5	5	8	4
3	4	4	4	5	5	8	4
4	5	12	7	19	4	8	4
5	5	7	7	17	5	14	4
6	5	13	7	18	5	11	3
7	5	11	6	11	3	4	4
8	2	2	3	3	0	0	3
9	5	10	7	17	5	11	4

Stage 1

	pdssynob	pdssyseb	pdssyrb	pdsdurb	pdsdelb	pdsdiagb
1	8	11	2	3	0	1
2	14	17	2	3	0	1
3	13	17	2	3	0	1
4	16	39	4	3	0	1
5	17	38	4	3	0	1
6	17	42	4	3	0	1
7	14	26	3	3	0	1
8	5	5	1	3	1	0
9	17	38	4	3	0	1

Appendix 11: Raw data from computed variables

	hadsdepc	hadsanxc	iesintrc	iesavc	pdsrexnc	pdsrexsc	pdsavnc
1	9	8	2	4	2	6	0
2	2	10	9	16	0	6	2
3	-1	5	1	7	1	3	0
4	-7	-5	-2	1	0	1	0
5	-3	-1	.	.	0	-1	0
6	4	5	12	6	0	1	0
7	5	5	8	6	0	3	1
8	3	6	7	1	3	6	1
9	1	5	4	-2	0	1	0

computed

	pdsavsc	pdsarnc	pdsarsc	pdsimpc	pdssynoc	pdssysec	pdssyrc
1	1	1	4	0	3	11	1
2	15	0	6	0	2	27	2
3	1	0	0	0	1	4	1
4	-1	-1	0	0	-1	0	0
5	-4	0	0	0	0	-5	-1
6	-3	-1	-1	1	-1	-3	0
7	6	2	9	0	3	18	1
8	6	4	6	1	8	18	2
9	2	0	2	0	0	5	0

computed

	pdsdurc	pdsdelc	pdsdiagc
1	0	0	0
2	0	0	0
3	0	0	0
4	-1	0	0
5	0	0	0
6	0	0	0
7	0	0	0
8	0	0	1
9	0	0	0

computed

	mbssdiff
1	3.00
2	6.00
3	5.00
4	2.00
5	14.00
6	7.00
7	10.00
8	.00
9	1.00

Appendix 12: SPSS output of bivariate correlation coefficients

		AGE	GENDER	SESSIONS	PERIOD	MBSSM
AGE	Pearson Correlation	1.000	.724*	.148	.274	-.026
	Sig. (2-tailed)	.	.027	.703	.476	.947
	N	9	9	9	9	9
GENDER	Pearson Correlation	.724*	1.000	.468	-.052	-.045
	Sig. (2-tailed)	.027	.	.204	.894	.909
	N	9	9	9	9	9
SESSIONS	Pearson Correlation	.148	.468	1.000	-.060	-.326
	Sig. (2-tailed)	.703	.204	.	.879	.391
	N	9	9	9	9	9
PERIOD	Pearson Correlation	.274	-.052	-.060	1.000	-.610
	Sig. (2-tailed)	.476	.894	.879	.	.081
	N	9	9	9	9	9
MBSSM	Pearson Correlation	-.026	-.045	-.326	-.610	1.000
	Sig. (2-tailed)	.947	.909	.391	.081	.
	N	9	9	9	9	9
MBSSB	Pearson Correlation	.351	.460	.169	-.009	-.522
	Sig. (2-tailed)	.355	.213	.664	.982	.150
	N	9	9	9	9	9
MBSSDIFF	Pearson Correlation	-.120	-.166	-.317	-.501	.971**
	Sig. (2-tailed)	.758	.670	.406	.170	.000
	N	9	9	9	9	9
HADSDEPC	Pearson Correlation	-.035	.249	.229	.059	-.063
	Sig. (2-tailed)	.930	.519	.554	.881	.871
	N	9	9	9	9	9
HADSANXC	Pearson Correlation	.168	.458	.137	.297	-.128
	Sig. (2-tailed)	.667	.215	.725	.438	.742
	N	9	9	9	9	9
IESINTRC	Pearson Correlation	.470	.746*	.293	-.059	.477
	Sig. (2-tailed)	.240	.034	.481	.889	.232
	N	8	8	8	8	8
IESAVC	Pearson Correlation	.203	.423	-.285	-.323	.772*
	Sig. (2-tailed)	.630	.296	.493	.435	.025
	N	8	8	8	8	8
PDSREXNC	Pearson Correlation	-.061	.224	.654	-.062	-.459
	Sig. (2-tailed)	.877	.563	.056	.873	.214
	N	9	9	9	9	9
PDSREXSC	Pearson Correlation	.032	.414	.417	.014	-.342
	Sig. (2-tailed)	.936	.268	.264	.972	.367
	N	9	9	9	9	9
PDSAVNC	Pearson Correlation	.260	.574	.389	-.017	.097
	Sig. (2-tailed)	.500	.106	.300	.965	.803
	N	9	9	9	9	9
PDSAVSC	Pearson Correlation	.166	.444	.284	.210	-.139
	Sig. (2-tailed)	.669	.231	.460	.587	.722
	N	9	9	9	9	9
PDSARNC	Pearson Correlation	-.197	.210	.871**	-.054	-.255
	Sig. (2-tailed)	.612	.588	.002	.891	.508
	N	9	9	9	9	9
PDSARSC	Pearson Correlation	-.208	.166	.535	.003	-.065
	Sig. (2-tailed)	.591	.670	.137	.993	.869
	N	9	9	9	9	9

Correlations

		AGE	GENDER	SESSIONS	PERIOD	MBSSM
PDSIMPC	Pearson Correlation	.445	.756*	.619	-.156	-.186
	Sig. (2-tailed)	.230	.018	.075	.688	.633
	N	9	9	9	9	9
PDSSYNOC	Pearson Correlation	-.068	.354	.848**	-.059	-.300
	Sig. (2-tailed)	.862	.351	.004	.880	.433
	N	9	9	9	9	9
PDSSYSEC	Pearson Correlation	.029	.390	.425	.117	-.177
	Sig. (2-tailed)	.941	.299	.255	.765	.648
	N	9	9	9	9	9
PDSSYRC	Pearson Correlation	.000	.500	.468	.022	-.346
	Sig. (2-tailed)	1.000	.170	.204	.955	.362
	N	9	9	9	9	9
PDSDURC	Pearson Correlation	.079	.250	.117	.212	.223
	Sig. (2-tailed)	.839	.516	.764	.584	.564
	N	9	9	9	9	9
PDSDELC	Pearson Correlation	.[a]	.[a]	.[a]	.[a]	.[a]
	Sig. (2-tailed)	.	.	.	.	.
	N	9	9	9	9	9
PDSDIAGC	Pearson Correlation	.192	.500	.936**	-.012	-.424
	Sig. (2-tailed)	.620	.170	.000	.975	.255
	N	9	9	9	9	9

Correlations

		MBSSB	MBSSDIFF	HADSDEPC	HADSANXC	IESINTRC
AGE	Pearson Correlation	.351	-.120	-.035	.168	.470
	Sig. (2-tailed)	.355	.758	.930	.667	.240
	N	9	9	9	9	8
GENDER	Pearson Correlation	.460	-.166	.249	.458	.746*
	Sig. (2-tailed)	.213	.670	.519	.215	.034
	N	9	9	9	9	8
SESSIONS	Pearson Correlation	.169	-.317	.229	.137	.293
	Sig. (2-tailed)	.664	.406	.554	.725	.481
	N	9	9	9	9	8
PERIOD	Pearson Correlation	-.009	-.501	.059	.297	-.059
	Sig. (2-tailed)	.982	.170	.881	.438	.889
	N	9	9	9	9	8
MBSSM	Pearson Correlation	-.522	.971**	-.063	-.128	.477
	Sig. (2-tailed)	.150	.000	.871	.742	.232
	N	9	9	9	9	8
MBSSB	Pearson Correlation	1.000	-.711*	.072	.221	-.248
	Sig. (2-tailed)	.	.032	.853	.567	.554
	N	9	9	9	9	8
MBSSDIFF	Pearson Correlation	-.711*	1.000	-.073	-.168	.497
	Sig. (2-tailed)	.032	.	.853	.666	.211
	N	9	9	9	9	8
HADSDEPC	Pearson Correlation	.072	-.073	1.000	.809**	.521
	Sig. (2-tailed)	.853	.853	.	.008	.185
	N	9	9	9	9	8
HADSANXC	Pearson Correlation	.221	-.168	.809**	1.000	.579
	Sig. (2-tailed)	.567	.666	.008	.	.133
	N	9	9	9	9	8
IESINTRC	Pearson Correlation	-.248	.497	.521	.579	1.000
	Sig. (2-tailed)	.554	.211	.185	.133	.
	N	8	8	8	8	8
IESAVC	Pearson Correlation	.165	.615	.173	.524	.426
	Sig. (2-tailed)	.695	.105	.682	.183	.293
	N	8	8	8	8	8
PDSREXNC	Pearson Correlation	.499	-.519	.413	.336	-.125
	Sig. (2-tailed)	.171	.153	.269	.377	.769
	N	9	9	9	9	8
PDSREXSC	Pearson Correlation	.635	-.460	.604	.737*	.140
	Sig. (2-tailed)	.066	.213	.085	.024	.742
	N	9	9	9	9	8
PDSAVNC	Pearson Correlation	.196	.025	.228	.534	.505
	Sig. (2-tailed)	.614	.948	.555	.139	.201
	N	9	9	9	9	8
PDSAVSC	Pearson Correlation	.297	-.198	.283	.642	.345
	Sig. (2-tailed)	.437	.610	.460	.062	.402
	N	9	9	9	9	8
PDSARNC	Pearson Correlation	.034	-.220	.449	.361	.188
	Sig. (2-tailed)	.930	.570	.226	.340	.655
	N	9	9	9	9	8
PDSARSC	Pearson Correlation	-.031	-.044	.541	.533	.331
	Sig. (2-tailed)	.937	.910	.132	.139	.423
	N	9	9	9	9	8

Correlations

		MBSSB	MBSSDIFF	HADSDEPC	HADSANXC	IESINTRC
PDSIMPC	Pearson Correlation	.273	-.230	.248	.159	.578
	Sig. (2-tailed)	.477	.552	.519	.682	.134
	N	9	9	9	9	8
PDSSYNOC	Pearson Correlation	.267	-.322	.474	.473	.188
	Sig. (2-tailed)	.487	.398	.197	.199	.656
	N	9	9	9	9	8
PDSSYSEC	Pearson Correlation	.302	-.231	.471	.692*	.334
	Sig. (2-tailed)	.430	.550	.200	.039	.419
	N	9	9	9	9	8
PDSSYRC	Pearson Correlation	.558	-.442	.462	.705*	.261
	Sig. (2-tailed)	.118	.234	.211	.034	.532
	N	9	9	9	9	8
PDSDURC	Pearson Correlation	-.328	.276	.675*	.760*	.616
	Sig. (2-tailed)	.388	.472	.046	.017	.104
	N	9	9	9	9	8
PDSDELC	Pearson Correlation	.[a]	.[a]	.[a]	.[a]	.[a]
	Sig. (2-tailed)	.	.	.	.	.
	N	9	9	9	9	8
PDSDIAGC	Pearson Correlation	.328	-.442	.124	.147	.162
	Sig. (2-tailed)	.388	.234	.750	.707	.701
	N	9	9	9	9	8

Correlations

		IESAVC	PDSREXNC	PDSREXSC	PDSAVNC	PDSAVSC
AGE	Pearson Correlation	.203	-.061	.032	.260	.166
	Sig. (2-tailed)	.630	.877	.936	.500	.669
	N	8	9	9	9	9
GENDER	Pearson Correlation	.423	.224	.414	.574	.444
	Sig. (2-tailed)	.296	.563	.268	.106	.231
	N	8	9	9	9	9
SESSIONS	Pearson Correlation	-.285	.654	.417	.389	.284
	Sig. (2-tailed)	.493	.056	.264	.300	.460
	N	8	9	9	9	9
PERIOD	Pearson Correlation	-.323	-.062	.014	-.017	.210
	Sig. (2-tailed)	.435	.873	.972	.965	.587
	N	8	9	9	9	9
MBSSM	Pearson Correlation	.772*	-.459	-.342	.097	-.139
	Sig. (2-tailed)	.025	.214	.367	.803	.722
	N	8	9	9	9	9
MBSSB	Pearson Correlation	.165	.499	.635	.196	.297
	Sig. (2-tailed)	.695	.171	.066	.614	.437
	N	8	9	9	9	9
MBSSDIFF	Pearson Correlation	.615	-.519	-.460	.025	-.198
	Sig. (2-tailed)	.105	.153	.213	.948	.610
	N	8	9	9	9	9
HADSDEPC	Pearson Correlation	.173	.413	.604	.228	.283
	Sig. (2-tailed)	.682	.269	.085	.555	.460
	N	8	9	9	9	9
HADSANXC	Pearson Correlation	.524	.336	.737*	.534	.642
	Sig. (2-tailed)	.183	.377	.024	.139	.062
	N	8	9	9	9	9
IESINTRC	Pearson Correlation	.426	-.125	.140	.505	.345
	Sig. (2-tailed)	.293	.769	.742	.201	.402
	N	8	8	8	8	8
IESAVC	Pearson Correlation	1.000	-.253	.431	.675	.643
	Sig. (2-tailed)	.	.546	.286	.066	.086
	N	8	8	8	8	8
PDSREXNC	Pearson Correlation	-.253	1.000	.669*	.051	.109
	Sig. (2-tailed)	.546	.	.049	.896	.780
	N	8	9	9	9	9
PDSREXSC	Pearson Correlation	.431	.669*	1.000	.620	.727*
	Sig. (2-tailed)	.286	.049	.	.075	.026
	N	8	9	9	9	9
PDSAVNC	Pearson Correlation	.675	.051	.620	1.000	.941**
	Sig. (2-tailed)	.066	.896	.075	.	.000
	N	8	9	9	9	9
PDSAVSC	Pearson Correlation	.643	.109	.727*	.941**	1.000
	Sig. (2-tailed)	.086	.780	.026	.000	.
	N	8	9	9	9	9
PDSARNC	Pearson Correlation	-.177	.750*	.587	.409	.382
	Sig. (2-tailed)	.676	.020	.097	.275	.311
	N	8	9	9	9	9
PDSARSC	Pearson Correlation	.258	.276	.664	.756*	.762*
	Sig. (2-tailed)	.538	.473	.051	.018	.017
	N	8	9	9	9	9

Correlations

		IESAVC	PDSREXNC	PDSREXSC	PDSAVNC	PDSAVSC
PDSIMPC	Pearson Correlation	-.155	.423	.132	.043	-.103
	Sig. (2-tailed)	.713	.257	.734	.912	.792
	N	8	9	9	9	9
PDSSYNOC	Pearson Correlation	-.028	.830**	.754*	.507	.499
	Sig. (2-tailed)	.948	.006	.019	.164	.171
	N	8	9	9	9	9
PDSSYSEC	Pearson Correlation	.536	.308	.843**	.896**	.955**
	Sig. (2-tailed)	.171	.420	.004	.001	.000
	N	8	9	9	9	9
PDSSYRC	Pearson Correlation	.529	.559	.939**	.746*	.832**
	Sig. (2-tailed)	.178	.118	.000	.021	.005
	N	8	9	9	9	9
PDSDURC	Pearson Correlation	.287	.224	.270	.229	.229
	Sig. (2-tailed)	.491	.563	.482	.553	.553
	N	8	9	9	9	9
PDSDELC	Pearson Correlation	.[a]	.[a]	.[a]	.[a]	.[a]
	Sig. (2-tailed)	.	.	.	.	.
	N	8	9	9	9	9
PDSDIAGC	Pearson Correlation	-.287	.783*	.445	.287	.222
	Sig. (2-tailed)	.491	.013	.230	.454	.565
	N	8	9	9	9	9

Correlations

		PDSARNC	PDSARSC	PDSIMPC	PDSSYNOC	PDSSYSEC
AGE	Pearson Correlation	-.197	-.208	.445	-.068	.029
	Sig. (2-tailed)	.612	.591	.230	.862	.941
	N	9	9	9	9	9
GENDER	Pearson Correlation	.210	.166	.756*	.354	.390
	Sig. (2-tailed)	.588	.670	.018	.351	.299
	N	9	9	9	9	9
SESSIONS	Pearson Correlation	.871**	.535	.619	.848**	.425
	Sig. (2-tailed)	.002	.137	.075	.004	.255
	N	9	9	9	9	9
PERIOD	Pearson Correlation	-.054	.003	-.156	-.059	.117
	Sig. (2-tailed)	.891	.993	.688	.880	.765
	N	9	9	9	9	9
MBSSM	Pearson Correlation	-.255	-.065	-.186	-.300	-.177
	Sig. (2-tailed)	.508	.869	.633	.433	.648
	N	9	9	9	9	9
MBSSB	Pearson Correlation	.034	-.031	.273	.267	.302
	Sig. (2-tailed)	.930	.937	.477	.487	.430
	N	9	9	9	9	9
MBSSDIFF	Pearson Correlation	-.220	-.044	-.230	-.322	-.231
	Sig. (2-tailed)	.570	.910	.552	.398	.550
	N	9	9	9	9	9
HADSDEPC	Pearson Correlation	.449	.541	.248	.474	.471
	Sig. (2-tailed)	.226	.132	.519	.197	.200
	N	9	9	9	9	9
HADSANXC	Pearson Correlation	.361	.533	.159	.473	.692*
	Sig. (2-tailed)	.340	.139	.682	.199	.039
	N	9	9	9	9	9
IESINTRC	Pearson Correlation	.188	.331	.578	.188	.334
	Sig. (2-tailed)	.655	.423	.134	.656	.419
	N	8	8	8	8	8
IESAVC	Pearson Correlation	-.177	.258	-.155	-.028	.536
	Sig. (2-tailed)	.676	.538	.713	.948	.171
	N	8	8	8	8	8
PDSREXNC	Pearson Correlation	.750*	.276	.423	.830**	.308
	Sig. (2-tailed)	.020	.473	.257	.006	.420
	N	9	9	9	9	9
PDSREXSC	Pearson Correlation	.587	.664	.132	.754*	.843**
	Sig. (2-tailed)	.097	.051	.734	.019	.004
	N	9	9	9	9	9
PDSAVNC	Pearson Correlation	.409	.756*	.043	.507	.896**
	Sig. (2-tailed)	.275	.018	.912	.164	.001
	N	9	9	9	9	9
PDSAVSC	Pearson Correlation	.382	.762*	-.103	.499	.955**
	Sig. (2-tailed)	.311	.017	.792	.171	.000
	N	9	9	9	9	9
PDSARNC	Pearson Correlation	1.000	.728*	.337	.964**	.580
	Sig. (2-tailed)	.	.026	.375	.000	.101
	N	9	9	9	9	9
PDSARSC	Pearson Correlation	.728*	1.000	-.063	.712*	.889**
	Sig. (2-tailed)	.026	.	.873	.031	.001
	N	9	9	9	9	9

Correlations

		PDSARNC	PDSARSC	PDSIMPC	PDSSYNOC	PDSSYSEC
PDSIMPC	Pearson Correlation	.337	-.063	1.000	.367	-.043
	Sig. (2-tailed)	.375	.873	.	.331	.912
	N	9	9	9	9	9
PDSSYNOC	Pearson Correlation	.964**	.712*	.367	1.000	.678*
	Sig. (2-tailed)	.000	.031	.331	.	.045
	N	9	9	9	9	9
PDSSYSEC	Pearson Correlation	.580	.889**	-.043	.678*	1.000
	Sig. (2-tailed)	.101	.001	.912	.045	.
	N	9	9	9	9	9
PDSSYRC	Pearson Correlation	.603	.699*	.189	.751*	.896**
	Sig. (2-tailed)	.086	.036	.626	.020	.001
	N	9	9	9	9	9
PDSDURC	Pearson Correlation	.367	.308	.189	.354	.287
	Sig. (2-tailed)	.331	.420	.626	.351	.454
	N	9	9	9	9	9
PDSDELC	Pearson Correlation	.[a]	.[a]	.[a]	.[a]	.[a]
	Sig. (2-tailed)	.	.	.	.	.
	N	9	9	9	9	9
PDSDIAGC	Pearson Correlation	.812**	.332	.661	.840**	.333
	Sig. (2-tailed)	.008	.383	.052	.005	.381
	N	9	9	9	9	9

Correlations

		PDSSYRC	PDSDURC	PDSDELC	PDSDIAGC
AGE	Pearson Correlation	.000	.079	.[a]	.192
	Sig. (2-tailed)	1.000	.839	.	.620
	N	9	9	9	9
GENDER	Pearson Correlation	.500	.250	.[a]	.500
	Sig. (2-tailed)	.170	.516	.	.170
	N	9	9	9	9
SESSIONS	Pearson Correlation	.468	.117	.[a]	.936**
	Sig. (2-tailed)	.204	.764	.	.000
	N	9	9	9	9
PERIOD	Pearson Correlation	.022	.212	.[a]	-.012
	Sig. (2-tailed)	.955	.584	.	.975
	N	9	9	9	9
MBSSM	Pearson Correlation	-.346	.223	.[a]	-.424
	Sig. (2-tailed)	.362	.564	.	.255
	N	9	9	9	9
MBSSB	Pearson Correlation	.558	-.328	.[a]	.328
	Sig. (2-tailed)	.118	.388	.	.388
	N	9	9	9	9
MBSSDIFF	Pearson Correlation	-.442	.276	.[a]	-.442
	Sig. (2-tailed)	.234	.472	.	.234
	N	9	9	9	9
HADSDEPC	Pearson Correlation	.462	.675*	.[a]	.124
	Sig. (2-tailed)	.211	.046	.	.750
	N	9	9	9	9
HADSANXC	Pearson Correlation	.705*	.760*	.[a]	.147
	Sig. (2-tailed)	.034	.017	.	.707
	N	9	9	9	9
IESINTRC	Pearson Correlation	.261	.616	.[a]	.162
	Sig. (2-tailed)	.532	.104	.	.701
	N	8	8	8	8
IESAVC	Pearson Correlation	.529	.287	.[a]	-.287
	Sig. (2-tailed)	.178	.491	.	.491
	N	8	8	8	8
PDSREXNC	Pearson Correlation	.559	.224	.[a]	.783*
	Sig. (2-tailed)	.118	.563	.	.013
	N	9	9	9	9
PDSREXSC	Pearson Correlation	.939**	.270	.[a]	.445
	Sig. (2-tailed)	.000	.482	.	.230
	N	9	9	9	9
PDSAVNC	Pearson Correlation	.746*	.229	.[a]	.287
	Sig. (2-tailed)	.021	.553	.	.454
	N	9	9	9	9
PDSAVSC	Pearson Correlation	.832**	.229	.[a]	.222
	Sig. (2-tailed)	.005	.553	.	.565
	N	9	9	9	9
PDSARNC	Pearson Correlation	.603	.367	.[a]	.812**
	Sig. (2-tailed)	.086	.331	.	.008
	N	9	9	9	9
PDSARSC	Pearson Correlation	.699*	.308	.[a]	.332
	Sig. (2-tailed)	.036	.420	.	.383
	N	9	9	9	9

Correlations

		PDSSYRC	PDSDURC	PDSDELC	PDSDIAGC
PDSIMPC	Pearson Correlation	.189	.189	.[a]	.661
	Sig. (2-tailed)	.626	.626	.	.052
	N	9	9	9	9
PDSSYNOC	Pearson Correlation	.751*	.354	.[a]	.840**
	Sig. (2-tailed)	.020	.351	.	.005
	N	9	9	9	9
PDSSYSEC	Pearson Correlation	.896**	.287	.[a]	.333
	Sig. (2-tailed)	.001	.454	.	.381
	N	9	9	9	9
PDSSYRC	Pearson Correlation	1.000	.250	.[a]	.500
	Sig. (2-tailed)	.	.516	.	.170
	N	9	9	9	9
PDSDURC	Pearson Correlation	.250	1.000	.[a]	.125
	Sig. (2-tailed)	.516	.	.	.749
	N	9	9	9	9
PDSDELC	Pearson Correlation	.[a]	.[a]	.[a]	.[a]
	Sig. (2-tailed)	.	.	.	.
	N	9	9	9	9
PDSDIAGC	Pearson Correlation	.500	.125	.[a]	1.000
	Sig. (2-tailed)	.170	.749	.	.
	N	9	9	9	9

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

a. Cannot be computed because at least one of the variables is constant.

Correlations

		HADSDEPA	HADSANXA	IESINTRA	IESAVA	MBSSB
HADSDEPA	Pearson Correlation	1.000	.585	.461	-.081	-.459
	Sig. (2-tailed)	.	.098	.212	.836	.214
	N	9	9	9	9	9
HADSANXA	Pearson Correlation	.585	1.000	.127	.310	-.386
	Sig. (2-tailed)	.098	.	.744	.416	.305
	N	9	9	9	9	9
IESINTRA	Pearson Correlation	.461	.127	1.000	.270	-.772*
	Sig. (2-tailed)	.212	.744	.	.482	.015
	N	9	9	9	9	9
IESAVA	Pearson Correlation	-.081	.310	.270	1.000	-.020
	Sig. (2-tailed)	.836	.416	.482	.	.960
	N	9	9	9	9	9
MBSSB	Pearson Correlation	-.459	-.386	-.772*	-.020	1.000
	Sig. (2-tailed)	.214	.305	.015	.960	.
	N	9	9	9	9	9

*. Correlation is significant at the 0.05 level (2-tailed).

Appendix 13: SPSS output of partial correlation coefficients, controlling for gender

- - - P A R T I A L C O R R E L A T I O N C O E F F I C I E N T S - - -

Controlling for.. GENDER

	MBSSB	HADSDEPA	HADSANXA	IESINTRA	IESAVA	HADSDEPC
MBSSB	1.0000	-.3118	-.2873	-.8126	-.0201	-.2577
	(0)	(5)	(5)	(5)	(5)	(5)
	P= .	P= .496	P= .532	P= .026	P= .966	P= .577
HADSDEPA	-.3118	1.0000	.5199	.5068	.0000	.1644
	(5)	(0)	(5)	(5)	(5)	(5)
	P= .496	P= .	P= .232	P= .246	P=1.000	P= .725
HADSANXA	-.2873	.5199	1.0000	.0916	.3940	.0592
	(5)	(5)	(0)	(5)	(5)	(5)
	P= .532	P= .232	P= .	P= .845	P= .382	P= .900
IESINTRA	-.8126	.5068	.0916	1.0000	.2226	-.0195
	(5)	(5)	(5)	(0)	(5)	(5)
	P= .026	P= .246	P= .845	P= .	P= .631	P= .967
IESAVA	-.0201	.0000	.3940	.2226	1.0000	-.5949
	(5)	(5)	(5)	(5)	(0)	(5)
	P= .966	P=1.000	P= .382	P= .631	P= .	P= .159
HADSDEPC	-.2577	.1644	.0592	-.0195	-.5949	1.0000
	(5)	(5)	(5)	(5)	(5)	(0)
	P= .577	P= .725	P= .900	P= .967	P= .159	P= .
HADSANXC	-.2201	.3260	.6265	-.1677	-.2949	.7833
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .635	P= .475	P= .132	P= .719	P= .521	P= .037
IESINTRC	-.8914	.2918	.2485	.6883	-.1236	.5943
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .007	P= .525	P= .591	P= .087	P= .792	P= .159
IESAVC	-.0037	-.1441	.5831	-.1514	.6012	.1100
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .994	P= .758	P= .169	P= .746	P= .153	P= .814
PDSREXNC	.4344	-.2107	-.2893	-.6275	-.5717	.3455
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .330	P= .650	P= .529	P= .131	P= .180	P= .448

(Coefficient / (D.F.) / 2-tailed Significance)

" . " is printed if a coefficient cannot be computed

- - - P A R T I A L C O R R E L A T I O N C O E F F I C I E N T S - - -

Controlling for.. GENDER

	MBSSB	HADSDEPA	HADSANXA	IESINTRA	IESAVA	HADSDEPC
PDSREXSC	.3880	.0631	.2634	-.5415	-.0761	.5010
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .390	P= .893	P= .568	P= .209	P= .871	P= .252
PDSAVNC	-.1750	.4183	.6532	.2133	.6415	.0783
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .707	P= .350	P= .112	P= .646	P= .120	P= .868
PDSAVSC	-.0852	.5138	.7775	.0866	.5529	.0977
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .856	P= .238	P= .040	P= .854	P= .198	P= .835
PDSARNC	-.1336	.1458	-.0281	-.0271	-.2827	.4148
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .775	P= .755	P= .952	P= .954	P= .539	P= .355
PDSARSC	-.3239	.4363	.3515	.2948	.1783	.4782
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .479	P= .328	P= .439	P= .521	P= .702	P= .278
PDSIMPC	-.1494	-.3727	-.7541	.0486	-.6742	.1003
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .749	P= .410	P= .050	P= .918	P= .097	P= .831
PDSSYNOC	.0593	.0945	.0125	-.2250	-.2565	.4048
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .899	P= .840	P= .979	P= .628	P= .579	P= .368
PDSSYSEC	-.0763	.4451	.5989	.0321	.3410	.3375
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .871	P= .317	P= .155	P= .945	P= .454	P= .459
PDSSYRC	.1737	.0619	.4540	-.3831	.1960	.2831
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .710	P= .895	P= .306	P= .396	P= .674	P= .538
PDSDELC	.	.	.	.	.	.
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .	P= .	P= .	P= .	P= .	P= .

(Coefficient / (D.F.) / 2-tailed Significance)

" . " is printed if a coefficient cannot be computed

- - - P A R T I A L C O R R E L A T I O N C O E F F I C I E N T S - - -

Controlling for.. GENDER

	MBSSB	HADSDEPA	HADSANXA	IESINTRA	IESAVA	HADSDEPC
PDSDIAGC	.1494	.0000	-.2828	-.1943	-.3371	.0000
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .749	P=1.000	P= .539	P= .676	P= .460	P=1.000
PDSDURC	-.4910	.2381	.4991	.0000	-.4616	.7689
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .263	P= .607	P= .254	P=1.000	P= .297	P= .043

(Coefficient / (D.F.) / 2-tailed Significance)

" . " is printed if a coefficient cannot be computed

- - - P A R T I A L C O R R E L A T I O N C O E F F I C I E N T S - - -

Controlling for.. GENDER

	HADSANXC	IESINTRC	IESAVC	PDSREXNC	PDSREXSC	PDSAVNC
MBSSB	-.2201	-.8914	-.0037	.4344	.3880	-.1750
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .635	P= .007	P= .994	P= .330	P= .390	P= .707
HADSDEPA	.3260	.2918	-.1441	-.2107	.0631	.4183
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .475	P= .525	P= .758	P= .650	P= .893	P= .350
HADSANXA	.6265	.2485	.5831	-.2893	.2634	.6532
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .132	P= .591	P= .169	P= .529	P= .568	P= .112
IESINTRA	-.1677	.6883	-.1514	-.6275	-.5415	.2133
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .719	P= .087	P= .746	P= .131	P= .209	P= .646
IESAVA	-.2949	-.1236	.6012	-.5717	-.0761	.6415
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .521	P= .792	P= .153	P= .180	P= .871	P= .120
HADSDEPC	.7833	.5943	.1100	.3455	.5010	.0783
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .037	P= .159	P= .814	P= .448	P= .252	P= .868
HADSANXC	1.0000	.4586	.4264	.2231	.6109	.3595
	(0)	(5)	(5)	(5)	(5)	(5)
	P= .	P= .301	P= .340	P= .631	P= .145	P= .428
IESINTRC	.4586	1.0000	.1829	-.3922	-.1833	.1741
	(5)	(0)	(5)	(5)	(5)	(5)
	P= .301	P= .	P= .695	P= .384	P= .694	P= .709
IESAVC	.4264	.1829	1.0000	-.3676	.3371	.5842
	(5)	(5)	(0)	(5)	(5)	(5)
	P= .340	P= .695	P= .	P= .417	P= .460	P= .168
PDSREXNC	.2231	-.3922	-.3676	1.0000	.6611	-.1182
	(5)	(5)	(5)	(0)	(5)	(5)
	P= .631	P= .384	P= .417	P= .	P= .106	P= .801

(Coefficient / (D.F.) / 2-tailed Significance)

" . " is printed if a coefficient cannot be computed

- - - P A R T I A L C O R R E L A T I O N C O E F F I C I E N T S - - -

Controlling for.. GENDER

	HADSANXC	IESINTRC	IESAVC	PDSREXNC	PDSREXSC	PDSAVNC
PDSREXSC	.6109	-.1833	.3371	.6611	1.0000	.5372
	(5)	(5)	(5)	(5)	(0)	(5)
	P= .145	P= .694	P= .460	P= .106	P= .	P= .214
PDSAVNC	.3595	.1741	.5842	-.1182	.5372	1.0000
	(5)	(5)	(5)	(5)	(5)	(0)
	P= .428	P= .709	P= .168	P= .801	P= .214	P= .
PDSAVSC	.4829	.0936	.5736	-.0576	.6013	.9655
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .272	P= .842	P= .178	P= .902	P= .153	P= .000
PDSARNC	.2960	.0776	-.2858	.7374	.6075	.3546
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .519	P= .869	P= .534	P= .059	P= .148	P= .435
PDSARSC	.4691	.3910	.2406	.2101	.6303	.8251
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .288	P= .386	P= .603	P= .651	P= .129	P= .022
PDSIMPC	-.3453	.0496	-.7794	.4038	-.3528	-.7319
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .448	P= .916	P= .039	P= .369	P= .438	P= .061
PDSSYNOC	.3479	-.0754	-.1878	.8195	.7519	.3875
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .444	P= .872	P= .687	P= .024	P= .051	P= .390
PDSSYSEC	.5630	.1509	.4669	.1934	.7713	.9319
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .188	P= .747	P= .291	P= .678	P= .042	P= .002
PDSSYRC	.5353	-.1317	.4168	.5365	.9025	.7294
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .216	P= .778	P= .352	P= .214	P= .005	P= .063
PDSDELC	.	.	.	.	.	.
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .	P= .	P= .	P= .	P= .	P= .

(Coefficient / (D.F.) / 2-tailed Significance)

" . " is printed if a coefficient cannot be computed

- - - P A R T I A L C O R R E L A T I O N C O E F F I C I E N T S - - -

Controlling for.. GENDER

	HADSANXC	IESINTRC	IESAVC	PDSREXNC	PDSREXSC	PDSAVNC
PDSDIAGC	-.1151	-.3469	-.6235	.8076	.3528	.0000
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .806	P= .446	P= .135	P= .028	P= .438	P=1.000
PDSDURC	.9037	.6243	.1878	.2212	.3479	.1336
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .005	P= .134	P= .687	P= .634	P= .445	P= .775

(Coefficient / (D.F.) / 2-tailed Significance)

" . " is printed if a coefficient cannot be computed

- - - P A R T I A L C O R R E L A T I O N C O E F F I C I E N T S - - -

Controlling for.. GENDER

	PDSAVSC	PDSARNC	PDSARSC	PDSIMPC	PDSSYNOC	PDSSYSEC
MBSSB	-.0852	-.1336	-.3239	-.1494	.0593	-.0763
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .856	P= .775	P= .479	P= .749	P= .899	P= .871
HADSDEPA	.5138	.1458	.4363	-.3727	.0945	.4451
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .238	P= .755	P= .328	P= .410	P= .840	P= .317
HADSANXA	.7775	-.0281	.3515	-.7541	.0125	.5989
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .040	P= .952	P= .439	P= .050	P= .979	P= .155
IESINTRA	.0866	-.0271	.2948	.0486	-.2250	.0321
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .854	P= .954	P= .521	P= .918	P= .628	P= .945
IESAVA	.5529	-.2827	.1783	-.6742	-.2565	.3410
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .198	P= .539	P= .702	P= .097	P= .579	P= .454
HADSDEPC	.0977	.4148	.4782	.1003	.4048	.3375
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .835	P= .355	P= .278	P= .831	P= .368	P= .459
HADSANXC	.4829	.2960	.4691	-.3453	.3479	.5630
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .272	P= .519	P= .288	P= .448	P= .444	P= .188
IESINTRC	.0936	.0776	.3910	.0496	-.0754	.1509
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .842	P= .869	P= .386	P= .916	P= .872	P= .747
IESAVC	.5736	-.2858	.2406	-.7794	-.1878	.4669
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .178	P= .534	P= .603	P= .039	P= .687	P= .291
PDSREXNC	-.0576	.7374	.2101	.4038	.8195	.1934
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .902	P= .059	P= .651	P= .369	P= .024	P= .678

(Coefficient / (D.F.) / 2-tailed Significance)

" . " is printed if a coefficient cannot be computed

- - - P A R T I A L C O R R E L A T I O N C O E F F I C I E N T S - - -

Controlling for.. GENDER

	PDSAVSC	PDSARNC	PDSARSC	PDSIMPC	PDSSYNOC	PDSSYSEC
PDSREXSC	.6013	.6075	.6303	-.3528	.7519	.7713
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .153	P= .148	P= .129	P= .438	P= .051	P= .042
PDSAVNC	.9655	.3546	.8251	-.7319	.3875	.9319
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .000	P= .435	P= .022	P= .061	P= .390	P= .002
PDSAVSC	1.0000	.3222	.7574	-.8022	.3854	.9399
	(0)	(5)	(5)	(5)	(5)	(5)
	P= .	P= .481	P= .049	P= .030	P= .393	P= .002
PDSARNC	.3222	1.0000	.7271	.2795	.9742	.5708
	(5)	(0)	(5)	(5)	(5)	(5)
	P= .481	P= .	P= .064	P= .544	P= .000	P= .181
PDSARSC	.7574	.7271	1.0000	-.3035	.7030	.9059
	(5)	(5)	(0)	(5)	(5)	(5)
	P= .049	P= .064	P= .	P= .508	P= .078	P= .005
PDSIMPC	-.8022	.2795	-.3035	1.0000	.1654	-.6146
	(5)	(5)	(5)	(0)	(5)	(5)
	P= .030	P= .544	P= .508	P= .	P= .723	P= .142
PDSSYNOC	.3854	.9742	.7030	.1654	1.0000	.6278
	(5)	(5)	(5)	(5)	(0)	(5)
	P= .393	P= .000	P= .078	P= .723	P= .	P= .131
PDSSYSEC	.9399	.5708	.9059	-.6146	.6278	1.0000
	(5)	(5)	(5)	(5)	(5)	(0)
	P= .002	P= .181	P= .005	P= .142	P= .131	P= .
PDSSYRC	.7624	.6731	.7201	-.4152	.7832	.8676
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .046	P= .097	P= .068	P= .354	P= .037	P= .011
PDSDELC	.	.	.	.	.	.
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .	P= .	P= .	P= .	P= .	P= .

(Coefficient / (D.F.) / 2-tailed Significance)

" . " is printed if a coefficient cannot be computed

- - - P A R T I A L C O R R E L A T I O N C O E F F I C I E N T S - - -

Controlling for.. GENDER

	PDSAVSC	PDSARNC	PDSARSC	PDSIMPC	PDSSYNOC	PDSSYSEC
PDSDIAGC	.0000	.8385	.3035	.5000	.8272	.1891
	(5)	(5)	(5)	(5)	(5)	(5)
	P=1.000	P= .018	P= .508	P= .253	P= .022	P= .685
PDSDURC	.2278	.3572	.3562	.0000	.3323	.3280
	(5)	(5)	(5)	(5)	(5)	(5)
	P= .623	P= .432	P= .433	P=1.000	P= .467	P= .473

(Coefficient / (D.F.) / 2-tailed Significance)

" . " is printed if a coefficient cannot be computed

- - - P A R T I A L C O R R E L A T I O N C O E F F I C I E N T S - - -

Controlling for.. GENDER

	PDSSYRC	PDSDELC	PDSDIAGC	PDSDURC
MBSSB	.1737	.	.1494	-.4910
	(5)	(5)	(5)	(5)
	P= .710	P= .	P= .749	P= .263
HADSDEPA	.0619	.	.0000	.2381
	(5)	(5)	(5)	(5)
	P= .895	P= .	P=1.000	P= .607
HADSANXA	.4540	.	-.2828	.4991
	(5)	(5)	(5)	(5)
	P= .306	P= .	P= .539	P= .254
IESINTRA	-.3831	.	-.1943	.0000
	(5)	(5)	(5)	(5)
	P= .396	P= .	P= .676	P=1.000
IESAVA	.1960	.	-.3371	-.4616
	(5)	(5)	(5)	(5)
	P= .674	P= .	P= .460	P= .297
HADSDEPC	.2831	.	.0000	.7689
	(5)	(5)	(5)	(5)
	P= .538	P= .	P=1.000	P= .043
HADSANXC	.5353	.	-.1151	.9037
	(5)	(5)	(5)	(5)
	P= .216	P= .	P= .806	P= .005
IESINTRC	-.1317	.	-.3469	.6243
	(5)	(5)	(5)	(5)
	P= .778	P= .	P= .446	P= .134
IESAVC	.4168	.	-.6235	.1878
	(5)	(5)	(5)	(5)
	P= .352	P= .	P= .135	P= .687
PDSREXNC	.5365	.	.8076	.2212
	(5)	(5)	(5)	(5)
	P= .214	P= .	P= .028	P= .634

(Coefficient / (D.F.) / 2-tailed Significance)

" . " is printed if a coefficient cannot be computed

- - - P A R T I A L C O R R E L A T I O N C O E F F I C I E N T S - - -

Controlling for.. GENDER

	PDSSYRC	PDSDELC	PDSDIAGC	PDSDURC
PDSREXSC	.9025	.	.3528	.3479
	(5)	(5)	(5)	(5)
	P= .005	P= .	P= .438	P= .445
PDSAVNC	.7294	.	.0000	.1336
	(5)	(5)	(5)	(5)
	P= .063	P= .	P=1.000	P= .775
PDSAVSC	.7624	.	.0000	.2278
	(5)	(5)	(5)	(5)
	P= .046	P= .	P=1.000	P= .623
PDSARNC	.6731	.	.8385	.3572
	(5)	(5)	(5)	(5)
	P= .097	P= .	P= .018	P= .432
PDSARSC	.7201	.	.3035	.3562
	(5)	(5)	(5)	(5)
	P= .068	P= .	P= .508	P= .433
PDSIMPC	-.4152	.	.5000	.0000
	(5)	(5)	(5)	(5)
	P= .354	P= .	P= .253	P=1.000
PDSSYNOC	.7832	.	.8272	.3323
	(5)	(5)	(5)	(5)
	P= .037	P= .	P= .022	P= .467
PDSSYSEC	.8676	.	.1891	.3280
	(5)	(5)	(5)	(5)
	P= .011	P= .	P= .685	P= .473
PDSSYRC	1.0000	.	.4152	.3411
	(0)	(5)	(5)	(5)
	P= .	P= .	P= .354	P= .454
PDSDELC	.	1.0000	.	.
	(5)	(0)	(5)	(5)
	P= .	P= .	P= .	P= .

(Coefficient / (D.F.) / 2-tailed Significance)

" . " is printed if a coefficient cannot be computed

- - - P A R T I A L C O R R E L A T I O N C O E F F I C I E N T S - - -

Controlling for.. GENDER

	PDSSYRC	PDSDELC	PDSDIAGC	PDSDURC
PDSDIAGC	.4152	.	1.0000	.0000
	(5)	(5)	(0)	(5)
	P= .354	P= .	P= .	P=1.000
PDSDURC	.3411	.	.0000	1.0000
	(5)	(5)	(5)	(0)
	P= .454	P= .	P=1.000	P= .

(Coefficient / (D.F.) / 2-tailed Significance)

" . " is printed if a coefficient cannot be computed

Appendix 14: Request for transcribed material.

Dear Colleague

Would you like to put your old process reports to another good use ?

I am conducting research into Posttraumatic Stress Disorder (PTSD) and the findings so far suggest some interesting implications for those of us working in the field of trauma. For the second stage of the study, I am particularly interested in how clients speak about their experience of having PTSD.

I am looking for transcribed sections of audio-taped counselling sessions with clients with PTSD, for qualitative analysis. These transcriptions can be of any duration, and must be anonymised, i.e.: have names and any other identifiers changed. Process reports that you have completed as part of your MSc or Post-MSc training would be ideal for this purpose. I do not need the tapes themselves, only the transcriptions.

As a token of my appreciation, I shall send a £20 book token for every transcription that I use and I would be pleased to acknowledge your contribution in my research report should you wish. All other transcriptions will, of course, be returned. Let me assure you that your transcriptions will be treated with the greatest respect and that all findings will be completely anonymised.

Naturally, I should be happy to discuss this with you if you would like further information. In the meantime, thank you for taking the trouble to consider helping me with this project.

Yours sincerely,

Jacqui Farrants, CPsychol.
Chartered Counselling Psychologist

Tel: _____

Email: _____

Appendix 15: Transcription notation.

Square brackets mark overlap between utterances, eg:

T: Yeah, [sure
C: [when you're tired or something

Numbers in brackets indicate pauses of 3 seconds or over, timed to the nearest tenth of a second, eg:

C: Um (5.7) these last few weeks have just been pure hell really

A full stop in brackets indicates a pause which has not been timed, eg:

C: The door's (.) don't know

Underlining indicates that words are uttered with added emphasis, eg:

C: it <u>can't</u> have been me

Small circles around utterances indicate that words are uttered in a lower voice than the surrounding utterances, eg:

C: whatever, um you hear on the telephone or something, °oh so and so's died°

Square brackets indicate that some transcript has been deliberately omitted. Material in square brackets is clarificatory information, eg:

C: um, [name of doctor] said this. He was quite happy for it to all to happen

The word *inaudible* in round brackets indicates an utterance or section of speech which was unclear at the point of transcription, eg:

C: but why it should come out now (inaudible) I just don't know

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