COMMISSION for VICTIMS and SURVIVORS

QUEEN'S UNIVERSITY BELFAST

Conflict, Trauma and Mental Health

How psychological services in Northern Ireland address the needs of victims and survivors

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Principal Investigator/Project Lead

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Report Number One

Prepared for the Commission for Victims and Survivors

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Report 1 Contents

Foreword

As the Mental Health Champion for Northern Ireland, I very much welcome this report, prepared by the Commission for Victims and Survivors (CVS) in collaboration with Queen's University Belfast (QUB).

This research, funded by PEACE IV, provides an invaluable insight into the impact of trauma-focussed psychological therapy for victims and survivors in Northern Ireland and the Border Region of Ireland.

I have long been concerned about the mental health impact of the Troubles on victims and survivors and on their families. We all want a society where people have access to evidence-based treatments for mental illness, and services to support their recovery. In assessing the impact of interventions, outcomes for people affected by conflict-related trauma in NI and the international evidence, this report will shape our understanding of how effective existing services are. It highlights strengths across the sectors and also identifies areas for improvement, and as such, will inform future provision.

Importantly, this Report also explores the first-hand experiences of those individuals who have accessed trauma counselling, psychotherapy and other interventions. Whilst there is evidence of resilience, there is a clear need for further interventions and an increase in the availability of support and services. The evidence from statutory and community-based service providers who are working directly with victims and survivors and their families is also vital; it illustrates the importance of partnership working and building upon existing provision.

I would like to thank CVS, QUB, and each and every project participant. Your voices, experience and expertise are already creating positive change. Together these studies provide invaluable evidence which will be used to guide mental health reform, particularly the development of the Regional Trauma Network and the Regional Mental Health Service, for this we are very grateful.

Professor Siobhan O'Neill
Mental Health Champion

Comment from the Commission for Victims and Survivors

This report is one in a suite of four studies commissioned by the Commission relating to the needs of, and services provided for, victims and survivors. The studies were undertaken over a three-year period which included the Covid-19 pandemic and were thus greatly restricted in terms of fieldwork and access to participants. The researchers engaged with victims and survivors who have accessed trauma counselling, psychotherapy and other supportive interventions. The researchers also engaged with psychological therapists and mental health managers in the statutory sector and with voluntary sector and community-based organisations that provide services for victims, survivors and their families. The report maps out and evaluates current practice and service provision and generates proposals on the optimal way to organise mental health services for victims and survivors in the primary, community and statutory systems. The Commission is grateful to all those who have contributed to the research process not least because of the sensitivities and reflections these considerations require.

A key focus of this study is the unique opportunity to conduct a clinical review of existing psychological therapy outcome data collected in specialist statutory trauma services and by service providers within the victims' sector. The report showcases effective practice across sectors including the formation of key patient datasets, and analyses outcome data for service users accessing psychological treatment. From the clinical analysis of psychological therapy outcome data, stakeholder engagement and an extensive review of trauma-related literature, the report presents a series of findings and recommendations that require serious consideration by service commissioners and providers, practitioners and policy makers.

Recommendations from the research include the development and regional implementation of a standardised outcome framework with validated disorder-specific session by session measures across statutory sector provision for victims and survivors, and the strengthening and streamlining of bi-directional referral pathways from non-statutory services to more specialised statutory mental health trauma teams. Other recommendations include an increased understanding and greater adherence to evidence-based practice, and the need for more consultant psychiatry input into psychological trauma services, especially for more complex trauma presentations. The report also identifies a number of areas for improvement including the need for enhanced IT recognition systems and the standardised coding of patients with Troubles / conflict related issues across the health system.

In treating victims' needs as societal needs, we build on a solid foundation towards a future that offers peace, prosperity and growth for all who live here.

Glossary of terms used throughout the documents reporting on all research strands

Chronic pain	Usually refers to physical pain that is long term, persistent or recurring and which impacts on the daily life of the individual who is suffering.
Cognitive Therapy	A range of therapeutic practices that try to produce change by directly influencing how we think about our problems and the impact they have on our lives. Cognitive treatments of anxiety disorders and PTSD focus on the identification and modification of misinterpretations that lead the patient to overestimate threat.
Cognitive Behavioural Therapy (CBT)	Cognitive-behavioural therapies (CBT) draw on psychological models describing the relationship between thoughts, emotions and behaviour. Cognitive-behavioural therapy employs a range of therapeutic techniques that aim to change people's distressing emotions by changing negative thoughts, beliefs and/or behaviours.
Cognitive processing therapy (CPT)	A specific type of cognitive behavioural therapy that has been effective in reducing symptoms of posttraumatic stress disorder (PTSD) that have developed after experiencing a variety of traumatic events including child abuse, combat, rape and natural disasters.[1]
Complementary Therapies	A range of therapeutic and supportive therapies that people sometimes use alongside conventional therapies/treatments to help them feel better or cope better with physical, emotional or mental difficulties.
Conflict-related traumatic events	As per The Victims and Survivors (Northern Ireland) Order (2006)[2] "References to 'victim and survivor' are references to an individual appearing to the [F1Commission] to be any of the following— (a)someone who is or has been physically or psychologically injured as a result of or in consequence of a conflict-related

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[1] https://www.apa.org/ptsd-guideline/treatments/cognitive-processing-therapy

[2] https://www.legislation.gov.uk/nisi/2006/2953/article/3

	incident; (b) someone who provides a substantial amount of care on a regular basis for an individual mentioned in paragraph (a); or (c) someone who has been bereaved as a result of or in consequence of a conflict-related incident. (2) Without prejudice to the generality of paragraph (1), an individual may be psychologically injured as a result of or in consequence of— (a) witnessing a conflict-related incident or the consequences of such an incident; or (b) providing medical or other emergency assistance to an individual in connection with a conflict-related incident.”
Co-morbidity	The presence of more than one form of severe psychological distress in an individual at the same time.
Depression	A mood disorder characterised by the existence of one or more depressive episodes, in which the person experiences low mood or loss of interest, accompanied by such symptoms as low energy, changes in appetite, poor concentration, feelings of guilt or worthlessness, and suicidal ideation.
DHSSPS(NI)	Department of Health, Social Service and Public Safety (Northern Ireland).
DoH(NI)	Department of Health (Northern Ireland)
Epidemiology	The study of the level/prevalence of a disorder within a population.
Eye Movement Desensitisation and Reprocessing (EMDR)	EMDR (Shapiro, 1991, 2001) is a form of imaginal exposure therapy which aims to help clients reprocess their memories of a traumatic event and involves the client visually following an external stimuli, such as the therapist’s finger back and forward across their line of sight as they focus on the traumatic memory.
Improving Access to Psychological Therapies (IAPT)	A newly developed mental health service commissioned by NHS England in 2008.
Prolonged Grief	The core element of Prolonged Grief Disorder is a persistent

Disorder	yearning or missing the deceased, or preoccupation with the circumstance of the death. Additional symptoms include difficulty accepting the death, feelings of loss of a part of oneself, anger about the loss, guilt or blame regarding the death, or difficulty engaging with new social or other activities.
Post-traumatic stress symptoms	Is the term often used to describe the stressful feelings, thoughts and behaviours a person might have following a traumatic experience, but which do not meet the criteria for post-traumatic stress disorder (see below).
Post-Traumatic Stress Disorder (PTSD)	A disorder that follows from the experiencing of a traumatic or highly stressful event characterised by intrusive and distressing memories of the event, hyper vigilance, numbness, and attempts to avoid anything associated with memories of the event.
Complex PTSD	Complex post-traumatic stress disorder (CPTSD) may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible.
Qualitative research	Research in which experiences, perceptions and observations, are interpreted and the characteristics (qualities) of the particular experience or event are identified.
Quantitative research	Research in which the phenomenon under investigation is measured and counted. Statistical analyses are used to determine potential patterns of cause and effect.
Prevalence	The prevalence of a disorder indicates the percentage of the population who have or have had the disorder in a given period. For example, the lifetime prevalence of depression is the percentage of the population who have had depression at some point in their life.
Prolonged Exposure (PE)	Prolonged exposure teaches individuals to gradually approach their trauma-related memories, feelings and situations. The patient learns that trauma-related memories and cues are not dangerous and do not need to be avoided.[3]

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[3] https://www.apa.org/ptsd-guideline/treatments/prolonged-exposure

Psychodynamic therapy	A family of psychological therapies which aim to help clients develop a greater awareness and understanding of the unconscious forces determining their thoughts, feelings and behaviours.[4]
Psycho-education	A range of educational strategies used to inform people about mental health problems and how to overcome them.
Psychopathology	Emotional or behavioural responses which are maladaptive or indicative of mental illness.
Trauma-Aware or Trauma-Informed	Adoption of practices, where practitioners, volunteers etc. focus on understanding or assessing a person's needs with reference to a loss or trauma the person might have had so as to better support them or refer them for other services.
Trauma-focused	Where practitioners or volunteers have a level of specialist knowledge that enables them to offer interventions aimed at addressing the traumatic features of a person's problems to aid their recovery or adjustment.
Trauma-focused Cognitive Behavioural Therapy (TF-CBT)	TF-CBT helps an individual come to terms with a trauma by explicitly addressing trauma memories. There a 3 main TFCBT protocols, all are exposure-based but have different components.[5]
The Troubles	This term is used to refer to the recent period of violence and civil conflict in Northern Ireland and the border areas of the Republic of Ireland (*NOTE- throughout this document the terms "the Troubles" and "The Conflict" will be used interchangeably*).

Project Aims and Objectives

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[4] a more comprehensive list of psychological therapies can be found at https://exploringyourmind.com/19-types-of-psychological-therapies

[4] a more detailed explanation of specific therapies recommended for PTSD can be found at http://www.nice.org.uk/guidance/cg26/resources/guidance-posttraumatic-stress-disorder-ptsd-pdf

[5] a more detailed explanation of specific therapies recommended for PTSD can be found at http://www.nice.org.uk/guidance/cg26/resources/guidance-posttraumatic-stress-disorder-ptsd-pdf

The main aim of this research project was to determine the best way to organise mental health services for survivors of the conflict in Northern Ireland and Border Regions, inclusive of primary, community and hospital systems. To this end, the Commission for Victims and Survivors appointed Queen's University Belfast to conduct a review of trauma services. The project's key objectives were to a) provide an overview of the effectiveness of current trauma treatment/services and b) map mental health services across Health and Social Care Trusts in Northern Ireland and the Health Service Executive border regions in relation to policies and provision of care, in order to make recommendations for future service provision.

Dr Michael Duffy, Senior Lecturer of Social Sciences, Education and Social Work at Queen University Belfast (QUB) assembled and led a multidisciplinary team of experts, clinicians and researchers who designed a mixed-methods research approach to address the project's objectives. This comprised a series of literature reviews, an examination of available outcome data and an evaluation of current service provision.

Ethical issues

Ethical approval for the various strands of this study was obtained from the School of Social Sciences Education & Social Work (SSESW) Research Ethics Committee. Ethical element covered all aspects of data collection including safeguarding the anonymity and confidentiality of those who participated. Information sheets, consent forms and invitations to participate were emailed to the participating individuals and organisations before interviews. The qualitative interviewees were recruited purposively by the organisations through email exchanges and telephone conversations. All study files, including audio-recordings and transcripts, were stored under passcode in a manner conforming to the Data Protection (Amendment) Act 2003 (Government of Ireland, 2003) and QUB regulations.

In light of the highly sensitive nature of the subject matter in these studies, the comments and views of interviewees may contain language or phrases which others may find uncomfortable. The research team have been as careful as possible in transcribing interviews not to include unnecessary detail which may cause distress to others.

Background

The Northern Ireland Troubles

The prolonged 30 plus year conflict in Northern Ireland (NI), and the extent of its impact on society, has been acknowledged at Government and community level, and corroborated by a number of academic studies and reports. During the period 1966-2006 there were 3,720 deaths (McKitterick et al. 2007) and 40,000 people were injured (Smyth et al., 1999). As a consequence, many families were bereaved, many citizens experienced considerable mental health difficulties and many others have provided substantive care to their loved ones (CVSNI, 2015).

(Note – hereafter the terms "Troubles" and "Conflict" are used interchangeably throughout the document).

Mental Health

It has been reported that people in NI experience higher rates of mental ill-health when compared with other parts of the United Kingdom (UK) (O' Reilly & Browne, 2001) and the Republic of Ireland (RoI) (Barry et al., 2002). These presentations include conditions such as Post-traumatic Stress Disorder (PTSD), depression, anxiety disorders and prolonged complex grief reactions. Recently two new diagnostic categories, Complex PTSD and Prolonged Grief Disorder, have been created in the International Classification of Diseases-11 (ICD-11) diagnostic manual (WHO, 2018). Both of these conditions are pertinent to the psychological distress experience by many victims of the Northern Ireland "Troubles".

One disturbing statistic often reported is that Northern Ireland has the highest rate of suicide in the UK, (Snowcroft, 2015; Tomlinson, 2013). However, it is worth noting that the 2019 provisional total for death by suicide (197) is a significant fall on previous years (307 in 2018). This decrease is primarily due to improvements in the statistical processing of data and reduces the number of deaths coded with a finding of 'undetermined intent', while increasing the numbers coded as 'accidental'. The latter group falls outside the definition of suicide (NISRA – see link below). In light of these refinements, the Northern Ireland Statistics Agency (NISRA) is working with the Coroners' Service to review drug-related deaths within the 'undetermined deaths' category from 2015 to 2018.[6]

A number of studies report the link between exposure to conflict-related violence in Northern Ireland and mental ill health. In 2008, researchers at the North and West Belfast Trauma Research Centre conducted studies with individuals referred to the centre (Dorahy et al., 2008). The research reported that many (n=81) had experienced significant Troubles-related traumatic incidents in both childhood and adulthood, alongside social deprivation and high levels of unemployment. The studies also reported that participants had experienced chronic, severe and complex PTSD. The

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[6] https://www.nisra.gov.uk/publications/registrar-general-quarterly-tables-2019

majority of participants had a lifelong history of complex PTSD, with symptoms of dissociation, alterations of self-perception (e.g. feelings of guilt and shame) and relationships with others (e.g. difficulty establishing trusting relationships, being susceptible to re-victimisation or victimising others). Results showed that two-thirds of the sample had a history of self-harm, and a quarter (27%) reported suicide attempts.

The Mental Health Foundation (2016) reported that approximately 60% of the NI population has been exposed to at least one traumatic event in their lifetime, with 19.5% experiencing a Troubles-related trauma. The study also reported an 8.8% lifetime prevalence for PTSD with 5.1% meeting PTSD criteria within the previous year to the study. For those who were exposed to a conflict-related traumatic event, 32% had a mental health disorder in the preceding 12 months. The report also commented on high prescription rates for psychotropic medications in Northern Ireland compared to the rest if the UK which have been linked by other studies to the high level of exposure to conflict-related trauma (Ferry et al., 2015).

Ferry and colleagues (2008) emphasised the importance of developing evidence-based trauma-focused interventions in Northern Ireland to respond to Troubles-related mental ill-health. This report also highlighted the need for more linked up working between statutory and non-statutory sectors to ensure that individuals with trauma-related needs are referred to the most appropriate trauma-focused service.

A high association has also been found between exposure to conflict and more complex PTSD (De Jong, et al., 2003). One Northern Ireland study (Dorahy et al. 2008) suggests that exposure to conflict-related trauma in adulthood is predictive of the development of PTSD whereas exposure to conflict related trauma in both childhood and adulthood is more predictive of complex PTSD.

The Commission for Victims and Survivors has commissioned a number of studies to explore the relationship between the “Troubles” and the mental health of the population. One publication ‘A report on the Mental Health Impact of The Civil Conflict in Northern Ireland’ (2011) highlights that four out of ten people in the region have experienced a traumatic event related to the Troubles and that Northern Ireland has one of the highest recorded rates of PTSD anywhere in the world. The report also estimates that one-third of those who develop PTSD will not recover unless they have access to evidenced-based trauma-focused therapy. Historically, the problems of individuals may not have been recognised as "trauma-related" and instead they may have been treated for important but secondary conditions such as depression which is very commonly linked to chronic PTSD. The Commission’s report also estimated that 39% of the adult population (almost 524,000 individuals) had experienced at least one conflict-related traumatic event during their lifetime. The research team estimated from their anonymised survey data that there were about 18,000 individuals with conflict-related experiences who met the diagnostic criteria for post-traumatic stress disorder (PTSD) at the time of their study. The research also highlighted that the conflict has resulted in higher levels of other mental health problems such as depression, self-harm, complex grief, anxiety, panic disorder and substance misuse.

A later Commission report (2015) entitled “Towards A Better Future: The Trans-generational Impact of the Troubles on Mental Health” found that over 213,000 NI citizens were experiencing significant mental health problems as a result of the Troubles. The report suggested that traumatic experiences and exposure to violence can lead to adverse mental health problems not only for the individuals, but also for children of victims and subsequent generations.

The clear message from these studies is that substantial proportion of victims and survivors of the recent Northern Ireland conflict have enduring mental health needs that requires a comprehensive, joined-up, evidence-based service response.

Historical provision of psychological services for victims and survivors

The recent conflict in Northern Ireland has left in its wake a high proportion of victims and survivors requiring psychological services. Access to psychological services has improved in comparison to the early decades of the Troubles when there was a lack of policy and service provision for those in need (Cairns & Wilson, 1984; Dillenburger, Fargas & Akhonzada, 2007; 2008; Ferry et al., 2008; Park, 1998).

Historically many trauma services in Northern Ireland have evolved without strategic guidance or policies and were delivered by a range of statutory and non-statutory organisations. This has led to a degree of fragmentation, under-funding and the absence of agreed treatment approaches and standards of care. In the past, this lack of a standard service model has meant that many victims and survivors and their families did not receive the necessary help and support to aid psychological and social recovery.

Earlier reports of psychological trauma services highlighted deficits in provision and were instrumental in leading to significant improvements in both the quality and standards of counselling services, along with training and supervision standards for psychological service providers (Park, 1998). The PAVE (People Affected by Violence) project report (Dillenburger et al., 2007) provided a detailed description of core-funded services in the non-statutory sector for victims of the Troubles, along with an assessment of their effectiveness in improving the psychological health of service users.

In more recent years, the emergence of findings from high quality, well designed clinical studies have improved our understanding of what works for specific mental health conditions. Highly respected meta-analyses and reviews of such data have been incorporated into authoritative guidelines published by the National Institute for Care and Excellence and The Cochrane Library. In Northern Ireland the DHSS Clinical Resource Support Team (CREST) produced guidelines for the management of PTSD in adults (CREST, 2003) and produced recommendations similar to those the in the UK NICE guidelines published two years later (NICE, 2005). Such resources are much more available today compared to the early days of the Troubles.

Psychological Care - Policy Developments

Northern Ireland has five Health and Social Care Trusts, serving a population of around 1.8 million. The Department of Health, Social Services and Public Safety (DHSSPS) introduced a strategy for developing Psychological Therapy Services (PTS) in 2009. In the Strategy, a Stepped Care Framework was adopted to guide decision making in relation to the provision of psychological therapies (see figure 1.1).

Psychological Therapy Services[7][8]

A key purpose of the stepped care model was to optimise the use of Psychological Therapy resources and improve access to therapy. The stepped-care model aids in the design of local care pathways for people with common mental health disorders. Stepped Care is a system of delivering and monitoring treatments so that the most effective, yet least resource intensive, treatment is delivered to patients first; only 'stepping up' to intensive/specialist services as clinically required (see figure 1.2)[9]. The non-statutory sector provides talking therapies mainly, but not exclusively, for those with mild to moderate psychological difficulties at steps one and two. Those with more severe, complex needs are allocated to steps three, four and five services that are usually located within the statutory sector.

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[7] The National Institute for Health and Care Excellence NICE develop guidelines for a range of mental disorders such as - NICE (2005) Post-traumatic stress disorder: The management of PTSD in adults and children in primary and secondary care (NICE Guideline 26).

[8] The Cochrane Library is a collection of databases in health specialties including systematic reviews and meta-analyses which summarize and interpret the results of multiple studies. https://www.cochranelibrary.com

[9] https://wellbeinginfo.org/self-help/mental-health/stepped-care/

Typically, step 1 care involves early recognition of psychological problems and the provision of support and advice. Step 2 care offers low-intensity therapies such as counselling, psychoeducation and coaching. Step 3 care offers higher intensity therapies such as CBT, EMDR and psychodynamic therapy. Steps 4 and 5 care offers therapies for more severe, complex disorders (see figures 1.1 and 1.2 below)

Figure 1.1. Stepped care model presented in the HSCB regional care pathway You in Mind publication (2015)[10]
http://www.hscboard.hscni.net/our-work/social-care-and-children/mental-health/

Step 1:

Low Impact on Personal Functioning

Self-Directed Help - Health and Well-being Advice and Support for Mild Emotional Problems.

Support involves self-directed therapies such as CCBT, Education, Bibliotherapy, Making lifestyle adjustments.

Step 2:

Low-Moderate Impact on Personal Functioning

Primary Care Talking Therapies

Support at this level usually involves responding to common mental health problems such as anxiety, stress and depression.

Talking Therapies will include a combination of Counselling, Low Intensity CBT, Interpersonal Therapy, Mindfulness, Solution Focused, Brief Therapy, Life Coaching and Creative Therapies.

Step 3:

Moderate High Impact on Personal Functioning

Specialist Psychological Therapies

Support at this level usually involves responding to mental health problems which are disrupting daily functioning. Talking therapies will be delivered by Psychologists, Family Therapist, CBT Therapist and other specially trained practitioners.

Talking Therapies will include High Intensity CBT, Family/ Couples Therapy, EMDR DBT, Cognitive Analytic Therapy

Step 4:

High Impact on Personal Functioning

Condition Specific Psychological Therapies

Support at this level usually involves providing care in response to complex comorbid mental health needs.

High intensity Talking Therapies are delivered as in Step 3 and may include access to Psychotherapies and highly specialist/ specific programmes of recovery delivered by a combination of

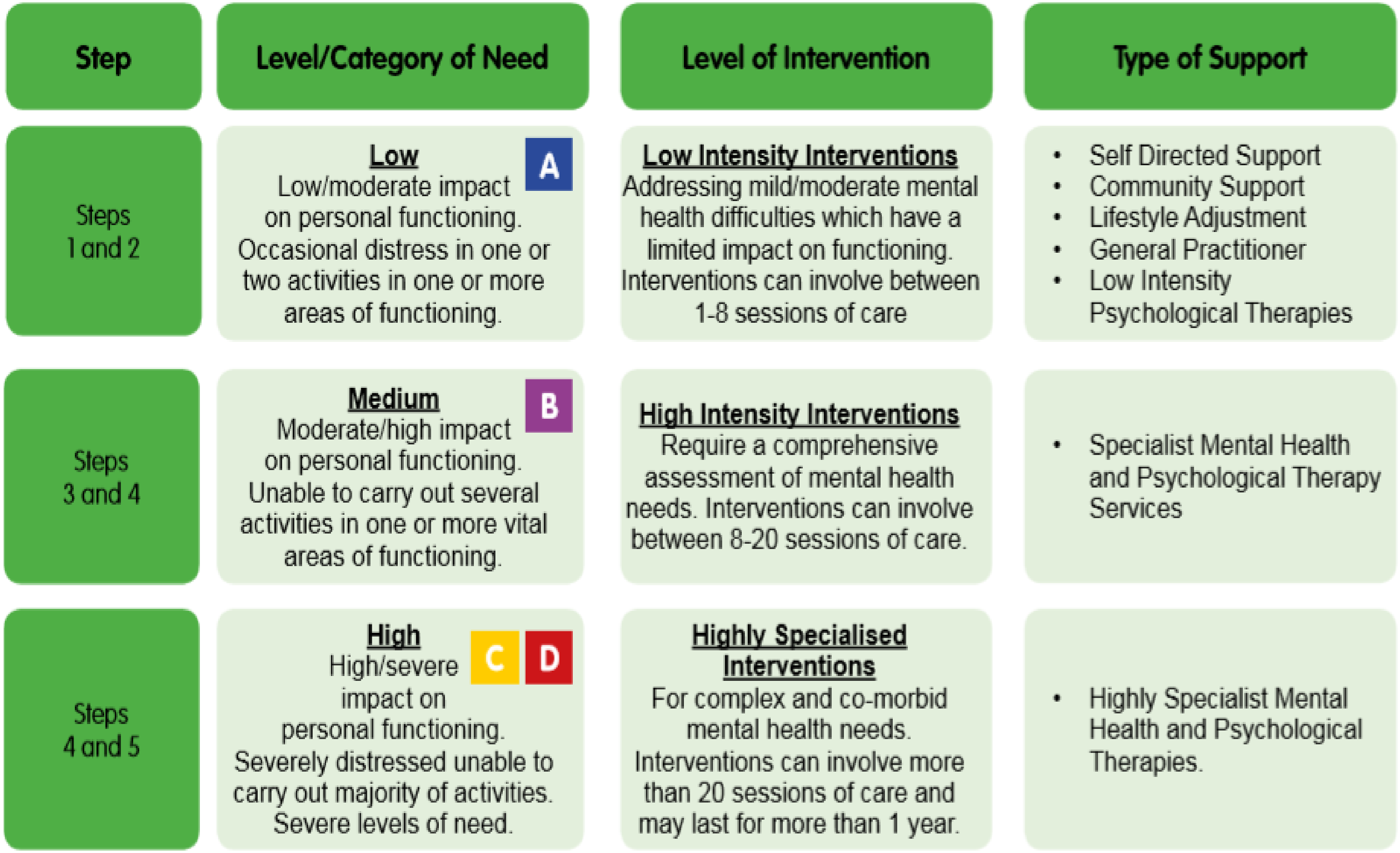
Step 5:

Severe Impact on Personal Functioning

Highly Specialised Therapies

Support at this level usually provided in response to highly complex mental health needs. Therapies involve highly specialist Psychological and Psychiatric Care. Combination of High Intensity Talking Therapies are provided to address personal and social risks.

Figure 1.2: Levels of Need, Interventions and Supports (You in Mind Talking Yourself Well, HSCB 2015)



Step	Level/Category of Need	Level of Intervention	Type of Support
Steps 1 and 2	**Low** A Low/moderate impact on personal functioning. Occasional distress in one or two activities in one or more areas of functioning.	**Low Intensity Interventions** Addressing mild/moderate mental health difficulties which have a limited impact on functioning. Interventions can involve between 1-8 sessions of care	• Self Directed Support • Community Support • Lifestyle Adjustment • General Practitioner • Low Intensity Psychological Therapies
Steps 3 and 4	**Medium** B Moderate/high impact on personal functioning. Unable to carry out several activities in one or more vital areas of functioning.	**High Intensity Interventions** Require a comprehensive assessment of mental health needs. Interventions can involve between 8-20 sessions of care.	• Specialist Mental Health and Psychological Therapy Services
Steps 4 and 5	**High** C D High/severe impact on personal functioning. Severely distressed unable to carry out majority of activities. Severe levels of need.	**Highly Specialised Interventions** For complex and co-morbid mental health needs. Interventions can involve more than 20 sessions of care and may last for more than 1 year.	• Highly Specialist Mental Health and Psychological Therapies.

In the implementation of the Psychological Therapies Strategy, the Health and Social Care Board (HSCB, 2010) produced the following set of recommendations for HSC Trusts:

1. Improve access to evidenced-based psychological therapies by embedding these therapies into all mental health care pathways.
2. Standardise service models and integrate the delivery of psychological therapy services across primary care and secondary mental health care services.
3. Provide information on all those therapies as recommended by the National Institute for Health and Care Excellence (NICE) Clinical Guidelines.
4. Match a person's need with the right level of intervention.
5. Access accredited training in line with NICE approved psychological therapies.
6. Provide supervision and support practitioners to undertake session by session measurement and routinely capture outcomes by using validated outcomes tool.

The report specifically recommends that the recent history of Northern Ireland must be acknowledged in a training framework in terms of training staff to treat specific problems associated with conflict such as chronic PTSD and complicated grief reactions. Training should also address the potential challenges for trainees providing therapy in a divided society.

Children's Mental Health

A recent review of Mental Health Services and Support for Children and Young People in Northern Ireland, conducted by the Northern Ireland Commissioner for Children and Young People (NICCY, 2018) highlighted alarming gaps in the collation of essential, basic operational data to efficiently plan, commission and deliver Child and Adolescent Mental Health Services (CAMHS). A key recommendation was for the establishment and maintenance of a comprehensive information monitoring system. Another key recommendation was for a whole systems approach, with joined-up working between statutory and community and voluntary sector organisations to support young people in the mental health system.

Psychological Therapies Services in the Voluntary sector

The Victims and Survivors Service (VSS) was established in 2012 to provide support and services, including the delivery of psychological therapies within the community and voluntary sector, to victims and survivors of the Troubles/conflict through the Victim Support Programme.

Through this programme, VSS supports approximately 12,000 individuals per annum to access a range of support and services across Step 1, 2 and 3 of the Step Care Model. Services include talking therapies, complementary therapies as well as social support activities such as welfare advice, personal and professional development, befriending and respite activities. Since 2017, £38.8m of funding has been allocated to 51 community and voluntary organisations to deliver these services across Northern Ireland.

In 2017, VSS established a needs-based service delivery model enhanced by PEACE IV funding. This funding provided the resources for a Health and Wellbeing Caseworker Network – 26 Health and Wellbeing Caseworkers employed by victim and survivor organisations across Northern Ireland, Republic of Ireland and Great Britain. Through this network, victims and survivors are able to access support and services that meet their individual needs at all stages of the Step Care Model. This model ensures that those in need of psychological therapies also have access to other support such as welfare advice and social support activities which will further enhance their wellbeing.

PEACE IV also provided the resources to build the capacity of those delivering psychological therapies to victims and survivors to ensure that adherence to standards and best practice.

In 2017-18 around £580,000 was allocated to 22 organisations to deliver ‘talking therapies’. In that period, these services were accessed by 1,669 individuals. Meanwhile, psychological therapies delivered under a needs-based framework as part of the delivery of the Individual Needs Programme had an allocated budget of around £300,000. The Impact of the Individual Needs Programme Report (2015) provided estimates of the number of victims presenting with psychological difficulties between April 2012 and November 2013. Up to 70% (i.e. 1,756 individuals) presented with moderate to severe anxiety levels and trauma-related symptoms, with an approximate waiting time of 13 weeks, depending on the assessed level of risk.

In subsequent years, VSS has supported psychological therapies delivered through approximately 20 community partner organisations for over 2,000 individual victims and survivors per annum.

Summary of methodology and project elements

This project is comprised of the following research elements which for the convenience of the readers have been published in 5 separate reports.

Report One: Executive summary, introduction, rationale, summary of key findings and recommendations

Report Two: Literature reviews

> Review 1 - Psychological interventions for PTSD related to war, terrorism and civil conflict: An overview of systematic reviews.
>
> Review 2 - A systematic review of the association between war Related parental post-traumatic stress on family functioning.
>
> Review 3 - Psychological and pharmacological treatments for comorbid PTSD and substance use disorders related to war and/or civil conflict: systematic review.
>
> Review 4 - The role of cognitive factors in the maintenance of complicated grief following conflict-related bereavement.
>
> Review 5 - The management of comorbid chronic pain and PTSD linked to war and civil conflict: a rapid review of the literature.

Report Three: An examination of available outcome data from services providing psychological services in Northern Ireland and the border regions.

Report Four: An exploration of the Experience of the Patient/Client Journey: a series of semi-structured interviews with Victims and Survivors

Report Five:

> Section 1- A survey of VSS funded groups providing talking therapies and Health & Social Care Trusts on current service provision.
>
> Section 2 - Focus groups and interviews with staff members from HSC Trust Mental Health Teams and Community and Voluntary Sector Organisations

Engagement with the research project

The research team are very grateful to those who engaged with us, opened up their data base and held open and honest discussions about services. In particular, we thank the VSS for facilitating access to groups and anonymised data sets and HSC managers who provided responses and access to available data.

It is important to acknowledge the context of a world Covid-19 pandemic which unfolded as the data collection was commencing in relation to some elements of this research. This had two main effects. Firstly, direct access to individual victims and survivors and some service providers was no longer possible and secondly members of the research team, comprised of clinicians and clinical researchers had to re-orientate from the study to provide treatment and care for Covid- 19 patients and provide support for frontline health staff.

Unfortunately, participation in some elements of the project was not at the optimum level. We understand the sensitivity within this area and hesitancy of some organisations in respect of how data might be analysed and presented. It is important to note that our research is governed by strict ethical guidelines of QUB ethical committees to ensure that data will be used in a manner that fully complies within GDPR, and rules of anonymity and confidentiality. It is widely accepted that research and data sharing are important mechanisms to advance learning, knowledge and improve services. The Improving Access to Psychological Therapies (IAPT) programme in England provides a model for how outcome measures can be used to great effect incorporating such principles as data sharing, transparency and a willingness to collaborate in the interests of improving patient/client care by reviewing and comparing outcomes across sites and learning from each other.

The data collection includes both quantitative data (VSS data set; HSC Trust outcome data; survey data) and qualitative data (interviews with individual service users, managers and practitioners). Each approach has strengths and limitations and some of these are addressed in the respective sections of this report. The views of an individual are important (for example, how services could be better provided, or complex PTSD can be treated more effectively) but they need to be tested empirically with future studies and well-designed trials. We consider how such studies may be developed in the final section of these studies.

Key Findings from the studies

1.1 Key points arising from Section Two/ Report Two – literature reviews

1.1.1 Review 1- Psychological interventions for PTSD related to war, terrorism and civil conflict: An overview of systematic reviews

In relation to psychological interventions for PTSD related to war, terrorism and civil conflict, the findings from our review concur with both UK and US guidelines recommending trauma-focused psychological therapies for civilians (adults and children) and military personnel exposed to conflict-related trauma. Although none include trauma-related Northern Ireland studies, the findings will be important to consider.

The components of therapy need to be specified (cognitive, behavioural, memory updating, appraisal modification, type of exposure) to ensure that evidence-based protocols are adhered to for optimal gains. As an example, it is now well established that CBT outcomes are linked to competent delivery of CBT protocols and adherence to the key components of treatment manuals.

1.1.2 Review 2 - A systematic review of the association between war-related parental post-traumatic stress on family functioning

All reviews are limited to the quality and characteristics of the identified studies. One specific feature that may be raised in relation to this review, is that samples of military families were used, so it can be argued that these studies have some elements that may not apply to the general population. However, core symptoms of PTSD and effects on family processes are similar across sub-groups. Indeed, many of the clinical trials that have produced data to test treatment models for PTSD have been conducted with military veterans, but this fact has not diminished the applicability of these models to civilian populations. Parental war-related PTSD may affect a family's ability to function effectively, so it is important the family unit needs are assessed in addition to the needs of a parent or a child or young person with PTSD.

Family-based approaches will be required for some clients. However, family-based approaches will not always be necessary or appropriate when a parent or a child has PTSD, so different approaches to supporting families should flow from accurate assessments and formulations.

Children may benefit from group work with other children in order to provide a space to share and process similar experiences. This approach could be an adjunct to a preventative approach such as psychoeducation regarding parental PTSD.

1.1.3 Review 3 - Psychological and pharmacological treatments for comorbid PTSD and substance use disorders related to war and/or civil conflict

Results for exposure-based therapies indicated significantly reduced PTSD symptoms at post-intervention junctures and a six-month follow-up (Back et al. 2019; Norman et al. 2019). Furthermore, Kobach et al. (2017) reported significantly reduced PTSD symptoms at six and 12 months together with reported reductions in drug dependence indicators.

Results from both Seeking Safety studies, (Boden et al. 2012; Najavits et al. 2018), showed significant decrease in drug and alcohol use and significant reductions in PTSD symptoms at post-intervention and follow up junctures.

Two web-based CBT studies showed mixed results. Acosta et al. (2017) found that there was a significant decrease in drinking days, but a non-significant decrease in drugs use and PTSD symptoms. Brief et al. (2013) indicated a significant decrease in drinking days, average weekly drinks, and PTSD symptoms in the post-treatment phase. The significant decrease in alcohol consumption was maintained at the follow up with no further changes in PTSD symptom scores for intervention participants during this period.

Topiramate reduced PTSD symptoms and incurred a significantly smaller number of drinking days at the post-intervention juncture (Batki et al 2014).

Two studies which considered Naltrexone (Petrakis 2006 and 2012) showed significant decrease in drinking days and a significant decrease in cravings but no significant change in drinking outcomes.

One study examined the efficacy of Prazosin for dually diagnosed PTSD and alcohol use disorder. Findings indicated no significant reduction in PTSD symptoms (Petrakis 2016). In addition, whilst there was a decrease in alcohol consumption for both intervention and control these were not significant.

1.1.4 Review 4 - The role of cognitive factors in the maintenance of complicated grief following conflict related bereavement

The studies included in this review reported significant variance with regards to prevalence rates for conflict-related CG (8%-82%). However, the study reporting 8% reported higher rates (31%) when using a Culturally Sensitive Measure of Grief Related Distress (CSM-G). There was considerable heterogeneity in relation to the psychometrics utilised to measure CG across the ten studies. This reinforces the importance of research using future standardized measures in order to facilitate learning from studies internationally.

Rumination and avoidance were the most commonly reported maladaptive cognitions underlying the development and maintenance of CG. Responsibility appraisals linked to guilt were also implicated as potential cognitive maintenance factors linked with elevated CG. Negative beliefs about the meaning of the loss and the world in general were strongly associated with CG severity, suggesting that the subjective interpretation of the loss may play a crucial role in the development and maintenance of CG.

CG may have a major influence in generating anger/negative appraisals, which is common amongst populations exposed to extensive human rights violations associated with severe traumatic losses. It has been suggested that peace building programmes may foster forgiveness which could be helpful for some suffering from prolonged grief reactions. However, there is also the risk that such programmes can cause exacerbations for individuals if there is an unrealistic expectation of forgiveness and the individual who is not able to forgive feels guilty for not meeting these expectations.

There was a clear link between CG and PTSD thus it will be important to explore these associations and develop treatments for comorbid CG and PTSD.

Treatments/therapies need to be sensitive to the history, culture, and context of those bereaved.

1.1.5 Review 5 - The management of comorbid chronic pain and PTSD linked to war and civil conflict: a rapid review of the literature

The rates of PTSD in chronic pain patients varies from 9-50% depending on the setting, population and the type of pain reported. People who report both pain and PTSD exhibit much greater PTSD symptoms, pain, anxiety, depression and disability and are more likely to be heavy users of pain medication.

Another feature of chronic pain is the cognitive bias of catastrophising, and this is considered a risk factor for PTSD. Physically injured patients with PTSD show poor pain control and catastrophising has a greater influence on their pain.

Much of the recent research on pain and PTSD has examined the effect of military personnel injured in overseas conflicts. Individuals injured in the Northern Ireland Troubles have had to live in the same environment where the injury occurred, and this may pose a different type of threat. Perceived threat is also a risk factor for PTSD.

Chronic pain (CP) is a chronic condition requiring continuous care with the patient at the centre ensuring that they (the patient) can learn and understand the importance of self-management. The presence of PTSD only adds to the difficulty of pain management as there is now another source of threat.

1.2 Key points arising from the Section Three / Report Three - analysis of outcome data

It is encouraging that greater attention to outcomes has been introduced across the VSS funded voluntary organisations by the VSS. In the statutory sector, Trusts have also introduced an outcomes framework but there is variation across Trusts and the psychological therapy teams operate under enormous Wait List pressures. The collection of outcome data allows us to check the patterns of service delivery, where interventions are effective and where there is room for further progress to be made. There are committed and dedicated staff working to help victims and survivors across many organisations and all sectors but there is a need to consider *what* is being offered and *how effective* different interventions are for specific problems.

In respect of VSS clients the data reports that 22% received person-centred counselling compared to 8% receiving CBT. This may fit with the level of need presenting at step care levels 1 and 2, for example mild to moderate depression responds well to counselling.

The VSS have subsequently informed the research team that “significant numbers” in the ‘multiple therapies’ cohort may also have received CBT so these results must be interpreted with a degree of caution. We did not have access to this data at the time of writing this report, but the general points are nonetheless valid: the type and level of therapy works best when matched to the type and severity of psychological problem being addressed.

The VSS data reports that the majority of clients who received person-centred counselling (PCC) did not improve (54% no improvement v 46% improvement) and also that non-completer rates were comparatively high for PCC (48%) compared to 28% non–completion for CBT. We note that the numbers in the cohort were relatively small.

It will help us to understand these differences when more details are collected in relation to the primary problem being treated – for example if the condition was PTSD, moderate depression or an anxiety disorder then PCC would not be the recommended treatment from NICE guidelines and could explain less favourable outcome results.

The precise type of therapy being provided needs to be described more accurately. As an example, the VSS data reported CBT as a form of therapy provided but there needs to be clarity whether the service provided is CBT or trauma focused CBT (TFCBT). The NICE guidelines for PTSD recognises the distinction between generic CBT and more specialist TFCBT explaining that the latter has more impressive treatment outcomes. When considering the VSS data reporting a ratio of 2/1 improvement for CBT service provision, the research team deemed this relevant. Approximately 60% of clients improved however 30% did not, and the question is posed how many of these service users received CBT and how many received trauma focused CBT?

Reliable improvement

Whilst the data demonstrates that “multiple therapies” has the highest reliable/clinical improvement of (67%) and is also is the largest data set, it is difficult to derive any learning from this data due to the complexity of the combination of therapies. For example - which component produced most therapeutic gain; was there a positive or a negative interaction between different interventions?

The VSS have subsequently informed the research team that victims & survivors “often” received a number of therapies in a sequential manner. We did not have access to these patterns of referral and are unable to comment on the efficacy of the mixed modalities. Therefore, these data should be interpreted with caution. However, the patterns are useful indicators of therapeutic gains and can help in discussions about tailoring interventions to the needs of specific individuals.

All the formal psychotherapies (CBT, Psychodynamic, psychotherapy, EMDR) recorded greater than 50% reliable/ clinically reliable improvement compared to counselling (Person Centred Counselling/Bereavement Counselling) and short-term solution focused approaches which all reported less than 50% reliable or clinically reliable improvement. Similar patterns emerged on all 4 domains on the CORE instrument.

As reported above, the VSS have subsequently informed the research team that victims & survivors “often” had a therapy such as CBT and subsequently opted to try an alternative. We did not have access to these patterns of referral and are unable to comment on these inter-action effects so these data should be interpreted with caution. However, the patterns are useful indicators of therapeutic gains and can help in discussions about how to target victims’ and survivors’ needs to specific therapeutic approaches.

Dropout rates

Non-completers are an important factor. A measure of success of any therapy is the ability of clients to tolerate and complete the course of treatment. The drop-out rates vary considerably for different interventions; Solution Focused Therapy (60%); Bereavement Counselling (56%), Person centred counselling (48%). EMDR also had a high drop-out rate (40%), Other Therapies (36%), and Psychotherapy (33%). The lowest dropout rates were found for Psychodynamic Therapy (18%), Life Coaching (27%), and CBT (28%). Although the dropout rates for CBT was comparatively low the non-completion rate is still unacceptably high compared to many clinical trials. This data, while based on relatively small numbers, emphasises the importance of improving retention rates as well as improving outcomes for mental health and social functioning.

Number of sessions

There was a wide variation in the number of sessions provided. The VSS data reports that 36% received multiple therapies and the North Belfast Trauma Resource Centre records a wide range of sessions provided which poses the question; why are these combinations of interventions required and what is the added gains from these combinations?

Whilst there is established recognition that more (or less) sessions may be required for specific cases, there need to be guidelines to ensure that substantial deviation from the norm is justified and explained by cases conceptualisations. Psychological therapies need to demonstrate that they are ***(a) clinically effective and (b) cost effective.***

Several psychological therapies use disorder specific models and are referenced by the NICE guidelines. Trauma-focused CBT (TF-CBT) including; Prolonged Exposure (Foa et al., 1991) Cognitive Processing Therapy (Resick et al., 2002) and Trauma focused Cognitive Therapy (Ehlers and Clark, 2000), are effective in the treatment of PTSD (Bradley et al. 2005; Bisson et al. 2007) and are currently recommended as first-line treatments for this condition (NICE, 2018) as is EMDR (eye movement desensitisation and reprocessing) (Also see Cochrane Reviews - Bisson et al., 2007; 2013).

Bereavement / Grief or Prolonged Grief Disorder

The statistics provided by the VSS in relation to bereavement indicate just how much the field is still evolving in our understanding of how to deal with traumatic/complex grief reactions.

The 2/1 ratio in terms of the effectiveness of bereavement counselling (63 % no improvement or deteriorated v 37% improved) is an important finding to explore further. It is of course possible that many in the ‘no improvement’ category may have reported small improvement but not enough to be considered reliable improvement. The data also reports that over half the clients did not complete therapy (drop-out rate of 56%).

These data are perhaps not surprising because typically a generic form of grief counselling has been offered to all who have been bereaved. A meta-analysis of 35 grief therapy studies found that generic treatments for grief had a limited and small effect (Allumbaugh & Hoyt, 1999).

Until relatively recently “all grief” conditions were provided with a generic response (medication; generic grief counselling). In more recent studies, as explained in the review, more severe forms of prolonged/traumatic grief respond better to specific targeted therapeutic responses.

Currier et al.’s (2008) meta-analysis of grief therapy trials found that interventions had a small effect at post-treatment stage, but no statistically significant benefit compared to control groups at follow-up. However, some treatments had a substantial, and long-lasting benefits for those suffering from severe and prolonged grief reactions. Only in recent years has the field begun to understand more fully the concept of complex /prolonged/ traumatic grief and has started developing more effective therapies. Prolonged Grief Disorder (PGD) differs from “normal” grief. There is a persistent yearning or missing the deceased, or pre-occupation with the circumstance of the death and difficulty engaging with new social or other activities due to the loss. In a meta-analysis of randomized controlled trials of psychological therapy for adults with Prolonged Grief Disorder, cognitive–behavioural grief-targeted interventions were found to be more effective than control conditions (i.e., supportive or other nonspecific therapy, or waitlist) for reducing PGD symptoms (Wittouck, et al., 2011).

Complementary therapies

There are extensive amounts of complementary therapies offered mainly in voluntary service but are also provided in some parts of the statutory service. There is little empirical evidence that these interventions are effective as a stand-alone treatment for conditions such as PTSD or related mental health conditions. However, there may be a case for supplementing more evidence-based therapeutic approaches with these services to enhance emotional and physical well-being, but we are unable to analyse these questions within the limitations of this study.

The VSS have subsequently advised the research team that the data on these services is recorded all complementary therapies (MYMOP) for reasons such as: stress relief, relaxation, a pathway to other services (psychological therapy) and building trust & confidence. VSS ‘MYMOP’ (Measure Your Medical Outcomes Profile) data has consistently (year on year since records were started in 2017) shown that on average, 80% of individuals engaged in complementary therapies report an improvement in symptoms. This data supports the positive feedback that VSS has been given that complementary therapies have immense benefits for victims and survivors in improving their overall health and wellbeing, as well as in building trust and confidence to access other services available to them.

Republic of Ireland

In the absence of a central data base in the HSE or non-statutory sector in the Republic of Ireland it is very difficult to ascertain the uptake of psychological or generic mental health care linked to the recent Troubles in Northern Ireland. The VSS funds groups providing services in the border regions, but the data indicates that less than 1% of service users reside in the Republic of Ireland.

There would need to be an undertaking to evaluate and quantify the scale of the problem in the Republic of Ireland and how best to address it within the configuration of primary care and mental health services.

Strengths of Current Psychological Service Provision for Victims and Survivors of the Troubles

The data captures how the Troubles have affected the people of this region including with some experiencing severe and chronic disabling conditions.

A large cohort of dedicated staff are working in the statutory and voluntary sector and have been dedicated to helping victims and survivors over many years.

Limitations of Current Psychological Service Provision for Victims and Survivors of the Troubles

Whilst recognising that many people are benefiting from current services, there is always room for improvement to more fully embrace the concept of evidence-based practice. Consistent use of standardized measures – session-by-session, or at least prior to mid and post points, and follow up data would strengthen current psychological service provision.

How to use outcome measures to great effect

The Improving Access to Psychological Therapies (IAPT) programme commissioned by NHS England in 2008, has been heralded as one of the most radical developments in psychological care provision in recent times. The goals and priorities for service development in the IAPT programme are ambitious, including the expansion of services to increase access to care, achieving improved outcomes for those with long term conditions, improving employment outcomes, and people's experience of psychological services.

The IAPT services have three key characteristics:

1. Evidenced based psychological therapies: which stipulates that all psychological therapies should be delivered by fully trained and accredited practitioners in order to improve outcomes. As of April 2018, all groups commissioning clinical services are required to offer IAPT services alongside physical healthcare pathways. The ideal pathway for implementing IAPT services is outlined in The IAPT Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms guidance[11] .
2. Routine outcome monitoring: to ensure ongoing monitoring and information in relation to an individual's progress for both the clinician and the individual. This outcome monitoring aims to encourage transparency in relation to individuals' progress in order to improve outcomes and encourages a partnership approach between the individual and their clinician in planning therapeutic goals.

Regular and outcomes-focused supervision: in order to support practitioners ongoing improvement and the provision of high-quality care.

1.3 Key points from Section Four /Report Four – interviews with individual victims and survivors

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[11] https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-iapt-pathway-for-people-with-long-term-physical-health-conditions-and-medically-unexplained-symptoms/

This was a small sample (N=10) and the recruitment was not in line with the agreed sampling frame so we cannot state that the views expressed are representative of the wider victims and survivors community. However, the themes highlighted are important and merit further investigation with well-designed larger studies.

Over half of the participants exhibited symptoms of re-experiencing, avoidance, hypervigilance and relationship difficulties which would indicate PTSD symptoms. There was evidence of experiences of multiple incidents of trauma and in particular, childhood trauma for over half of the respondents. It is recognised in the literature (see review number 1) that more complex presentations of post-traumatic stress disorder (cPTSD) are associated with childhood abuse (ICD-11, 2018).

None of the participants received any professional support at the time of the trauma incidents. The effects of the trauma appeared to be augmented by the long duration of time from trauma to treatment (average 20 years) which is probably related to a number of factors:the availability of services and the lack of a coordinated approach to victims needs in the earlier phases of the Troubles, the socio-cultural environment where trauma was rarely talked about; associated stigma and shame, the fact that clinicians did not routinely ask about trauma history in clinical settings.

Some respondents raised the issue of trust have when deciding where to get help. A majority of the respondents expressed feeling unsafe when in an environment with those whom they perceive to be of different religion/political backgrounds. This is notably a sensitive area which in a post-conflict divided society. However, evidence suggests that there is a therapeutic benefit in the timely and skilful exposure to that which is feared in order to challenge any over-generalised beliefs about "out-group" members and discover a renewed sense of safety.

The majority of participants reported greater resilience and suggested that counselling helped with the symptoms giving a safe space to talk about their experiences of conflict. However, almost all suggested that they would require further psychological therapy to recover from ongoing symptoms (especially avoidance, re-experiencing and hypervigilance). There appears to be a need for further and possibly more specialist treatment for probable PTSD.

The participants included in this study report that the VSS funded organisations have been working diligently to create structures which aids in recovery processes including social attachment and support, promoting proactive coping style. In addition, the interviews point toward the need for specialist services to help with more complex presentations of trauma.

1.4 Key points from Section Five/ Report Five (1)– surveys of VSS and HSCT staff

As fits within a Stepped Care, model most cases appear to receive care at the appropriate level matching their need. Cases attending specialist trauma centres in the statutory sector generally appear to have more challenging mental health problems compared with those cases presenting in the voluntary sector. The most commonly cited therapeutic approaches provided within statutory and non-statutory services mainly reflect the Stepped Care Model employed across sectors with some exceptions.

The absence of a regional standardized outcomes framework across the statutory sector, which codes more specific details, limits the possibility of an accurate picture of types of mental health problems presenting, the severity and chronicity of psychological trauma presentations, the effectiveness of interventions provided and importantly the service demand from victims and survivors of the Troubles.

An outcomes framework has been introduced by the VSS across the non-statutory sector however there are issues related to assessment, data capture and coding which need to be addressed to provide an accurate picture of specific presentations/ disorders such as PTSD, Substance Use Disorders, and risk/history of Self-Harm/Suicide.

There were differences in staff profiles across the statutory and non-statutory sector, in line with the Stepped Care Model employed across sectors. There was a higher proportion of practitioners with specialist training such as CBT Therapists and Clinical Psychologists responsible for treating moderate – severe Step 3-5 conditions such as PTSD in the statutory sector. The non-statutory sector, responsible for treating mild to moderate Step 1-2 client presentations, cited Counsellors as the most common profession.

1.5 Key points from section five (2) interviews and focus groups with staff

There is a need to develop a partnership approach to build relationships and trust between statutory and non-statutory sectors.

There is lack of clarity in matching levels of mental health needs with levels of Stepped Care. The type and number of therapeutic sessions should match client need.

There is a need for greater parity of access to services for victims and survivors across NI. All needs of victims and survivors cannot be met by psychological services in isolation but require a biopsychosocial approach.

Awareness raising and knowledge transfer of key skills and services across both statutory and non-statutory sectors is important.

The new Regional Trauma Network can facilitate the advancement of knowledge and skills in the field by providing opportunities for high quality clinical research to further improve the quality-of-service provision for victims and survivors.

It is important for patient choice that the therapy on offer is accurately described (the modality; the protocol etc.). It is unhelpful and does not help clients make informed choices, for example, if everything is described as “counselling”.

1.6 General Observations from the studies

Treating Trauma in all its forms

The focus of much research in relation to the effects of traumatic experiences has, understandably, been on PTSD. However, there are other important, more recent categories that need to be considered and more fully understood within all Trauma services such as the following:

1.6.1 - ASD Acute/PTSD - early interventions

A Cochrane review of early psychological interventions to treat acute traumatic stress symptoms (Roberts et al., 2010) reported evidence that individual TF-CBT was effective for individuals with acute traumatic stress symptoms compared to both waiting list and supportive counselling interventions. The quality of trials included was variable and sample sizes were often small.

One important research finding emerging in recent years related to psychologically-focused debriefing (CISD) The NICE guidelines (2018) reported that psychologically-focused debriefing, either individually or in groups, showed no benefit for children or adults, and some suggestion of worse outcomes than having no treatment (Mayou, et al. 2000). The NICE expert reference group agreed that active monitoring within the first month after the trauma could help professionals to judge whether people with less severe symptoms would need further intervention (NICE, 2018).

A study by Bryant et al. (1999) found that fewer individuals who received exposure therapy (14%) and exposure plus anxiety management (20%) met criteria for PTSD following treatment than those who received supportive counselling (56%). Another study found TF-CT to be effective as an early intervention for acute PTSD when compared with a self-help or repeated assessment (Ehlers et al, 2003).

1.6.2 Complex PTSD

The ICD-11 (2018) criteria for trauma-related disorders define PTSD and complex posttraumatic stress disorder (cPTSD) as separate disorders. ICD-11 (2018) defines Complex post-traumatic stress disorder (Complex PTSD) as a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible such as; torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse (Cloitre et al, 2012; Karatzais et al., 2017). Although a phase-based model (Herman,1992), has been put forward as the best treatment approach there is not enough evidence as of yet to recommend this approach for the effective treatment of complex PTSD (Karatzais et al., 2019). Proponents of the phased approach reason that complex PTSD requires stabilisation (i.e., addressing safety, emotional and social skills required for daily functioning) prior to trauma-focused work (Cloitre et al., 2010), while others contend that the stabilisation phase may also have adverse consequences in terms of delaying trauma focused work (De Jongh et al., 2016).

1.6.3 Prolonged Grief Disorder (PGD)

This new concise definition of PGD is predated by different terminology (i.e., traumatic grief, complicated grief, persistent complex bereavement disorder) and different diagnostic criteria for a disorder of grief (Boelen and Smid, 2017; Killikelly and Maercker, 2018). Evidence shows that between 10% (Kersting et al., 2011) and 20% (Shear et al., 2011) will experience bereavement difficulties that persist rather than diminish over time, with many failing to seek clinical help (Lichtenthal et al., 2011) despite significant social impairment and increased risk of suicidality (Latham and Prigerson, 2004). Whilst there is increasing evidence that prolonged grief has distinct characteristics (Bryant, 2012), there are clinical features that overlap with PTSD, such as intrusive memories, emotional numbing, and avoidance of trauma or loss reminders (Killikelly et al., 2019; Duffy and Wild, 2017).

Recommendations

Recommendations for Practice

1. It is important that assessment procedures capture the main mental health problem as accurately as possible: Various methods should be explored including- more detailed GP referrals; liaison with other mental health professionals; disorder specific self-report measures.
2. Assessments should record any identified co-morbidities including substance misuse disorders.
3. There should be a streamlined pathway enabling referrals onward from non-statutory services to more specialised statutory services and vice-versa.
4. There needs to be more specificity in describing the type of psychological service being provided and who provides the therapy. For example, there needs to be clarity whether a service user receives generic CBT or trauma focused CBT (TFCBT).
5. Authoritative clinical guidelines, such as NICE and Cochrane Reviews, should be used for recommendations of therapies to be provided for specific conditions and for indications of the average number of sessions usually required.
6. It is important to assess bereaved clients and provide therapeutic interventions such as trauma focused CBT or Complex Grief Therapy to those who meet criteria for PGD and who are likely to gain from interventions with a strong evidence base.
7. A research-based rationale should be developed for the provision of complementary therapies either as part of a mental well-being service or to augment more mainstream therapeutic interventions for conditions such as PTSD, for example, in the treatment of co-morbid chronic/persistent pain.
8. All teams need to consider using more distinct staff titles that specify the services/therapies they are qualified to provide and clarify for the public specified staff competencies to provide evidence-based protocols.
9. The data from all agencies suggests that a proportion of service users are presenting with more complex trauma presentations. Consultant Psychiatry input into psychological trauma services, especially in the statutory services, may be necessary given the potential role for medication in this area.
10. There is a need for greater consistency of psychological service provision for victims and survivors across the region. For example, at the time of this study, only two HSCTs had a dedicated Troubles related trauma service. A more standardised regional approach and partnership between the statutory and voluntary sector is important in this respect

Recommendations related to the new Regional Trauma Network

1. The new RTN needs to address a range of mental health conditions as well as PTSD with specific reference chronicity, co-morbidity and Troubles related trauma presentations.
2. The RTN should also address complex PTSD specifically as well as prolonged grief disorder using evidence-based therapies.

3. The RTN can be an important asset in raising the profile of research and should systematically collect outcome data by introducing a standardised outcomes framework for trauma services.
4. The research remit of the RTN should facilitate therapists to practice as research clinicians to further test new therapeutic approaches for more complex and new diagnostic categories such as CPTSD and PGD presentations.

Recommendations regarding Training and Regulation of workforce

1. Trauma-focused training and education should be available for suitable staff in both statutory and non-statutory organisations providing psychological services and more specialist training for those working above step care level 3- i.e., specialist trauma qualifications.
2. Therapists should preferably be accredited by the relevant professional body.

Recommendations regarding Research

A research/outcomes culture should be encouraged across all sectors. Specific research projects should be considered to address the following issues:

1. To develop effective interventions to treat complex PTSD. Given the uncertainty around the effectiveness of a phased approach, more research is urgently required, specifically comparing the phased approach to non-phased approaches (Katarzais et al., 2019). The RTN should consider supporting an RCT to test effective treatments for CPTSD.
2. To develop effective interventions to advance our understanding of how to help those with prolonged traumatic and complex grief.
3. To understand the concept and break the cycle of transgenerational trauma.
4. To understand potential benefits of providing complementary therapies as an adjunct to evidence-based models such as TF CBT for conditions such as PTSD and chronic pain.
5. To consider current early interventions and preventative measures and design a research project to test effective responses after selected traumatic events.
6. To improve our understanding of what works best for children and young people’s Trauma.
7. To consider barriers that may exist to victims and survivors' engagement.
8. An adequately funded cross border research study should be considered to gather data from a range of sources to ascertain current levels of mental ill-health and physical ill health in the border regions related to the Troubles.

Recommendations relating to Regional Policy/Regional Operational Change

1. A more strategic and co-ordinated response between and across Statutory HSC Services, VSS and Community and Voluntary Sector Services and organisations should be considered.
2. A Partnership model involving the Voluntary Sector and the new Regional Trauma Network can create an opportunity to remove barriers and traditional blocks to accessing help across

sectors; help to integrate services at a local level and streamline care pathways; help to mainstream evidence-based services and improve outcomes for individuals.

3. Options should be explored via established HSE/HSC networks to consider the possibility of developing a trauma initiative in the RoI similar to the RTN to work in partnership with the RTN.
4. Adequate I.T. systems need to be in place and sufficient time made available for staff to input appropriate data. Software systems should enable data sharing for monitoring and transparency.
5. Outcome measures should be standardized and specific to be able to comment on specific treatments effects on specific disorders and problems.
6. For a specified period, it is recommended that HSC Trusts' PTS and trauma teams should code patients with Troubles related mental health problems where this is evident at assessment.
7. Whilst progress has been made with the introduction of the CORE outcome measure in some agencies, a Standardised Outcomes Framework with validated disorder specific session by session measures, (or at least pre, post and repeated intervals), should be developed across all HSCT trauma teams and VSS funded groups. It should be explored whether such a data set can be shared about services, therapies and effects to enhance understanding about what works for whom.

Concluding comments

1.7.1 A Regional Trauma Network

The Northern Ireland Executive made a commitment in Stormont House Agreement (2014) to the establishment of a comprehensive Mental Health Trauma Service and access to high quality services and prioritizing the mental health needs of victims and survivors. Paragraph 27 of the Agreement states:

> "The Commission for Victims and Survivors' recommendation for a comprehensive Mental Trauma Service will be implemented. This will operate within the NHS but will work closely with the Victims and Survivors Service (VSS), and other organisations and groups who work directly with victims and survivors"[12].

This commitment to developing a Mental Health Trauma Service within the National Health Service (NHS) and working closely with organisations and groups working directly with victims and survivors, builds on the Commission for Victims and Survivors Comprehensive Needs Assessment conducted in 2012. Their findings identified mental health as the number one priority for victims and survivors, and therefore recommended:-

> "The inequitable provision of trauma-related services within the health and social care system and to establish an effective and sustainable cross-sectoral approach to treating

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[12] https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016804a74f9

> conflict-related trauma, the Commission would encourage consideration of developing a trauma-focused coordinated service network by OFMDFM and DHSSPS. Based on the model of a managed clinical network, the development of a trauma-focused coordinated service network could deliver a comprehensive regional trauma network drawing largely on existing resources and expertise from the statutory, independent and voluntary sectors".

1.7.2 Importance of the RTN and the Sector treating all forms of trauma

As reported in the previous sections, the majority of those interviewed in the qualitative data research reported multiple incidents and various trauma types including a combination of Troubles and non-Troubles related traumas (inter-personal traumas, childhood abuse and neglect). Therefore, it is important that the RTN and the sector in general address trauma related problems regardless of the "stated" explicit index trauma. It may be more difficult for a victim to disclose traumas related to a more personal sources (parental; family abuse) than to report traumas linked to "external" sources (paramilitaries; army etc.)

In addition, Ireland, North and South, has a well reported history of other forms of large-scale abuse not linked directly to the Troubles. Institutional abuse in agencies such as the Mother and Baby homes and the Magdalene laundries have negatively impacted the mental health of large numbers of people. Surely these victims deserve access to specialist trauma services.

Finally, in recent times, Northern Ireland's political leaders have offered refuge to others who suffer as a result of human conflict elsewhere. Many incoming refugees will have experienced trauma in many forms and will benefit from the expertise garnered within local trauma services. The expertise of trauma practitioners can only be enhanced by working with such a wide range of trauma experiences which in turn will enhance services for victims of the local conflict. If there can be any positive legacy from the Troubles, surely one would be that we have greater empathy toward the suffering of others and we are willing to share what we have learned and are prepared to continue learning, about how to address trauma-related mental health problems effectively**.**

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A Series of Literature Reviews

Report Number Two

Prepared for the Commission for Victims and Survivors

by Queen's University Belfast

ID 1238782

Report 2 Contents

Introduction

There are five literature reviews in this section

1. An overview of systematic reviews of psychological interventions for PTSD related to war, terrorism and civil conflict:
2. A systematic review of the association between war-related parental post-traumatic stress on family functioning:
3. A systematic review of psychological and pharmacological treatments for comorbid PTSD and substance use disorders related to war and/or civil conflict:
4. A systematic review of the role of cognitive factors in the maintenance of complicated grief following conflict-related bereavement:
5. A rapid review of treatments and psychological Interventions for treating war and civil conflict-related comorbid chronic pain and PTSD:

All reviews were undertaken by a sub-group of members of the research team and each review followed the same systematic approach to searching the literature, quality assessing selected papers for each review and reporting findings. Inclusion/exclusion criteria varied according to the purpose and aims of the review. Reviews 1, 3 and 5 only include treatment/intervention studies. The review of treatments for PTSD (review 1) did not include studies with refugees and asylum seekers because this group present with a wide range of psychosocial/ legalistic needs that often require multi-agency responses. However, such studies were not excluded from the complex grief review (review 4) because the purpose was to try to locate as many cognitive predictors as possible. Therefore, the wider the range of participants the more variables the review would be likely to locate.

Information Sources

The search strategy for each review was developed by extracting the relevant search terms, each term was then searched for in the database thesauri in OVID Medline to create a complete list of potentially relevant terms. Review authors reviewed each list, added any missing terms, and removed unnecessary terms. The search strategy included search strings for population (PTSD), setting (war/conflict, terrorism, political violence) and other appropriate terms such as intervention (psychological) and systematic reviews. Established data bases were searched including Medline, The Campbell Collaboration Library of Systematic Reviews, Cochrane Database of Systematic Reviews, Published International Literature on Traumatic Stress (PILOTS), PsycINFO, EMBASE, CINAHL Plus, and Web of Science. Reference lists of relevant reviews were also checked to identify further reviews.

Screening

The same rigorous screening process was used to identify individual studies from the selected systematic reviews.

Study Selection and Data Extraction

All identified studies were reviewed by the first author to determine eligibility. Studies were screened by title and abstract and irrelevant studies were excluded. The remaining studies were assessed via full text according to the inclusion and exclusion criteria by the first author and an independent reviewer. Relevant data was then extracted from each study.

Any discrepancies in data extraction were discussed and resolved by two review authors. A data extraction table was developed for each review to support the synthesis of included studies.

Risk of Bias

To reduce the potential confounding effect of publication bias, a grey literature search was conducted in the reviews.

Risk of bias in the included reviews was assessed using the Cochrane Collaboration's 'Risk of Bias' tool.

More specific details relating to each review are available in the appendices including flow charts outlining the selection process.

2.1 Review 1 - Psychological interventions for PTSD related to war, terrorism and civil conflict: An overview of systematic reviews

2.1.1 Introduction

High rates of PTSD have been found among people exposed to war, terrorism and civil conflict-related trauma (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995; Kitchiner Roberts, Wilcox & Bisson, 2012). A number of studies of PTSD in veteran samples indicated lifetime prevalence rates for PTSD between 30.9% and 26.9% in Vietnam Veterans (Kulka et al., 1990), 12.1 % in Gulf War Veterans (Kang, Natelson, Mahan, Lee & Murphy, 2010), and 13.8% in Afghanistan and Iraq Veterans (Tanielian & Jaycox, 2008).

In a population survey (Muldoon, Schmid, Downes, Kremer and Trew, 2005) 10% of participants reported PTSD symptoms, attributable to exposure to the political conflict in Northern Ireland (NI). Furthermore, children who had direct exposure to the Omagh bomb in NI had higher rates of PTSD compared to the general population (McDermott, Duffy, Percy, Fitzgerald & Cole, 2013). Those with chronic PTSD are also at higher risk of developing secondary problems, such as substance misuse (Kessler et al., 1995), suicidality (Panagioti, Gooding & Tarrier, 2010), chronic pain (Schnurr & Green, 2003), and many other medical problems (Ouimette et al., 2004).

As wars, civil unrest and political conflict persist, and recognition of the association between conflict and PTSD develops, it is imperative to identify the most effective treatments and interventions to facilitate clinical recovery, prepare mental health responses, and improve public health outcomes for both civilians and military personnel in affected communities (Mugisha, Muyinda, Wandiembe & Kinyanda, 2015).

Effective treatments for adults, children and young people experiencing PTSD are outlined in clinical guidelines such as the National Institute for Health and Care Excellence (NICE) in the U.K. (NICE, 2013; 2018). Trauma-focused psychological therapies, in particular TF-CBT, have a strong evidence base, and are therefore recommended treatments for PTSD. Trauma-focused CBT incorporates various therapies, but the three most prominent models are Prolonged Exposure (P.E.) (Foa, Rothbaum, Riggs & Murdock, 1991), Cognitive Processing Therapy (CPT) (Resick, Nishith, Weaver, Aston & Feuer, 2002) and Trauma focused Cognitive Therapy (TF-CT) (Ehlers & Clark, 2000).

Other trauma focused exposure-based therapies include Narrative Exposure Therapy (NET) (Schauer Neuner & Elbert, 2005) and Eye Movement Desensitisation & Reprocessing (EMDR) (Shapiro, 1996). Whilst both contain elements of CBT, these approaches include certain idiosyncratic treatment procedures. For example, NET does not identify a single traumatic event as a target in therapy but involves constructing a narrative that covers the patient's entire life. EMDR involves rhythmic bilateral eye stimulation regarded as a core therapeutic component by its originator (Shapiro, 1996) who considers the approach to be a distinct treatment (Shapiro, 2001). The published research which informs clinical guidelines for PTSD treatments relates to non-conflict traumas, such as road traffic accidents, inter-personal assaults, fire or natural disasters and war combat studies have been published particularly relating to the Veterans Studies in the USA. The evidence base for effective treatments for PTSD linked to civil conflict or terrorist violence is less developed.

The justification for reviewing treatments for this specific population are:

1. There are different rates of PTSD associated with different types of trauma. Human inflicted traumas such as child abuse, physical attack, kidnapping or being held hostage produce high rates of PTSD compared to natural disasters or accidents (Kessler, 1995).

2. Many traumatic events linked to conflict and terrorism have specific features which present additional challenges in the treatment of PTSD and require further examination. For example, prolonged exposure to long periods of violence after a trauma, can make it difficult for individuals to make accurate judgements about levels of threat in the environment. Through the lens of their "trauma memories" traumatised individuals often unintentionally exaggerate the level of threat long after violence subsides and consequently remain socially disconnected.

Therefore, the key question addressed in this review is:

> What psychological treatments/intervention(s) are effective for treating PTSD in populations exposed to war, terrorism and civil conflict including; military, adult civilians and children and young people?

2.1.2 Methods

The findings from this review have been reported in line with the Preferred Reporting Items for Systematic Reviews (PRISMA). We conducted an overview of existing reviews, identifying existing relevant reviews (as distinct from conducting a new systematic review of trials). This is a new approach to the summary of evidence and is especially useful in subject areas where there are several related reviews (Becker & Oxman, 2011).

We extracted individual studies from published systematic reviews based on two criteria:

(1) The focus of the study was on PTSD related to conflict, war and terrorism.
(2) Key methodological considerations.

In terms of the first criteria, the majority of reviews did not make a distinction between conflict and non-conflict related PTSD. Therefore, it was necessary to screen all included studies in the eligible reviews and only select studies that related to conflict, war and terrorism-related PTSD and not PTSD more broadly.

In terms of methodology, many review authors do not address the overlap issue of G studies being included in several reviews. This results in the volume and significance of evidence being overestimated or overstated (Polanin, Maynard & Dell, 2017). Our approach, focusing on individual randomised controlled trials (RCTs) and not merely restating the findings of existing reviews, aimed to address this issue of overlap.

2.1.3 Selection Criteria

The selection process was conducted in two stages:

1. Selection of eligible reviews
2. Selection of eligible Randomised Controlled Trials (RCTs) included in the reviews identified in stage one.

The selection criteria were guided by the topic focus of the review, which included PTSD, war, civil conflict and terrorism-related trauma and treatments/intervention(s).

For stage one, study type included systematic reviews and/or meta-analysis. Reviews were deemed to be systematic if a) the literature search included a replicable search strategy; b) quality assessment of individual studies was conducted. Reviews were included if a) the population of interest were people with a diagnosis of PTSD; b) reviews included studies on people exposed to war, terrorism and civil conflict-related trauma (defined as exposure to bombs/explosions, seeing dead bodies, murder of family member(s)), physical injury, combat, abductions, and torture; c) the review evaluated psychological interventions d) included PTSD symptoms as an outcome using standardised PTSD measures. We did not apply any limits based on publication status or language of publication of reviews. Systematic reviews that focused on prevalence of PTSD only, sexual violence only, non-conflict-related trauma only, or pharmacological treatments were excluded. Reviews that focused on refugee/asylum seekers only were not included. However, a recent systematic review and meta-analysis of PTSD for this specific sub-group has been published and highlights additional socio/politico needs for this population (see Thompson, Vidgen & Robert, 2018).

2.1.4 Results

Study Characteristics

In all, 40 RCTS fulfilled our criteria for inclusion, with data reported for 4,496 participants. The RCTs covered a time period between 1994 and 2015. There was significant heterogeneity in relation to gender, age, intervention type, trauma type, and location across the RCTs extracted from the included systematic reviews. Twenty-three studies were conducted in the United States, seven in Africa, six in Asia, one in Europe, one in the UK, one in Israel, and one in Australia, with sample sizes ranging from 20 to 495. Nine studies focused on children, ranging in age from 5-18 years, and 30 studies focused on adults, ranging in age from 18-58. Studies were grouped in relation to participant and intervention type.

In relation to children, three studies focused on TF-CBT, and six other studies focused specifically on School-Based interventions which included a range of therapeutic approaches. In relation to adults, 13 focused on TF-CBT, and seven other studies focused on Trauma-Focused Exposure Based therapies such as NET (TF-EB), one on Trauma-Focused Non-Exposure Based Therapies (TF-NEB-psychoeducation only), one on Non TF-CBT, and 13 on other therapies for adults. 25 studies focused on military personnel (21 on veterans, four on active-duty soldiers), and 15 focused on civilians (children and adults). Trauma type ranged from exposure to bombs/explosions, seeing dead bodies, murder of family member(s), physical injury, combat, abductions, and torture. Characteristics of the included studies are presented in Table 1 (See Appendix 1.2.5), along with a quality rating for strength of evidence.

Effectiveness of Psychological Therapies for PTSD

Of the 40 included studies, 31 RCTs evaluated the effectiveness of trauma-focused exposure based (TF-EB) psychological therapies including NET and EMDR, TF-CBT (including PE, CPT, TF-CT), one Non TF-CBT, and one TF-NEB therapy for war civil conflict and terrorist related PTSD in both children/young people and adults. When we refer to conflict-related trauma/PTSD throughout the results and discussion section, we are referring to *war, terrorism or civil conflict*-related trauma/PTSD). The quality of evidence was mostly high (13 RCTs) to moderate (10 RCTs), with eight RCTs rated as of low quality.

Adult Civilians

Two RCTs evaluated a TF-EB psychological therapy involving NET (Ertl, Schauer, Pfeiffer, Elbert, & Neuner, 2011) and a Testimony Intervention vs wait-list (Igreja, Kleijn, Schreuder, van Dijk & Verschuur, 2004). Three RCTs evaluated TF-CBT for adult civilians (Knaevelsrud, Brand, Lange, Ruwaard, & Wagne, 2015; Bryant et al., 2011; Duffy, Gillespie, & Clark, 2007).

All but one study (Igreja et al., 2004) demonstrated statistically significant improvements in conflict-related PTSD levels compared to supportive counselling and a wait-list control (Ertl et al., 2011), wait-list controls only (Knaevelsrud et al., 2015; Duffy et al., 2007), and TAU consisting of supportive counselling (Bryant et al., 2011). Between-group effect sizes were reported in four studies and ranged from medium to large d=0.72 (Ertl et al., 2011); d=0.92 (Knaevelsrud et al., 2015); d=1.78 (Bryant et al., 2011) d=2.10 (Duffy et al., 2007). However, one study had a small sample size of 28 participants (Bryant et al., 2011), limiting the power to demonstrate a statistically significant effect (Button, Ioannidis, Mokrysz1, Nosek, Flint, Robinson, & Munafò, 2013). Igreja et al.'s (2004) study focused on African civilians exposed to civil war, using a Testimony Intervention (a modification of a trauma exposure technique inviting participants to share their trauma story) vs wait-list.

The Testimony intervention showed no significant difference in PTSD symptoms compared to wait-list controls. However, the authors (Igreja et al., 2004) did note this may be due to the intervention only comprising one session, along with intervention contamination with the control group due to uncontrolled interaction between all community participants.

One TF-NEB RCT, of moderate quality, involved a Psychoeducation workshop with African civilians, vs an active control workshop with no psychoeducation, and vs a wait-list group (Yeomans et al., 2010). Both active groups showed statistically significant improvements in PTSD severity post intervention compared to wait-list controls as measured by the short version (items 1-16) of the Harvard Trauma Questionnaire (HTQ) ($p < .01$, partial $\eta 2 = .11$). However, greater improvements were noted for those in the workshops without PTSD psychoeducation compared to workshops with the psychoeducation element as measured by both short (HTQ) and long (HTQ-b) versions of the Harvard Trauma Questionnaire (HTQ: trend of $p = .08$; HTQ-b: $p< .05$).

Military Personnel

Of the 25 studies focused on military personnel, 16 RCTs evaluated psychological therapies. Three studies evaluated TF-CBT, involving CPT for veterans (Monson et al., 2006; Forbes et al., 2012) and one for active-duty soldiers (Resick et al., 2015). In one of the Veterans studies (Monson et al., 2006), CPT showed statistically significant improvements in PTSD symptoms compared to wait-list controls with a large effect size (d=0.12; Confidence Interval (CI) 0.58, 1.67) although this was not maintained at one-month follow-up (d=0.67; CI 0.15, 1.19).

In two trials, CPT was compared to either TAU or a present-centered therapy (Forbes et al., 2012; Resick et al., 2015). Forbes et al.'s (2012) study found clinically significant improvements in PTSD symptoms for CPT vs TAU in Australian veterans (d=0.97). Although loss of diagnosis and clinical symptom improvement were not significant between groups at three-month follow-up, the CPT group maintained significant reductions in PTSD symptoms.

CPT also outperformed group present-centred therapy for active-duty soldiers. Although statistically significant improvements in PTSD symptoms were found for both groups ($P < 0.001$), the reduction was more significant in the CPT group (Cohen d = 1.1, P < 0.012), with a drop of 12 points from baseline in the CPT group (clinically significant improvement in PTSD severity (Cohen d = 1.1) compared to a drop of seven in the PCT group (Resick et al., 2015). However, the difference was not significant post-treatment and at 12-month follow-up for interviewer assessed PTSD.

Three small RCTs with veterans (sample size ranging from 30 - 52) compared TF-CBT, PE with TAU (Nacasch et al., 2011), minimal attention (Yehuda et al., 2014), and present-centered therapy (Rauch et al., 2015). In a small trial with Israeli veterans, (Nacasch et al., 2011) PE showed statistically significant improvements in PTSD symptoms compared to TAU, with a large effect size reported (d=1.80). Improvements were maintained at 12-months follow-up. However, when PE was compared with minimal-attention (MA), consisting of weekly 30-minute phone calls to monitor symptoms (Yehuda et al., 2014), significant improvements were found for both groups, (P<0.0005) but not between groups. Although reduction in pre-post Clinician-Administered PTSD Scale (CAPS) (Blake, Weathers, Nagy, Kaloupek, Gusman, Charney, & Keane, 1995) scores was slightly higher for those in the PE group (23-point mean reduction) compared to the MA group (14-point mean reduction). Similarly, a small RCT comparing PE with present-centred therapy found statistically significant improvements in PE completers, (Cohen d = 3.16, P = .008) but no significant differences between groups for the intention to treat sample (P=.03, d=.98) (Rauch et al., 2015).

Three RCTs evaluated the effectiveness of trauma-focused therapy involving EMDR for treating military-related PTSD. Two trials with small samples and brief treatments of 1-3 sessions demonstrated no statistically significant improvements in PTSD symptoms (Devilly et al., 1998; Jensen et al., 1994). However, in an RCT which used EMDR in adequate doses, a large proportion of completers (78%) were diagnosis free (Carlson et al., 1998). This study reported a large effect size (d=2.10) for EMDR compared to no treatment (wait-list) and for EMDR compared to biofeedback assisted relaxation (d = 1.07), with improvements maintained at 9-month follow-up (Carlson et al., 1998). However, this finding was not based on an intention to treat analysis.

The remaining RCTs evaluated a further three TF-EB psychological therapies, including exposure therapy only (Beidel, Frueh, Uhde, Wong & Mentrikoski, 2011), trauma-focused exposure-based group psychotherapy (Schnurr et al., 2003), and implosive (flooding) therapy (Keane, Fairbank, Caddell, & Zimering, 1989). Only one of these RCTs, rated as moderate quality, found clinically significant improvements in PTSD symptoms, with a small effect size (d=0.3), compared to a wait-list control (Keane et al., 1989). Another RCT, rated as high quality, found clinically significant improvements in PTSD symptoms for both the intervention (exposure therapy only) and control group (trauma management therapy) (Beidel et al., 2011). A trauma-focused exposure-based psychotherapy delivered in group form (Schnurr et al., 2003) was found to be no more effective than non-trauma-focused present-centred group therapy in ITT analysis (Schnurr et al., 2003).

Four RCTs evaluated technology-based treatment modalities for veterans, such as group CBT via telepsychiatry (Frueh et al., 2007) or virtual reality exposure therapy (VRE) (Ready, Gerardi, Backscheider, Mascaro & Rothbaum, 2010; McLay et al., 2011; Miyahira et al., 2012). A high quality RCT found significant group differences post-treatment, favouring in-person group CBT vs.

telepsychiatry (SMD=11.53, 95% CI -2.35, 20.71) (Frueh et al., 2007). However, low rates of clinical change were observed in both groups. Two RCTs evaluating VRE found clinically significant improvements when compared to minimal attention or TAU (Miyahira et al., 2012; McLay et al., 2011). However, these two studies were of low quality and had small samples (10-20 participants). No difference was found in the fourth small study (N=11) comparing VRE to person-centred therapy (Ready et al., 2010).

Children and young people

Three RCTs, of high quality, focused on children and young people. One compared TF-CBT to a group-based psychosocial intervention – Child-Friendly-Spaces (SFS) which focuses on building resilience and wellbeing through creative, expressive and discursive activities. ITT analysis showed statistically significant improvements in PTSD symptoms for both groups, but no difference between groups (O'Callaghan, McMullen, Shannon & Rafferty, 2015). Two RCTs found statistically significant improvements in PTSD symptoms, with medium to large effect sizes for those in the TF-CBT group compared to TAU (d=2.39 (Murray et al., 2015), and a wait-list control group (d=0.7) (McMullan, O'Callaghan, Shannon, Black, & Eakin, 2013) with improvements maintained at three-month follow-up.

Effectiveness of School-Based interventions for PTSD

Six of the included RCTs focused on school-based interventions for children and young people ranging in age from 8-18 years. Only one study was rated as high quality (Tol et al 2012), four were rated as of moderate quality due to lack of blinding outcome assessors (Tol et al., 2008; Jordans et al., 2010; Barron, Abdallah, & Smith, 2013; Tol et al., 2014) and one was rated as low quality due to a high risk of bias for more than one key domain (Gordon, Staples, Blyta, Bytyqi, & Wilson, 2008).

Only three studies of moderate and low quality evidence, reported significant improvements in PTSD for the intervention group compared to wait-list controls (Barron et al., 2013; Gordon et al., 2008; Tol et al., 2008). Two of these studies reported medium effect sizes (d=0.5 (Gordon et al., 2008); d=0.55 (Tol et al., 2008)), while one study reported a large effect size (d=0.8 (Barron et al., 2013)). However, Barron et al. (2013) did not report an intention to treat analysis. The first RCT evaluated a cognitive-behavioural program delivered by trained counsellors over five weeks using trauma-focused techniques. These included focusing on normalising trauma and strategies for intrusive memories, hyperarousal, and avoidance symptoms of PTSD (Barron et al., 2013).

The second RCT, by Gordon et al. (2008), evaluated a mind-body skills group program, delivered by schoolteachers trained in this approach. The program consisted of guided imagery, relaxation techniques, meditation, autogenic training, and biofeedback, for two hours per week over six weeks (12 sessions in total). The third evaluated a 15 session manualised intervention consisting of CBT and creative expressive elements with groups of 15 children, delivered over five weeks by non-specialised facilitators trained and supervised to deliver the intervention for one year prior to the study. The intervention consisted of psychoeducation, strengthening coping skills, discussion of trauma through drawing, and creative expressive elements such as cooperative games, music, drama and dance (Tol et al., 2008).

The remaining three studies of moderate to high quality, evaluated the same intervention as Tol et al (2008) but found no significant improvements in PTSD for the intervention group compared to wait-list controls (Jordans et al., 2010; Tol et al., 2012; Tol et al., 2014).

Effectiveness of other therapies

Of the nine RCTs evaluating other therapies, eight focused on US veterans (Wahbeh, Oken & Goodrich, 2016; Possemato et al., 2015; Polusny et al 2015; Engel et al., 2014; Seppala et al., 2014; Church et al., 2013; Bormann, Thorp, Wetherell, Golshan & Lang, 2012; Harris et al., 2011), one focused on returning US active-duty personnel (Jain et al., 2012). The range of interventions consisted of Mindfulness-Based interventions, and also including interventions as diverse as Building Spiritual Strength. The quality of evidence was mostly high (5 RCTs), with the remaining four RCTs rated as low (n=2) to moderate (n=2) quality.

Military Personnel

RCTs evaluating mindfulness-based (Wahbeh et al., 2016; Possemato et al., 2015; Polusny et al., 2015) and meditation-based interventions (Bormann et al., 2012) for veterans had the highest strength of evidence among other therapies, along with one RCT evaluating Healing Touch alongside Guided Imagery tailored specifically for use in PTSD (Jain et al., 2012). All of these studies showed statistically significant improvements in PTSD post-treatment, with Mindfulness-Based Stress Therapy showing a clinically significant improvement in PTSD post-treatment and at two-month follow-up in US veterans compared to Present Centred Group Therapy (Polusny et al., 2015). Similarly, Bormann et al.’s (2012) RCT evaluating a Mantram Repetition Program (meditation-based intervention involving concentrative meditation, slowing down, training attention to help regulate emotions (Wadlinger & Isaacowitz, 2011)) and treatment as usual (TAU) (medication and case management only) found clinically significant improvements in PTSD for twice as many US veterans in the intervention group compared to the TAU only group. However, the effect size for these studies was small in intention to treat analysis.

Three RCTs of moderate to low quality evaluated other alternative therapies for veterans. One evaluated Building Spiritual Strength (Harris et al., 2011), and although they found a statistically significant improvement in PTSD compared to wait-list controls, this study was rated as low quality.

Furthermore, although these authors reported a modest effect size, they did not provide the statistics to support this statement. Similarly, Church et al. (2013) found a statistically significant improvement in PTSD symptoms for veterans receiving Emotional Freedom Technique (EFT) compared to TAU/wait-list controls, but no effect size was reported, and this study was also rated as low quality. One RCT of moderate quality found statistically significant improvements in PTSD symptoms, with a large effect size reported (d=1.7) for acupuncture combined with TAU (involving psychotherapies and medications commonly used for patients with PTSD) compared to TAU alone (Engel et al., 2014). Another study of moderate quality evaluated Sudarshan Kriya Yoga for US veterans (Seppala et al., 2014), and found a statistically significant reduction in PTSD symptoms, with a large effect size (d=1.16), compared to wait-list controls. However, the sample size for the study was small (n=21) and statistically significant improvements were not maintained at one-year follow-up.

2.1.5 Discussion

We extracted all relevant studies from the selected systematic reviews to ascertain the most effective psychological interventions for military and civilian populations with conflict-related PTSD. While there are a small number (six) of randomised controlled trials (RCTs), and the sample size is relatively small, it should be noted that RCTs are the most scientifically rigorous method of hypothesis testing available. In an RCT, sample size is taken into effect, and with randomisation and control mechanisms are in place. We note that for some treatment may commence 30-50 years after the incident. However, time has not been found to be a predictor of outcome.

Adult civilians

In this review, evidence for effective interventions for adult civilians with conflict related PTSD was limited to six RCTs (15% overall) focusing on this specific sub-group, a limitation recognized by other authors (Goral, Lahad, & Aharonson-Daniel, 2017). The evidence for civilians identified in this review concurs with UK guidelines for PTSD (NICE, 2013; 2018), which recommend TF-CBT, delivered on an individual basis.

Although based on only two RCTs of moderate quality, findings suggested that TF-CBT may be effective for treating PTSD in civilians in the context of *ongoing threat and* may also be effective for use in non-Western cultures (Bryant et al., 2011; Knaevelsrud et al., 2015); two areas which should be explored further through high quality research.

Military personnel

The evidence for veterans and active-duty soldiers was much more comprehensive in the literature, with 25 (63%) of all selected RCTs evaluating psychological interventions for this sub-population. The strongest evidence for effectiveness in this sub-group was found for TF-CBT including models such as CPT and PE-based therapies. Overall, RCTs evaluating CPT for military-related PTSD were of high quality, and when compared to no treatment (wait-list control) or treatment as usual (TAU) produced large effect sizes. These findings are in line with a previous high-quality review specifically for this sub-population (Kitchiner et al., 2012). However, when compared to a non-trauma focused active control (present-centered therapy), CPT was only marginally more effective in improving PTSD symptoms (Resick et al., 2015). Similarly, although trauma-focused psychological therapies delivered via telepsychiatry (Frueh et al., 2007) and virtual reality demonstrated clinically significant improvements in PTSD vs TAU (McClay et al., 2011) and an active minimal attention control group (Miyahira et al.,2011), improvements were not significant when compared to person-centred therapy (Ready et al., 2010). However, all of these studies had very small sample sizes, ranging from 10-20 participants, limiting the statistical power to capture between group differences. Furthermore, these studies did not include a combination of cognitive and behavioural components, excluding either cognitive (Ready et al., 2010) or behavioural strategies (Resick et al., 2015). Resick et al.'s (2015) study involved active-duty soldiers and other studies have focused on non-military populations in conflict locations (Bryant et al., 2011; Knaevelsrud et al., 2015) suggesting that TF-CBT can be effective for treating PTSD in both military and civilians in the context of ongoing threat.

Although EMDR has been recommended in USA Veterans guidelines as a first-line treatment for PTSD in military populations (US Department of Veterans Affairs and Department of Defense, 2010), our review found little evidence of support for EMDR for this specific sub-group. However, these findings were based on low quality RCTs, conducted 25-29 years ago (Devilly et al., 1998; Jensen et al., 1994). A recent update to the UK NICE guidelines reported that EMDR may be less effective for military populations (NICE, 2018), suggesting that further high-quality research is required to guide practice.

In relation to technology-based treatment approaches, our findings were in line with Kitchiner et al.'s (2012) conclusion that more high-quality research is required to determine their efficacy for military personnel. Recent UK guidelines have recommended computerised TF-CBT as an option for PTSD in adults, particularly for those who struggle with face-to-face therapies (NICE, 2018). Technology based approaches may offer an important way forward in relation to treatment uptake and completion, especially in light of the high drop-out rates noted as a major problem within the military population (Cully et al., 2008). Technology may help overcome some of the key barriers to receiving help for military personnel, such as the fear of stigma, shame and rejection (Kantor, Knefel & Lueger-Schuster, 2017).

RCTs evaluating mindfulness-based therapies (Possemato et al., 2015; Polusny et al., 2015) for veterans had the highest strength of evidence among alternative therapies, demonstrating clinically significant improvements in PTSD symptoms compared to TAU and Present Centered Group Therapy. Similarly, UK NICE guidelines found some evidence for the effectiveness of mindfulness-based stress reduction, although we concur with the guidelines that there is currently not enough evidence to make any firm recommendations for this treatment approach (NICE, 2018), and more high quality RCTs are required.

Children and young people

Evidence for effective psychological interventions for children/young people was sparse, with only nine RCTs out of 40 included in the review attending to children/young people (22%). This may in part be due to the nascent stage of this research area, with the oldest RCT included in a recent meta-analysis of evidence-based treatments for conflict-related problems in children and young people published only twelve years previously (Morina, Malek, Nickerson, & Bryant, 2017).

In relation to how conflict-related interventions for children/young people should be implemented, findings were mixed. For example, half of the RCTs focused on school-based interventions showed promise in reducing PTSD symptoms, whereas half demonstrated no benefit. However, Tol et al.'s (2008) study, showing a significant improvement in PTSD symptoms, involved children and young people in a post-conflict setting whereas the other three studies, showing no effect, involved children and young people in settings with ongoing political violence. However, despite the paucity of studies evaluating PTSD interventions for children and young people exposed to conflict the NICE (2018) evidence update concludes that Trauma-focused CBT is effective for PTSD in children and young people and is more effective when it is provided individually than in a group.

Although our review found evidence that, in relation to children and young people, TF-CBT can be effective in the context of ongoing threat among adult civilians (Bryant et al., 2011), the security of the child may need to be addressed before therapy can be commenced. Similar to adults, it may be that treatment has to be adapted (more work on appraisals of on-going threat), or a higher dose of therapy is required for children/young people exposed to ongoing conflict. More research is required to answer these uncertainties.

As noted in the most recent NICE consultation document (2018), the evidence base for effective treatments for children/young people who have experienced large-scale shared trauma is less robust than for adults. However, TF-CBT is recommended for PTSD arising from other forms of trauma, so it is likely that this approach may be effective with conflict related traumas as well.

Strengths and Limitations

The majority of systematic reviews to date have focused on specific treatment approaches (i.e. TF-CBT) for specific populations (i.e. military personnel). A strength of this current review is the inclusion of a diverse array of interventions evaluated within the literature for both civilians and military populations. A limitation is that we were unable to under-take a systematic review of all the specific studies, however, the methodology employed in this review is a valid mechanism accepted as a reliable method by esteemed scientific publications.

Concluding Comments and Implications for Clinical Practice

Overall, the findings from this review concur with UK and USA professional guidelines recommending trauma-focused CBT models for civilians (adults and children) and military personnel with PTSD linked to conflict-related traumas (NICE, 2005; US Department of Veterans Affairs (VA) and Department of Defense, 2010).

There is extensive evidence that trauma-focused CBT interventions improve PTSD symptoms as well as other related outcomes, and that these improvements can be maintained up to a year later. Benefits were seen across a wide range of trauma types, including both single and multiple incident traumas. Trauma-focused CBT is more effective for adults and children when it is provided individually rather than a group setting. It is important that guidelines such as NICE and Cochrane are referred to as a means of guiding practice. CBT and EMDR are recommended based on randomised control trials and outcomes emerging in data during recent years.

This review highlights the importance of researching the needs of specific populations (i.e. children, adults, military), different delivery modes (in-person, via technology), and specific elements of therapeutic protocols (cognitive, behavioural and exposure elements) to optimise effectiveness of treatments for PTSD related to war, terrorism and civil conflict.

2.2 Review 2 - A systematic review of the association between war related parental post-traumatic stress on family functioning

2.2.1 Introduction

Parental civil conflict or war related Post-Traumatic Stress Disorder/Post-Traumatic Stress Symptoms (PTSD/PTSS) have been linked with disrupted family functioning and poor mental health outcomes in children (Davidson & Mellor, 2001; Kritikos, Comer, He, Current & Thomson, 2018). Typically, where families encounter stressful situations, especially where the stressor is prolonged in nature (e.g. parental PTSD), there is a risk that other members of the family unit may bear the negative effects of the stressor also. Characteristics of the disorder are evident in the way in which dysfunction presents in families where a parent has PTSD. The development of unhealthy familial communication, for example, ranging from silences to intrusive attempts to share traumatic experiences which may be involved in the transgenerational transmission of trauma (Dekel & Goldblatt, 2008; McNally, 2014).

The emotional numbing component of PTSD symptomatology may also contribute to or act as a barrier to effective communication within the family (Brende & McCann 1984). McNally (2014) postulates that the person may be unable to effectively function in their role as a parent due to difficulties coping with their own trauma (McNally, 2014) and this may in turn serve to influence how the family as a unit function generally (Davidson et al., 2001). While the literature purports the considerable impact veteran PTSD can have on the psychological wellbeing of partners/spouses (Galovski & Lyons, 2004), adverse outcomes in children where a parent is suffering from PTSD include internalising and externalising problems, as well as altered hypothalamic-pituitary-adrenal axis functioning (Leen-Feldner et al., 2013).

In military families, children of deployed parents have additional visits to mental health services, and are more likely to sustain injuries and child mal-treatment post-deployment (Hisle-Gorman et al., 2015). The importance of examining and seeking to understand further how family functioning is affected by parental PTSD is highlighted given the reported negative and adverse outcomes that war/civil conflict related parental PTSD/PTSS can have on a child and the wider family.

The family unit is examined through the lens of family systems theory within the present review to help conceptualise and understand the working mechanisms of the family (Bertalanffy, 1968). In family systems theory, the family is viewed as a cohesive emotional unit (Kerr, 2000) and aspects of the theory as described by Epstein and colleagues, form the basis for the McMaster Model of Family Functioning (Epstein, Bishop & Levin, 1978). Within this model, the family grouping cannot be understood by examining the characteristics of individuals or specific interactions between pairs of members, but rather transactional patterns of the family system and the family's organization and structure are what serve to predict the behaviour of individuals within the family. Therefore, Epstein et al. (1978) postulate that many dimensions should be assessed as opposed to one single dimension. The McMaster Model considers family functioning within and across the following broad dimensions; problem solving, communication, roles, affective involvement, affective responsiveness and behaviour control (Epstein et al., 1978). Other aspects of family functioning as described within other models such as the Circumplex Model include family cohesion and adaptability (Olson, 2000).

The study of family functioning in light of parental mental ill health is important in order to increase our understanding of the potential mechanisms through which the family as a whole are affected. Reviews in this area tend to set restrictions regarding samples for inclusion such as limiting the population from the outset to military families. The present review thus sought to examine both war-related parental PTSD and PTSD in parents stemming from civil conflict around the world (e.g. civil conflict in Northern Ireland). In addition, and in contrast to previous studies, this review sought to examine specific aspects of family functioning (as opposed to just total score) through the inclusion of studies that utilised broad based measures of family functioning. In doing so, the present review aimed to provide a more comprehensive examination and understanding of how families are impacted by parental war or civil conflict related PTSD. Furthermore, highlighting key difficulties regarding how PTSD relates to family functioning may assist in the development and implementation of family interventions. Indeed, research has highlighted the paucity of theoretically informed and well-validated interventions for use with military families (Gewirtz, 2018). A review of this nature may provide important information for the development of such interventions and potential insights regarding treatment aims for PTSD in this population.

2.2.2 Method

Eligibility Criteria

The inclusion criteria comprised the following: a) assessed the association between parental war or civil conflict-related post-traumatic stress symptoms and family functioning (as assessed by a validated and reliable measure of broad dimensions of family functioning or instruments designed to assess specific components of family functioning), b) were published after 1980, c) were published in English. Exclusion criteria included the following; a) systematic reviews, b) where the full sample were not parents d) qualitative studies, e) studies with refugee samples due to additional variables/factors that could potentially impact on family functioning (e.g. displacement).

Studies were included in the present review if they utilised family functioning measures that assessed broad dimensions of family functioning, or utilized instruments designed to assess specific components of family functioning. Examples of broad measures of family functioning include; The Family Adaptability and Cohesion Scale (FACES; Olson, Portner & Lavee, 1985) and the McMaster Family Assessment Device (FAD; Epstein et al., 1978). Given the nature of the samples under study (typically studies in this area are relating to military parents), a family functioning subscale from a post-deployment measure designed specifically for military families (the Deployment Risk and Resilience Inventory-2; (DRRI) Vogt et al., 2013) was also included. Within this, studies were included if they used these measures in their entirety (i.e. included all subscales) or provided a global or general score of family functioning (e.g. Total Score of the FAD). Examples of sub-components within broad measures of family functioning include roles, problem solving, cohesion, adaptability and communication.

2.2.3 Results

A total of 1338 studies were identified across all the databases. From this, 144 duplicates were removed, leaving 1194 studies (Appendix 1.2.3). These studies were then screened by title and abstract following which 1156 studies were removed, leaving a remaining 38 studies. The inter-rater reliability for the assessment of the eligibility of the 38 studies was .93 (97% agreement as measured by Cohen’s Kappa). The raters disagreed on the eligibility of one study, which was discussed and resolved, and the final sample included 9 studies. The reference lists of the final 9 studies were scanned to see if other relevant studies could be included.

2.2.4 Study Characteristics

In Table 1 (Appendix 1.2.5) the details of the characteristics of selected studies are presented. All included studies (*n*=9) were of military family populations. All studies were in the English language and the dates range from 1990 to 2015. The FAD was used by four studies (Al-Turkait et al., 2008; Davidson et al., 2000; Marsanic et al., 2014; Vukovic et al., 2015) and the FACES was used by three studies (Harkness, 1990; Hendrix et al., 1993; Jordan et al., 1992). The remaining studies used the Family Environment Scale (FES) (Westerink et al., 1999) and the DRRI-2 (Vaughn-Coaxum et al., 2015). Two studies utilized a self-report measure of family functioning from the veteran with PTSD only (Hendrix et al., 2003; Vaughn-Coaxum et al., 2015), two studies reported from the perspective of offspring only (Marsanic et al., 2013; Vukovic et al., 2015) and two studies utilised reports from veteran, offspring and spouse/partner (Al-Turkait et al., 2008; Harkness, 1990). All other studies utilised a combination of veteran, spouse/partner and offspring; veteran and offspring (Davidson et al., 2001), veteran and spouse (Jordan et al., 1992) and offspring and spouse (Westerink et al., 1999). The sample sizes pertaining to informants across the included studies were 975 veteran parents, 2130 offspring and 573 spouses/partners. The weighted mean age of the veteran informants across studies that reported mean ages was 39 years and the weighted mean age for offspring participants was 14 years. In relation to war-exposed parents, three studies included only male participants (Al-Turkait et al., 2008; Harkness, 1990 & Jordan et al., 1992) and one study included males and females (Hendrix et al., 1993). Gender was not specified in the study by Davidson et al. (2001). Gender was both male and female and on average evenly split across offspring samples (Al-Turkait et al., 2008; Harkness, 1990, Marsanic et al., 2013 & Vukovic et al., 2015) with the exception of one study (Westerink et al., 1999; F; *n*=16, M; *n*=6). The majority of studies were conducted in the U.S.A. (*n*=4) and the rest were conducted in Croatia (*n*=2), Australia (*n*=2) and Kuwait (*n*=1). All 9 studies were cross-sectional by design.

2.2.5 Overall Association

Table 2 and Table 3 (Appendices 1.2.6 and 1.2.7) (broken down by specific measures used) present the associations between parental PTSD and family functioning. While there was heterogeneity between studies in relation to participants, measures used and subscales reported on, overall, all nine studies reported that parental war-related PTSD is associated with impaired family functioning. Of the studies that reported effect sizes (*n*=6), small to large effect size differences between groups were found in the association between parental PTSD and family functioning (AL-Turkait et al., 2008; Davidson et al., 2000; Harkness, 1990; Hendrix et al., 1993; Marsanic et al., 2014; Vukovic et al., 2015). This suggests that parental PTSD resulting from war exposure has a negative effect on overall family functioning.

Closer observation of the specific subscales of family functioning suggests that parental PTSD had a differential effect on specific aspects of family functioning. In studies that reported effect sizes of specific subscales (e.g. communication) using the FAD measure (*n*=3; Al-Turkait et al., 2008; Davidson et al., 2000; Marsanic et al., 2014), domains of family functioning that appear to be most consistently associated with parental PTSD are affective responsiveness, problem-solving and communication (Table 3, Appendix 1.2.7). The domains found to be least associated with parental PTSD (not significant and nil to small effect sizes) as measured in these studies, were roles and behaviour control. Of studies that reported FAD Total Score (*n*=2; Marsanic et al., 2014; Vukovic et al., 2015), medium to large effect sizes were observed in the association between parental PTSD and family functioning.

2.2.6 Association between Parental PTSD and Specific Dimensions of Family Functioning

As can be seen from Table 2 and Table 3 (Appendices 1.2.6 and 1.2.7), there were six studies that reported on subscales of family functioning (Davidson et al., 2001; Al-Turkait et al., 2008; Marsanic et al., 2013; Hendrix et al., 1993; Harkness, 1990 & Westerink et al., 1999). Utilizing the FAD measure, Davidson et al. (2001) found that affective involvement, affective responsiveness, communication and problem solving were significantly worse in the PTSD group compared to veterans and controls as reported by parents (veterans). These subscales all had small to medium effect sizes, but the largest differences were in affective responsiveness and problem-solving. According to offspring ratings, only problem-solving and affective responsiveness were found to be significantly worse in the PTSD group than in the veteran without PTSD and civilian groups, with small effect sizes. There was no statistically significant difference in the ratings of behaviour control, affective involvement, roles and communication between the three offspring groups.

AL-Turkait et al. (2008) also utilized the FAD measure and found that parental PTSD was associated with significantly worse communication and problem-solving when controlling for parental age, child age and child's education. However, this difference was only found where both parents had PTSD, or where the mother had PTSD. The only domain found to be significantly impacted by the father's PTSD symptom severity was affective responsiveness and the effect was small in magnitude. Marsanic et al. (2013), again using the FAD measure, reported significantly worse family functioning in the areas of affective involvement, affective responsiveness, communication and problem solving in the PTSD group compared to controls, with large effect sizes. The largest difference was in affective responsiveness.

Two studies (Harkness, 1990 & Hendrix et al., 1993) reported on specific subscales of family functioning using the FACES measure (adaptability and cohesion). Harkness (1990) found that severe PTSD (when compared to participants with mild PTSD), was associated with worse adaptability and cohesion but this difference was only significant for the cohesion subscale as reported by parents. No significant differences were found between the two offspring groups (parents with mild versus severe PTSD) on cohesion and adaptability, but both groups showed significant differences when compared to general population norms on the adaptability subscale only. This effect was small in magnitude. Hendrix et al. (1993) found that there were significant correlations with medium effect sizes between PTSD symptom clusters (intrusion and avoidance) and both cohesion and adaptability. However, neither cohesion nor adaptability correlated with global perception of distress scores as measured by the PPTSDS (Purdue Post-Traumatic Stress Disorder Scale). Finally, Westerink et al. (1999) found significantly worse cohesion, more conflict and less expressiveness in the PTSD group than controls when reported by spouse/partner. While offspring of parents with PTSD reported worse cohesion in their families, only conflict was found to be significantly worse than for controls.

2.2.7 Observations regarding Differences between Groups

As some studies measured degrees/severity levels of PTSD (*n*=2; Harkness 1990; Vukovic et al., 2015), or included control groups who had been exposed to war but did not develop PTSD, it was possible to explore whether more severe PTSD was associated with a higher impairment on family functioning. For example, Vukovic et al. (2015) found that there was significantly worse family functioning among offspring who had a veteran father with full PTSD compared to those with a veteran father with partial PTSD, and also significantly worse family functioning in the partial PTSD group compared to the no PTSD group. Further, Harkness (1990) found worse family functioning (parental ratings) in the severe PTSD group versus the mild PTSD group. Finally, Vaughn-Coaxum et al. (2015) found that higher PTSD severity was associated with worse family functioning scores in partnered but not single parents.

In studies that included a control group of veterans that had been exposed to war but had not developed PTSD, differences between groups were observed with regard to the association between parental PTSD and family functioning (*n*=3; Davidson et al., 2001; Jordan et al., 2001; Marsanic et al., 2015). Davidson et al., (2001) were the only study to include a comparison group of civilians as well as a group of veterans without PTSD. They found that those with PTSD had worse family functioning than veterans without PTSD, but the veterans without PTSD had worse family functioning than the civilian group. This suggests that although the veterans did not reach diagnostic criteria for PTSD, they might have had some symptoms due to the war exposure, which impacted family functioning. This study also observed the same pattern between parental PTSD and family functioning as rated by the offspring. The offspring of those with PTSD reported worse family functioning on problem solving and affective responsiveness, followed by the veteran offspring, and then the civilian offspring.

2.2.8 Discussion

Synthesis of Findings

This systematic review sought to examine the association between war or civil conflict related parental PTSD with impaired family functioning. While the original intention of the review was to include both war exposed and civil-conflict exposed parents with PTSD, the only studies (*n*=9) that met selection criteria were military family populations. This highlights the paucity of research regarding the study of family functioning in families where a parent was exposed to civil-conflict related trauma.

The included studies were diverse in terms of samples and outcome measures utilised which precluded the use of meta-analysis. A narrative synthesis was therefore employed as the method of analysis. While aggregate estimates of the pooled effect sizes could not be analysed, the results suggest that overall, parental PTSD/PTSS is associated with impaired family functioning. Drawing from the studies that reported on specific aspects of family functioning, as opposed to just total score, the present synthesis may make tentative suggestions regarding the components of family functioning that are perhaps most commonly affected by parental PTSD. In doing so, this review can highlight key areas for intervention both for wider family interventions, parenting interventions and in terms of treatment aims for PTSD in this population.

Differences between Groups

Differences regarding reported levels of healthy or impaired family functioning tended to vary depending on the severity of parental PTSD (e.g. Harkness, 1990; Vukovic et al., 2015). For example, Vukovic et al. (2015) observed significantly worse family functioning as reported by offspring of the veteran group with a diagnosis of PTSD compared to the veteran group with a partial diagnosis of PTSD. This is unsurprising given that people with sub threshold or partial PTSD are typically not as affected across multiple domains than those with full PTSD (Zlotnick, Franklin & Zimmerman, 2002). Further, a lower proportion of people with sub threshold PTSD than full PTSD will experience symptoms for more than 2 years (Breslau, et al., 2004). As the present review suggests that severity levels of PTSD affect family functioning to different degrees, it is important for clinicians to be aware that different degrees of treatment intensity and/or tailored family interventions may be required relative to the severity of the illness.

Differences were also observed between veteran groups with PTSD and veteran groups without PTSD (*n*=3; Davidson et al., 2001; Jordan et al., 1992; Marsanic et al., 2014). For example, Davidson et al. (2001) observed worse family functioning overall in the veterans with PTSD group than the veterans without PTSD group. This is an interesting observation given there are several potential risk factors relating to the psychosocial functioning of military families. These include parental separation and absence, or family relocation (Palmer, 2008), while the pre- and post-deployment periods are reportedly high stress periods for families (Saltzman, Lester, Beardslee, Layne, Woodward & Nash, 2011). Given the entire sample used in this study were veterans, this finding suggests that parental PTSD may affect family functioning over and above other risk factors relating to military families.

Reporting on Specific Dimensions of Family Functioning

While the included studies found parental PTSD to be associated with most dimensions of family functioning, studies that reported on effect sizes (*n*=6) can provide tentative insights into the greatest difficulties experienced by families. For instance, in relation to studies that utilized the FAD, parental PTSD was consistently found to be associated with impaired affective or emotional responsiveness across the studies. Furthermore, in studies that utilized the FACES, parental PTSD was consistently found to be associated with worse levels of cohesion (e.g. Harkness, 1990; Hendrix et al., 1993). Indeed, the cohesion subscale of the FACES, has been likened to the affective responsiveness subscale of the FAD as they measure similar constructs (Olson & Gorall, 2003).

In hypothesising why these dimensions might be particularly linked to parental PTSD from the perspective of the parent with mental ill health, spouse/partner, or child, it makes sense to consider specific symptoms of PTSD that might be at play in this regard. For instance, negative alterations or changes relating to thinking and mood involve feeling detached from others, increased difficulty maintaining close relationships and feeling emotionally numb. Changes in emotional reactions also include increased irritability and anger outbursts (NICE, 2018). In addition, PTSD is associated with having a diminished awareness of one's emotions and thoughts (Tull, Barrett, McMillan & Roemer, 2007) and lack of emotional acceptance (McLean & Foa, 2017). What might be particularly difficult for families is the tendency to withdraw interpersonally so as to avoid situations or people that may serve to trigger memories of the trauma. In turn, this might lead to a reduction in engagement in family events (Galovski et al., 2004). This fits with findings by Hendrix et al. (1993) in the present review where avoidance symptoms were found to be moderately associated with worse family cohesion. Indeed, findings in the literature with a focus on intimate relationships, have noted that the avoidance symptom (Evans, McHugh, Hopwood & Watt, 2003; Evans, Cowlishaw, Forbes, Parslow & Lewis, 2010; Sayers, Farrow, Ross & Oslin, 2009) and the emotional numbing cluster of PTSD (Possemato, Pratt, Barrie, Ouimette, 2015) appear to be consistently associated with worse family functioning. These specific PTSD symptoms could also explain other difficulties highlighted in the results across studies in this review including a family's ability to communicate and problem solve effectively (e.g. Davidson et al., 2001). More studies that report on specific symptom clusters are needed in studies examining parental war related PTSD within the broader family unit to explore and further understand the specific components of PTSD that disrupt family functioning.

Variations in Self-Report between Participant Groups

Variations regarding participant report of family functioning were observed across the included studies whereby parents (veteran and spouse/partner) were more likely to report worse family functioning than offspring (*n*=3). This was true for Davidson et al. (2001) who found that just two subscales of the FAD measure were significant with medium effect sizes in the offspring group as opposed to four subscales in the veteran group (large effect sizes). Differences in reports between the veteran with PTSD and their spouses were also observed. For example, Jordan et al. (1992) found that veterans with PTSD reported significantly less healthy family functioning than controls but there were no significant differences between groups as reported by spouses/partners. Finally, with regard to differences between spouse/partner and offspring, Westerink et al. (1999) found that conflict, cohesion and expressiveness were significantly worse than healthy controls as reported by spouse/partner. However, only conflict was found to differ significantly in the offspring group. Overall, it appears that parents tend to perceive their families as functioning in less healthy ways than offspring while spouse/partners tend to perceive healthier family functioning than the parent with PTSD. This may fit with symptoms of PTSD experienced by the individual given there typically exists an amplification of negative cognitions concerning the self and the world which can persist in the long term (Dekel, Peleg & Solomon, 2013).

Given the variations amongst family members regarding perceived family functioning difficulties, the importance of ensuring multiple perspectives are sought in research is highlighted for the purposes of comprehensive assessment. In addition, acknowledging differences regarding perceptions across different family members is a key factor to consider in the development and implementation of interventions for families where a parent has PTSD.

Limitations of Identified Studies

There are several limitations of the included studies that should be highlighted. Firstly, all included studies were cross-sectional in design which limits the overall interpretation of results given longitudinally designed studies are required to decipher potential casual relationships. Secondly, most of the identified studies did not measure and consider the impact of potential co-morbidities alongside a PTSD diagnosis. Given comorbid psychopathologies are reportedly high in a veteran sample with PTSD (Iverson & Greenberg, 2009; Murphy & Turgoose, 2019), it would be important for this to be examined in future studies in an attempt to decipher how much family functioning is affected by PTSD as opposed to other risk factors.

Further, potentially important factors that might impact on the association between parental PTSD and family functioning, over and above the war-exposed parent's diagnosis of PTSD, is the unexposed parent's emotional and mental well-being. Only one study in the present review examined the impact of the unexposed parent's PTSD symptoms on family functioning (Al-Turkait et al., 2008). Considering the impact that veteran's PTSD can have on the psychological functioning of their spouses/partners (Galovski et al., 2004) and the reported impact that maternal well-being can have on child and family outcomes (Yehuda, Teicher, Seckl, Grossan, Morris & Bierer, 2007), it is important that future studies consider the impact of wider factors such as these in the study of family functioning.

Moreover, most of the included studies did not contain analyses to control for potentially confounding or mediating factors. While one study (Al-Turkait et al., 2008) controlled for age and education of offspring, studies did not consider the influence of other factors that could potentially affect family functioning in military populations (e.g. whether or not the veteran or family had received treatment for PTSD symptoms). More comprehensive measurement and analyses of potential confounding factors would help to isolate and decipher the true effect parental PTSD symptoms have on family functioning.

Limitations and Strengths of Review

Although the present review provides an important synthesis of information on the association between parental PTSD symptoms and family functioning, limitations should be noted. Firstly, all identified studies were samples of military families which limits our ability to generalise the results beyond this population. Next, the review was limited to the inclusion of studies that utilized broad based measures of family functioning. Potential design and measurement issues exist with these instruments and therefore caution should be taken in the interpretation of the findings. While these measures have established and documented reliability and validity, the DRRI-2 family functioning subscale was the only measure that was designed for specific use with military families. Furthermore, only two of the identified studies reported on reliability of the family functioning measure (e.g. coefficient alpha) in their respective samples (Hendrix et al., 1993 & Vaughn-Coaxum et al., 2015). The importance of ensuring future studies test the reliability of scales on their own data set is highlighted given the lack of information pertaining to the use of this measure in such populations. The FAD was the most consistently used family functioning measure across the identified studies (*n*=4), and although the scale has high levels of internal consistency across various types of families (Epstein, Baldwin & Bishop, 1980) some contradictory reports exist (Kabacoff, Miller, Bishop, Epstein & Keitner, 1990; Ridenour, Daley & Reich, 1999). Given the potentially high correlations that exist between subscales, caution should be taken in the interpretation of findings from this measure. The FACES measure too has received some criticism in the literature, particularly regarding the theoretical model that the measure was devised from (Circumplex model; Olson, Sprenkle & Russell, 1979). However, Place and colleagues (Place, Hulsmeier, Brownrigg & Soulsby, 2005) note that the FACES is a useful way of describing family functioning provided the dimensions are viewed as relatively independent elements. Overall, while advantages of these broad-based measures include the fact that they cover many dimensions of family functioning and allow for group comparison, families are complex systems, and it is therefore challenging to identify simple evaluation methods.

Regarding strengths, the current systematic review is the first to the authors’ knowledge to synthesise information regarding the association between parental PTSD symptoms and family functioning studies that utilised broad based measures of family functioning. In addition, this review considered family functioning from the perspective of the whole family allowing for a more comprehensive review of areas that are potentially most affected by parental war-related PTSD.

Conclusions

This systematic review sought to examine the association between war or civil conflict-related parental PTSD and family functioning from the perspective of the wider family unit. Through the inclusion of studies that utilised broad-based measures of family functioning, and considering potential limitations of these measures, the findings provide insights into the salient challenges that may be experienced by such populations. The findings provide useful information for clinicians in practice, especially regarding the development and implementation of interventions for families where a parent is suffering from war-related PTSD. Finally, the review highlights the paucity of research regarding the association between civil conflict-related parental PTSD and family functioning. This demonstrates the need for future research in this area to broaden our understanding and identify any differences that might exist between these groups in how families are affected by parental PTSD, culturally or otherwise.

Although the review is based on studies with families of veterans, the findings may well be applicable to populations exposed to prolonged traumas arising from civil conflict, but further research is required with these groups.

Concluding comments and Implications for Clinical Practice

There are many published studies demonstrating a relationship between different forms of parental mental illness (Depression, PND, Schizophrenia, Bi-polar Disorder) and negative impacts on parenting and family functioning. However, the focus of this review is specifically on PTSD and indicates that parental war-related PTSD may affect a family's ability to function effectively across various domains.

Negative effects of Parental PTSD can include:

- **negative alterations or changes relating to thinking and mood involve feeling detached from others, increased difficulty maintaining close relationships and feeling emotionally numb**
- **increased irritability, anger outbursts, a diminished awareness of one's emotions and thoughts and lack of emotional acceptance**
- **a tendency to withdraw interpersonally to avoid situations or people that may serve to trigger memories of the trauma, leading to a reduction in engagement with family events**

significantly worse communication and problem-solving where either the mother or both parents have PTSD. In light of these observations, it is important that the individual with PTSD be

assessed alongside a consideration of the family unit's needs to provide appropriate interventions for parents with war related PTSD and, where appropriate, for families.

1) **Family functioning can be more, or less impacted depending on the severity of PTSD. Clinicians may thus consider providing levels of intervention intensity for families based on the severity of parental PTSD (tiered approach).**
2) **Whole family approaches to treatment may be inappropriate and different approaches to supporting families may thus be required in addressing family problems. For instance, offspring may benefit from group work with other children with a parent with war-related PTSD in order to provide a space to share and process similar, shared experiences. This approach could be an adjunct to a preventative approach such as psychoeducation regarding parental PTSD.**
3) **Consider and adjust for the potential differences between single and partnered families (e.g. single parents may have access to more external supports). As this finding is reported by just one study included in the present review, this point is made tentatively but highlights the importance of prior assessment of need so that specific interventions can be provided depending on levels of support required.**

2.3 Review 3 - Psychological and pharmacological treatments for comorbid PTSD and substance use disorders related to war and/or civil conflict: systematic review

2.3.1 Introduction

Key findings from several random controlled trials indicates that trauma-focused psychotherapies delivered concomitantly with evidence-based substance use disorder treatments appear to be effective in reducing PTSD symptoms and substance use. However, from an initial scoping exercise it appeared that the number of quality RCTs are relatively small, and there is considerable heterogeneity in the treatments reviewed. A Cochrane review by Roberts et al. (2016) suggested that while combined trauma/SUD interventions can help reduce PTSD symptom severity for individuals with PTSD and co-morbid SUD, the effect sizes were small and treatment groups had higher levels of attrition, suggesting potential problems with treatment tolerance/compliance. Therefore, further evidence was required to identify the most helpful evidence-based interventions and support services for co morbid substance use disorders and PTSD.

Aim of the review:

To examine the efficacy of psychosocial and pharmacological interventions for individuals who have concomitant PTSD and Substance Use Disorders, which are linked to war or conflict related trauma.

2.3.2 Method

Search Strategy

The search strategy was developed by extracting the search terms from previous relevant reviews. Review authors reviewed each list, added any missing terms, and removed unnecessary terms. The search strategy included search strings for population (PTSD and SUD), setting (war/conflict, terrorism, political violence) and intervention (psychological). We included searches within OVID Medline, Web of Science, Social Care Online, Published International Literature on Traumatic Stress (PILOTS), EMBASE, Cochrane, Campbell, and PsycINFO databases for peer-reviewed literature published from to February 2020. Two reviewers for inclusion independently assessed all potentially relevant articles.

Population

We have defined the population of interest as adults with a diagnosis of comorbid PTSD and substance use disorders (SUDs) linked to war and/or civil conflict related trauma. The intervention was defined as any psychological or pharmacological intervention that targeted comorbid symptoms of PTSD and substance use disorders. The comparison where relevant was defined as any type of control group, including active treatment, as well as any inactive or “no treatment,” placebo, or waitlist alternatives. The outcome has been defined as changes in comorbid PTSD and substance use disorder symptoms and/or diagnostic status. (Appendix 1.3.3).

Eligibility Criteria

Selection criteria is presented in Table 1 below.

Table 1. Eligibility Criteria

Inclusion Criteria

Peer reviewed Journals

English Language

RCT and quasi experimental designs

Substance / Alcohol use /misuse or disorder

Comorbidities and PTSD

Interventions Psychosocial or Pharmacological

War and/or civil conflict related trauma

Exclusion

Participants under 18 years

Policy or framework document

Full-text was not available

Grey literature (e.g. unpublished reviews)

Animal studies

Included children or adolescents (less than 18 years of age).

Screening process

The screening process is explained appendices, the data extraction process is explained in appendix 1.3.5 and the review process and results are outlined in the PRISMA flow chart (Appendix 1.3.6). Reviews with clearly identifiable populations not specific to this review or not addressing psychological or pharmacological treatments for PTSD and SUD (e.g. prevalence studies), were rejected at title screening by one review author. Two authors discussed and reviewed abstracts of all retrieved articles against the inclusion criteria. The two authors independently reviewed any potentially relevant articles retrieved in full text. Interrater agreement was 95% and a record was kept of all excluded reviews along with the reason for exclusion. 1825 publications were identified from a number of database and 17 studies met the eligibility criteria.

2.3.3 Findings

Study measures

All studies included participants who presented with SUDs and conflict-related PTSD. Studies utilised a wide range of standardised and non-standardised measures. The most common alcohol outcome assessment included the Substance Abuse Calendar/Timeline Follow-Back Interview (TFLB; Sobell & Sobell, 1992), the Obsessive-Compulsive Drinking scale (OCDS; Anton et al., 1995) and The Addiction Severity Index (ASI). The most common PTSD outcome assessment was The Clinician-Administered PTSD Scale (CAPS), a clinical interview considered a gold standard for PTSD assessment (Blake et al., 1995) and the PTSD Symptom Scale Interview (PSS-I).

Settings and population

All studies[13] were outpatient based and involved veterans as participants. Outpatient settings included health service research departments, veteran clinics, or substance use clinics based in hospitals, psychiatric and community mental health settings. All studies used veterans as participants.

Interventions

Twelve studies utilised psychosocial interventions. Five studies used forms of Trauma-focused CBT, of which three studies focused on exposure-based interventions (Back et al., 2019; Norman et al.,

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[13] Petrakis et al., 2012; Petrakis et al., 2015; Petrakis et al., 2006; Batki et al., 2014; Capone et al., 2014; Schumm et al., 2015; Boden et al., 2011; Brief et al., 2013; Acosta et al., 2017; Najavits at al., 2005; Norman et al., 2019; Kaysen et al., 2014; Rotunda et al., 2008; 2016; Köbach et al., 2017; Back et al., 2019; Luciano et al., 2019; Foa, et al., 2013.

2019; Köbach et al., 2017). One study incorporated Integrated Cognitive Behavioural Therapy (ICBT; Capone et al., 2014) and one focused on Cognitive Processing Therapy (CPT; Kaysen et al., 2014). Two studies used Behavioural Couples Therapy (Rotunda et al., 2008; Schumm et al., 2015). Three studies (Najavits at al., 2018; Boden et al., 2011; Norman et al., (2019) incorporate the 'Seeking Safety' model (SS) which uses present-centred integrated coping skills (I-CS), teaching coping skills for both SUDs and PTSD. Present-Centred Therapy (PCT) is a time-limited treatment for PTSD that focuses on increasing adaptive responses to current life stressors and difficulties that are directly or indirectly related to trauma or PTSD symptoms. Najavits at al., (2018) compared the SS model to a new past-focused model 'Creating Change' (CC) which claims to be more integrated than other past-focused treatments in terms of past-focused PTSD/SUD content: guiding clients to process painful SUD memories as well as trauma memories and exploring the life trajectory of both disorders in relation to each other in detail. Two studies reported using web-based interventions for veteran subpopulations with PTSD and substance use disorders (Acosta et al., 2017; Brief et al., 2013). One study (Luciano et al., 2019) investigated the effectiveness of a brief intervention programme for individuals diagnosed with PTSD and concomitant diagnosis of Alcohol Use Disorder (AUD). Four studies utilised a number of pharmacological interventions for PTSD and problematic substance use (Petrakis et al., 2012; Petrakis et al., 2015; Petrakis et al., 2006; Batki et al., 2014). One study conducted an integrated treatment intervention using pharmacological and psychosocial components (Foa, et al., 2013).

Psychosocial Interventions

Exposure based interventions

Three studies focused on exposure-based interventions (Back et al. 2019; Norman et al. 2019; Köbach et al., 2017). Köbach et al. (2017) focused on Narrative Exposure Therapy adapted for Forensic Offender Rehabilitation (FORNET) compared to treatment as usual (TAU). The participants assigned to TAU remained in a demobilisation camp for 2–3 weeks or completed TAU in the local reintegration centre. In the demobilisation camp, they received medical care and had access to psycho-social support. Köbach et al. (2017) reported that six months post-intervention, FORNET significantly reduced PTSD symptoms ($p \leq 0.001$). Moreover, beneficial effects were indicated for depression severity and drug dependence, as well as for reintegration indices (assessment to gauge the degree to which individuals achieve reintegration into normal social activities). Treatment gains for PTSD severity were retained at 12 months ($p \leq 0.001$).

Norman et al. (2019) compared the efficacy of integrated prolonged exposure (I-PE) therapy (a past-focused therapy) with present-centred integrated coping skills (I-CS) therapy. The authors included 186 veterans seeking Veterans Affairs mental health services. Norman et al. (2019) also found that exposure therapy precipitated a greater reduction in PTSD symptoms and results showed that the I-PE arm had significantly higher PTSD-related treatment gains than the I-CS arm after treatment ($P = .047$) and 3-month follow-up ($P = .03$).

Back et al. (2019) evaluated the efficacy of an integrated treatment that incorporates Prolonged Exposure (PE) (Concurrent Treatment of PTSD and SUDs using PE) compared to Relapse Prevention (RP) among veterans. Intent-to-treat analyses revealed that PE, in comparison to RP, resulted in significantly greater reductions in The Clinician-Administered PTSD Scale (CAPS) ($p = 0.001$) and PTSD checklist-military (PCL-M) scores ($p = 0.01$). Both groups evidenced significant and comparable reductions in PTSD severity during treatment ($p = .001$). At 6-months follow-up, participants in the PE reported significantly fewer drinks per drinking day than participants in RP ($p = .05$).

‘Seeking Safety’

Two studies focused on a well-established, evidence-based present-focused treatment for PTSD/SUD ‘Seeking Safety’ (SS) (Najavits at al., 2018; Boden et al., 2011). Both studies were veteran focused. Najavits at al., (2005) used fifty-two male and female veterans with current PTSD/SUD and Boden et al., (2011) used ninety-eight male military Veterans with a SUD and co-occurring PTSD symptomatology.

Boden et al.’s (2011) study focused on whether substituting Seeking Safety (SS), a manualised therapy for comorbid substance use disorders (SUD) and post-traumatic stress disorder (PTSD), for part of treatment-as-usual (TAU) improves substance use outcomes. Boden et al., (2011) found that SS and TAU compared to TAU was associated with better drug use outcomes ($P < 0.05$), but alcohol use and PTSD severity decreased significantly under both treatments ($P < 0.01$). SS versus TAU was associated with increased treatment attendance, client satisfaction and active coping (all P's < 0.01).

Najavits at al., (2018) compared past-focused treatment (Creating Change; CC) compared to Seeking Safety (SS) a more established, evidence-based present-focused treatment for PTSD/SUD. Both conditions improved over time, with reductions in PTSD ($p=0.001$) and alcohol use ($p= 0.005$). Change over time was primarily seen as an improvement from baseline to end-of-treatment, with gains sustained at follow-up, although for alcohol use there was continued improvement from end-of-treatment to follow-up.

Behavioural Couples Therapy

Rotunda et al., (2008) and Schumm et al., (2015) focused on the effectiveness of Behavioural Couples Therapy. Rotunda et al., (2008) examined the outcomes of Behavioural Couples Therapy (BCT) for nineteen dually-diagnosed veterans with combat-related PTSD and a substance use disorder (SUD, primarily alcohol dependence) and nineteen veterans with SUDs only. Each outcome showed improvement from before BCT to immediately after ($p=-0.01$) and 12-months after BCT ($p=0.01$). Both groups that received BCT indicated increased abstinence from drinking days and a decrease in negative consequences of drinking ($p=0.01$). Specific improvements noted were increased relationship satisfaction ($p=0.04$) and reductions in drinking, negative consequences of drinking, male-to-female violence ($p=0.012$), and psychological distress symptoms ($p=0.001$).

Schumm et al., (2015) focused on evaluating the effectiveness of Couples Treatment for alcohol use disorder (AUD) and for posttraumatic stress disorder (PTSD) (CTAP). CTAP is a 15-session, manualised therapy, integrating behavioural couple’s therapy for AUD with cognitive–behavioural therapy for PTSD. Schumm et al., (2015) used U.S. male military veterans (N=13) and their female partners. There were 8 veterans who showed clinically reliable pre- to post-treatment reduction of PTSD outcomes. Schumm et al., (2015) found that there were significant group-level reductions in clinician-, veteran- and partner-rated PTSD symptoms. The study also reported that most veterans showed clinically reliable reductions in percentage days of heavy drinking (p=.022).

Integrated Cognitive Behavioural Therapy and Cognitive Processing Therapy

Capone et al., (2014) examined the effectiveness of Integrated Cognitive Behavioural Therapy (ICBT) and Kaysen et al., (2014) investigated the efficacy of Cognitive processing therapy (CPT). Capone et al., 2014 examined the feasibility of delivering integrated Cognitive Behavioural Therapy (ICBT) for co-occurring PTSD-SUD for Veterans who served in Iraq and Afghanistan. The individual analysis of Clinician Administered PTSD Scale (CAPS) scores and Patient Health Questionnaire-9 (PHQ-9) total scores found that three out of a total of eight participants exhibited a decrease in PTSD symptoms. However, it is noteworthy there are significant limitations to this study as the sample is very small (n=8) and the dropout rate was considerable (45.5%), higher than previous studies of ICBT (McGovern et al. 2010). It should also be noted that two of the participants who demonstrated clinically noticeable change in PTSD symptoms at post-treatment were non-completers of ICBT and there were no p values or effect sizes reported.

Kaysen et al., (2014) examined the effectiveness of CPT for veterans with PTSD and AUD, compared to veterans with PTSD only. Kaysen et al., (2014) found that PTSD and depression symptoms improved over time, regardless of the presence or absence of an AUD diagnosis. Those with past AUD, had higher pre- but not post-treatment PCL scores when compared to those with PTSD only, pre-treatment ($p < .001$) post-treatment ($p > .22$).

Web based CBT Based Interventions

Two studies focused on web-based interventions for veteran subpopulations with PTSD and substance use disorders (Acosta et al., 2017; Brief et al., 2013). Both studies reported using CBT based interventions within RCT research designs. Acosta et al. (2017) developed and examined the efficacy of a web-based self-management intervention based on Cognitive Behavioural Therapy (CBT) which focused on PTSD symptoms and hazardous substance use.

Veterans with diagnosed PTSD and hazardous substance use were randomised to primary care treatment as usual (TAU; n = 81) or to TAU plus a web-based CBT intervention called Thinking Forward (n = 81). Thinking Forward participants reported significantly greater decrease in the number of drinking days in comparison with TAU participants. (p= 0.125) after all mediating variables were included in the analysis. Similarly, the intervention group showed a greater decrease in drug use days compared to TAU, although the results were not statistically significant (p=0.25). Likewise, there were no clinically significant change in PTSD symptoms in treatment groups as indicated by chi-square analyses.

In a similar vein, Brief et al. (2013) investigated the efficacy of a newly developed; 8-module, self-management web intervention (VetChange) founded on cognitive-behavioural and motivational principles to reduce alcohol consumption, address alcohol-related problems, and reduce PTSD symptoms in post combat veterans. Six hundred participants were randomised to either the VetChange group or the delayed intervention group. Results from the RCT indicated that intervention group participants showed a significant decrease in Drinking days (p.001), average weekly drinks (p.001), percent heavy drinking days (p.001), and PTSD symptoms (p.001) from Time 1 to Time 2. Between end-of-intervention and 3-month follow-up, all alcohol consumption variables (DDD p.01], AWD [p.001], PHDD (p.001) continued to show a significant decrease. There were no further changes in PTSD symptom scores for intervention participants during this juncture.

Brief Intervention

One study (Luciano et al., 2019) investigated the effectiveness of a brief intervention programme for individuals diagnosed with PTSD and concomitant diagnosis of AUD. This study found that PTSD severity was reduced after a one-session personalised feedback intervention that focused primarily on alcohol misuse, but also included information about PTSD symptoms and coping styles. One aim of the study was to understand whether PTSD symptom severity and diagnostic status changed after exposure to an intervention that targeted alcohol misuse and integrated feedback on PTSD. PTSD symptom severity was significantly lower at the 6-week and 6-month and follow-up appointments relative to baseline (p < .001). However, it is apparent that caution should be taken with the interpretation of findings as the study did not include a no-treatment control group and that the small sample size limited statistical power. The authors also underline that it is possible that change in PTSD occurred because of other unmeasured variables.

Pharmacological Interventions

Four studies used a number of pharmacological interventions for PTSD and problematic substance use (Petrakis et al., 2012; Petrakis et al., 2015; Petrakis et al., 2006; Batki et al., 2014). The pharmacological interventions included Topiramate, Dilsulfiram, Naltrexone, Prazosin, Paroxetine and Desipramine.

Results from a pilot randomised study by Batki et al. (2014) considered the effectiveness of Topiramate as treatment of alcohol use disorder in veterans with posttraumatic stress disorder. Topiramate is a medication used to treat epilepsy and prevent migraine and has been used in the treatment of alcohol dependence. Results from the pilot of study indicated that Topiramate was effective in reducing in PTSD symptom severity as measured by the PTSD checklist score (PCL) and all three subscale scores from baseline through weeks 1- 12. Between-group comparisons showed the drug intervention group as having a significantly smaller number of drinks during weeks 1-12 compared to control group (p=0,099). In addition, there was a significant reduction in Obsessive Compulsive Drinking (OCDS) scores from baseline through week 12 within TOP (p=0.002).

Two studies Petrakis et al. (2006) and Petrakis et al. (2012) considered the effectiveness of Naltrexone as an intervention for substance use disorders and psychiatric symptoms of PTSD. Naltrexone is an opioid antagonist and works by blocking the effects of opioids from both inside and outside the body. It is also widely used in the treatment of alcohol craving. Petrakis et al. (2006) utilised a double-blinded RCT to investigate the efficacy of Naltrexone and Disulfiram in patients with alcohol dependence and current depression. The sample (n=254) was comprised of almost 40% veterans who had a diagnosis of PTSD. There was a randomised assignment of subjects to either Naltrexone or Disulfiram. Antabuse (Disulfiram) is a drug used to support the treatment of chronic alcoholism by producing an acute sensitivity to alcohol. The intervention group reported significantly fewer drinking days per week (p=0.02) and a greater number of abstinence (p=0.04). Overall psychiatric symptoms of PTSD improved for all groups. The sub-sample of subjects with PTSD showed a significant decrease in PTSD symptoms over time in total Clinician Administered PTSD Scale (CAPS) score (p=001). The study used a predominately male veteran sample; hence the results are not generalisable to other clinical settings.

Petrakis (2012) also evaluated the adjunctive efficacy of naltrexone, relative to placebo in a study which compared the Serotonin uptake inhibitor (SSRI), Paroxetine, to the norepinephrine uptake inhibitor (SNRI), Desipramine. The all-male veteran sample (n=88) were randomly assigned under double-blind conditions to one of four groups: Paroxetine + Naltrexone, Paroxetine + placebo; Desipramine + Naltrexone; Desipramine + placebo. Findings indicated that Paroxetine did not show statistical superiority to Desipramine for the treatment of PTSD symptoms. However, Desipramine was superior to paroxetine with respect to study retention and alcohol use outcomes. Relative to paroxetine, Desipramine significantly reduced the percentage of heavy drinking days (p = 0.009) and drinks per drinking days (p = 0.027). In comparison with placebo, the effect of Naltrexone significantly decreased craving (p = 0.012); but it showed no advantage on drinking use outcomes. Petrakis (2015) also conducted a double blind RCT on the efficacy of Prazosin for (n=96) veterans with post-traumatic stress disorder and comorbid alcohol dependence.

Results showed that symptoms of PTSD improved over time, but there was no significant effect of Prazosin on PTSD symptoms. Alcohol consumption also decreased over time, but again there were no significant differences in outcomes between intervention and control group. During the treatment phase of the study, there was a significant decrease in the average number of drinks over time (p=0.0001), but no significant effect of due to Prazosin. This was confirmed by GGT levels that significantly declined over time (baseline, weeks 4, 8, and 12) (p =0.0001). There were no significant differences in GGT levels for either intervention or placebo grouping (p = 0.39), or medication by time interaction (p=0.17). Similar to other Petrakis studies, limitations are apparent as the study was primarily with a male veteran subgroup and therefore most likely render the results non generalisable to other populations.

A mixed pharmacological and psychosocial interventions study also considered the efficacy of Naltrexone plus an evidence-based treatment for PTSD (prolonged exposure therapy), their combination, and supportive counselling. The RCT included n=165 adult participants who met the DSM-IV criteria for current Alcohol Use Disorders and PTSD. They were randomly assigned to four groups; prolonged exposure therapy plus naltrexone (100 mg/d); prolonged exposure therapy plus pill placebo; supportive counselling plus naltrexone (100 mg/d) or supportive counselling plus pill placebo. Results from the study indicated that those who received naltrexone had a lower number of drinking days than those who received a placebo pill (p = .008). There was also a reduction in

PTSD symptoms in all four groups, but the effect of prolonged exposure therapy was not statistically significant.

Limitations

Whilst the studies included in the interventions review above demonstrate a range of positive outcomes, the results must be interpreted with a level of caution. This is due to identified gaps in methodological rigour and study design. Despite most studies reporting randomised controlled trials there were a number of design flaws in the methodologies. For example: small samples, missing data, high attrition rate at follow-up and lack of control comparisons. Psychosocial studies were also more likely to report small sample sizes and showed a higher degree of heterogeneity (most notably in the brief intervention, integrated cognitive behaviour therapy and behavioural couples therapy studies). All studies focused on veteran populations which may limit transferability to general population contexts. Finally, future research should utilise high-quality randomised controlled trials to investigate single or integrated treatment modalities which include both pharmacological and psychosocial interventions.

Concluding comments and Implications for clinical practice

The primary aim of the study was to examine psychosocial and pharmacological interventions for individuals who have concomitant PTSD and Substance Use Disorders which are linked to war or conflict related trauma. All studies included participants who presented with substance use disorders and conflict-related PTSD. In addition, all studies retrieved from the structured search were outpatient based and focused on veteran populations.

Twelve studies considered the effectiveness of psychosocial interventions with either single or integrative interventions vs treatment as usual (TAU) or relevant treatment models.

Five studies used forms of Trauma-focused CBT, of which three studies focused on exposure-based interventions. One study incorporated Integrated Cognitive Behavioural Therapy (ICBT) and one focused on Cognitive Processing Therapy (CPT). Two studies used Behavioural Couples Therapy whilst three studies incorporated the 'Seeking Safety' model (SS) which uses a present-

centred integrated coping skills (I-CS), teaching coping skills for both SUDs and PTSD. Four studies focused on pharmacological only based interventions.

Results for exposure-based therapies indicated significantly reduced PTSD symptoms at post intervention junctures and six month follow up (Back et al. 2019; Norman et al. 2019). Furthermore, Kobach et al. (2017) reported significantly reduced PTSD symptoms at six and 12 months together with reported reductions in drug dependence indicators.

Results from both Seeking Safety studies, (Boden et al. 2011; Najavits et al. 2018), showed significant decrease in drug and alcohol use and significant reductions in PTSD symptoms at post intervention and follow up junctures.

Two web-based CBT studies showed mixed results. Acosta et al. (2017) found that there was a significant decrease in drinking days but a non-significant decrease in drugs use and PTSD symptoms. Brief et al. (2013) indicated a significant decrease in drinking days, average weekly drinks, and PTSD symptoms in the post-treatment phase. The significant decrease in alcohol consumption was maintained at the follow-up with no further changes in PTSD symptom scores for intervention participants during this period.

Topiramate reduced PTSD symptoms and incurred a significantly smaller number of drinking days at the post-intervention juncture (Batki et al. 2014). Two studies which considered Naltrexone (Petrakis, 2006 and 2012) showed significant decrease in drinking days and a significant decrease in cravings but no significant change in drinking outcomes.

One study examined the efficacy of Prazosin for dually-diagnosed PTSD and alcohol use disorder. Findings indicated no significant reduction in PTSD symptoms (Petrakis 2015). In addition, whilst there was a decrease in alcohol consumption for both intervention and control, these were not significant.

2.4 Review 4 - The role of cognitive factors in the maintenance of complicated grief following conflict-related bereavement

2.4.1 Introduction

Losing a loved one is arguably one of the most painful experiences in life. However, for the majority of the bereaved, the painful and debilitating symptoms of acute grief usually subside within the first year after the loss, leading to a restoration of satisfactory, if changed, life (Shear, 2011; Prigerson et al., 1995). Here, successful adaptation to a life without the deceased is possible without developing any severe physical or mental symptoms (Shear et al., 2015; Bonanno et al., 2004). These individuals experience a grief which is very painful but does not normally require clinical intervention, as it is considered a natural response to the loss of a loved one (Neimeyer and Currier, 2009). This grief process is commonly referred to in the literature as either "normal" or "uncomplicated grief" (Zisook and Shear, 2009). For the purpose of this review, we will use the term uncomplicated grief or UG to denote adaptive grief.

However, evidence suggests that there is a subgroup of individuals whose grief symptoms do not remit, instead developing into a chronic syndrome, commonly referred to as complicated grief (CG hereafter) (Horowitz, Wilner, Marmar and Krupnick, 1980; Horowitz, Stinson and Fridhandler, 1993; Horowitz, Bonanno and Holen, 1993; Prigerson et al., 1995; Shear, Simon, Wall, Zisook, et al., 2011). CG is also termed as prolonged grief disorder (PGD) (Prigerson et al., 2009), a protracted, incapacitating, and sometimes life-threatening response to the loss of a primary attachment figure (Neimeyer et al., 2014). For the purposes of this review, we will use the term complicated grief or CG to denote maladaptive grief. CG has been identified as a bereavement specific psychiatric syndrome, characterised by persistent separation distress. It can manifest in intense yearning for the deceased, together with shock, disbelief, anger, bitterness, and intrusive or preoccupying thoughts of the deceased that last more than 6 months after the death, resulting in a feeling that life is meaningless without the deceased (Shear et al., 2011). CG has been found to be associated with functional impairment, cognitive, emotional and behavioural symptoms, that persist after the death of a significant other, resulting in reduced quality of life as well as increased morbidity and mortality (Prigerson, Bierhals et al., 1997).

Until recently, researchers and clinicians have used different diagnostic criteria and different assessment measures for disordered grief, as the previous diagnostic criteria had not been established and recognised (Killikelly and Maercker, 2018). Recently, however, a new diagnostic entity ‘persistent complex bereavement disorder’ (PCBD) was introduced to be included in Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) as a compromise between the two proposed diagnostic criteria for PGD (Prigerson, et al., 2009) and CG (Shear et al., 2010) and placed in section III of the 5th Edition of DSM (DSM-V) as a disorder requiring further study (Maciejewski, Maercker, Boelen and Prigerson, 2016; Reynolds, Cozza and Shear, 2017). Whilst the DSM-V has established working groups to investigate the validity, specificity, and treatability of the condition, the International Classification of Diseases (11th ed.; ICD-11; World Health Organization, 2016) accepted that PGD should now be accepted for inclusion in the recently published ICD-11.

There has been considerable debate in the literature as to whether CG warrants a distinct diagnostic category (Prigerson et al., 2009; Strobe et al., 2007) from its nearest neighbours, namely Major Depression Disorder (MDD) and Post Traumatic Stress Disorder (PTSD heareafter). Over the past three decades, an increasing body of research has shown that whilst CG and MDD share some similarities, they also have some key differences (e.g., Boelen, van den Bout, and de Keijser, 2003; Boelen and van den Bout, 2005; Horowitz et al., 1997; Latham and Prigerson, 2004; Ogrodniczuk et al., 2003; Prigerson et al., 1995; Prigerson et al., 1996; Prigerson, Horowitz and Jacobs et al., 2009). A key distinction between CG and MDD is whether the content of thoughts and emotions in the bereaved centres around the deceased (CG) or whether these are more generalised and associated with the loss itself (MDD). While intense and persistent longing for the deceased person is a core symptom of CG, a generally reduced interest in or ability to enjoy life is a core symptom of MDD, Kristensen Dyregrov and Dyregrov, (2017). In addition, there is evidence that CG, does not respond well to tricyclic antidepressants and seems to respond poorly to therapies designed to treat MDD (Shear et al., 2005).

In contrast, psychotherapy designed specifically for CG appears to be superior to non-specific interpersonal therapy (Shear et al., 2005), providing further support for the distinction between CG and MDD. Theorists have also questioned whether CG could be considered a form of chronic PTSD. However, research has demonstrated that there are key distinctions in symptoms of PTSD and CG. A central feature in PTSD is that the trauma memory has not been updated thus a common emotion is fear that the trauma will be re-experienced. In some PTSD presentations other emotions such as shame and guilt are also common. The primary emotions with CG are sadness and a "yearning" for a loved one. Whilst both conditions share some common symptoms such as intrusive thoughts and avoidance, those with PTSD commonly re-experience thoughts and images of the traumatic event, while people with CG experience intrusive images and preoccupation with the deceased person. Furthermore, in PTSD, avoidance is used to prevent recurrence of danger, whereas in CG avoidance is used to avert painful thoughts or feelings related to loss (Shear et al., 2011).

The majority of existing studies on the epidemiology of CG have involved clinical samples or specific subgroups (e.g., widowed elderly). Studies vary in their estimations regarding the prevalence of CG within the general population, however they do tend to report within the range of 2.4% (e.g. Fujisawa, 2010) and 7% (Kersting, 2011; Kristensen et al., 2017) for loss following natural deaths. However, higher CG prevalence rates of 18.6% have been found in hospitalised patients with unipolar depression (Kersting et al., 2009), and a prevalence rate of 24.3% has been reported by Simon et al. (2005) for bipolar patients. Within the bereavement literature, a range of factors have been identified as placing the bereaved at risk of developing CG. One, which is relatively consistent in the bereavement literature is gender, where females have been found to be at an increased risk for CG than males (e.g. Stroebe and Schut,2005).

The literature also indicates that those who have suffered a loss early in life are at an increased risk for psychopathology, such as CG following the loss of a loved one during adulthood (Silverman et al., 2001; Luecken, 2008; Prigerson et al., 2009). Loss type, such as the loss of a partner or child, have also been associated with an increased risk of severe chronic grief (Cleiren et al., 1991; Murphy et al., 2003; Songetal et al., 2010; Meert, Donaldson, Newth et al., 2010). One study by Kersting et al. (2011) found that those who had lost a child had the highest prevalence of CG (23.6%). They also reported that the second-highest group with CG where those who had lost a partner (20.3%) which supported findings reported the previous year by Fujisawa et al. (2010), who demonstrated that the loss of a spouse was associated with a higher risk of CG than the loss of a parent or a sibling. In addition to the loss of a partner or child, another important grief-related factor in the context of CG is the cause of death. Sudden or violent losses are among the strongest predictors for the development of CG, as these loss types are more difficult to integrate than expected loss (Parkes, 1985; 2008). However, whilst sudden loss is commonly referred to as traumatic, evidence remains inconclusive with some studies reporting a relationship between sudden loss and CG (Lundin, 1984); whilst others have not (e.g., Bonanno et al., 1995). Violent loss on the other hand has been more conclusive with regards to its links with CG. Many survivors of violent loss (i.e., family and friends who lost a loved one to homicide, suicide, or fatal accidents) are at increased risk for a variety of psychological symptoms and disorders including PTSD, depression, and substance abuse (e.g., Amick-McMullen, Kilpatrick and Resnick, 1991; Kaltman and Bonanno, 2003; McDevitt-Murphy, Neimeyer, Burke, Williams, and Lawson, 2012; Zinzow, Rheingold, Hawkins, Saunders and Kilpatrick, 2009), as well as CG (Lobb et al., 2010). The prevalence of reported CG among those bereaved by violent death varies greatly 12.5% to 78.0% (Nakajima et al., 2012).

During times of war and civil conflict, sudden, violent losses are sadly commonplace, and evidence has shown significantly higher rates of CG within these populations (Mercer and Evans, 2006; Stammel et al., 2013). Again, rates vary widely across studies, ranging from 8% among Rwandan war widows and orphans (Schaal et al., 2010) to 54% in resettled Bosnian refugees (Craig et al., 2008). The variance in reported prevalence rates is thought to reflect factors such as comorbid mental disorders, lack of readiness for the death, difficulty in making sense of the death, as well as high levels of negative appraisal about the self, others and world.

Cognitive Behavioural theorists (e.g. Prigerson., 1995; Ehlers., 2006; Boelen et al., 2007; Shear et al., 2012; Duffy and Wild, 2017) have proposed hypotheses about the mechanisms that underlie CG which should be targeted in treatment. Three processes are seen as crucial in the development and maintenance of CG: (a) insufficient integration of the loss into the autobiographical knowledge base, (b) negative global beliefs and misinterpretations of grief reactions, and (c) anxious and depressive avoidance strategies. These processes are offered to account for the occurrence of CG symptoms, whereas the interaction among these processes is postulated to be critical to symptoms becoming marked and persistent. However, there is a dearth of studies focused on examining the underlying mechanisms of CG in populations who have suffered from conflict-related loss and, to the best of our knowledge there are no published systematic reviews comparing and contrasting those studies that do exist. Thus, the aim of this systematic review was to provide a narrative synthesis of the current state of evidence, concerning the identification and role of specific cognitions which underlie CG. This included those who have suffered a sudden violent loss, as a result of war or civil conflict, as evidence suggests that subgroups of CG sufferers (e.g. sudden/violent versus natural loss) may differ with regards to their maladaptive cognitions. Given the potential long-term course of pathological distress following the loss of significant others (Byrne and Raphael, 1997; Chen et al., 1999; Morina et al., 2011), it is important to more accurately identify psychological factors associated with the maintenance of grief-related pathological distress. Thus, the research questions we wish to address are:

(a) What are the key cognitive factors implicated in the maintenance of CG in adults bereaved by conflict-related violent loss?
(b) How can these inform treatment practices?

2.4.2 Method

The search strategy for this study was conducted in two stages. The rationale for searching this way was to ensure that no key studies were overlooked. Prior to the review, the protocol for the study was submitted to PROSPERO - a prospective international register for review protocols - in January 2019 (registration number: CRD42019110319). Search methods and results were conducted and documented in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009). The search strategy is explained in more detail in appendix 1.4.1 and the study selection and data extraction methods are explained in appendix 1.4.2.

2.4.3 Results

The combined electronic searches of seven databases and two libraries (Campbell and Cochrane) retrieved 2849 titles and abstracts. After adjusting for duplicates, 1348 studies were removed. In the first phase of the screening for eligibility, 1501 titles and abstracts were screened against the inclusion and exclusion criteria, resulting in a further 1298 studies being excluded as they did not meet the inclusion criteria. In the second full text phase, 203 were assessed for eligibility, of which 140 records were excluded for the following reasons: Does not report on cognitive maintenance factors: = n 61; No validated grief measure used: n = 12; Not published in a peer-reviewed article: n = 20; Same study, different article: n = 4; Not focused on traumatic or violent loss: n = 38; In patient study: n = 2; Duplicate n = 13 (see Fig. 1.4.4 in appendices). The rationale for the data analysis methodology is provided in appendix 1.4.3.

2.4.4 Study Characteristics

In total, 53 studies fulfilled our criteria for inclusion, 43 of which focused on violent, non-conflict related CG, with the 10-remaining studies focusing on violent conflict-related CG. For the purposes of the present sub review, we have conducted a narrative analysis of the 10 conflict-related studies. These will later form part of more extensive comparative analysis comparing the conflict and non-conflict studies (total = 53).

The 10 conflict studies presented in the present review reported data for 4,421 participants. The studies were published between 2010 and 2018. There was significant heterogeneity in relation to gender, age and loss type from the included studies. One study was conducted in the United States; two in Africa; four in Asia; two in Europe and one in Oceania, with sample sizes ranging from 21 to 2964. Eight studies focused primarily on adults, ranging in age from 18-97. Two studies included data from children aged between 12-18 alongside data for adults aged 18 and older. With these studies, data was only extracted for adults over the age of 18. Of the 10 studies, one focused on Survivors of Terror Killings, four on Survivors of Mass Conflict, three focused on Survivors of Genocide, one on Widowed Survivors of War and on military personnel (service members and veterans).

Trauma types present within the studies related to loss ranged from seeing dead bodies, the murder of family member(s), physical injury, witnessing strangers tortured and not being able to perform cultural ceremonies for their dead. As outlined above, the included studies focused on war, civil conflict and terrorist-related CG, in both children/young people and adults. When we refer to conflict-related CG throughout the results and discussion section, we are referring to *war, terrorism or civil* conflict-related CG). The quality of evidence was mostly high (9 studies, range 20/22-22/22) to moderate (1 study rated 15/22), none were rated as of low quality. Characteristics of the included studies are presented in the Table 1 (Appendix 1.4.6), along with a quality rating for the strength of evidence.

2.4.5 Prevalence of CG

Rates of conflict-related CG have varied widely in the literature, ranging from 15.8% in one study of refugees/asylum seekers (Bryant et al., 2020) to 54% in a study reporting on resettled Bosnian refugees (Craig et al., 2008). Of the 10 studies included in the present review, six reported prevalence rates for conflicted-related CG, to varying degrees. The remaining four studies reported only on the individual symptoms of CG. The six studies reporting on prevalence rates estimates ranged from 8% (Hinton, Nickerson et al., 2103; Hinton, Field et al., 2013; Schaal et al., 2010) to 24.75% (Simon et al., 2017), higher rates of 49% (Rees et al., 2017) and 82% (Dyregrov et al., 2015) were also reported. However, whilst Hinton and Nickerson et al., (2013) reported prevalence rates of 8% using the Prolonged Grief Scale (PG-13) they also recorded significantly higher prevalence rates (31%) in the same study when they assessed CG using the Culturally Sensitive Measure of Grief-Related Distress (CSM-G). This raises the question, do the varying prevalence estimates for conflict-related CG reflect the differences in choice around psychometric measurement?

There was a notable amount of heterogeneity surrounding the psychometric measurement of CG in the studies. Whilst five of the studies used the PG-13 (PG-13; PGS; Prigerson & Maciejewski, 2007) to assess CG (Chukwuorji et al., 2018; Hinton, Nickerson et al., 2013; Hinton, Field et al., 2013; Weder et al., 2010; Schaal et al., 2010), two used the Inventory of Complicated Grief (ICG; Prigerson et al,1995) to assess CG (Simon et al., 2017; Dyregrov et al., 2015). One study used the Prolonged Grief Disorder Interview (PGD-I; Prigerson et al, 2009) (Morina et al., 2011) and two used their own 4 item pool to assess the core symptoms of CG (Tay et al., 2017; Rees et al., 2016). It is noteworthy that Tay et al., (2017) reported on the importance of cultural differences as their primary reason for creating a culturally adaptive measure of CG.

2.4.6 Maladaptive Cognitions

Rumination and avoidance were among the cognitive maintenance factors reported on most within the included studies. One study (Chukwuorji et al., 2018) investigated the associations of rumination and rebirth concerns, with symptoms of CG following conflict-related loss. Their results showed that both intrusive and deliberate rumination had a positive association with CG. Another study (Morina et al., 2011) examined the independent contributions of rumination and experiential avoidance in predicting symptoms of psychological distress among widowed female survivors of war. Here, results demonstrated that both rumination and experiential avoidance significantly predicted the symptom severity of CG, depression and posttraumatic stress.

Furthermore, rumination accounted for additional variance above and beyond experiential avoidance and vice versa. Another study, investigating the consequences following unnatural and violent deaths linked with mass killings (Dyregrov et al., 2015), found that the bereaved siblings and parents oscillated between rumination with and avoidance of memories of their dead sibling or child. However, a noteworthy finding by Hinton, Nickerson et al. (2013) was the poor performance of the avoidance of reminders item in their study. They argue that avoidance of reminders is strongly influenced by cultural factors and that there is great variation in the extent to which forgetting or remembering the deceased is sanctioned across cultural groups (Rosenblatt, 2008).

2.4.7 Guilt/Responsibility Appraisals

Cognitive appraisals around guilt and responsibility have also been widely reported across the present studies. For example, Chukwuorji et al., (2018) studied the impact of rebirth concerns with symptoms of CG and found a strong association, however only in relation to males. They speculated that in these societies it was believed that the man is the owner of the home. Thus, the male participants may see the performance of the funeral rites, of the bereaved persons, as their primary responsibility. In situations where the rites are pending, the burden of such situations may manifest in poorer mental health outcomes for the males. Related findings by Hinton, Nickerson et al., (2013) also found rebirth concerns to be a strong predictor of the severity of CG similar to findings by Chukwuorji et al. (2008), who speculated that this is due to the culturally prescribed rituals, including thinking about the deceased in a particular way and it is believed that failure to fulfil this ritual can have negative consequences for the deceased. Thus, rebirth concerns promote the continual thinking about the soul of the deceased, increasing responsibly and guilt appraisals and reducing cognitive avoidance. In their second paper, which focused on dreams (Hinton, Field et al., 2013) they reported that catastrophic cognitions, attributed to nightmares upon wakening, provokes negative emotions such as guilt and overwhelming responsibility to help the soul to be reborn through repeated rituals. Guilt and responsibility appraisals were also reported by Simon et al.(2017) who found that CG was associated with greater levels of trauma-related guilt and guilt cognitions, specifically hindsight bias/responsibility and wrongdoing.

2.4.8 Intrusive thoughts/Global Negative Beliefs

Intrusive thoughts, together with global negative beliefs and negative assumptive world views were also implicated in the severity of CG. In a study by Dyregrov et al. (2015) exploring the impact of the mass killing in Norway in July 2011, they found that bereaved parents and siblings struggled with a persistent and intense longing and yearning for the deceased, combined with intrusive thoughts and images of the killings, and that they moved between ruminating and avoiding these intrusions. Interestingly, the authors speculated that the persistently high levels of intrusion in most of the grieving family members may relate to the constant reminders in the media and in the community at large, thereby postponing the reduction of intrusion that normally takes place (Boerner et al., 2013).

The role of cognitive perspectives in the development and maintenance of CG was examined by Weder et al. (2010). They found, (in their study of Israeli Jews and Palestinians, n=21), that those who were more able to forgive, were less likely to report cognitive, emotional, and behavioural symptoms (CEBS) and psychological distress. In addition, they reported a significant negative correlation between hope, separation and CEBS: that is, the more hopeful they were, the less likely the participants are to report separation distress and cognitive, emotional, and behavioural symptoms associated with the loss. These findings suggest that the cognitive lens through which we view others and the world (e.g., appraisals of peace processes, beliefs about the future) can be considered protective factors associated with CG.

It has been suggested that peace building programmes may foster forgiveness which could be helpful for some suffering from prolonged grief reactions. However, there is also the risk that such programmes can cause exacerbations for individuals if there is an unrealistic expectation of forgiveness and the individual who is not able to forgive feels guilty for not meeting these expectations.

Schaal and colleagues (2010) reported that religious/spiritual beliefs appeared to be protective factor against the development of problematic grief. They postulate, that this belief system, might offer potential consolation and the knowledge that there will be an afterlife and a reunification of family members, which can aid in the grieving process.

In contrast to the aforementioned studies, Tay et al. (2016) reported that those who had a strong perception of injustice, stemming from human rights violations, scored highest in the CG domains of anger/negative appraisal in addition to yearning/preoccupation and shock/disbelief. They also reported that the clustering of anger and negative self-appraisal, into a distinct subdomain, reflects the relationship between symptoms of emotional distress (intense bitterness and anger, difficulties in trusting others, negative appraisals of self an others) that arise from experiences of extensive traumatic losses, associated with gross forms of injustice. Together their findings resulted in the emergence of a novel dimension in the construct of CG (confusion/diminished identity) reflecting the shattering of global beliefs and assumptive world views.

2.4.9 Bitterness/Injustice

Bitterness is a negative emotion caused by a seemingly irreversible thwarting of a goal. Something in between anger and sadness, like anger it is often due to a perceived sense of injustice, but it entails a sense of impotence both to react to injustice and to express one's anger. It's an emotion linked to disappointment concerning the behaviour of oneself, or another person one is affectively involved with, or of some agency one believes should guard justice. The disappointed expectation may take the form of a sense of betrayal, but sometimes simply comes from a disproportion between lavished effort or commitment and actual outcomes, and, when processed through rumination, results in bitterness (Poggi and D' Errico, 2009). Bitterness, stemming from an overwhelming sense of injustice, has been reported in a number of our studies. Weder et al.(2010) found that those participants who were not involved in peace and reconciliation groups reported more cognitive, emotional, and behavioural symptoms (CEBS) of CG (e.g., difficulty accepting the loss, bitterness or anger related to the loss, difficulty moving on with life, numbness; feeling that life is empty) than those who were engaged in such groups. Similarly, Hinton and Nickerson et al. (2013) reported the strong performance of the bitterness item in predicting CG severity, the item was often endorsed and had high sensitivity, and also had high negative predictive power, meaning that in its absence grief-related impairment was unlikely. These findings are in line with previous studies on the centrality of bitterness (Shear et al., 2011). Thus, they argue that bitterness may be a key factor in the maintenance of CG, independent of culture. Regarding the related theme of injustice, Rees et al. (2016) reported on the relationship between preoccupations with injustice and CG severity. They found, that compared to the low CG symptom class, both the grief and grief-anger CG classes reported more preoccupations with injustice for the two historical periods of conflict (the Indonesian occupation and the later internal conflict). Tay et al. (2016) supported these findings, concluding that conflict and loss, associated with a preoccupation with injustice, may be especially pathogenic in generating the anger/negative appraisal component of CG amongst refugees.

2.4.10 Meaning Making

Contemporary grief theories (e.g. Neimeyer et al., 2009) have highlighted the role of meaning-making in assisting the bereaved with the integration of their loss into their autobiographical memory. Meaning making, unsurprisingly therefore, has been highlighted in a number of our included studies as a crucial process in bereavement adaptation. The

Hinton and Field et al.(2013) study provides interesting findings on the cultural aspects of meaning-making. They proposed the ‘‘bereavement nightmare–PTSD model”, which suggests that once a nightmare of a deceased relative or friend occurs, it will worsen PTSD symptoms, which will, in turn, worsen nightmares, starting a vicious cycle. The problem here appears to be the distressing cognitions (appraisals) about these dreams, which commonly mean that the deceased has not been reborn and is in distress, triggering a process of rumination fuelled by guilt appraisals on the part of the dreamer. These highly negative appraisals are thought to block the process of meaning making and contribute to the severity in CG observed in this population. Thus, the authors recommend that treatment should include an assessment of the meaning of the dreams in that culture, the perceived spiritual status of the deceased, and the rituals indicated to assure a healthy spiritual status of the deceased Hinton and Field et al., (2013). Dyregrov et al., (2014) also found that parents and siblings, with severe CG, following the loss of a loved one in the Norway mass killings, reported an inability (understandably) in making sense of their loss. Interestingly, they speculated, that because the distress has remained elevated over time possibly due to ‘‘public noise”, meaning making may have evolved into rumination and further exacerbated distress and deteriorated understanding and integration of the loss.

2.4.11 Cultural Norms - Rebirth

Two of our included studies (Hinton, Nickerson et al., 2013; Hinton, Field et al., 2013) suggest that CG has culturally specific manifestations, in the Cambodian population, that are likely to influence the endorsement of one of the CG items, namely avoidance of the reminders of the deceased. In the Cambodian cultural context, complicated bereavement is closely related to concerns about the rebirth status of the deceased. If the deceased dies an unnatural death and does not receive a proper burial, the deceased is thought not to be reborn, but instead roam the earth, visiting the bereaved in dreams and thoughts. It is culturally mandated that surviving relatives think of the deceased and convey blessings to the deceased so that he or she may be reborn. Thus, in the Cambodian context, owing to rebirth concerns, the living are under a cultural mandate to complete ceremonies and daily rituals of remembering, to help the deceased to be reborn, which necessarily involves thinking of the deceased. This practice necessitates a degree of constant approach behaviour, in contrast to the functional avoidance reported in Western forms of CG. Thus, it is likely that avoidance of reminders is strongly influenced by cultural factors. An additional finding by the authors, relates to the cultural context of dreams. In their discussion they point out that nightmares, which are frequent in trauma victims, have considerable cross-cultural pathoplasticity (i.e. the content varies by cultural beliefs) (Hinton et al., 2009), and that among persons with unresolved grief issues, these nightmares may take the form of nightmares about deceased relatives and friends (Hinton and Field et al., 2013).

2.4.12 PTSD CG link

When the mode of death is not only unexpected and unnatural but also violent, it increases the risk for comorbid CG and posttraumatic stress disorder (PTSD) Kaltman & Bonanno, (2003). Thus, it was not a surprise that a number of our studies have demonstrated a strong association between PTSD and CG. For example, Dyregrov et al. (2014) reported high levels of CG reactions (81%) in parents of lost loved ones which corresponded with high levels (61%) of PTSD. Their results show that both parents and siblings oscillated between an anxious preoccupation with (yearning: CG response) and avoidance of (PTSD response) memories of their dead siblings or child, suggesting that neither grief nor trauma symptoms can fully capture the unique experiences following the violent death of a loved one (Neria, Nandi, & Galea, 2008). Schaal et al. (2010) also reported, that the severity of PTSD symptoms was the variable that had the highest correlation with grief severity. They concluded that it is possible that symptoms of PTSD might interfere with the survivor’s ability to successfully complete the mourning process. Any thoughts about the deceased may be suppressed, as they may automatically trigger trauma reminders, thus it could be, that the treatment of PTSD might facilitate the mourning process (Schaal et al., (2010). Simon et al. (2017) also found that CG in service men and veterans was associated with significantly greater PTSD severity, trauma-related guilt and guilt cognitions.

2.4.13 Discussion

This systematic review has identified and systematically analysed the available evidence on the cognitive maintenance factors underlying CG in those bereaved by conflict. To date, and to the best of our knowledge, no other systematic reviews have addressed the role of specific cognitions, implicated in the maintenance of CG, in those suffering from conflict-related bereavement. The studies included in this review reported significant variance with regards to prevalence rates for conflict-related CG (8%-82%). The rate of 8% is considered low in the context of violent conflict related CG, as previous studies undertaken with other refugee groups and persons who had experienced traumatic loss, including individuals who had lost a loved one during the September 11 terrorist attacks, recorded significantly higher prevalence rates (43%; Neria et al., 2007). This can also be seen amongst Bosnian refugees (54%; Craig et al., 2008) and survivors of the war in Kosovo (38.3%; Morina et al., 2010). A number of factors may have accounted for this variation. The first regards measurement, as noted earlier there was considerable heterogeneity in relation to the psychometrics utilised across the ten studies, thus making comparisons difficult.

Interestingly, of the six studies reporting on prevalence rates, those who utilized the PG-13 (PG-13; PGS; Prigerson & Maciejewski, 2007) reported prevalence rates of 8%, whereas those who reported higher prevalence rates (e.g., 24.75%; 49% and 82%) utilised either the ICG (Prigerson et al, 1995) or their own 4 item pool. Also of interest was the Hinton et al., (2013) study, here they utilised a single item measure of CG alongside the PG-13. Whilst the PG-13 yielded a prevalence rate of 8%, the single-item measurement yielded a prevalence of 31%, which is more in line with current prevalence rates reported in this area. It is also noteworthy that Tay et al.(2017) reported cultural differences as their primary reason for creating their own culturally adaptive measure of CG. Other possible explanations for the variability across the studies include caseness criteria and time since death.

Maladaptive Cognitions

Rumination and avoidance were the most commonly reported maladaptive cognitions reported upon among the studies presented in the present review. There were a number of interesting findings with regards to rumination and avoidance. The first (Chukwuorji et al., 2018) was a distinction between intrusive and deliberate rumination, moreover how they were both associated with increased CG symptoms. This is in line with previous research which has consistently shown that ruminative tendencies predicted greater severity of post-bereavement grief (e.g. Allen, 2012; Delespaux and Zech, 2015; Harper, 2010; Morina, 2011; van der Houwen et al., 2010). Also, of interest were Dyregrov et al's. (2015) findings relating to the oscillation between rumination and avoidance of memories of their loved ones. Given that this study reported a strong correlation between PTSD symptoms and CG symptoms it is possible that what these individuals are experiencing, is the tragic push and pull between symptoms of PTSD and CG, where the symptoms of one are serving to maintain the other. Another notable finding arose in two studies by Hinton et al., (2013) relating to the cultural context of the avoidance of reminders item associated with CG. Thus, in the context of conflict-related CG, both rumination and avoidance need to be considered carefully in the context of culture and comorbidity to better understand their functions.

Guilt/Responsibility Appraisals

In this review, guilt/responsibility appraisals were implicated in a number of studies as potential cognitive maintenance factors linked with elevated CG. What was of interest in the present review was that cognitive appraisals around guilt and responsibility were reported primarily in relation to males. An obvious explanation for this finding is the protective role males play in the context of conflict. In two of the studies, however, the guilt/responsibility appraisals associated with CG severity were also attributed to cultural factors. Future studies may wish to explore this finding further in the context of conflict, gender and culture.

Intrusive thoughts/Global Negative Beliefs

In line with cognitive theories of grief, several of our studies investigated the impact of cognitive interpretations of the loss on CG outcomes and found global negative beliefs and negative assumptive worldviews to be associated with CG severity (e.g. Tay et al., 2017; Chukwuorji et al; 2008; Morina et al., 2011). This suggests that the subjective interpretation of the loss may play a crucial role in the development and maintenance of CG. Rumination has been defined as repetitive thinking about negative emotions and a focus on causes, meanings, and consequences (Nolen-Hoeksema, 1991). Evidence from the studies presented here indicate that survivors of conflict-related violent loss may be more likely to engage in ruminative thoughts about the deceased's death, or what the survivor could have done to prevent this from happening (Dyregrov et al., 2014; Simon et al., 2017; Hinton, Nickerson et al., 2013; Hinton, Field et al., 2013).

Bitterness/Injustice

Studies examining the factorial structure of the CG reactions have consistently identified anger and bitterness as core components (Simon et al., 2011; Prigerson et al., 1999). In keeping with this and other research, the constellation of anger-bitterness has been included in the categories of persistent complex bereavement disorder (PCBD) [DMS ref], defined as a diagnosis requiring further empirical evidence in the DSM-5, as well as in the recently accepted ICD-11 definition of prolonged grief disorder (PGD) [ICD-11 ref]. In the present review one of the papers (Tay et al., 2017) outlined how two subdomains of shock/disbelief and anger/ negative appraisal were identified together to constitute the broad constellation of emotional distress included in CG.

The clustering of anger and negative self- appraisal into a distinct subdomain was thought to reflect the close nexus between symptoms of emotional distress (intense bitterness and anger, difficulties in trusting others, negative appraisal of self and others) that arise from experiences of extensive traumatic losses associated with gross forms of injustice. The authors concluded that it may be that losses associated with the extreme traumas of mass conflict and persecution are particularly potent in provoking these specific domains of grief, a finding that is broadly consistent with other studies in the field (Silove et al., 2009; Cardozo et al., 2004). Unsurprisingly, lack of access to justice arising from human rights violations was strongly associated with the CG domains of anger/negative appraisal in addition to yearning/preoccupation and shock/ disbelief. The nexus between the sense of injustice and anger/negative appraisal is consistent with general findings in past research amongst populations exposed to persecution and gross human rights violations (Rees et al., 2013; Silove et al., 2009; Silove et al., 2014; Brooks et al., 2011). The findings from Tay et al's. (2017) study may assist in defining more clearly the nature of this link by emphasising the importance of CG as a major influence in generating anger/negative appraisals amongst populations exposed to extensive human rights violations associated with extensive traumatic losses.

Comorbid PTSD - CG

Violent death may evoke visual images of the deceased's final minutes, and cognitions about what he or she must have gone through (Baddeley et al., 2015; Smid et al., 2015). Survivors may subsequently engage in avoidance of these intrusive images. Several of the studies presented here have reported high comorbidities between CG and PTSD (Dyregrov et al., 2015; Schaal et al., 2010; Rees et al., 2016)). Depression and anxiety have likewise been considered as comorbid with CG (Simon et al., 2011; Morina, 2011). Thus Simon et al., (2017) concluded from their study, that individuals with PTSD may be at unique risk for CG, a finding also reported by Marques et al., (2013). This is not surprising, given that depression, PTSD, and CG are all disorders that can develop in response to a traumatic life stressor, such as a death, and they fall on a continuum of stress-related syndromes with partially overlapping symptoms and clinical presentations (Bonanno et al., 2007; Simon, 2012; Sung et al., 2011). Extensive research has focused on the treatment of symptoms of PTSD in the aftermath of violent conflicts (e.g. Duffy, Gillespie and Clark, 2007).

Considerably less research has engaged in developing and evaluating combined intervention programs for both PTSD and CG. Given the high prevalence rates of people experiencing comorbid CG and PTSD after exposure to conflict-related loss and trauma, there is a pressing need to extend research into the development of effective interventions for those suffering from CG and PTSD arising from conflict-related violence. In particular, it is important to determine whether a specific focus should be in trans-diagnostic psychological therapies provided for CG, PTSD, depression, and other reactions that constitute the usual focus of interventions for these populations. In devising interventions, research should investigate the treatment sequencing in comorbid CG and PTSD (integrated, sequential, parallel or single diagnosis) or whether treatment that helps with CG may result in an improvement of PTSD (and vice versa). It will be important to adapt the approach to ensure that it is sensitive to the history, culture, and context of each group.

2.4.13 Conclusions

The studies included in this review reported significant variance with regards to prevalence rates for conflict-related CG (8%-82%). There was considerable heterogeneity in relation to the psychometrics utilised to measure CG across the ten studies, thus making comparisons difficult however future studies may wish to examine the impact that both measurement and culture have on reported prevalence rates of CG.

Rumination and avoidance were the most commonly reported maladaptive cognitions underlying CG development. However, in the context of conflict-related CG, both rumination and avoidance need to be considered carefully in the context of culture and comorbidity to understand their functions better.

Guilt/responsibility appraisals were also implicated as potential cognitive maintenance factors, linked with elevated CG. In this review, cognitive appraisals around guilt and responsibility were reported primarily in relation to males. Future studies may wish to explore this finding further in the context of conflict, gender and culture.

Global negative beliefs and negative assumptive worldviews were strongly associated with CG severity, suggesting that the subjective interpretation of the loss may play a crucial role in the development and maintenance of CG.

This review highlights how CG may have significant influence in generating anger/negative appraisals, common amongst populations exposed to extensive human rights violations associated with extensive traumatic losses.

Finally, the link between CG and PTSD was evident in this review. Thus, it will be important to continue to provide current treatment approaches for this vulnerable population in the future, and continue to intervene in ways which are sensitive to the history, culture, and context of each group.

2.5 Review 5 – The management of comorbid chronic pain and PTSD linked to war and civil conflict: a rapid review of the literature

2.5.1 Introduction

It has been estimated that Northern Ireland has some of the highest rates of PTSD anywhere in the world, with some 8.8% of the adult population estimated to have PTSD at some point in their life (Mental Health Foundation, 2016). A proportion of victims of the recent Troubles have suffered from both psychological and physical problems as a consequence of violent attacks, beatings, shootings and explosions (Muldoon et al., 2005) and witnesses to traumatic incidents have reported with PTSD and chronic physical pain symptoms. Therefore, those citizens can benefit from any potential treatment breakthroughs for this particular combination of conditions. Such knowledge would also be of value to other countries and contexts where populations have been exposed to war and/or conflict-related trauma.

2.5.2 Definition of chronic pain

Chronic Pain (CP) is a complex multifactorial condition which has a myriad of implications not just for the patient as an individual but also for society as a whole.

The International Association for the Study of Pain defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage" this pain becomes CP when it "persists or recurs for longer than 3 months" (IASP, 2011). Recent epidemiological analysis has estimated the prevalence of CP in the United Kingdom (UK) population to be 43.5% (Fayaz et al, 2016). Further analysis reveals that some 10-14% of the population suffer moderate-severely disabling CP, and in certain age groups i.e. Over 75, the prevalence of CP can be as high as 62%. It is therefore unsurprising that the financial cost to the population is massive, back pain alone costs the UK economy £10 Billion per year (Maniadakis & Gray, 2000).

Chronic Pain

Chronic pain is a by-product of a modification of the Central Nervous System, this modification is due to central sensitisation. Central sensitisation leads to an increase in reported pain with less and less provocation. This increase in reported pain is reportedly worse than it "should" be because there is nothing to compare other than previous pain experiences.

There is no specific factor that makes individuals more vulnerable to pain. In some people pain continues and flourishes. Many on the general adult population describe low back pain. There is also an even larger group that does not report pain. In imaging studies, the prevalence of reported structural change in the lumbar spine increases with age. These studies demonstrate that the degree of change reported on images does not correlate with the degree of pain and disability being related. The question then becomes, is this truly “back” pain?

Non-specific modifiable risk factors for persistent pain:

1. Smoking, excessive alcohol intake
2. Lack of exercise, poor nutrition, obesity
3. Stress, anxiety, depression, social isolation, discrimination, poverty
4. Poor sleep
5. Drug side-effects especially prescribed pain medication.

These risk factors weave a tangled web with each factor directly affecting the other. Thus, simple single treatment strategies are unsuccessful in providing pain relief.

Chronic pain can be considered as a series of false alarms generated by the human pain system. This pain system was designed as a threat detection system. The level of threat is governed by the brain’s perception of how great the danger is. When the brain becomes sensitised to pain the false alarms occur frequently and loudly. With this increase of inputs, the filters in the CNS become overwhelmed and so the pain is perceived as persistent.

Activity in the in the brain’s limbic system, responsible for motivation, behaviour and memory is a predisposing factor for chronic pain. The limbic system is particularly important in controlling the emotions that are connected with the pain experience. These emotions affect what we learn from painful experiences. An improvement in the emotional and learned response to pain can lead to an improvement in function.

Ongoing or continuous pain is more about sensitivity than injury. Managing this condition needs to take into account all potential stressors and the patient/client must be active in their own care.

Injury or a specific occurrence is often attributed to the start of the reported pain. However, can pain that persists beyond three months, normal tissue healing, be attributed to the ‘original’ injury. More likely it is the brain’s interpretation of a situation that becomes increasingly more important and dominant.

The Victim and Survivor Service (VSS) undertook a Persistent Pain Review between 2017 – 2019 by engaging the expertise of Specialist Pain Management Consultant Dr John O’Hanlon and Specialist Pain Management Clinical Psychologist Dr Briege Hanna to carry out a holistic and professional review of 50 injured individuals in receipt of ongoing pain management interventions within VSS. The review aimed to ensure that interventions were being provided in a tailored way to meet individual needs and circumstances of those experiencing persistent pain in line with best-practice guidelines and emerging research in line with National Standards and recommendations by the British and Irish Pain Society.

The review recommended that more than half of the individuals to continue the same treatment as previously funded by the VSS. These interventions included Physiotherapy and Complementary Therapies.

In addition, it was recommended that long term trigger point steroid-based injections were not currently recognised as a sustainable pain management approach by the NICE guidelines without the addition of programmes to develop patients/clients skills in managing their own pain. On this basis those in receipt of pain injections were supported in their transition to their local Health and Social Care Trust and VSS no longer fund this pain management approach.

2.5.3 Chronic Pain (CP) and Post Traumatic Stress Disorder (PTSD)

Among CP patients there exists a particular subset with comorbid Post Traumatic Stress Disorder (PTSD). Coupled with and complicated by Post Traumatic Stress Disorder (PTSD), these CP conditions prove particularly intractable and difficult for patients to endure.

To our knowledge, there is still a gap in the knowledge base regarding effective treatments for comorbid chronic pain and PTSD as a result of exposure to war and/or civil conflict.

2.5.4 Review Methods

A rapid review follows most of the principal steps of a systematic review, using systematic and transparent methods to identify, select, critically appraise and analyse data from relevant research. However, to provide timely evidence, a rapid review, by definition, differs from a systematic review in a number of respects as follows: the scope of the review is more targeted and focused; processes are either simplified or omitted, for example, by targeting or reducing the number of databases; a single reviewer is assigned at each step whilst another reviewer verifies the results; grey literature may be excluded or have limited use, for example targeting specific policy, Government or clinical sites. All of these elements formed part of this review methodology. We have systematically collated the various treatment strategies published in the literature which could benefit this subset of patients with co-morbid CP and PTSD.

Eligibility Criteria for the selection of papers

Ovid-Medline and Web of Science were searched for publications from 1994-2018. This timeframe was to correspond with the Diagnostic and Statistical Manual of Mental disorders (DSM-4) publication which was first to outline more precise criteria for the diagnosis of Post-Traumatic Stress Disorder.

A literature search was undertaken using MedLine and PubMed. The following terms were used: Post Traumatic Stress Disorder, PTSD, Stress, Anxiety, Pain, Chronic Pain, Catastrophising and Injustices

Studies selected for inclusion.

All studies located in the literature search are in the reviews section of the Appendices.

2.5.5 Initial findings from the first phase of the review

There is a wide range (22-93%) of people who report pain after a musculoskeletal injury (Rosenbloom). Rivara et al (2008) suggest that patients who are injured and have a psychological vulnerability such as pre-existing anxiety and/or depression are more likely to develop fear avoidance (Vlaeyen & Linton, 2000), catastrophising, anxiety, PTSD and all features of chronic pain.

Central sensitization is a condition of the nervous system that is associated with the development and maintenance of chronic pain. Predisposition to the development of central sensitisation is likely to include biological, psychological, and environmental factors.

Psychophysiological factors, such as the stress-response, are also apt to play a role in the development of central sensitisation. Direct experimental evidence on animals (Alexander, Imbie) and humans (Kuehl, et al, 2010) as well as prospective studies on humans (Slade et al, 2007) have shown a relationship between stress and lowering of pain thresholds. Psychophysiological factors suggest that the pre-existing state of the nervous system is important in the development of central sensitisation in response to pain including pain after injury.

A prior history of anxiety, physical and/or psychological insult and depression are significantly predictive of onset of chronic pain later in life (Nahit, et al, 2003). The pre-existence of these illnesses is more likely to lead to the development of chronic pain following an injury or physical illness. An already dysfunctional nervous system, at the time of injury may interfere with the normal healing time frame thus preventing pain from easing after the injury or tissue damage has healed.

Asmundson and Katz (2009) describe the role that anxiety and fear avoidance play in the development and maintenance of chronic pain. Depression is also a feature of chronic pain with a reported incidence of 32-54%. If mood is altered there is an increase in fear avoidance with an increase in reported pain (Kind & Otis, 2019).

PTSD or PTSD related symptoms can interfere with physical and /or emotional functioning. 3.5%-4.7% of people in the US experience PTSD each year (Goldstein et al., 2016). The rates of PTSD in chronic pain patients varies from 9-50% depending on the setting, population and the type of pain reported (Fishbain, et al., 2017). People reporting pain and PTSD exhibit much greater PTSD symptoms, pain, anxiety, depression and disability and are more likely to be a heavy user of pain medications (Jenewin, et al., 2018). Another feature of chronic pain is catastrophizing (Vlaeyen & Linton, 2000) and this is considered a risk factor for PTSD. Returning US veterans (Alschuler & Otis, 2012) with PTSD show poor pain control and emotions and catastrophizing have a greater influence on their pain.

Concluding comments and Implications for Clinical Practice

When the brain becomes sensitised to pain, false alarms occur frequently and loudly and so the pain is perceived as persistent.

An improvement in the emotional and learned response to pain can lead to an improvement in function.

Activity in the in the brain's limbic system, responsible for motivation, behaviour and memory is a predisposing factor for chronic pain. The limbic system is particularly important in controlling the emotions that are connected with the pain experience. These emotions affect what we learn from painful experiences. An improvement in the emotional and learned response to pain can lead to an improvement in function.

Managing this condition needs to take into account all potential stressors and the patient/client must be active in their own care.

Management of chronic pain is moving from a medical based model reliant on single interventions such as medication and/or injections. For example, NICE guidance NG_59[14] for the management of low back pain in adults no longer recommends the use of steroid based injections and medications. What is also not recommended in this guidance is the use of surgery as a solution to back pain.

The focus is much more on the bio-psycho-social elements of the pain experience and if each of the three components is not addressed then the pain will continue and will continue to be reported as severe or getting worse.

Psychological distress can affect the psychosocial elements of chronic pain and if this is not managed appropriately, then there is no progress. Because pain has a physical dimension the patients are looking for a purely medical answer and most of the evidence indicates that this approach alone is not effective.

Trevino et al. (2020) and Dunne et al. (2012) have shown that early psychological therapies can reduce the impact of PTSD symptoms on chronic pain. The initial focus with this population group can be on the physical injuries and it is only in the post-injury period that there is consideration of the other potential sequelae of trauma.

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[14] https://www.nice.org.uk/guidance/ng59

An Examination of Outcome Data from Services Providing Psychological Services

Report Number Three

Prepared for the Commission for Victims and Survivors

by Queen's University Belfast

ID 1238782

Report 3 Contents

3.1 Introduction

This chapter reports on available psychological therapies data for Troubles-related trauma across statutory (HSC) and non-statutory (community and voluntary) sectors in Northern Ireland and the Republic of Ireland.

3.2 The importance of an outcomes framework

Within an outcome-based monitoring and evaluation framework, outcomes represent the impact of a service and demonstrate the value of the service in terms of improving mental health and wellbeing and quality of life. An outcomes-based approach helps maintain a focus on the actual difference services are making to victims and survivors and enable services to measure the effects of services provided and compare interventions so that services can continually improve. In England, the IAPT service[15] is an excellent example of how an outcomes framework can be integrated into psychological services effectively to monitor and improve service development.

3.3 Current psychological service provision in the community and voluntary sector

The Role of the Victims & Survivors Service (VSS)

The Victims and Survivors Service (VSS) was established in 2012 to administer funding to organisations that provide services and support to victims and survivors across Northern Ireland, elsewhere in the UK and in the Republic of Ireland.

In the initial operational phase, the VSS provided grants and financial support to victims and survivors. In 2016, this model changed to a Needs-Based Service, informed by a process and report that reviewed in partnership with sectoral partners standards framework that would underpin the delivery of service to victims and survivors.[16] The VSS aims to ensure that victims and survivors, and the wider community, are aware of available support and services available and supports victims and survivors to access quality services in line with their individual needs. The VSS Corporate Plan (2019-2022) explained how the aims were met by implementing three funding programmes:

1) The Individual Needs Programme (INP), which delivers financial support and access to goods and services to individual victims and survivors, via a needs-based casework approach.

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[15] https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-iapt-pathway-for-people-with-long-term-physical-health-conditions-and-medically-unexplained-symptoms/

[16] See final-standards-document-2016.pdf (cvsni.org)

2) The Victims Support Programme (VSP), which provides Health and Wellbeing and Social Support services to victims and survivors through our partners in the community and voluntary sector based in Northern Ireland.

3) PEACE IV EU Programme for Peace and Reconciliation (PEACE IV).

The VSS is the Lead Partner responsible for the Provision of Services for Victims and Survivors Programme. The areas of need addressed, and the associated work undertaken are described by the VSS as follows:

1. Health and Wellbeing

2. Social Support

3. Individual Financial Needs

4. Truth, Justice and Acknowledgement

5. Welfare Support

6. Transgenerational Issues and Young People

7. Personal and Professional Development

The VSS funded organisations are mainly based in Northern Ireland but also support those in ROI, and the GB if linked to the Troubles (two organisations are funded to operate in GB through PEACE IV funding). Services funded by the VSS include psychological services, complementary therapies, physical activity, mobility aids and bereavement support for individuals and families. At the time of this publication, 21 organisations are funded to deliver talking therapies.

In 'Standards for Services Provided to Victims and Survivors' (Commission for Victims and Survivors, 2016)[17] the guidance for organisations offering counselling services specifies that registered personnel should have a minimum of 300 hours of supervised practice with two years post-qualification experience.

One important item led by the VSS has been the introduction of an Outcomes-Based Monitoring and Evaluation Framework within the community and voluntary sector, which is available on the VSS website.[18] The VSS produced guidance on Monitoring and Evaluation for all VSS funded services in 2017. This document outlines the importance of monitoring and evaluation for ensuring that services are meeting the needs of victims and survivors, identifying what aspects of practice models are working well, and where there is a need for improvement. The key aims of implementing an outcome-based monitoring and evaluation framework are to:

- Demonstrate the impact/benefit/changes to individuals who engage in funded services and activities.

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[17] final-standards-document-2016.pdf (cvsni.org)

[18] **www.victimsservice.org**

- Capture the ongoing and complex needs of the individuals supported through funded services and activities.
- Ensure funded services are aligned with the Northern Ireland Executive's Programme for Government Outcomes Framework.

CORE Net has been established as the main online monitoring and evaluation tool, accessible for all VSS funded organisations delivering talking therapies and life coaching. All VSS funded organisations are required to monitor the following outcomes and provide monthly and quarterly outcomes to the VSS.

- Clinical Outcomes in Routine Evaluation (CORE) (Talking Therapies) (see above section for more details).
- Measure Yourself Medical Outcome Profile (MYMOP) (Complementary Therapies) The MYMOP measures patient-perceived changes in symptom severity, wellbeing and ability to undertake activities to provide a 'profile' of before and at one or more intervals during a course of therapy.
- Work & Social Adjustment Scale (WSAS) The Work and Social Adjustment Scale (WSAS) is a self-report scale of functional impairment related to an identified problem. This simple, five-item scale is a sensitive and useful outcome measure used to study the effects of therapies on an individual's functioning.

CORE Outcome Measurement Tools

CORE Net has been introduced by the VSS as the online monitoring and evaluation tool, accessible for all VSS funded organisations delivering talking therapies and life coaching. The CORE-OM has 34 items measuring general psychological distress and can be completed in approximately 5-10 minutes. This measure is not specific to any particular therapeutic approach or presenting problem, but rather draws on clinicians' views of what they consider to be the most important aspects of general psychological wellbeing to measure. The CORE-OM is made up of 4 domains:

1. Well-being (4 items)
2. Symptoms (12 items)
3. Functioning (12 items)
4. Risk (6 items)

The CORE-10 is a shorter version of the CORE-OM which can be used as a screening and outcome measure if/when the CORE-OM is considered to be too long for session-by-session use. This measure covers items such as anxiety (2 items), depression (2 items), trauma (1 item), physical problems (1 item) functioning (3 items - day to day, close relationships, social relationships) and risk to self (1 item).

The system currently has 14 measurement and assessment tools available, developed over ten years based on customer needs, and innovative research programmes. For more detail on the range of measurement and assessment tools see here.[19]

Prior to implementing the CORE Net system, training was provided to all VSS funded organisations and a CORE Net lead was nominated for each organisation. CORE Net leads have responsibility for supervising the quality of data, along with protocol adherence.

Psychological service provision in the statutory sector

A Regional Demand Analysis of Generic Adult Mental Health Clinical Psychology & Psychological Therapy Services across the statutory sector was conducted in 2013 (Kelly et al., 2013). Data were collected for 3018 cases over a one-year period during 2011-2012. Results from this analysis highlighted the prevalence of different psychological presentations, and which levels of stepped care require the most resources (i.e. which step(s) had the highest level of clinical demand).

Anxiety disorders (which included post-traumatic stress disorder at that time) and depression had the highest prevalence rates (80%) and accounted for 90% of co-morbid disorders across all steps. Post-traumatic stress disorder accounted for 12% of the sample, and although clinicians were asked to circle the type of trauma (physical, emotional, sexual, troubles related trauma), these individual figures per trauma type were not reported.

An important finding related to the duration of mental health problems, which ranged from 5.7 years for those in step two and 13.6 years for those in step five, suggested significant delays/barriers to accessing treatment. Rates for re-referral were also found to be highest among those in step 4 and step 5 care (30%), with those returning for treatment presenting with the same problems as for their initial referral. This perhaps reflects the complexity of mental health difficulties among these sub-groups, and more research is required to determine effective treatments for those with more complex presentations (Karatzias et al., 2019).

3.4 Statutory Sector - Specialist Trauma Services for Victims and Survivors

The Belfast HSC Trust Trauma Resource Centre

The Trauma Resource Centre (TRC) was established in North Belfast by the Belfast HSCT in 2005. The centre offers a range of services to adults who have been affected by the Troubles and are described on the Belfast HSC Trust webpage as follows:

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[19] http://www.coreims.co.uk/About_Measurement_Tools.html

Counselling - *You can talk with a professionally trained trauma counsellor about the impact the event(s) may be having on your life. Counselling sessions usually last an hour and take place each week at the start of therapy.*

Occupational therapy -*You get an opportunity to assess your quality of life and the negative impact trauma may have on your ability to cope. An occupational therapist will set up a programme that meets your individual needs. The aim is to improve your sense of wellbeing.*

Physiotherapy - *This will help you understand the physical impact of trauma on your body. It may provide insight into unexplained pains and aches and show you practical ways of coping with your symptoms.*

Who provides the service? *Counsellors, Occupational therapists, Physiotherapists*

How to access the service *- Referrals are made through the mental health referral management service (Belfast Health and Social Care Trust).*

The Southern Health & Social Care Trust Trauma Service

In the Southern HSC Trust, a small team was created to take referrals specifically for Troubles-related traumas. The team was comprised of psychological therapists and to provide outpatient psychological care with links to existing mental health services within the Trust.

Family Trauma Centre

A specialist regional trauma service for children and adolescents was developed in the statutory sector in 1999 and located in the Belfast HSC Trust. The Centre is a regional resource for children, young people and their families and does not have an exclusive remit for Troubles-related traumas. The FTC also provides consultation to tier 3 & 4 and supervision to some Family Therapists regionally. This service accepts referrals from a wide range of sources.

3.5 Examination of currently available psychological outcome data

The key aim of this study was to report on an examination of the currently available psychological therapy treatment outcome data on victims and survivors who have received trauma-focused psychological therapy services in both the statutory and non-statutory sectors.

Method

A letter was sent via email from the Commissioner for Victims and Survivors, followed-up by a letter from the Service Evaluation team to the Directors of Adult Mental Health Services in all five HSCTs, and Directors/Managers in VSS funded organisations delivering talking therapies. This letter outlined the purpose of the Evaluation, and requested access to routinely collected available psychological therapy treatment data on victims and survivors who have received trauma-focused psychological therapy services.

Data Analysis

Basic descriptive data analysis was undertaken to examine client outcomes by service characteristics and client demographics (age group, gender etc.). Data were only reported in aggregate form and did not report individual or low cell count examples that would make this information identifiable for any specific individual or organisation.   The returned dataset was only accessible to the Evaluation team, and was stored on a password protected computer.

3.6 Results

Statutory Sector

Outcome data collection

Although HSCTs report the routine collection of psychological outcome data, in some Trusts this data is collected on an individual basis and retained case by case in the client's file but not inputted into a computerised data base. This data was not accessible for inclusion in this report. Those trusts that did have a computerised outcomes framework in place recorded data for patients with PTSD but do not record if the trauma were specifically Troubles related.

North Belfast Trauma Resource Centre

A review of cases discharged in 2019

Sample

Sixty files were sampled from cases that were discharged during 2019. Case files were examined to record the following items: demographics, previous treatment, prescribed medication, symptomology, time from referral to assessment, treatment initiation, Troubles related trauma incidents and any outcome measures available.

Fifty-nine files were included in the analysis as one file was deemed outside of the originally agreed time frame.

Demographics

85% (n=50) were male and 15% (n=9) were female service users. 37% (n=22) lived alone whilst 63% (n= 37) lived with partners or other family members. The majority of individuals were in receipt of Disability Living Allowance (DLA) (49%, n=29) and Employment and Support Allowance (ESA)/ Personal Independence Payment (PiP) (27% n=16) (see Table 3.1).

Table 3.1 Current Employment Status

	Frequency	**Percent**
DLA	29	49.2
ESA/PIP	16	27.1
Employed	10	16.9
Pension	3	5.1
Retired	1	1.7
Total	**59**	**100**

The minimum age recorded was 21 years with a maximum age of 65 years and the mean age for the group was 49 years (sd 10.97).

The majority of the cohort did not receive previous treatment (58% n=34), whilst of those who reported they did, the highest majority 14% (n=8) stated that they had received counselling on a previous occasion (see table 3.2).

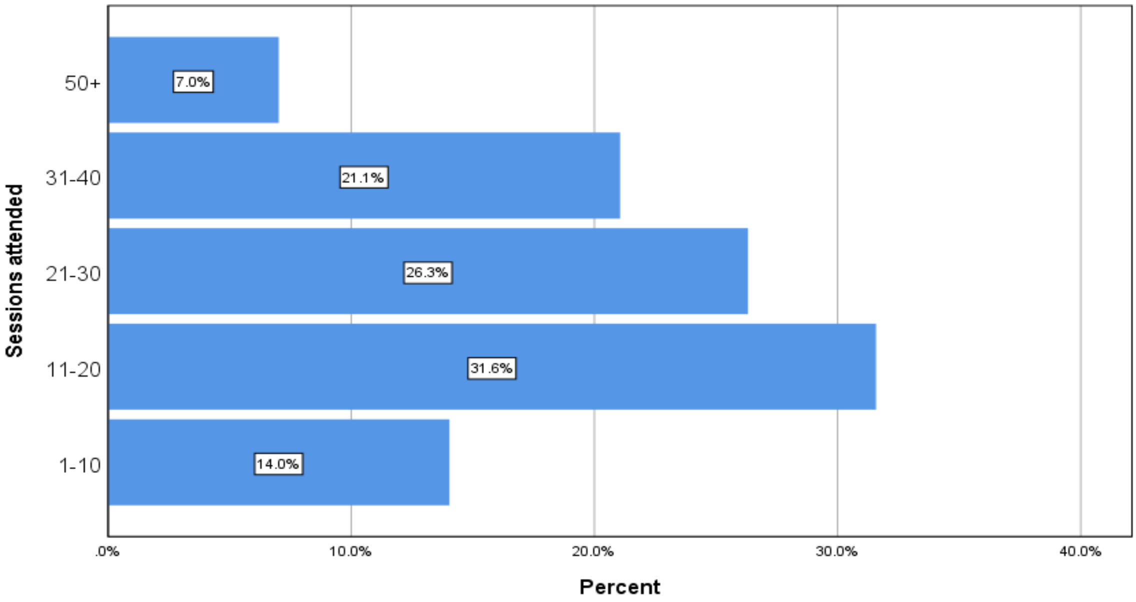
Table 3.2 Previous Treatment

Previous Treatment	**Frequency**	**Percent**
None recorded	34	57.6
Counselling	8	13.6
Psychiatry	6	10.2
CBT	5	8.5
EMDR	1	1.7
OCC	1	1.7
Cruse	1	1.7
Wave	1	1.7
Addiction Services	2	3.4
Total	**59**	**100**

Findings

The mean time from referral to assessment (recorded for n=52 individuals) was 3.2 months and the mean time from assessment to treatment (recorded for n=43) was 2.5 months. Sessions attended are recorded in figure 3. 1.

Fig 3.1. Number of Sessions attended



Information was gathered in relation to medication reported within the case files. The majority of the cohort 31% (n=18) had been prescribed a combination of Anti-depressants and Anxiolytics followed by a combination of Anti-depressants, Anxiolytics and Anti psychotics 24% (n=14) (see Table 3.3).

Table 3.3. Medication

	Frequency	**Percent**
Anti-depressants	15	25.4
Anti-Psychotics	4	6.8
Ads + Anxs	18	30.5
Ads+Anxs+APs	14	23.7
Ads+Anxs+Aps+Nsaids	2	3.4
Missing	6	10.2
Total	**59**	**100**

Individuals were also asked to comment on indicators of trauma during the initial assessment. The majority of the cohort experienced seven or more of the following symptoms (see Table 3.4).

Table 3.4. Symptomology

Symptoms	YES	NO
Hypervigilance	97%	3%
Flashbacks	95%	5%
Intrusive thoughts	92%	8%
Panic attacks	93%	7%
Lack of energy	88%	12%
Anxiety and Depression	86%	14%
Anger	83%	13%
Aches and Pains	76%	24%
Social Isolation	70%	30%
Increase in drugs and alcohol	63%	37%
Suicide Ideation	34%	66%

The analysis also indicated that all service users (n=59) had experienced Troubles related trauma; 25% had experienced physical assault, 19% assault with a weapon, 31% had witnessed sudden violent deaths. Transgenerational trauma was overtly stated in the case files for 10% (n=6) of individuals; all had experienced some form of transgenerational trauma as indicated implicitly within the case file narrative.

Description of Therapies provided

Case notes were recorded for each patient but individual case conceptualisations, treatment plans or protocols were not routinely recorded on file. The type of counselling provided was not clearly defined in the case files selected, but the interventions appeared to involve elements from different approaches. In correspondence, the recently appointed new Trauma manager explained that the Centre traditionally provided a number of therapeutic approaches including; CBT, EMDR, Humanistic Integrative counselling and Sensory Motor Psychotherapy.

Therapy outcomes

The analysis indicated that all individuals in this sample (n=59) received Counselling with a number of individuals receiving other forms of intervention EMDR (n=4) and Physiotherapy (n=12).

Initial core 34 outcome scores were recorded for (n=27) and end outcome scores for (n=14) individuals. In respect of these 14 cases a paired sample t-test indicated that there was a significant positive difference between the pre and post outcome Core 34 scores (pre M=69.5, SD=4.7) (post M=22.7, SD=3.1) t (13) =-8.11 p = 0.000).

Pre and post CORE 10 outcome scores were provided for n=33 individuals within the case files sampled (56% of the sample). A paired sample t-test also showed a significant decrease in Core 10 outcomes pre (M=22.8 SD 7.2) and post-intervention (M=10.9, SD=6.4) t (32) =-8.12 p = 0.000).

3.7 Key Observations

The psychological therapy team in North Belfast Trauma Resource Centre have evidently been working with many complex presentations of trauma for many years. In the current sample, there were high rates of psychiatric co-morbidity (86% Anxiety and Depression) and co-morbid physical illness and pain (76%) with high rates of anger problems (83%) and increased use of drugs or alcohol (63%). Almost 90% of the sample were on some form of prescribed psychotropic medication. These statistics suggest that the cases were in the severe/ complex range of trauma-related disorders and therefore it is encouraging to see improvement in the available outcome scores.

However, there are a number of points which could be considered to improve reporting and psychological service provision as outlined below.

Therapies provided

The treatment intervention for the majority of cases appears to have been person-centred counselling. An examination of case files found minimal use of case formulations or treatment plans and generally little evidence of a specific model of an evidence based psychological approach. Two files reported EMDR as an evidence-based treatment, however on detailed examination no protocol or template of EMDR was evidenced within the case file with limited brief notes referring to the treatment. In another file, the evidence-based intervention, TFCBT was indicated. However no formal model of Trauma-focused treatment was included in the notes, nor was there a case conceptualisation or session recordings that indicated adherence to a TFCBT or a CBT protocol.

Data collection - limitations in the use of outcome measures

The outcome analysis for the cases with pre and post measures is encouraging as it suggests that these patients made good progress. However, the absence of pre and post treatment scores for almost half the sample (44%) greatly limits any outcome analysis.

One main problem was that data does not appear to be collected consistently or systematically which makes outcome analysis very difficult. In some cases, different measures were used within the same case (core 10, core 34, PCL). The PCL-5 a recommended valid and reliable test of the measurement of PTSD was included in a number of case files but were often incomplete and did not record mid or end outcomes so were of little value to comment on pre- to post-treatment effects.

Another limitation is the absence of validated trauma specific measures; the CORE is a generic measure of mental health and does not adequately capture PTSD or CPTSD depression or complex grief symptomatology.

Length of therapy

It is evident that the Centre has a well-established history of treating challenging trauma cases linked to the Conflict in Northern Ireland, with a wealth of experience in this area. It is also evident that therapists are working diligently with complex trauma presentations and may have drawn on a range of approaches to help patients manage complex trauma conditions.

However, there are a number of issues that require further exploration**.** The majority of counselling sessions provided ran over significant periods of time (54% had 20 sessions and more) with some patients in therapy for up to 2/3 years covering up to 70+ sessions (see figure 1). Previous studies from the Centre describe a profile of the patients who attend for treatment, and many have severe forms of trauma related conditions that could meet criteria for complex PTSD (Dorahy et al., 2013). Such cases would be expected to require more prolonged therapeutic inputs and in this respect the fact that 46% of cases received 20 sessions or less is to be commended. However, it would be helpful to discover if a phased-based approach was included as part of therapy and may explain why 28% of cases required 30 or more sessions.

It would be useful to explore the complexity of these cases more fully with the team and discuss the rationale for more extended periods of therapy to discover what approaches are deemed necessary and helpful for such complex work. Such discussions can generate learning for the field and hypotheses that can be empirically tested by well-designed clinical studies.

The Southern Health & Social Care Trust Trauma Service

SHSCT Trauma clients by locality

The SHSCT provided a breakdown of the number of clients seen in each locality in 2017, the availability of notes and the number and percentage of PCL-5 pre- and post- scores completed (see Table 3.5). The mean percentage of completed scores varied between localities from (38.9%) in Craigavon and Banbridge, Newry and Mourne, Armagh and Dungannon compared to 51.4% in the Newry and Mourne district.

Table 3.5: SHSCT Troubles-related Trauma Clients (2017) by locality

Total number of clients seen in Craigavon and Banbridge Locality	15
Total number of notes not available/patients not seen for Trauma Therapy	2
Total number of PCL-5 pre and post scores completed	3
Completed Scores (%)	**23%**
Total number of clients seen in Newry and Mourne Locality	41
Total number of notes not available/patients not seen for Trauma Therapy	6
Total number of PCL-5 pre and post scores completed	18
Completed Scores (%)	**51.4%**
Total number of clients seen in Armagh and Dungannon Locality	45
Total number of notes not available/patients not seen for Trauma Therapy	16
Total number of PCL-5 pre and post scores completed	9
Completed Scores (%)	**31%**
Total Number of Clients Seen	**101**
Total number of notes not available/patients not seen for Trauma Therapy	**24**
Total number of PCL-5 pre and post scores completed	**30**
Completed Scores (%)	**38.9%**

Data Analysis

The SHSCT Trauma team provided outcome data from 3 main instruments, the Posttraumatic Stress Disorder Checklist (PCL-5), the Posttraumatic Cognitions Inventory (PTCI) and the Impact of Events Scale Revised (IES-R).

The PCL-5 is a 20-item self-report measure that assesses the presence and severity of PTSD symptoms. Items on the PCL-5 correspond with DSM-5 criteria for PTSD. The PCL-5 can be used to quantify and monitor symptoms over time, to screen individuals for PTSD, and to assist in making a provisional or temporary diagnosis of PTSD. The results from the pre-test (M = 58.3, SD = 12.4) and post-test (M = 36.6, SD = 16.1) PCL-5 scores (Table 3.1) indicate that TF-CBT resulted in a significant improvement in PTSD symptoms t = 9.4., p = .001 (Table 2.2).

The PTCI (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999) was developed to assess posttraumatic appraisals and their relationship to PTSD and other posttraumatic reactions, such as symptoms of depression and anxiety. The results from the pre-test (M = 150.39, SD = 48.01) and post-test (M = 109.56, SD = 40.79) PTCI scores (table 2.1) indicate that the TF-CBT resulted in a significant improvement in PTSD symptoms t = 6.62, p = .001 (table 3.2).

The IES-R is a 22-item self-report measure (for DSM-IV) that assesses subjective distress caused by traumatic events. Given that the sample size was significantly small for the IES-R (n=2) it is impossible to ascertain whether there was a generalisable meaningful change.

Data analysis

A paired-sample t-test was conducted to compare the pre and post-TF-CBT scores of PTSD in clients in the sample provided by the SHSCT (see tables 3.6 and 3.7 below).

Table 3.6 Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	PCL-5	58.28	40	12.410	1.962
	PCL5post	36.60	40	16.134	2.551
Pair 2	PTCI	150.39	18	48.012	11.317
	PTCI post	109.56	18	40.790	9.614
Pair 3	IES-R	81.50	2	.707	.500
	IESR post	59.00	2	15.556	11.000

Table 3.7: Paired Samples Test

		Paired Differences							
					95% Confidence Interval of the Difference				
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper	t	df	Sig. (2-tailed)
Pair 1	PCL-5 PCL5 post	-21.675	14.579	2.305	17.013	26.337	9.403	39	.001
Pair 2	PTCI PTCI post	-40.833	26.185	6.172	27.812	53.855	6.616	17	.001
Pair 3	IES-R IES-R post	–22.500	14.849	10.500	-110.915	155.915	2.143	1	.278

Key points:

It is a positive development that the SHSCT are collecting outcome data using validated measures (PCL-5, PTCI and IES-R. The pre-to post-treatment changes on the PTCI and the PCL5 are statistically significant, and it is evident from the pretreatment PCL-5 scores that staff are working with very challenging cases.

However, the absence of pre- and post-treatment scores for more than half the sample (61%) greatly limits any outcome analysis. Given the limited information we cannot comment on issues such as the length of therapy. In correspondence with the SHSCT, it was explained that the primary therapies provided are CBT and TF-CBT. However, as no case notes case were available to the research team, we cannot comment on issues such as case diagnoses, conceptualisations or adherence to TFCBT or CBT protocols. Nevertheless, the outcome analysis for the cases with pre- and post-measures is very encouraging, suggesting these patients who were treated indicate significant improvement in symptoms of PTSD.

VSS funded organisations

Routinely collected psychological outcome data are held centrally by the VSS on their CORE Net dataset. The CORE-OM has 34 items measuring general psychological distress, and can be completed in approximately 5-10 minutes. This measure is not specific to any particular therapeutic approach or presenting problem, but instead draws on clinicians' views of what they consider to be the most important aspects of general psychological wellbeing to measure. The CORE-OM is made up of 4 domains:

1. Well-being (4 items)
2. Problems/Symptoms (12 items)
3. Functioning (12 items)
4. Risk (6 items)

The CORE-10 is a shorter version of the CORE-OM, which can be used as a screening and outcome measure if/when the CORE-OM is considered to be too long for session-by-session use. This measure covers items such as anxiety (2 items), depression (2 items), trauma (1 item), physical problems (1 item) functioning (3 items - day to day, close relationships, social relationships) and risk to self (1 item).

We have outlined summary tables for the following outcomes from 22 VSS funded organisations delivering talking therapies during 2017-2018 (one organisation has since closed):

- Number receiving talking therapies, and number of sessions per therapy type
- Number showing improvements per therapy type, across four key domains of Wellbeing, Risk, Problems and Functioning

- Drop-out figures per therapy type
- Types of symptoms experienced by clients
- Initial severity and duration of symptoms

Number of clients receiving therapy (broken down by therapy type and number of sessions) 2017/18

Out of 1732 clients who received a talking therapy, the majority of clients attended person-centred therapy (n=385), followed by *Other Therapies (n=245) such as Systemic or Art Therapy, Psychotherapy (n=159), CBT (n=147), Life Coaching (n=77), Psychodynamic (n=55), EMDR (n=20), Bereavement Counselling (n=16), and Solution Focused Therapy (n=10). Most clients received multiple therapies (n=618).

The number of sessions for each therapy type ranged from 0-6, 7-12, 13-20, to 21+. The majority of clients received 0-6 sessions across all therapy types (n=534), followed by 7-12 sessions (n=369), 13-20 sessions (n=193) and 21+ sessions (n=18) (see Table 3.8).

Table 3.8 Number of clients receiving therapy

	Type of Therapy									
	Bereavement Counselling	CBT	EMDR	Life Coaching	Other*	Person Centred	Psycho-therapy	Psycho-dynamic	Solution Focused	Multiple** Therapies
Number of Sessions	**Number of clients**									
0-6	12	61	11	77	108	199	47	12	7	216
7-12	2	57	4	0	96	118	64	25	3	247
13-20	2	28	5	0	39	58	46	15	0	130
21+	0	1	0	0	2	10	2	3	0	25
Total	**16**	**147**	**20**	**77**	**245**	**385**	**159**	**55**	**10**	**618**

*’Other Therapy Types’, some of which include: Systemic, Somatic experiencing, Sensorimotor psychotherapy, Integrated, Art Therapy, Gestalt, Humanistic, Transactional Analysis.

**'Multiple Therapies' means the client has received more than one type of therapy. The data suggest that there are many combinations including combinations of more than two types of therapy (see Table 3.9).

Table 3.9 Combinations of 'Multiple Therapies'

Therapy	Bereavement	CBT	EMDR	Life Coaching	Other	Person Centred	Psycho-therapy	Psycho-dynamic	Solution Focused
Bereavement	151								
CBT	63	397							
EMDR	6	15	47						
Life Coaching		3		118					
Other	23	51	7	1	399				
Person Centred	102	249	14	5	136	820			
Psychotherapy	28	36	7	1	5	48	210		
Psychodynamic	22	60	2		22	98	9	162	
Solution Focused	33	73	11	2	36	135	26	28	180

Footnote

1. Table 3.9 indicates that most cases have received more than one type of therapy The VSS have advised the research team that the actual number of multiple therapies provided may exceed the numbers presented in table 3.9.

2. The VSS have also explained that the majority of clients typically received person centred counselling followed by CBT and other types of therapy and EMDR typically was offered when other avenues did not appear to be working. At the point of data analysis the research team did not have the access to data with this level of detail so are unable to comment on therapy combination effects.

Clinical change measured by Core for each type of therapy 2017/18

The following tables provide pre- and post- outcome scores by therapy type and gender (Tables 3.10 - 3.19).

The CORE Net system records the initial severity and duration of the symptoms on the following scales:

Duration Pre-Scores	Severity Pre-Scores	Severity Post-Scores
< 6 Months 6 -12 Months > 12 Months Recurrent No Data	Causing minimal difficulty Causing mild difficulty Causing moderate difficulty Causing severe difficulty	Causing no difficulty Causing minimal difficulty Causing mild difficulty Causing moderate difficulty Causing severe difficulty

Table 3.10 Psychodynamic Therapy

Change Type	Female	Male	Total	Percentage
No Reliable Improvement	9	10	19	**34.55%**
Reliable Deterioration	0	2	2	0
Reliable Improvement	8	6	14	**61.82%**
Clinical Reliable Improvement	13	7	**20**	
Improvement by gender	**70.00%**	**52.00%**		
Total	**30**	**25**	**55**	

Table 3.11 EMDR

Change Type	Female	Male	Total	Percentage
No Reliable Improvement	5	3	8	**40.00%**
Reliable Deterioration	0	1	1	**5.00%**
Reliable Improvement	1	3	4	**55.00%**
Clinical Reliable Improvement	3	4	7	
Improvement by gender	**44.44%**	**63.64%**		
Total	**9**	**11**	**20**	

Table 3.12 CBT

Change Type	**Female**	**Male**	**Total**	**Percentage**
No Reliable Improvement	24	22	46	**31.29%**
Reliable Deterioration	3	2	5	**3.40%**
Reliable Improvement	17	16	33	**65.31%**
Clinical Reliable Improvement	39	24	**63**	
Improvement by gender	**67.47%**	**62.50%**		
Total	**83**	**64**	**147**	

Table 3.13 Psychotherapy

Change Type	**Female**	**Male**	Total	**Percentage**
No Reliable Improvement	22	34	56	**35.22%**
Reliable Deterioration	2	2	**4**	**2.52%**
Reliable Improvement	15	25	40	
Clinical Reliable Improvement	36	23	**59**	**62.26%**
Improvement percentage by	**68.00%**	**57.14%**		
Total	**75**	**84**	**159**	

Table 3.14 Solution Focused

Change Type	**Female**	**Male**	**Total**	**Percentage**
No Reliable Improvement	4	1	5	**50.00%**
Reliable Deterioration	0	1	**1**	**10.00%**
Reliable Improvement	0	1	1	
Clinical Reliable Improvement	1	2	**3**	**40.00%**
Improvement by gender	**20.00%**	**60.00%**		
Total	**5**	**5**	**10**	

Table 3.15 Bereavement Counselling

Change Type	**Female**	**Male**	**Total**	**Percentage**
No Reliable Improvement	5	4	9	**56.25%**
Reliable Deterioration	1	0	1	**6.25%**
Reliable Improvement	4	0	**4**	**37.50%**
Clinical Reliable Improvement	1	1	**2**	
Improvement percentage by	**45.45%**	**20.00%**		
Total	**11**	**5**	**16**	

Table 3.16 Life Coaching

Change Type	Female	Male	Total	Percentage
No Reliable Improvement	25	4	29	**37.66%**
Reliable Deterioration	0	0	**0**	**0.00%**
Reliable Improvement	8	2	10	**62.34%**
Clinical Reliable Improvement	28	10	38	
Improvement by gender	**59.02%**	**75.00%**		
Total	**61**	**16**	**77**	

Table 3.17 Person-Centred

Change Type	Female	Male	Total	Percentage
No Reliable Improvement	94	90	184	**47.79%**
Reliable Deterioration	12	13	**25**	**6.49%**
Reliable Improvement	45	28	73	**45.71%**
Clinical Reliable Improvement	67	36	**103**	
Improvement percentage by gender	**51.38%**	**38.32%**		
Total	**218**	**167**	**385**	

Table 3.18 Other

Change Type	Female	Male	Total	Percentage
No Reliable Improvement	46	42	88	**35.92%**
Reliable Deterioration	2	5	**7**	**2.86%**
Reliable Improvement	33	44	77	**61.22%**
Clinical Reliable Improvement	41	32	**73**	
Improvement by gender	**60.66%**	**61.79%**		
Total	**122**	**123**	**245**	

Table 3.19 Multiple

Change Type	Female	Male	Total	percentage
No Reliable Improvement	113	77	190	**30.74%**
Reliable Deterioration	7	7	**14**	**2.27%**
Reliable Improvement	92	53	145	**66.99%**
Clinical Reliable Improvement	163	106	**269**	
Improvement by gender	**68.00%**	**65.43%**		
Total	**375**	**243**	**618**	

The CORE NET system uses ordinal, discrete variables and the data provided does not comment on statistically significant differences between therapies.

Clients who received multiple therapies had the highest improvement rate overall for (67%). In terms of specific modalities, clients who received CBT demonstrated the highest overall clinical improvement irrespective of gender (65%), followed by Psychodynamic therapy, Psychotherapy and Life Coaching (62%), other therapies (61%), EMDR (55%), Person-Centred Therapy (46%), Solution Focused Therapy (40%), and Bereavement Counselling (38%).

There were notable gender differences in terms of effective interventions, with females demonstrating better outcomes for clinical reliable improvement with Psychodynamic therapy (70%), Psychotherapy (68%), multiple therapies (68%) compared to solution-focused therapies (20%). Males demonstrated better outcomes from Life Coaching (75%), and EMDR (64%), compared to Bereavement Counselling (20%). However, it should be noted that only 4 males attended Life Coaching compared to 25 females, so this finding should be interpreted with caution.

Both males and females appeared to benefit from CBT (63%, and 67% respectively) and Other Therapies (62% and 61% respectively).

Number of clients showing improvements across four key domains 2017/18

The following tables provide Pre- and Post- Wellbeing data for clients (n=1732) across the four key CORE OM domains, including Wellbeing, Risk, Problems and Functioning (measuring general psychological distress), broken down by therapy type (Tables 3.20 – 3.23).

Table 3.20 Wellbeing

Therapy Type	Sample	Pre-Below	%	Post-Below	%
	1732	**256**	14.78%	**856**	49.42%
Bereavement	16	0	0.00%	5	31.25%
CBT	147	27	18.37%	87	59.18%
EMDR	20	6	30.00%	11	55.00%
Life Coaching	77	22	28.57%	48	62.34%
Multiple Therapies	618	93	15.05%	359	58.09%
Other	245	25	10.20%	98	40.00%
Person-Centred	385	54	14.03%	133	34.55%
Psychodynamic	55	4	7.27%	37	67.27%
Psychotherapy	159	22	13.84%	74	46.54%
Solution Focused	10	3	30.00%	4	40.00%

Table 3.21 Problems

Therapy Type	Sample	Pre Below	%	Post Below	%
	1732	**183**	10.57%	**821**	47.40%

Bereavement	16	2	12.50%	5	31.25%
CBT	147	22	14.97%	78	53.06%
EMDR	20	3	15.00%	11	55.00%
Life Coaching	77	17	22.08%	49	63.64%
Multiple Therapies	618	67	10.84%	339	54.85%
Other	245	12	4.90%	87	35.51%
Person-Centred	385	37	9.61%	121	31.43%
Psychodynamic	55	4	7.27%	34	61.82%
Psychotherapy	159	16	10.06%	63	39.62%
Solution Focused	10	3	30.00%	4	40.00%

Table 3.22 Risk

Therapy Type	Sample	Pre Below	%	Post Below	%
	1732	**704**	40.65%	**990**	57.16%
Bereavement	16	1	6.25%	5	31.25%
CBT	147	73	49.66%	100	68.03%
EMDR	20	8	40.00%	11	55.00%
Life Coaching	77	49	63.64%	54	70.13%
Multiple Therapies	618	283	45.79%	396	64.08%
Other	245	71	28.98%	121	49.39%
Person-Centred	385	120	31.17%	164	42.60%
Psychodynamic	55	25	45.45%	40	72.73%
Psychotherapy	159	69	43.40%	94	59.12%
Solution Focused	10	5	50.00%	5	50.00%

Table 3.23 Functioning

Therapy Type	Sample	Pre Below	%	Post Below	%
	1732	**239**	13.80%	**787**	45.44%

Bereavement	16	1	6.25%	5	31.25%
CBT	147	34	23.13%	79	53.74%
EMDR	20	5	25.00%	10	50.00%
Life Coaching	77	13	16.88%	48	62.34%
Multiple Therapies	618	81	13.11%	332	53.72%
Other	245	20	8.16%	92	37.55%
Person-Centred	385	57	14.81%	116	30.13%
Psychodynamic	55	3	5.45%	25	45.45%
Psychotherapy	159	25	15.72%	77	48.43%
Solution Focused	10	0	0.00%	3	30.00%

The following table (3.24) shows the percentage of clients (n=1732) scoring below the clinical cut-off for general psychological distress (positive outcomes) across all four domains.

Table 3.24

Number of clients with a positive outcome	1038
Total number of clients	1732
Percentage improved across all four domains	**60%**

Results showed that 60% of clients improved across all four domains, indicating that over half of clients had improved psychological outcomes (scored below the clinical cut-off for general psychological distress) following talking therapies.

In terms of Wellbeing, 256 (14.78%) scored below the clinical cut-off pre-therapy. Post-therapy, this has increased to 856 (49.42%), indicating that 35% of the entire sample had a clinical improvement in their wellbeing. *When broken down by therapy type, the highest improvement was seen for psychodynamic therapy, with a 60% increase in wellbeing for those receiving this therapeutic approach, followed by CBT (41% improvement), Life Coaching (34%), Psychotherapy (33% improvement), and Other Therapies (30%*). Much smaller improvements in wellbeing were seen for Person-Centred and Solution Focused therapy (21% and 10% respectively).

In terms of Problems/Symptoms, 183 (10.57%) scored below the clinical cut-off pre-therapy. Post-therapy, this has increased to 821 (47.40%), indicating that 37% of the entire sample had a clinical improvement in their Problems/Symptoms. *Again, the highest improvement was found for psychodynamic therapy (55%), followed by Life Coaching (42%), EMDR (40%), and CBT (38%).* As for Wellbeing, much smaller improvements in Problems/Symptoms were seen for Person-Centred and Solution Focused therapy (22% and 10% respectively).

Looking at risk to self, 704 (40.65%) scored below the clinical cut-off pre-therapy. Post-therapy this has increased to 990 (57.16%), indicating that 17% of the entire sample had a clinical improvement for this domain. *As with Wellbeing and Problems/Symptoms, the highest improvement was found for psychodynamic therapy (27%). Positive outcomes were also higher for those receiving Bereavement Counselling (25%), Other Therapies (20%), and CBT (18%).* As for Wellbeing and Problems/Symptoms, much smaller improvements were seen for Person-Centred, Life Coaching, and Solution Focused therapy (11%, 6% and 0% respectively) for the Risk to Self-domain.

Overall, positive outcomes, in terms of being above the clinical cut-off, were much smaller than for Wellbeing and Problems domains. However, positive pre-therapy scores were also much higher across all therapy types, indicating that risk to self was less problematic to begin with for the entire sample with the exception of the sub-sample receiving Bereavement Counselling, who appeared to have higher pre-therapy clinical symptoms for this domain. Perhaps indicating greater risk to self for those who are bereaved due to the Troubles.

For the fourth domain, considering functioning, 239 (13.80%) scored below the clinical cut-off pre-therapy. Post-therapy this has increased to 787 (45.44%), indicating that 32% of the entire sample had a clinical improvement for this domain. In contrast to the other three domains, the highest improvement for the Functioning domain was found for Life Coaching (45%), and Solution Focused Therapy was also found to have a relatively high level of positive outcomes for this domain (30%). As was found across the other three domains, psychodynamic therapy had a high level of positive outcomes (40%), followed by Psychotherapy (33%), and CBT (31%) and Other Therapies (29%). Consistent with findings across all domains, the smallest improvement was seen for Person-Centred Therapy (15%).

Number of drop-outs (planned and unplanned) broken down by therapy type 2017/18

The following Tables (3.25 – 3.34) indicate the numbers and percentages of clients with an unplanned end of therapy.

Table 3.25 Psychodynamic Therapy

Psychodynamic Therapy				
Number of Clients with Planned Ending	**Reason**	**Unplanned Ending**	**Reason**	**Dropout percentage**
1	Agreed at end of therapy	3	Client did not wish to continue	6.25%
29	Agreed during therapy	0	Due to crisis	0.00%
1	Other	1	Due to loss of contact	2.08%
14	Planned from outset	6	Other	12.50%

Total with Planned Ending	**Total with Unplanned Ending**	**Grand Total number of clients**	**Grand Total dropout**
45	10	**55**	**18.18%**

Table 3.26 EMDR

EMDR				
Number of Clients with Planned	**Reason**	**Unplanned Ending**	**Reason**	**Dropout percentage**
3	Agreed during therapy	2	Client did not wish to continue	7.69%
8	Agreed at end of therapy	1	Due to crisis	3.85%
		3	Due to loss of contact	11.54%
1	Other	**2**	Other	7.69%

Total with Planned Ending	**Total with Unplanned Ending**	**Grand Total number of clients**	**Grand Total**
12	**8**	**20**	**40.00%**

Table 3.27 Solution Focused

Solution Focused				
Number of Clients with Planned Ending	**Reason**	**Unplanned Ending**	**Reason**	**Dropout percentage**
1	Agreed at end of therapy	1	Client did not wish to continue	6.67%
		2	Other	13.33%
3	Planned from outset	**3**	Due to loss of contact	20.00%
Total with Planned Ending	**Total with Unplanned Ending**		**Grand Total number of clients**	**Grand Total dropout percentage**
4	**6**		**10**	**60.00%**

Table 3.28 Bereavement Counselling

Bereavement Counselling				
Number of Clients with Planned Ending	**Reason**	**Unplanned Ending**	**Reason**	**Dropout Percentage**
3	Agreed during therapy	2	Client did not wish to continue	10.00%
3	Planned from outset	4	Due to loss of contact	20.00%
1	Other	3	Other	15.00%
Total with Planned Ending	**Total with Unplanned Ending**		**Grand Total number of clients**	**Grand Total dropout percentage**
7	9		**16**	**56.25%**

Table 3.29 Life Coaching

Life Coaching

Number of Clients with Planned Ending	**Reason**	**Unplanned Ending**	**Reason**	**Dropout Percentage**
1	Agreed during therapy	4	Client did not wish to continue	3.60%
0	Other	1	Due to crisis	0.90%
55	Planned from outset	11	Due to loss of contact	9.91%
		5	Other	4.50%

Total with Planned Ending	**Total with Unplanned Ending**	**Grand Total number of clients**	**Grand Total dropout percentage**
56	21	**77**	**27.27%**

Table 3.30 Person Centred

Person Centred

Number of Clients with Planned Ending	**Reason**	**Unplanned Ending**	**Reason**	**Dropout percentage**
103	Agreed during therapy	50	Client did not wish to continue	14.58%
8	Other	17	Due to crisis	4.96%
57	Planned from outset	82	Due to loss of contact	23.91%
33	Agreed at end of therapy	35	Other	10.20%

Total with Planned Ending	**Total with Unplanned Ending**	**Grand Total number of clients**	**Grand Total dropout percentage**
201	184	**385**	**47.79%**

Table 3.31 CBT

CBT				
Number of Clients with Planned Ending	**Reason**	**Unplanned Ending**	**Reason**	**Dropout Percentage**
51	Agreed during therapy	18	Client did not wish to continue	15.38%
1	Other	17	Due to loss of contact	14.53%
6	Planned at end of therapy			
48	Planned from outset	6	Other	5.13%
Total with Planned Ending	**Total with Unplanned Ending**		**Grand Total number of clients**	**Grand Total dropout percentage**
106	41		**147**	**27.89%**

Table 3.32 Psychotherapy

Psychotherapy				
Number of Clients with Planned Ending	**Reason**	**Unplanned Ending**	**Reason**	**Dropout Percentage**
35	Agreed during therapy	21	Client did not wish to continue	15.44%
5	Other	7	Due to crisis	5.15%
58	Planned from outset	19	Due to loss of contact	13.97%
9	Agreed at end of therapy	5	Other	3.68%
Total with Planned Ending	**Total with Unplanned Ending**		**Grand Total number of clients**	**Grand Total dropout percentage**
107	**52**		**159**	**32.70%**

Table 3.33 Other Therapies

Other Therapies				
Number of Clients with Planned Ending	**Reason**	**Unplanned Ending**	**Reason**	**Dropout percentage**
65	Agreed during therapy	32	Client did not wish to continue	13.22%
15	Other	10	Due to crisis	4.13%
62	Planned from outset	28	Due to loss of contact	11.57%
16	Agreed at end of therapy	17	Other	7.02%

Total with Planned Ending	**Total with Unplanned Ending**	**Grand Total number of clients**	**Grand Total dropout percentage**
158	87	**245**	**35.51%**

Table 3.34 Multiple Therapies

Multiple Therapies				
Number of Clients with Planned Ending	**Reason**	**Unplanned Ending**	**Reason**	**Dropout percentage**
209	Agreed during therapy	63	Client did not wish to continue	11.52%
15	Other	14	Due to crisis	2.56%
166	Planned from outset	72	Due to loss of contact	13.16%
52	Agreed at the end of therapy	27	Other	4.94%

Total with Planned Ending	**Total with Unplanned Ending**	**Grand Total number of clients**	**Grand Total dropout percentage**
442	176	**618**	**28.48%**

Of a total of 1732 clients, 1138 (65.70%) had planned therapy endings (i.e. therapy cessation was planned from the outset of therapy, during, or at the end of therapy), and 594 (34.30%) had unplanned therapy endings (i.e. therapy cessation was due to the client no longer wishing to continue with therapy, crisis, loss of contact, or other reasons not specified).

Table 3.35: Number of clients (broken down by age and gender) completing therapy 2017/18

Age Group	Number of females clients that completed therapy	Total number of female clients	Percentage of female clients that completed therapy
18-25	55	95	57.89%
26-35	118	186	63.44%
36-45	149	220	67.73%
46-55	167	255	65.49%
56-65	117	169	69.23%
66-75	40	53	75.47%
76-85	10	11	90.91%
Total	**656**	**989**	

Age Group	Number of males clients that completed therapy	Total number of male clients	Percentage of male clients that completed therapy
0-17	1	2	50.00%
18-25	35	51	68.63%
26-35	77	135	57.04%
36-45	91	158	57.59%
46-55	135	195	69.23%
56-65	107	167	64.07%
66-75	30	34	88.24%
76-85	1	1	100.00%
Total	**476**	**743**	

When considering other factors, such as age and gender, there was little difference between the percentage of males and females completing therapy (table 3.35). For example, 656 females out of a total of 989 completed therapy (66%), compared to 476 out of a total of 743 male clients (64%). Likewise, little difference was found between the percentage of those who completed therapy in the different age categories in both the male and female subgroups. Those in the older age categories (75-86 years old) were more likely to complete therapy for both male and female subgroups. However, numbers in this age category were very small (female n=11; male n=1).

The following tables record the level of improvement for all forms of intervention (Tables 3.36 – 3.43)

Table 3.36 CBT

Row Labels	**ClinRel Improvement**	**No Reliable Improvement**	**Reliable Deterioration**	**Reliable Improvement**	**Total**
18-25	7	3	1	1	12
26-35	15	17	2	9	43
36-45	13	10		10	33
46-55	15	5	1	2	23
56-65	8	9	1	9	27
66-75	3	2		3	8
76-85	1				1
Grand Total	***64***	***46***	***5***	***34***	***149 147***

Table 3.37 EMDR

Row Labels	**ClinRel Improvement**	**No Reliable Improvement**	**Reliable Deterioration**	**Reliable Improvement**	**Total**
18-25	1				1
26-35		1			1
36-45	1	1		1	3
46-55	3	2		1	6
56-65	2	3	1	2	8
66-75		1			1
Grand Total	**7**	**8**	**1**	**4**	**20**

Table 3.38 Life Coaching

Row Labels	**ClinRel Improvement**	**No Reliable Improvement**	**Reliable Improvement**	**Total**
18-25	5	1	1	7
26-35	12	11	2	25
36-45	7	7	3	17
46-55	5	6	3	14
56-65	5	3	1	9
66-75	3	1		4
76-85		1		1
Grand Total	***37***	***30***	***10***	***77***

No Reliable Deterioration recorded for life coaching.

Table 3.39 Psychotherapy

Row Labels	**ClinRel Improvement**	**No Reliable Improvement**	**Reliable Deterioration**	**Reliable Improvement**	**Total**
18-25	5	2		2	9
26-35	18	9	1	3	31
36-45	15	11		8	34
46-55	9	15		18	42
56-65	12	19	3	6	40
66-75	1			2	3
Grand Total	***60***	***56***	***4***	***39***	***159***

Table 3.40 Solution Focused

Row Labels	**ClinRel Improvement**	**No Reliable Improvement**	**Reliable Deterioration**	**Reliable Improvement**	**Total**
18-25		1			1
36-45	2	1	1	1	5
46-55		2			2
56-65	1				1
66-75		1			1
Grand Total	***3***	***5***	***1***	***1***	***10***

Table 3.41 Person Centred

Row Labels	**ClinRel Improvement**	**No Reliable Improvement**	**Reliable Deterioration**	**Reliable Improvement**	**Total**
18-25	10	20	2	7	39
26-35	17	29	2	17	65
36-45	21	39	3	15	78
46-55	25	50	13	16	104
56-65	20	38	3	13	74
66-75	8	4	3	5	20
76-85	2	2			4
Grand Total	***103***	***182***	***26***	***73***	***384***

Table 3.42 Other

Row Labels	**ClinRel Improvement**	**No Reliable Improvement**	**Reliable Deterioration**	**Reliable Improvement**	**Total**
18-25	7	9	1	7	24
26-35	14	14	1	12	41
36-45	17	20	2	25	64
46-55	14	22	2	23	61
56-65	11	18	2	8	39
66-75	9	1		2	12
76-85	1				1
Grand Total	***73***	***84***	***8***	***77***	***242***

Table 3.43 Multiple Therapies

Row Labels	**ClinRel Improvement**	**No Reliable Improvement**	**Reliable Deterioration**	**Reliable Improvement**	**Total**
0-17	1				1
18-25	23	15	2	14	54
26-35	43	37	2	23	105
36-45	68	40	4	26	138
46-55	73	46	2	51	172
56-65	50	33	3	29	115
66-75	16	10	1	10	37
76-85	2	3			5
Grand Total	**276**	**184**	**14**	**153**	**627**

Table 3.44: Summary of clients with scores broken down by nature of trauma 2017/18

Number of Clients	**Client Circumstances**
4	Bereaved and Physically Injured
4	Carer and Bereaved
7	Carer, Physically Injured and Psychologically Injured
12	Carer, Bereaved, Physically Injured and Psychologically Injured
21	Physically Injured
19	Carer
1	Carer and Physically Injured
53	Carer and Psychologically Injured
45	Carer, Bereaved and Psychologically Injured
63	Bereaved, Physically Injured and Psychologically Injured
66	Bereaved
103	Physically Injured and Psychologically Injured
199	Bereaved and Psychologically Injured
1123	Psychological Injured
12	Unknown
1732	**Total Number of Clients**

The nature of trauma experienced by victims and survivors included psychological injuries, bereavement, and physical injuries. The majority of the sample experienced psychological injuries (n=1123), followed by bereavement, often alongside psychological and physical injuries (n=393) and physical injuries (n=211).

Table 3.45: Timeframe from trauma to treatment

Number of Clients	Time of trauma to therapy engagement
417	> 30 years
485	20 to 30 years
297	15 to 20 years
178	10 to 15 years
276	5 to 10 years
0	3 to 5 years
0	2 to 3 years
60	< 1 year
19	No data
1732	**Total**

As can be seen in Table 3.45, the length of time between trauma and engagement in psychological therapy was considerable for the majority of the sample. For example, 1653 (95%) of the sample had experienced Troubles related trauma 5 to >30 years previously. A small percentage (3%) had experienced Troubles related trauma within the previous year.

Table 3.46: Summary of symptoms experienced by clients 2017/18

Symptoms experienced by Clients	
Addictions	162
Anxiety / Stress	1434
Bereavement / Loss	594
Cognitive / learning	69
Depression	1218
Eating Disorder	55
Interpersonal Relationship	595
Living / Welfare	202
Personality Problems	68
Physical Problems	354
Psychosis	25
Self Esteem	780
Trauma / Abuse	875
Work / Academic	152

In terms of symptoms, anxiety/stress (n=1434) and depression (n=1218) were the most commonly experienced difficulties, followed by trauma/abuse (n=875), self-esteem issues (n=780), difficulties with interpersonal relationships (n=595), bereavement/loss (594), living/welfare issues (n=202), addictions (n=162), work/academic issues (n=152), cognitive/learning issues (n=69), personality problems (n=68), eating disorders (n=55) and psychosis (n=25).

3.8 Key points in relation to VSS funded organisations:

The VSS has worked hard to integrate an outcomes framework into the sector and requires measures to be used across the region. Such developments are important to help monitor the effects of various interventions in responding to the mental health needs of victims and survivors. The main measure that is used is Core-OM which is a generic tool that does not adequately capture symptom change in disorders such as PTSD or complex grief. The VSS has explained that the current scheme will develop further to include more disorder specific measures with continuous scales. Such developments will greatly assist the analysis of outcomes and help improve service developments across all sectors.

More trauma-specific measures will more accurately measure the effects of specific interventions for specific problems and conditions. Nevertheless, it is commendable and helpful to future research that the VSS has been rigorous in ensuring that therapists record treatment outcomes and organisations provide information reports regarding demographics and outcomes relating to the clients attending psychological services.

3.9 The Police Rehabilitation and Retraining Trust (PRRT)

We contacted the Police Rehab and Retraining Trust to discuss the impact of the Troubles on police personnel. The Psychological Therapies Department within the Police Rehabilitation and Retraining Trust (PRRT) was established in Northern Ireland in 1999 to provide a specialist clinical service to retired police officers who have been psychologically affected through their experiences as a serving officer. The clinical lead in the PRRT unit, explained that they are predominately a treatment team and limited in their research capacity. However, we were able to access a study that the unit conducted in 2003 of a randomly selected sample of 3000 retired officers (Black et al., 2013). The results suggested that 5 years after the ceasefires and the Good Friday Agreement, there was a considerable level of psychopathology among the retired police population of Northern Ireland. In the sample that responded (N= 972), 55% of respondents scored clinically on at least one of the clinical measures; 27% scored clinically on the of post-traumatic stress scale (the Modified PTSD Symptoms Scale-Self Report; 50% were found to have some form of depression (mild – severe ranges) on the Beck Depression Inventory (BDI) and 41% scored clinically on the General Health Questionnaire (GHQ-12). In addition, 49% of respondents reported experiencing intrusive thoughts recently and 25% of respondents viewed retirement as a trigger to their current problems.

3.10 Republic of Ireland (ROI)

Background

Primary care and mental health services in the Republic of Ireland (RoI) have a very different configuration to those in Northern Ireland. Primary care is particularly varied in how it is organised and delivered with many small practices in private premises. Some primary care services clustered in Primary Care Centres have been built by the HSE in recent years in larger towns and cities. Roughly half the population are entitled to free primary care services with the remainder paying privately for primary care services and prescriptions. Mental health services are typically funded and managed by the Health Service Executive (HSE) but services vary widely by geographical location and there has been an acknowledged under-investment in mental health services for decades.

How Psychological Therapies are provided in the Republic of Ireland (ROI)

A considerable amount of psychological therapies are provided by independent counselling and psychotherapy practitioners and services, which charge clients for treatment.

In the last 10–15 years a National Counselling Service was established to meet the needs of those impacted by abuse in residential institutions and other settings. Although this was established as a national service, many different independent agencies were commissioned to provide this service in different geographical areas and although data is available on the numbers seen there is no clear diagnostic or outcome data reported.

Psychological therapies are also provided within mental health services but the provision is characterized by very uneven availability, long waiting times and a dearth of descriptive or outcome data available. There is currently a HSE working group exploring a new Model of Care for the provision of Talking Therapies in Mental Health Services. A Collaborative Layered Care Delivery Model is anticipated with routine collection of outcome data. It is unclear when this model will be finalized, funded and implemented. At present there is also no significant integration of primary and secondary care mental health services that might allow stepped care models to evolve and be adequately supported.

How current services are evaluated - available outcome data

More recently, Counselling in Primary Care (CiPC) has been established in most areas and is run and managed by HSE. It managed 19,000 referrals in 2017 but reports on a very limited set of outcome data. Its National Evaluation Study Phase 1 (Health Service Executive/NCS Counselling in Primary

Care Service Research Group, 2018) reported data on just 122 service users and had post-therapy data available on just 54% of this sample.

The HSE reliably collects two main forms of data from mental health services

a) Hospital admission and discharge data including ICD 10 diagnosis
b) New outpatient referrals to Community Mental Health Services which is mainly focused on waiting times rather than diagnoses or outcomes.

Within this context it has been difficult to locate the numbers presenting with Troubles related problems and thus difficult to report on outcomes for individuals in the RoI that have been affected by the Troubles

Methodology for current Republic of Ireland (ROI) study

Two strands for accessing data on relation to the ROI were adopted:

1. The VSS was approached to check the proportion of psychological services accessed by residents in the ROI from VSS funded groups.

2. 20 semi-structured telephone or face-to-face interviews were organised with health professionals, specifically focusing on those working in the border counties of Louth, Monaghan, Cavan, Leitrim and Donegal. As there is a mixture of public and private mental health hospitals/services a small convenience sample of private psychiatrists or therapists were also interviewed. Consultant Psychiatrists are typically the recipients of referrals to mental health services and have a responsibility for managing overall caseloads and resource allocation within mental health teams. The majority of information about presentations to services was drawn from a sample of 10 psychiatrists currently working in or who have historically worked in the border counties.

3.11 Findings from VSS data in relation to the Republic of Ireland (ROI)

The VSS data base records country of origin but does not hold data on which county in the ROI service users reside. During the period between Mar 2019–Jan 2020, 2084 clients have engaged in psychological therapies of which only seven individuals are residing in ROI**.** An examination of historic data from mid-year 2016 to date found that 4430 individuals had accessed psychological therapies of which only fifteen resided in the ROI.

The VSS have also funded four individuals that reside in the R.O.I. to access Psychological Therapies privately through the Individual Needs Programme which launched in April 2017.

3.12 Key Findings from interviews with professionals

The consistent feedback is that they had very few, if any referrals of individuals who indicated that they were directly affected/traumatised by the Troubles. Some may have indicated that they had difficulties if they had been previously resident in NI, but they rarely spontaneously disclosed the nature of those difficulties and clinicians typically did not enquire in great detail about their specific experience of the Troubles.

There also seem to have been a small number of retired RUC and British Army members who have resettled in border areas and have presented to HSE services with anxiety, low mood, addictions and emotional dysregulation. However, clinicians indicated that this cohort generally have not linked their difficulties to specific trauma or events occurring during the Troubles in Northern Ireland.

Other health professionals interviewed include psychologists or CBT therapists who have worked in the border area for a number of years. These staff reported that in their experience it was very rare for patients/clients to link their problems to the Troubles. Despite media reports suggesting ongoing criminal activity/intimidation in border areas by newer paramilitary groupings, staff did not report treating patients/clients with paramilitary involvement or intimidated by paramilitaries.

Within the private psychiatric hospitals in Dublin, clinicians report that a small but steady number of individuals have presented over the years with psychological problems associated with the Troubles. This includes both individuals originally from Northern Ireland who resettled in ROI and individuals from border counties who have disclosed negative impacts on their lives as a result of the Troubles. The private hospitals typically provide group and individual therapies whilst individuals are in hospital with more limited inputs upon discharge from hospital. There is currently no mechanism to quantify the number of presentations linked to the Troubles over the years.

The overall lack of presentations to mental health services identified in ROI led the researcher to interview a former Clinical Lead at the NI Centre for Trauma and Transformation, about the experience of working in mental health services in Northern Ireland. This senior clinician explained that individuals who had problems associated with the Troubles similarly had not presented to local catchment area mental health services until after the specialist Omagh Trauma Centre opened. They were presumed to have done so then because there was an identified space/context for presentations linked to the impact of the Troubles.

All services identified significant numbers of now older adults who moved South in the early 1970's due to the escalation of the Troubles. This group have been in contact with services for a range of psychiatric problems but they have not specifically sought services for traumas related to the Troubles. The passage of time may mean they have more general psychological problems rather than ones specifically related to the reasons for their departure from Northern Ireland. However, the migration south at that time did often leave individuals and families more socially isolated and dislocated from extended family supports who remained in Northern Ireland. Overall this cohort did appear to be less well-integrated in their communities than local counterparts, and often struggled to retain good contact with members of their families in NI.

Contact was also made with health professionals working in An Garda Siochana (the National Police Service) and the Irish Army, where the impact of the Troubles may have been experienced during the course of their employees work.

There have been a large number of individuals in An Garda Siochana (national police force) who have had direct exposure to violence / danger associated with paramilitary & criminal activities associated with the Troubles since the outset of the Troubles to the present day. The Gardai have a private medical insurance scheme and individual members can use this to independently seek medical and psychological care. The Gardai also have sessional input from a consultant psychiatrist in their Occupational Health Department who approves referrals for counselling for occupational injuries/problems etc. The counselling occurs outside the organisation and outcome data is not collected other than their ability to return to work.

Their members are not typically accessing public health services or do not get psychological treatments within the organisation itself. The Gardai have a welfare service for current members and provide a peer support network for retired members. The latter is relatively informal and it is difficult to access information about how these services might help individuals, or the degree to which former members may have been affected by the Troubles during their working lives.

The Irish Army employ a psychiatrist with an explicit role in managing trauma related services to the armed services. There is no clearly available data on the numbers of serving members who had exposure to traumatic experiences relating to the Troubles. There was limited frontline deployment of the Irish Army during the Troubles but they did have a significant long term role in securing high security prisons where those convicted for terrorist offences were held. They also had a significant role escorting cash in transit throughout duration of the Troubles and this continues to date. Soldiers in the last few decades have not reported much impact on their lives linked to the Troubles, particularly when compared to tours of Lebanon or other UN peace-keeping missions.

3.13 Concluding Comments relating to services in the ROI

It appears that very few individuals residing in the ROI have accessed psychological trauma services in either jurisdiction in recent years or if they have done so, any links with the Northern Ireland Troubles have either not been made evident, explicit or recorded. Less triggers in terms of media coverage or reminders of the Troubles in the ROI may also help explain why less linkage is being made between enduring psychological problems and exposure to traumatic events associated with the Troubles. There may be a hidden cohort who have problems related to the Troubles and do not access any services, but at present it is difficult to quantify the presence or the needs of any such cohort.

Exploring the Experience of the Patient/Client Journey: A series of semi-structured interviews with victims and survivors

Report Number Four

Prepared for the Commission for Victims and Survivors

by Queen's University Belfast

ID 1238782

Report 4 Contents

Exploring the Experience of the Patient/Client Journey: a series of semi-structured interviews with Victims and Survivors

4.1 The Client Journey

Introduction

The aim of this qualitative part of the overall study was to seek insights from victims and survivors of the conflict who have accessed psychological therapies from organisations funded by the VSS.

Method

A semi-structured interview method was chosen to explore this research topic. The semi-structured interview questions, participant information sheet, consent form and invitation to participate can be found in appendices. The participants were recruited using purposive sampling (Sarantakos, 2005), whereby those participating were selected according to agreed criteria. The sampling frame for this selection was: 10 individuals who had experienced conflict-related trauma and attended VSS funded organisations for psychological therapy.

Participants

This study aimed to employ a stratified method; we asked three VSS funded organisations to select three service users who are no longer attending a VSS organisation for psychological therapy. In order to explore the convergences and divergences of experiences, we requested that organisations use their CORENET data to select participants based on a review of the service user's presenting problems post-treatment. Each organisation was asked to select:

a) One service user who identified on their assessment form that the severity of their presenting problems (post-treatment) was causing minimal/mild difficulty.

b) One service user who identified on their assessment form that the severity of their presenting problems (post-treatment) was causing moderate/severe difficulty.

c) One service user who had an unplanned ending to treatment.

Based on the interview findings, we believed that there were approximately, six service users selected from category 'a', three from category 'b' and one from category 'c'.

Thematic analysis

Thematic analysis was used to explore the perceptions of individuals who have been subject to conflict-related trauma and their experience of psychological therapy. Thematic analysis is widely used in qualitative studies and seen as a foundational method of qualitative analysis through the emergence of key themes (Braun and Clarke, 2006). Boyatzis (1998) confirms that this method can be used to construct meanings while also producing explorable observations.

Method of analysis

A coding structure was designed, and the data coded to anticipate emergent themes (Bazeley and Jackson, 2013). The themes and issues addressed in the interviews have been linked together under a category system (Burnard, 1991). In analysing the data patterns, differences, themes and sequences were initially identified. Collected data was then coded, conceptually organised, interrelated, analysed and evaluated. Methodological insights from Braun and Clarke (2006) and Burnard (1991) were used during open, focused and theoretical coding.

The limitations of the research

It is widely recognised that considerations of research quality, particularly in exploratory qualitative research, are essential. However, as this methodology explains, and as Oakley (2000) notes, the distinguishing mark of all 'good' research is the awareness and acknowledgement of potential error. An inherent aspect of the use of qualitative research methods which explicitly calls reliability into question is the small sampling when compared to quantitative methods. Although these narratives are illustrative of the experiences of victims and survivors, the themes that have emerged (when triangulated with other data) will potentially inform service provision and help to improve the quality of care for those who have experienced conflict-related trauma and are seeking psychological therapy.

4.2 Core themes

The core themes which were derived from the semi-structured interview questions have emerged as being relevant, in differing measures, to the interviewees. The themes will be described and explained concerning the frequency of the references to each core theme. Related parent nodes (being a methodological term used during thematical analysis) will structure and categorise the core themes, and child nodes (methodological term) will structure the subsidiary themes as below (Table 4.1). These will function as a series of subheadings under the general themes, which will aid in producing clarity and will illustrate the formation of these themes. All names presented in these findings are fictitious.

Table 4.1

Overarching Themes (Parent Nodes)	**Sub-Themes (Child nodes)**
Multiple incidents of trauma	A combination of Troubles and inter-personal traumas Childhood Trauma
Barriers to receiving/seeking psychological therapy	Lack of support post-trauma Stigma and shame Silencing the traumatic past

Symptoms of trauma	Re-experiencing Avoidance Hypervigilance Suicidal thoughts Relationship difficulties
Reflections on Psychological Therapy	Community in VSS organisations * Issues of trust in therapy Further therapy sessions A need for specialised trauma therapy A need for more strategic trauma services

NOTE

"Community in organisations" is referring to the sense of safety the participants found when availing of the services provided by VSS

A combination of Troubles and inter-personal traumas

Eight of the ten participants had direct experience of either bombings, shootings, kidnappings or interrogations. Two of those interviewed were affected as a secondary impact of a close family member being killed or were subject to a threat through an incident during the Troubles/conflict in NI. For the majority of those interviewed, there were multiple incidents and various trauma types, many of which were not related to the conflict/Troubles including inter-personal trauma such as childhood abuse and neglect.

As C10 explained:

"When I was 11 my brother was killed, I knew it wasn't an accident it was the SAS, they'd knocked him and two other fellas down, it changed everything at home. I've also been in an abusive relationship. I found that very hard to open up about when we first started talking, and there was abuse as a child, so there was a lot."

The majority of participants also mentioned the skilfulness of the therapists in helping them to work through and understand their experiences of childhood trauma. When referring to a series of traumatic events, there was an understanding that this may have affected their ability to process emotions. Traumatic experiences in childhood appeared to be disclosed to therapists as a secondary issue to Troubles/conflict related trauma for over half of the interviewees. C3 explains:

"I was reluctant; why would I need it? I've dealt with it for years now but once it started there was a lot of stuff coming out and some of it was related to my work some of it not, some of it related to childhood and that from that point I found it very beneficial."

When discussing the effect of Troubles/conflict related trauma on childhood functioning, C7 explained the physical manifestations of the trauma. As C7 explained:

"My father was 34 when he was murdered. I was 4 years old; I don't remember my father… I was around that age even when I started primary school; I remember wetting the bed, so, I must have been deeply traumatised."

Similarly, other victims and survivors of childhood trauma noted physical manifestations alongside the absence of opportunity to talk about the experience as a child. There was a sense that trauma which occurred in childhood was not a valid issue to talk about as an isolated event which delayed treatment seeking. As C6 outlines:

"Unfortunately, I fell between the cracks because of the trauma I sustained because it was childhood trauma and it was never addressed by any service at all and didn't really do anything about it to a very long time after it that I needed to get some help."

The respondents who mentioned childhood trauma appeared to have a deep awareness of the complexity associated with their experiences. Although there was mostly a deep appreciation of the work to date with the therapists, there was also evidence of the need for more support to help integrate these traumatic experiences in childhood. As C7 explains:

"When I look objectively to that child; there's some issues that were there that have been locked away and stored away… I'd need a professional to tell me, I nearly think you'd need to unlock that box; you'd need to look into all those deep held issues and reprogram and move on…"

4.3 Barriers to seeking psychological therapy

Lack of support post-trauma

None of the participants received any professional support at the time of the trauma incidents. The majority were not aware of any professional services which could have helped with processing what had happened to them. As C1, an armed-forces veteran, recalls:

"… There was 9 of us and we were blown up. No one killed. We were actually on an exercise and this particular person decided to try and get rid of us. I got no, absolutely no help. I was in the hospital for three days before my wife even knew where I was. I got no counselling at the time. I came out of the hospital on the Sunday and was told to be back on duty on the Monday morning and carried on."

Similarly, for those involved in security forces and the prison service, there was little opportunity to access professional services. As C2 recalls, it was somewhat culturally normal to suppress emotions:

"I was out working and an incident happened like one of our friends was killed and they were murdered, there was no counselling then it was back to the police club and a chat among ourselves a few drinks and then go home and plan the funeral more or less, and that's the way I was, I just bottled it and never talked."

For most of the participants the lack of support was accepted at the time as a 'normal' part of the role. Experiencing incidents of trauma were described as common happenings as C4 describes:

“Everybody has had close shaves, stones, petrol bombs. But we never got any support. If you were out at a scene and something happened, you had to be back in at 8am. There was no provision for taking time off.”

Many of the traumatic incidents that the interviewees described indicated exposure to horrific scenes. C1 describes the lack of support he experienced at that time:

“... I went back to work, never got any counselling of any kind, I didn't even know of any.”

All of the participants who served in the security forces and prison service suggested that there was a lack of sensitivity and understanding of the needs of those suffering with mental ill-health during the Troubles/conflict.' For C5 there was notable anger and frustration concerning the lack of provision:

*“I think they didn't give a f*** in the prison service if anyone was having a mental health issue it was his boilers going, he's got a boiler leak or then when you heard about someone killing themselves or attempted suicide, you would hear his boilers gone, it's officially gone.”*

4.4 Stigma and shame

There were various reasons why the time from trauma to seeking psychological help was, in all cases, over ten years. Primarily the lack of availability and stigma seemed to be significant issues which prevented active help-seeking. These are factors are not unique to the situation in Northern Ireland.

Approximately half of the participants, previous to engaging in therapy, deemed psychological support as nonsensical and had preconceptions that those offering the services would not understand what they had experienced. As C5 recalls:

“I was always of the opinion that counselling was conducted by feather merchants by people selling myths, selling nonsense, I didn't feel I needed it, I laughed off any offers of counselling. I shot down the whole idea, do you really think I'm going into a room with someone who isn't in this job, who doesn't understand this job, and spill my guts to them?”

The majority of the participants expressed feelings of embarrassment and a fear of others judging and potentially deeming them to be 'weak'. The stigma underpinned by fear appeared to be a deterring factor when it came to accessing mental health services for approximately half of those interviewed. As C2 explains:

“You had to go to see a psychiatrist for your claim, and he was a lovely wee man don't get me wrong. And it was just the experience of it all was just too much, you know how you had the stigma and I didn't realise at the time and he said I was suffering from PTSD, and I laughed and said what does he mean PTSD, but I was you know, and you laugh, but it was.”

Some participants such as C7 expressed a fear of having a diagnosis of a mental disorder:

“Daily life I sometimes suspect, I've had a bit of depression but I've never gone to the doctor as I'm scared of having that stigma attached”.

The shame and guilt experienced was particularly poignant for those whose family were affected by their involvement in The Troubles/conflict as C3 explains:

“No, you see you don’t like to, it’s the guilt, I know I nearly lost my daughter and that was hard to deal with but I didn’t and she’s still with me. Look at this one that one who’ve had something really awful happen.”

Approximately half of the participants expressed an increase in self-awareness after receiving psychological therapy. As C10 explains, being labelled as having a mental health issue is often linked to shame and leads to silence and therefore long periods between the traumatic incident and help-seeking:

“Depression was the taboo thing, you didn’t talk about it. I say now that there’s so many things I’ve learned over the years that you place your own taboo on yourself. I think even today, people still do.”

Recollections of low self-worth were evident for participants. In particular, comparison between other people’s traumatic experiences was used to prevent them seeking for help as C3 explains:

“And I just felt that I didn’t deserve it cause there was people out there that needed it more than I did but I now know that's not true.”

The majority of participants commented that the therapy they received helped with various symptoms of the trauma including anxiety, depression and anger management.

The issues reported in this section relating to stigma are unfortunately an international phenomenon. Thornicroft (2008) reported the following key factors that increasing the likelihood of avoidance or long delays before seeking treatment: lack of knowledge about the illness and treatability; ignorance about how to access assessment and treatment; prejudice against people who have mental illness; and expectations of discrimination against people who have a diagnosis of mental illness.

4.5 Silencing the traumatic past

The majority of the participants recalled a time when they felt that talking about the traumatic incidents would not help in recovery, and the “norms” of the time were not to talk about such problems:

C4 said: “*I'm a very private sort of person. I didn't like to talk about it.*”

C7 recalls: “*There was no support over the years, could you imagine raising three rowdy boys we had a good childhood. We gritted our teeth and got on with it.*”

C6 explains: “*Unfortunately we came from a family who believed you have to put on a face, a stoic one, we're survivors and we get up and get on with things. So that obviously had an effect. That caused huge issues throughout my life cause it wasn't addressed.*”

For those who experienced trauma as a child, there were misconceptions that children could recover more easily. The lack of support for familial issues was identified. C10 recollects:

“I feel as an adult, I was put in that category where it doesn't bother kids. I couldn't have got better parents but as a child there was no acknowledgement of what happened. My mum took a mental breakdown. I had went to live with one of my sisters”.

Similarly, interviewees recalled a larger socio-cultural trend that it was important not to talk about the traumatic incident, to show a stoicism; not to be seen to being affected by the conflict. C6 explains:

"The community was a very bad example of resilience; in that, this town had decided collectively that it was going to ignore or play down what had happened and show a face to the world that everything was okay and a joined up community. That was very damaging cause people have internalised a lot of stuff that they wanted to be able to say and perhaps if they had been able to say it, it would have dealt with it".

For approximately half of the participants, the lack of ability to talk about what had happened was further augmented by unhelpful past experiences with previous therapists. For various reasons and in many cases, it was deemed a waste of time. As C5 explains:

*"… they were never going to help me, cause I wouldn't have admitted weakness, I got talking to one guy and I thought this is a f****** waste of time and what's worse you're f******wasting mine".*

Participants who were in the security forces or prison service explained that they felt it was hard for others to understand the relentless and enduring nature of the traumas they experienced through the Troubles/conflict. C5 explained:

"It's hard for people to understand… I stuck it out and I stuck it out and thought you're not going to harden me, I'll harden them. I thought it was going over the top of my head but it wasn't".

Almost all of the participants presented a stoical front, despite the physical and emotional pain inflicted by the traumas of the past. C2 illustrates:

"*…you know I wouldn't take my crutches. I was up them stairs with a broken foot, they were saying why wouldn't you take your chair why wouldn't you do that? I says naw if the wife saw me or nobody near me I'd use them but naw maybe someday I'll get over it".*

The majority didn't see themselves as a victim as this would be considered an admission of weakness, as C4 explains:

"I never saw myself as a victim I just accepted what I had. There's a lot have self-pity, but I don't."

One participant expressed concern over the definition of victim and expressed a need to redefine the categorization:

"I think the help that is available is diluted given the fact that there is a wide definition of victim. I don't even think that the people who really need the help don't get it just cause it's so widely spread. That's where I see it."

Irrespective of the terminology, the majority suggested that their experience of psychological therapy helped manage the feelings associated with their traumatic experiences. As C6 explains:

"I still think I would like to talk about the trauma, but I don't carry that feeling of being a victim with me every day."

4.6 Symptoms of trauma

Re-experiencing

Nightmares were the most common symptom referred to by the interviewees. C5 describes his experience:

"I'd noticed that most of my problems occur at night either during sleep or in between sleep and the best way I could describe them it's like dreaming on HD, I'm dreaming of dead people, I'm interacting with dead people which is so weird. A lot of these people I avoided them like the plague when I knew them whether friends or colleagues not just talking about prisoners who have a grisly end and I said the fact that I'm interacting with these people."

Similarly, C8 describes the intensity of the physical manifestation of the nightmares:

"The nightmares were wrecking me, I was waking up, I was getting up during the night I was sweating and shaking that fella was with me and he was screaming like a pig, I am having nightmares about me behind the wall and them shooting at me."

Flashbacks also were referred to by over half of those who were interviewed. C4 explains:

"I still have enough scenes in my mind to get flashbacks of them and if you go to Belfast or you go to some places you still get flashbacks and it comes back to you, I was in Belfast a couple of weeks ago and you know it all just came back."

Reactivity stimulated by an intense fear was the predominant manifestation of traumatic memories. As C8 recalls:

"You know what I mean, things that happened to me as a young lad, anytime I go near certain areas that kicks it all off again."

The therapy received by those interviewed appeared to help approximately half of those who referred to nightmares. C8 described his therapist helping him to take the role of an observer in the dreams he comments:

"I never had another one after that. They've all stopped".

C6 also commented on the effects of counselling on nightmares; however, she also referred to needing further help:

"I'm not waking up in the middle of the night with all those living nightmares, that has been a very positive experience, but I still think there's more to do. And I don't know where to go to get that help".

Similarly, C5 suggested that although the therapy had helped there is still more work to be done:

"Oh yeah but it hasn't stopped the dreams, it has altered the frequency of the dreams".

Avoidance

Avoidance of triggering factors such as television programmes, listening to the news and going to specific locations or amongst crowds appeared to be a default position for the majority to help manage the symptoms. C8 recalls:

"When you're sitting in the house with the family and something comes on the news, and then I start thinking I always get up and get out of the room."

Similarly, C5 explained:

"I now don't do things I used to do, don't read the Sunday papers any more cause it's looking at all these tramps you used to lock up and I don't watch documentaries about 'The Troubles' cause again you're seeing people I know of."

For half of the participants there are still geographical areas which are avoided because of the memories and feelings this evokes, C4 explains:

"I still search the car every morning, areas I don't go, don't really tell anybody what I do cause we've seen how bad it is when people get blown up and shot."

Humour was used as an avoidance technique used to protect oneself against feeling the emotional impact of the trauma, this was especially evident amongst those in the security forces and prison service as C1 recalls:

"*…you just get up and get on with it, it was there but you laughed about it. You thought you were letting yourself down you thought you were letting your mates down if you were to talk about the nightmares, so you just worked at doing what you do every day."*

Post-therapy approximately, a third of the victims and survivors noted an awareness of their past avoidance of the horror of their experiences. C9 illustrates:

"At that time, it didn't bother me I thought I was a real Jack the lad you know saying to my mates' aw they tried to do me in last night again'. I lived in an interface area you know but in later years it seemed to have an effect on me as to how close I came to losing my life and things in life that you know."

Hypervigilance

The majority of victims and survivors interviewed noted a hypervigilance which, despite the positive effects of therapy, is still present. C9 explains that because there was such a need to be alert and conscious of threat through the Troubles/conflict that this is ingrained and something which is still present:

" *…in regards to sitting and being vigilant and all, it's obviously because of the Troubles, but you know we grew up being vigilant, maybe people who were directly in a situation where the Troubles were, where I was you had to be, I still have it."*

C5 also explains the nature of the work the nature of the individuals the security forces and prison service were interacting with:

"I never would have assumed I was threat-free, I still don't assume I'm threat free."

For most of the interviewees, there was evidence of a continual threat and by consequence they spoke of a necessity to be reactive and defensive caused by surviving through years of conflict, C8 recalls:

"…they came out 6 or 7 of them round me… it was getting to me, it was getting to me, it was wrecking my head, but I never let them beat me".

The effects of the Troubles/conflict appeared to be an influencing factor on polarised thought patterns for most of those interviewed as C5's comment illustrates:

"I don't feel under threat cause you know I'm a big fella but I do believe in score-settling. I do believe any number of them would love to settle the score with me, but you know I was forced to work with them."

The sense of vigilance because of being under threat despite the conflict being over is a very real issue for the majority of those who were interviewed. C9 explains:

"You're always on edge, if I go to a restaurant or bar I go to the far corner. If I go to buy a pair of trousers I won't go into the changing rooms I always have this fear, for my safety. That's always on my mind."

Suicidal Thoughts

Almost all of the interviewees referred to the time of help-seeking recalling a sense of urgency and deep distress and all commended the VSS organisations for their approachability, ease of access and the rapid response when being appointed a therapist. C8 recalled:

"I can't even remember driving to it and next thing I just broke and they say men aren't supposed to cry but I broke down and I cried."

Suicidal thoughts were prevalent for approximately a third of the interviewees C2 recalls his experience of being at his lowest point:

"I was sitting in the house, and I poured Bacardi down my neck, and I put the revolver in my mouth, and I don't know what the hell then, I called 999 and the police came and I said take that there out of the house I don't want to see that again. Then they stayed with me for a few hours, and then I fell asleep and no one came round after to check and see if I was alright… I never saw a sinner."

The lack of trauma awareness and empathy increased distress in previous help-seeking experiences for approximately half of those interviewed. C10 explained his experience of speaking to a health professional about insomnia he was experiencing:

"I'd slept with a bottle of tablets wanting to end this, not knowing what was wrong. He said what was in it, I said diazepam, he said you should have took them you'd have got a sleep. I remember thinking, I'm here because I'm feeling low and suicidal I'm not here cause I'm stupid".

Although the majority of the interviewees did not refer to suicide attempts or feeling suicidal; most commented on suicide concerning a sense of urgency and a need to be treated when help-seeking. C1 explains:

“I never at any time thought about taking my own life I never thought about it. But if you had to wait that length of time it could be too late.”

Approximately half mentioned suicide in the context of past work colleagues or friends who had experienced trauma through 'The Troubles'. C5 recalls:

“I can remember that either had very close involvement with or used to work with and then they went off the rails for some reason, that's the bit I feel really sad about, but I think of the folk who never made it who never got to have a retirement, it is painful to think about.”

Relationship difficulties

The majority of the interviewees commented on how living through The Troubles/conflict impacted relationships and how it affected their family. C5 recalled:

“I didn't think it did, but now that my kids are adults, I know it did”.

Similarly, C8 explained:

“…they were going to try to shoot me… it wasn't the scariest one but it was because my child my daughter and my wife could have been involved”.

Approximately half commented on how the therapy has helped improve their relationships through improved communication. C8 explains:

“The wife and me seem to get on more, cause I was feeling it inside and I was a wee bit quick with her cause I wasn't saying it and that wasn't right, you know what I mean? Being hard on the wife, now she knows what I went through and she can help me out”.

C2 explained:

“My other half there would say have you seen that fella in [VSS organisation] later, you know I never even told her I was going, you know and she was like 'what are you at, are you on something?' You're in good form; whatever it is you're doing keep it up”.

However, most of the interviewees spoke about the need to access further support to help with relationship issues exacerbated by symptoms they were still experiencing.

4.7 Reflections on Psychological Therapy

Community in organisations

As explained earlier, the subtheme of ‘community in organisations’ is referring to the sense of safety the participants found when availing of the services provided by the VSS.

The majority of participants expressed deep gratitude for the opportunity to talk openly about their experiences in a safe space as C1 explains:

“She was very, very good, she was very easy to talk to, she made you feel at ease, you are more or less relaxed and were able to talk to her easily about what happened”.

Over half of those who availed of the psychological therapies provided by VSS funded organisations suggested that they also found a sense of safety in the community aspect of the organisations. C10 explains:

“I came in very tender, a very dark place just asking for help. I think it was the best thing that I've done in regards to taking care of my mental health. That's the thing here it's a very friendly atmosphere, and that's the thing, like in the art classes, sometimes people talk about their circumstances sometimes people talk about the weather, sometimes we do nothing but drink tea or coffee, I've found it very helpful”.

Finding a sense of community to cope with the effects of the trauma was apparent especially among those who were former or presently serving in the security forces and the prison service.

Issues of trust in therapy

The importance of being mindful of the context of a divided society was referred to by the majority of interviewees. Again, the theme of safety and trust was particularly important in therapy and was deemed to be a result of The Troubles/conflict in Northern Ireland. C3 explained her experience of accessing therapy, and despite the competency of the therapist, she had difficulties with feeling safe enough to share her story:

“…it's very difficult for us in such a closed society to open up cause it's always in the back of your mind and it's something ingrained are they Catholics or Protestants … the other one I went to she was excellent, that was through [VSS organisation] she was very good, but at the bottom of it … when I heard this woman was from a certain area, I'd no idea of her religious beliefs, it's so silly but I couldn't let go and that's what you're dealing with over here it's not just your straightforward counselling that you'd be dealing with in England or over there.”

Similarly, C2 explains the unique nature of help-seeking in Northern Ireland, explaining that in certain areas it’s difficult to feel safe and having a therapist from the same background increases a sense of safety:

“…there are therapies but there's no places for me to go… I don't think there should be separate places to go. I opened up with my therapist cause I felt safe.”

In reference to referrals, the lack of sensitivity to the traumatic background also presented as an issue for one interviewee as C9 explained:

“He should have had more insight there he should have thought more about who he's going to send me to rather than he'll do rightly.”

One interviewee suggested receiving therapy outside of a Northern Irish setting would be a helpful way of managing the issues related to this, C4 comments:

“…probably take somebody out of NI and interview them somewhere else if you take somebody out of that it might be a lot easier.”

Number of therapy sessions

There was a wide variation in the participant's perception of the number therapy sessions received. The timeframe for therapeutic input was mentioned by almost all the participants as C6 mentions:

"Knowing that you only have 6-8 sessions of treatment does invariably add a little bit of pressure, in a good way you know you need to address things in a very streamlined way and get through them but in a bad way once you know that door is closed and you're on your own and that's quite frightening."

In regard to the duration of the therapy, the majority of those who had under twenty sessions had a desire for further therapy. The majority of the interviewees positively described a period of stabilisation. C2 explains:

"It was unreal. The first sessions was really just a getting to know feeling it was really good and relaxed, I'd say after the third or fourth I was in a better place, a hell of a better place you know after. To me it seemed a bit short after all the sessions were done. I thought I wasn't, I thought there was more."

Similarly, C5 explained his feelings at the end of most sessions:

"I felt myself coming-out of the chair and feeling there's more. I think it should have went on longer."

The standard duration of therapeutic input was deemed too short by almost all the interviewees. C10 comments:

"In the Health Service you would definitely need to be seen or something implemented into the care packages much quicker. It certainly needs to be longer than six-eight weeks. I mean all the counselling type therapies, they were all very good but there needs to be something more sustained, a steady thing."

There was a desire for further therapy among all the interviewees and a sense of not having explored in as much a depth as is necessary. C6 comments:

"I still feel there's more I want to do but I don't know how to do it myself, suppose in that respect I would like that opportunity to see someone on a yearly basis in a safe environment, and that's what I felt I had in those sessions."

The need for specialist trauma therapy

Like the majority of the participants, C10 expressed that the counselling helped to provide coping techniques to manage the symptoms:

"… there's no medicine that's going to take 100% of the pain away, it allows room for the pain to be there. It gives you coping techniques that you didn't have before".

However, the majority of those interviewed who had engaged in therapy were not aware of any of the different types of therapy available through the VSS and all received counselling. As C2 outlines:

"You know when you said those other therapies, I didn't even know what you were talking about that's like double Dutch, the only therapy I've had was talking to that fella in the VSS organisation, I don't even know if those other therapies would be good. Are they offered through the VSS?"

In relation to the different types of therapies, C7 suggested that a potentially different approach may be helpful to ensure that all victims and survivors are fully aware of the VSS screening, assessment process and treatment recommendations:

“I wasn't aware there were different types until you mentioned that so you mentioned psychotherapy and different things. If there's different types of therapies, it would be nice to be able to identify exactly what's needed and then you're set for success rather than failure”.

Almost all reported that the therapy was helpful in reducing symptoms of Troubles/conflict related trauma. C10 explained:

“It was very good, it wouldn't matter who is on the other side of the table they're not going to get everything 100%, but I was more than quite happy”.

Amongst all participants, there was a sense of gratitude for the opportunity of help as C4 explains:

“… it was therapeutic and cathartic for me”.

One of the participants did not deem the therapy to be helpful for him personally, however, he was grateful for the availability of the service.

A need for more strategic trauma services

The majority of participants were disappointed in the care they received from the Health Service, and an overarching theme that emerged was that there is a need for a more specialised service to care for those who have experienced conflict/Troubles-related trauma. As C4 explains:

“As regards to the actual physical injury that was fine, but for mental I wasn't offered anything that's the problem, you can deal with this physically that's fine but mentally there's no provision”.

Interactions with the Health Service primarily appeared to augment the feelings of distress for the majority of victims and survivors as C2 explains:

“I wasn't feeling 100% for years and every time I went to the health professional it was just, it's good to talk to somebody, I was like "who?" "Well you're bound to have somebody at home you could talk to" and I left it at that.”

For approximately half of the interviewees, the stigma of going to a recognised location for treatment or assessment of mental health issues was also deemed as a barrier to care combined with the fear of labelling as C5 explains:

“I wasn't impressed when I got to meet this woman and I thought, I'd a cousin who actually worked in that hospital, and I thought I don't want to go there she's going to tell the family I'm a nutter or something. I thought it was an acknowledgement of weakness to go to therapy or something like that”.

Approximately half of interviewees expressed a need for some other environment which is more specialised for conflict-related trauma. C2 explains:

“If you're walking through and you're going down to such and such a clinic you know he's you know? I'm sure people aren't saying it, but you know if there was somewhere like a centre to go.”

Again, more rigorous trauma screening, systematic care and prioritising the varying needs of victims was suggested as C7 comments:

“I think a really good set of processes and governance around the initial meetings with the individuals where you're able to identify the needs at the start, people have different needs. And if

you're able to get a nice bit of processing governance at the start that would probably define what type of counselling needs to be made available…There's got to be a priority a structure set up… somebody actively looking at the victims, and prioritising who needs what."

The main limitations of the study were:

1. The small sample size (N=10).
2. The sample was not representative:

- only three VSS funded organisations were involved.
- the proposed sampling frame was not adhered to – only 1 service user had an unplanned ending to treatment
- the majority (6) were in the category indicating that the severity of their presenting problems (post-treatment) was causing minimal/mild difficulty.

It is important to remember that the interviewees' narratives have provided accounts from their own point of view. However, these findings must be interpreted with caution as the interviewees may not have grasped the various approaches or may not have recalled their therapist describing other approaches prior to the commencement of their therapy sessions. Nevertheless, whilst acknowledging that there can be no single correct interpretation of qualitative data, this does not preclude evidence of quality and rigour.

Validity in qualitative research is premised on a declaration of epistemological and methodological assumptions as providing means for evaluation (Silverman, 2016), all of which we have sought to provide. The triangulation of the data with existing literature and quantitative data are important methods to interpret the findings. Guest et al. (2011) suggest that "using verbatim quotes increases the validity of findings by directly connecting the researcher's interpretations with what participants actually said"; thus we have included verbatim quotes throughout this section.

Although there are limitations to this research methodology we have endeavoured to be rigorous, accurate and thorough in capturing the multifacetedness of the experiences of those who have experienced conflict-related trauma.

4.8 Concluding comments

This qualitative thematic analysis from this small sample generally yielded positive findings supporting the role of the organisations providing therapeutic input, community support and promoting recovery from Troubles/conflict-related trauma. The majority of participants experienced multiple incidents of trauma and reported co-morbid symptoms of anxiety and depression. Almost half of the participants mentioned co-morbid depression and anxiety consistent with research that individuals who have experienced traumatic events are more likely to have symptoms of one or more mood (e.g. depression), anxiety or substance use disorders. (Helzer et al., 1987; Davidson et al., 1991; Breslau et al., 1991; Kessler et al., 1995; Breslau et al., 1997; Perkonigg et al., 2000; Creamer et al., 2001). Kessler et al. (1995) indicate that 88.3% of men and 79% of women with PTSD had a history of at least one other lifetime disorder.

The disclosure of multiple incidents of inter-personal trauma for some participants suggests that a proportion of those presenting to VSS organisations may have more complex traumatic histories, which may in part explain why more extended periods of therapy interventions are recorded.

However, to effectively treat those who have presented with symptoms of probable PTSD, it is apparent that more rigorous trauma screening/assessment would be important if indicated. This is not to infer a failure in treatment, but that the majority found it helpful and wanted more. As recommended in the reviews in a previous section of this study and in established treatment guidelines, these individuals should have access to evidence-based treatments such as EMDR or TF-CBT (NICE, 2018) for the recommended durations of therapy.

As a result of therapeutic input from the organisations the majority of participants reported greater resilience. However, although the majority of those interviewed suggested that counselling helped with the symptoms giving a safe space to talk about their experiences of conflict, almost all suggested that they would require more psychological therapy to recover from ongoing symptoms (especially avoidance, re-experiencing and hypervigilance).

Surveys and Interviews with Service Providers

Section 1 - A Survey of VSS funded organisations providing talking therapies and Health & Social Care Trusts on Current Service Provision

Section 2 - Focus Groups and Interviews with individual staff members from VSS funded organisations and Health & Social Care Trusts Mental Health Services

Report Number Five

Prepared for the Commission for Victims and Survivors
by Queen's University Belfast

ID 1238782

Report 5 Contents

Section One: A Survey of VSS funded groups providing talking therapies and Health & Social Care Trusts on Current Service Provision

5.1 Introduction

The next sections of the study sought to identify strengths and any gaps in psychological service provision for victims of the Troubles within the statutory and non-statutory sectors.

This section will present the findings from a survey to map existing trauma-related psychological therapy service provision in Northern Ireland and the Border Region of Ireland.

5.2 Survey mapping of existing trauma-related psychological therapy services

5.2.1 Primary Aim

The survey was designed to gather information on the current provision of psychological services to victims and survivors across both statutory and non-statutory services over a one-year period – 2017-2018.

5.2.2 Methodology

Participants

The survey was distributed to 21 VSS funded groups that were registered as providing talking therapies and to all 5 HSC Trusts in Northern Ireland. Exploratory discussions with Senior clinicians in the ROI concluded that no details indicating whether a mental health problem was related to a Troubles event were systematically recorded on any HSE database. In addition, outcome measures were not yet systematically used in mental health services, therefore surveys were not distributed to HSE leads in the ROI.

Survey Instrument

Development of the survey tool was informed by mental health leads in both the statutory and non-statutory sector. In December 2018, our research team attended two VSS Practitioner Working Group meetings for all VSS funded organisations who deliver counselling and psychological therapies, to explain the project's aims and process.

This project was explained as a potentially key step to decide the best approach to organise mental health services. An approach that is inclusive of primary, community and hospital services, and to help develop a streamlined care pathway of mental health services for survivors of the conflict in Northern Ireland and the Border Regions.

5.2.3 Survey Design

The survey aimed to capture the following information:

1. Whether the Trust/VSS organisation had a dedicated psychological trauma service/team.
2. If no to Q (1) above, how were psychological trauma services provided to people who have experienced Troubles related mental health problems and if there was a mechanism for identifying such cases.
3. The number of individuals/families seen with PTSD and related disorders, and the percentage who were seen for Troubles-related PTSD and related disorders over a one-year period; 2017-2018.
4. The number and percentage who had a diagnosis of PTSD, substance abuse, self-harm/suicide.
5. The type of treatment approach(es) used.
6. Staff profile, including the total numbers of therapists employed, and their professional background.
7. How often patients/clients seen, referral agency, and average waiting time from referral to treatment.
8. Whether the Trust/VSS organisation routinely collect information on people who have experienced Troubles-related PTSD and related disorders, and if so, what information is collected.
9. Whether the Trust/VSS Organisation routinely collect mental health outcome data, and if so, how.
10. Specific to HSCTs - How the needs of patients/clients exposed to Troubles-related PTSD and related disorders are addressed within existing policies/protocols.
11. Specific to VSS Organisations – how the mental health needs of victims and survivors are met by the organization by methods other than talking therapies.

The opportunity was also provided in the survey for the HSCTs/VSS organisations to note any additional information that may be relevant to the advancement of psychological services for victims and survivors.

5.2.4 Data Analysis

Survey data were collated and analysed using descriptive statistics and content analysis to identify key themes in relation to the provision of care, specifically description and identification of differences between mental health services across HSCTs and the community and voluntary sector in Northern Ireland.

5.2.5 Responses

The survey was distributed to all groups funded by the VSS to provide talking therapies and to all 5 HSC Trusts.

- All five HSC Trusts and the 21 groups identified by VSS responded to the questionnaire.
- One trust returned a partially completed survey, because the CORE Net system was undergoing development, and therefore could not access all the required data.
- Four HSCTs returned fully completed surveys.

5.3 Results

5.3.1 Psychological service provision for victims and survivors

Two HSCTs had specialist Troubles-related psychological trauma services, and as such completed the survey for this specific service rather than the generic psychological services. At the time of this study a dedicated Troubles-related trauma service for victims and survivors had been in existence in the Southern HSC Trust for 13 years and a dedicated Centre for victims and survivors had existed for 15 years in the Belfast HSC Trust. The remaining 3 Trusts provided data from their Adult Psychological Therapy Services (APTS) which provide therapy for adults presenting with all types of mental health conditions. All 21 VSS funded organisations provided talking therapies. The length of time since formation for the VSS funded groups ranged from 4 to 30 years.

In Table 5.1, an outline is presented across both statutory and non-statutory services in relation to the number of trauma patients/clients in general, and those presenting with Troubles-related trauma. However, this is not a complete estimate of victims treated within statutory services, as one Trust was unable to provide complete data as explained above, and one Trust had no mechanism in place to routinely collect data in relation to Troubles-related PTSD and were therefore unable to answer a number of questions.

The three HSCTs that did not have a dedicated psychological service/team received referrals for Troubles related trauma from GPs and Secondary Care Professionals to Mental Health, Clinical Psychology and Adult Psychological Therapies Services.

In relation to a specific diagnosis, the figures in Table 5.1 are based on those data provided by the two specialist Troubles related trauma services in two trusts, and as such do not provide a true representation of patient demand across all five HSCTs.

Obtaining accurate figures for these specific diagnoses was also problematic in the non-statutory sector because the CORE Net system does not include disorder-specific measures. As a result, of the 17 organisations providing psychological trauma service/team, only 14 provided figures for PTSD, 13 provided figures for Substance Use Disorder, and 15 provided figures for self-harm/suicide.

Table 5.1: Psychological service provision for victims and survivors: service profile and patient/client demand 2017-2018

	*HSCTs Step 3-5	VSS organisations Step 1-2/3
Number with dedicated Troubles related psychological trauma service	2	17
Number of trauma patients/clients	1,178	8,971
Number with troubles related trauma	412 (35%)	8,971
PTSD Diagnosis	355 (86%)	*420 (5%)
Substance Use Disorder	261 (63%)	*617 (7%)
Self-harm/suicide	169 (41%)	*909 (10%)

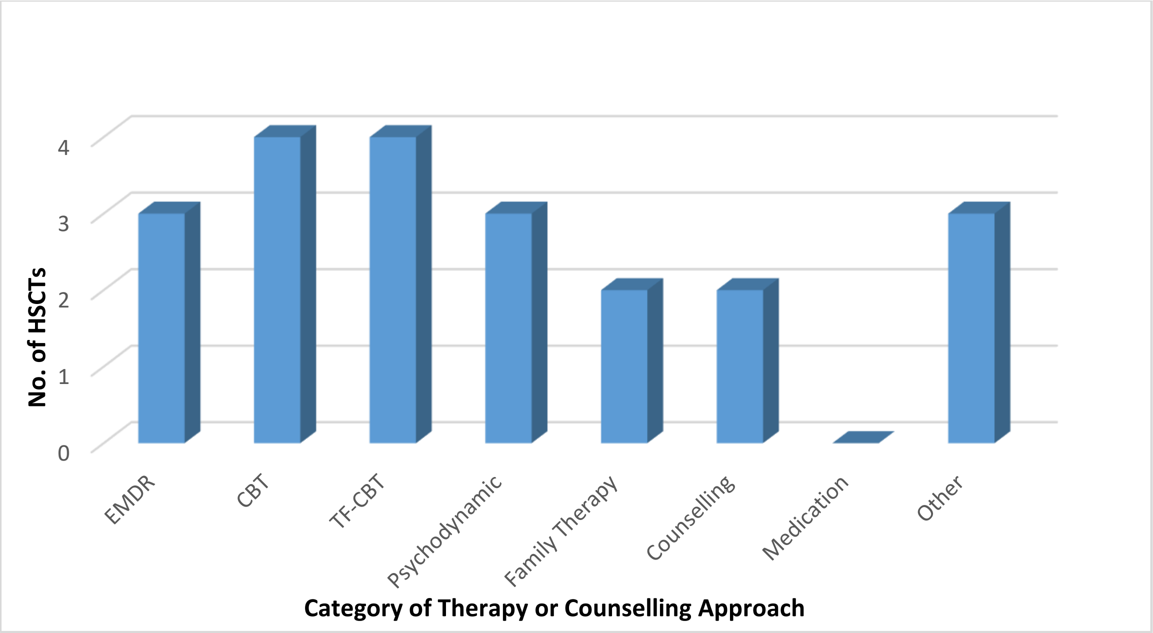
**Note:* *this Table includes only HSCT data provided by 2 dedicated Trauma Centres (Belfast HSCT and SHSCT)*

A higher proportion of those treated for Troubles related traumas in the statutory sector services met criteria for specific disorders compared to the non-statutory sector (PTSD – ratio 17:1) (substance abuse - ratio 9:1). The statutory sector Troubles-related traumas also reported higher levels of self-harm and suicidal risk (Ratio 4:1).

5.3.2 Type of Psychological Therapies provided

In relation to the types of psychological therapy or counselling delivered by the four HSCTs that provided data for this section of the survey, the most commonly cited approaches used were Cognitive Behavioural Therapy (CBT) and Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), followed by Eye Movement and Desensitisation Reprogramming (EMDR) and Psychodynamic therapy. The least common approaches provided were Family Therapy and Counselling. Three HSCTs reported provision of a wide range of other types of therapy including the following: a phased approach using most therapeutic approaches in an integrative way that also includes body orientated psychotherapy; Schema Therapy; Acceptance and Commitment Therapy (ACT); Compassion-focused therapy (CFT); Brief dynamic interpersonal therapy; Counselling for depression; Interpersonal Psychotherapy; Couple therapy for depression; Person-Centred (humanistic therapy); Solution-focused, Behavioural Activation; Cognitive Analytic, Art Psychotherapies; Mindfulness Based Cognitive Therapy (MBCT); Dialectical Behaviour Therapy (DBT); and Problem-Solving Therapy. In the Chart 5.1 below the main types of therapies being delivered are presented.

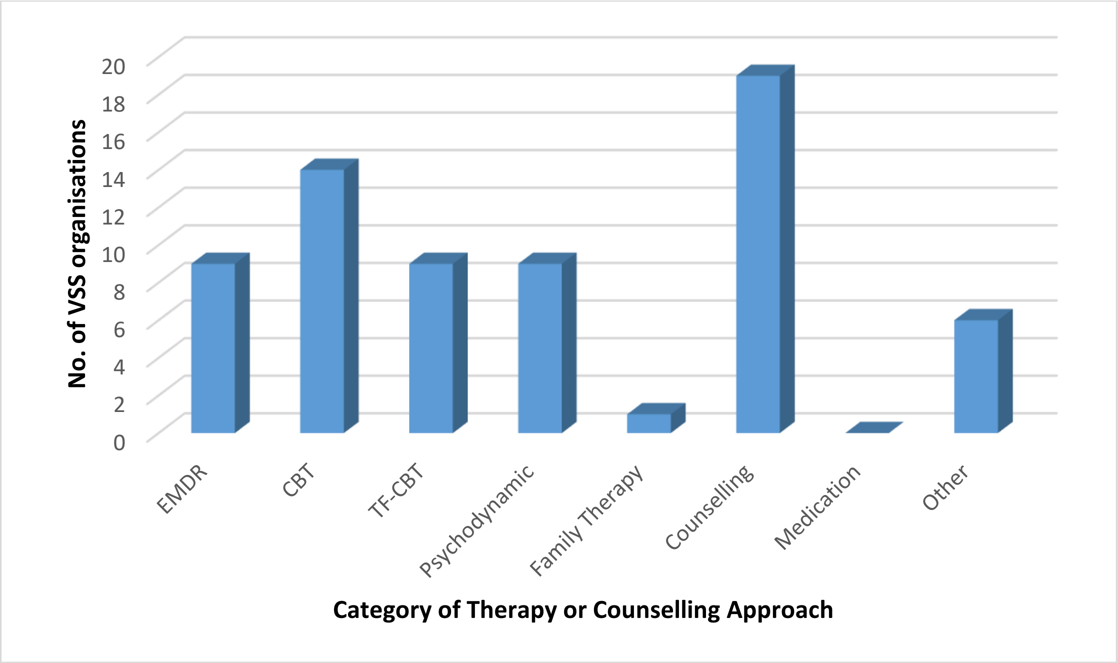
Figure 5.1: Broad categories of therapy or counselling approaches provided by four HSCTs during 2017-2018



In relation to the types of psychological therapy or counselling approaches provided by the 21 VSS funded organisations, the most commonly cited approach used was Counselling, followed by Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR). The least common approach adopted was Family Therapy. A small number of other approaches were reportedly used by six VSS funded organisations, including Child Therapy (n=2), Low intensity CBT (n=1), Person-Centred therapy (n=2), Solution Focused Therapy (n=2), Psychotherapy (n=1) and Grief Counselling (n=1).

One organisation preferred not to use the term ‘treatment’ because the respondent stated that the term medicalises and “pathologises” an area of support that can incorporate a variety of different approaches in terms of trauma recovery. The respondent stated that Counsellors/Psychotherapists employed by the group adopt a ‘person-centred’ approach to include various therapeutic approaches. In Figure 5.2 the types of therapies being delivered are presented.

Figure 5.2: Categories of therapy or counselling approaches provided by VSS funded organisations during 2017-2018



All VSS funded organisations reported providing other types of service in addition to talking therapies, highlighting the wide diversity of wrap-around care provided to victims and survivors in the non-statutory sector. These services ranged from complementary therapies, personal and professional development, to drop-in services, suggesting ongoing support in the community. In Table 5.2 the types of additional/complementary services provided by the VSS funded organisations are listed

Table 5.2: Other services provided by VSS organisations during 2017-2018

VSS Funded Organisation	Additional/complementary services .
VSS 1	Complementary Therapies; Personal and Professional Development skills and/or wellbeing.
VSS 2	Awareness-raising programmes.
VSS 3	Classes; Complementary Therapies; Life Coaching; Truth, Justice and Acknowledgement activities.
VSS 4	Complementary Therapies; Personal and Professional Development skills and/or wellbeing.
VSS 5	Psycho-social support.
VSS 6	Complementary Therapies; Welfare Advice.
VSS 7	Complementary Therapies; Drop-In (people can drop in without appointment for information and advice).
VSS 8	Complementary Therapies; Psychosocial support.
VSS 9	Complementary Therapy provision in partnership with another organisation.
VSS 10	Advocacy Support; Befriending; Classes; Complementary Therapies; Drop-In (people can drop in without appointment for information and advice) Personal and Professional Development skills and/or wellbeing; Remembrance and Commemoration Activities; Respite Activities Truth, Justice and Acknowledgement activities; Welfare Advice; Youth Services.
VSS 11	Classes; Drop-In (people can drop in without appointment for information and advice); Personal and Professional Development

	skills and/or wellbeing; Youth Services.
VSS 12	Classes; Drop-In (people can drop in without appointment for information and advice); Personal and Professional Development skills and/or wellbeing; Remembrance and Commemoration Activities; Respite Activities; welfare Advice.
VSS 13	Crisis weekend intervention service for anyone who is experiencing emotional distress that presents some form of risk – provided with either face to face and/or telephone support.
VSS 14	Youth Services.
VSS 15	Classes; Complementary Therapies; Drop-In (people can drop in without appointment for information and advice); Personal and Professional Development skills and/or wellbeing; Respite Activities; Truth, Justice and Acknowledgement activities; Welfare Advice; Youth Services.
VSS 16	Advocacy Support; Befriending; Complementary Therapies; Truth, Justice and Acknowledgement activities; Welfare Advice
VSS 17	Advocacy Support; Befriending; Classes; Complementary Therapies; Drop-In (people can drop in without appointment for information and advice); Personal and Professional Development skills and/or wellbeing; Remembrance and Commemoration Activities; Respite Activities; Truth, Justice and Acknowledgement activities; Welfare Advice; Youth Services.
VSS 18	Advocacy Support; Classes; Complementary Therapies; Drop-In (people can drop in without appointment for information and advice); Personal and Professional Development skills and/or wellbeing; Remembrance and Commemoration Activities; Respite Activities; Welfare Advice.
VSS 19	Personal and professional development; Educational workshops and seminars Complementary therapy skills workshops (e.g. Energy healing, Emotional Freedom Technique (EFT); Complementary therapies; Art therapy; Self-help lending library; Community events; Historical Field Trip; Reconciliation focused

	history of UK and Ireland series; Fairs and fundraisers.
VSS 20	Advocacy Support; Befriending Classes; Complementary Therapies; Personal and Professional Development skills and/or wellbeing.
VSS 21	Advocacy Support; Befriending; Classes; Complementary Therapies; Personal and Professional Development skills and/or wellbeing; Welfare Advice; Youth Services

5.3.3 Staff Profile

The number of staff employed within the two HSCT specialist troubles related trauma services and the number of staff employed by Adult Psychological Therapy Service (APTS) within the 3 other Trusts is reported in tables 5.3 and 5.4 below.

Table 5.3: Number of staff within HSCTs specialist troubles related trauma services during 2017-2018

HSCTs specialist troubles related trauma services	Number of staff
Southern HSCT	2
Belfast HSCT	8 (not including Family Trauma Centre)

Table 5.4: Number of staff within HSCTs General Adult Psychological Therapy Services during 2017-2018

HSCTs General Adult Psychological Therapy Services	Number of staff
Northern HSCT	39.4 WTE (whole time equivalent)
Western HSCT	29 WTE
South Eastern HSCT	21.1 WTE

In Table 5.3 and Table 5.6 the number of HSCTs Staff broken down by Professional Background and employed on a full-time/part-time basis during 2017-2018 are presented. The most commonly cited professions across the HSCTs Adult Psychological Services and the two specialist troubles related trauma services were CBT Therapists (n=43) (82.5% full-time) and Clinical Psychologists (n=40) (75% full time). Other forms of psychotherapy made up a small proportion of the overall staffing compliment.

None of the HSCT services reported inputs from psychiatrists or mental health nurses other than those employed as CBT therapists. Three trusts reported having other inputs, including Sessional Counsellors; Honorary placements for part-time counsellors and students; two Counselling psychologists (1 full-time,1 part-time); and four full-time assistant/associate psychologists.

5.3.4 Staff profile of the Specialist Trauma Services

The three specialist trauma specific units were of particular interest to this study.

- Unfortunately, no responses or data were provided to the research team by the Belfast based Family Trauma Centre
- The North Belfast Trauma Resource Centre (Table 5.6) reported that the majority of staff were employed /described as counsellors, with no staff employed specifically as psychological/CBT therapist. Two staff were seconded on accredited CBT training courses but continued to be employed as generic counsellors. The Trauma Resource Centre also employed a full-time Occupational Therapist and a Part-time Physiotherapist.
- The SHSCT trauma team was comprised of CBT staff, some of whom have had additional training on TF-CBT on the MSC Specialist Programme at Queen’s University.

Table 5.5: Staff profile of Trauma Resource Centre (BHSCT)

Profession/ therapist	Number	Full time/ part time
Clinical psychologist	1	PT
Psychiatrist	0	
Social worker	0	
Mental health nurse	0	
Cognitive Behavioural Psychotherapist (CBT)	0	
Psychotherapist	1	PT
Counsellor	5	3 FT 2 PT
OT	1	FT
Physiotherapist	1	PT

Figure 5.3: Number of HSCTs Staff broken down by Professional Background during 2017-2018

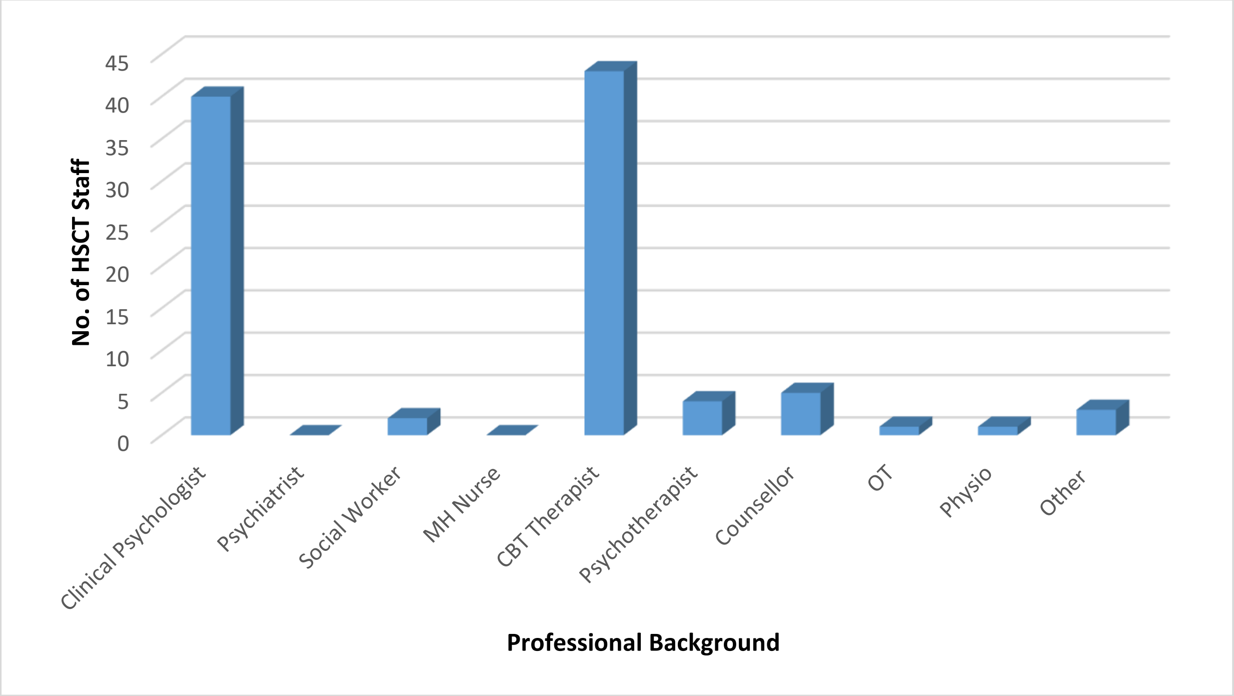
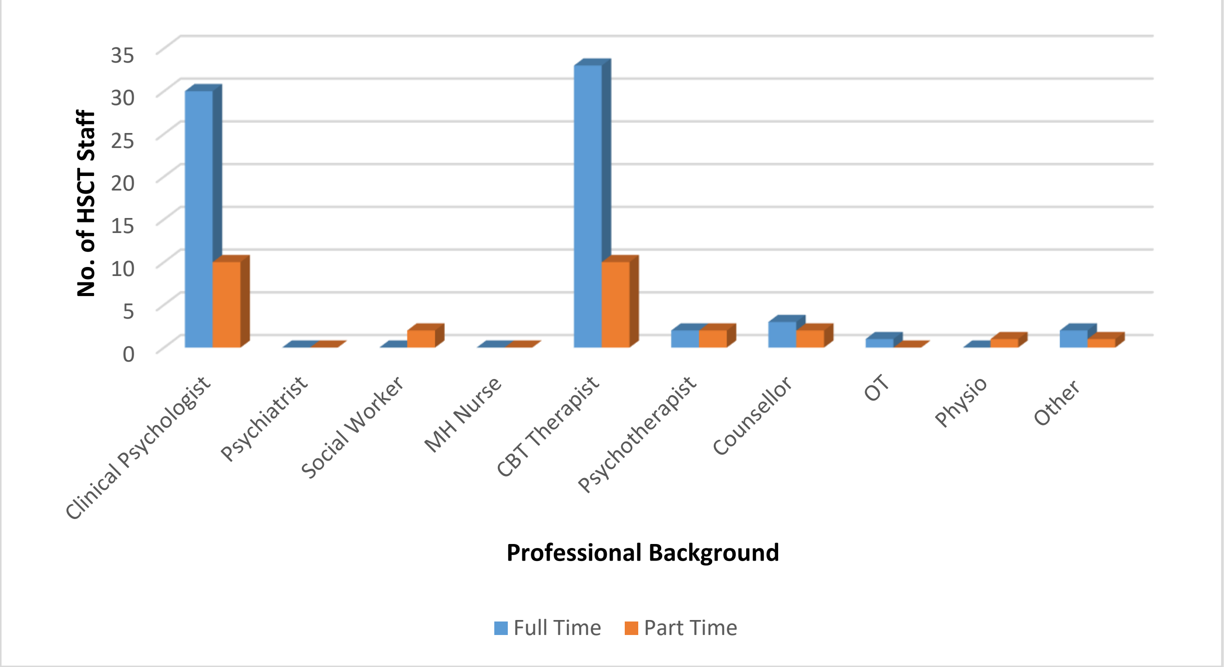


Figure 5.4: Number of Full-Time and Part-Time HSCTs Staff broken down by Professional Background during 2017-2018



The number of staff providing talking therapies within the non-statutory sector varied significantly, most likely reflecting the differences in organisational size. Three out of the 21 organisations reported relying solely on sessional staff. See Table 5.6 below:

Table 5.6: Number of staff within VSS funded organisations during 2017-2018

Organisation	Number of staff
VSS 1	14 - 2 dedicated for clients meeting VSS eligibility criteria.
VSS 2	1
VSS 3	24 sub contracted practitioners
VSS 4	13
VSS 5	4
VSS 6	4
VSS 7	4
VSS 8	21
VSS 9	4
VSS 10	0 sessional only
VSS 11	3
VSS 12	6 (17 sessional therapists)
VSS 13	28
VSS 14	28 *24 staff working therapeutically with VSS referrals, and 4 VSS Assessments only
VSS 15	7
VSS 16	14
VSS 17	5
VSS 18	1
VSS 19	14
VSS 20	2
VSS 21	23 sessional staff

The most common form of psychological therapy reported within the non-statutory sector was Counsellor/Psychotherapist (n=159). There were a smaller number of CBT Therapists (n=26) and Clinical Psychologists (n=8). The majority of Counsellors/Psychotherapists were employed on a part-time basis (107; 67%) as were CBT Therapists (21; 81%), and Clinical Psychologists (6; 75%). Six organisations reported employing a total of 15 other staff, including two full-time Counselling Psychologists, two sessional complementary therapists, four sessional EMDR Therapists, three volunteer Counsellors, and four part-time Clinical Supervisors. In Figures 5.5 and 5.6 the number of VSS funded staff are presented by professional background and full-time or part-time basis during the period 2017-2018.

Figure 5.5: Number of VSS Funded Organisational Staff broken down by Professional Background during 2017-2018

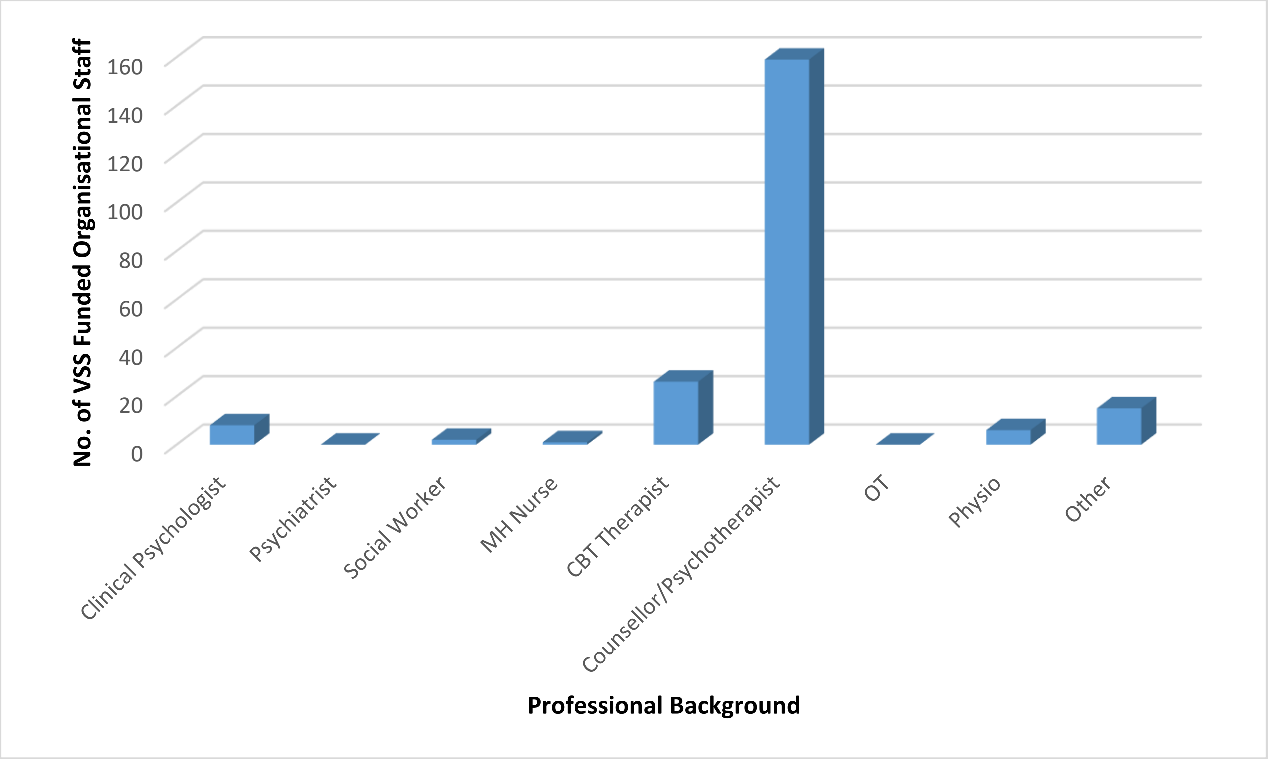
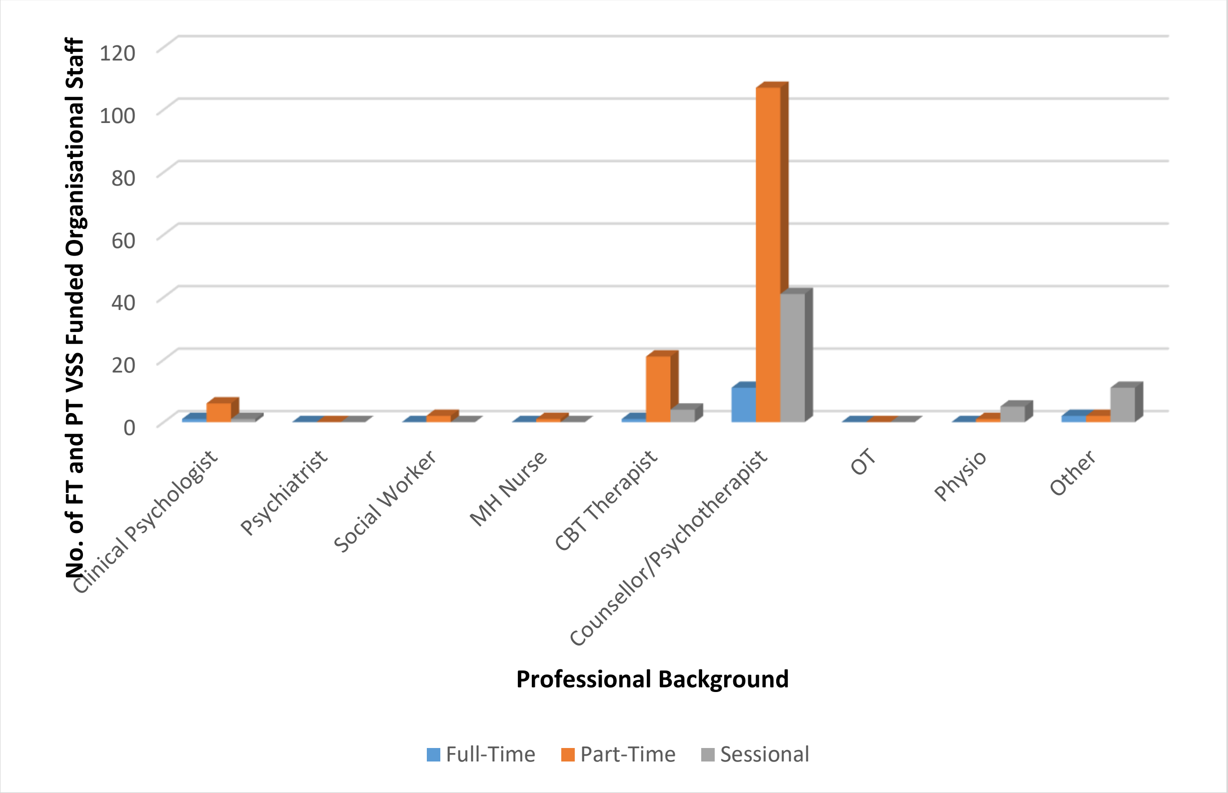

No. of VSS Funded Organisational Staff
0
20
40
60
80
100
120
140
160
Clinical Psychologist
Psychiatrist
Social Worker
MH Nurse
CBT Therapist
Counsellor/Psychotherapist
OT
Physio
Other
Professional Background

Figure 5.6: Number of Full-Time and Part-Time VSS Funded Organisational Staff broken down by Professional Background during 2017-2018



5.4 Waiting Times for Psychological and Talking Therapy Services

Patients and clients were seen either weekly or fortnightly in both the statutory and non-statutory sector. However, the waiting time from referral to treatment was longer for patients in the statutory sector compared to those receiving therapies in the non-statutory sector. In three HSCTs, waiting times were between 2-6 months; in the fourth HSCT up to 10 months; in the fifth HSCT waiting times were reported as variable depending on the treatment approach required. The majority of clients referred for therapy in the non-statutory sector had a much shorter waiting times; 71% up to one month and 29% between 2-6 months.

Figure 5.7a: Average waiting time from referral to treatment within HSCTs during 2017-2018

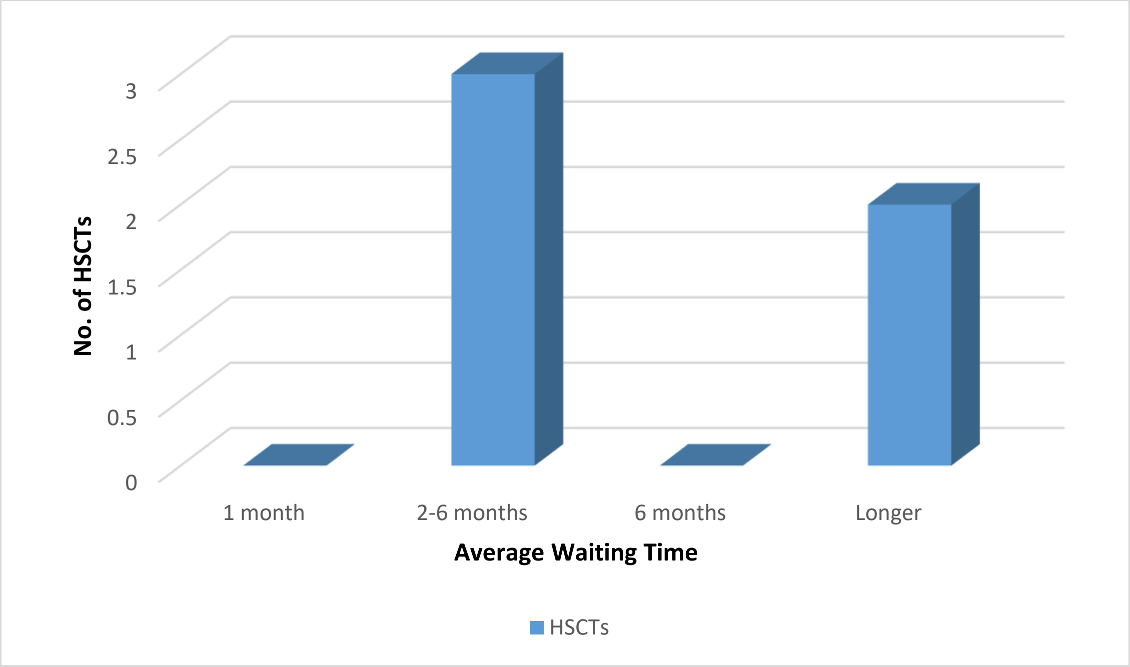
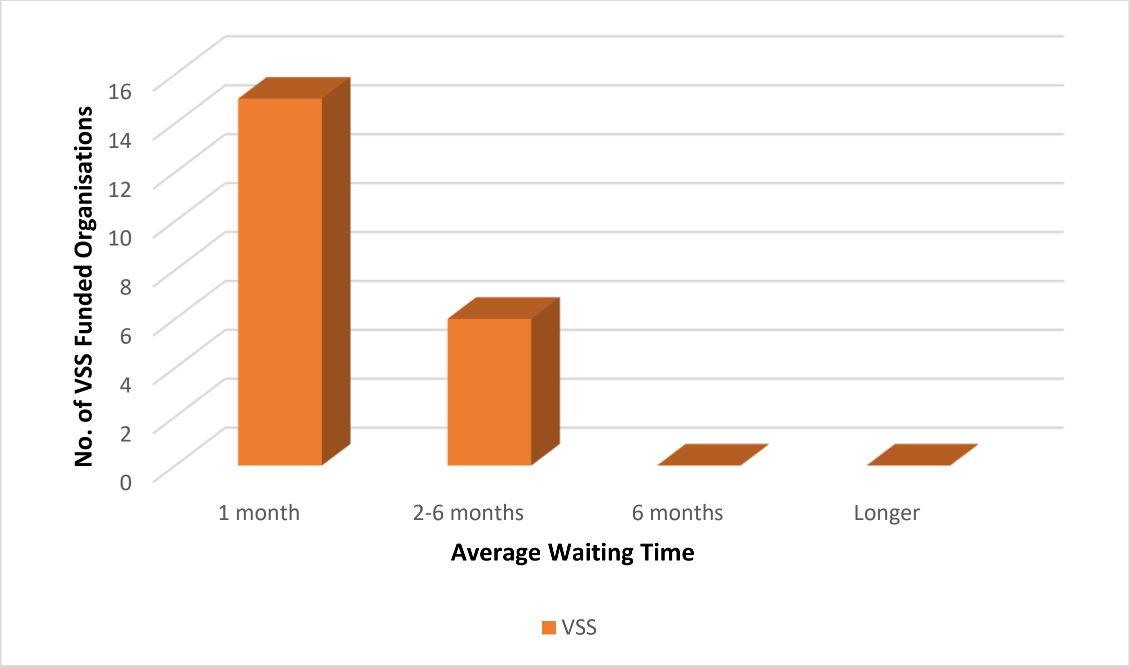


Figure 5.7b: Average waiting time from referral to treatment within VSS funded organisations during 2017-2018



5.5 Referral pathways

The majority of referrals to psychological services in the statutory sector were via GPs and Psychiatrists, followed by referrals from Social Workers and Community Mental Health Teams. A smaller proportion of referrals were made from the Community and Voluntary Sector, and from Self-Referrals. Four HSCTs also reported referrals from other agencies, such as Addiction Services, Inpatient care, Home Treatment teams, and Primary Care Liaison Services.

In contrast, the majority of referrals to talking therapies in the non-statutory sector were by self-referral, followed by referrals from GPs and the Community and Voluntary Sector. Six VSS funded organisations reported referrals from a range of sources such as Health visitors, Family Support Hubs, Primary Care Mental Health Hubs, Friends and Family, Teachers, School Nurses, Local Clergy, and Local Employers. In Figures 5.8a and 5.8b below the referral pathways to HSCTs and VSS funded organisations during 2017-2018 are presented (chart 5.8).

Figure 5.8a: Referral pathways to HSCTs during 2017-2018

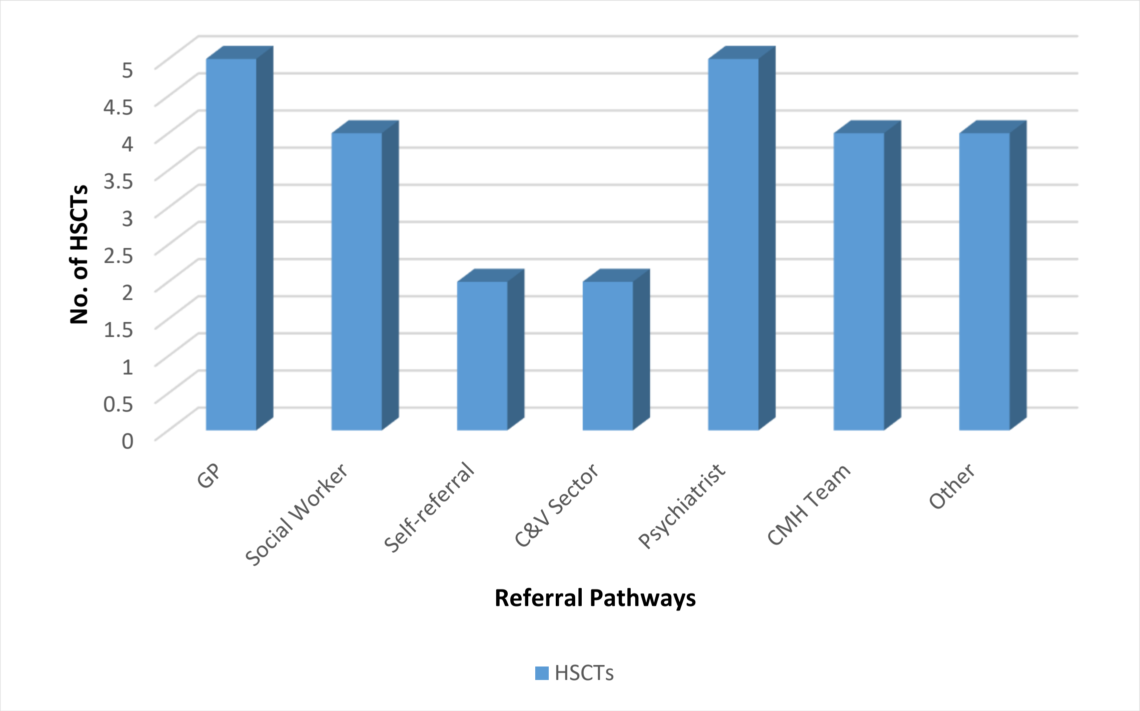
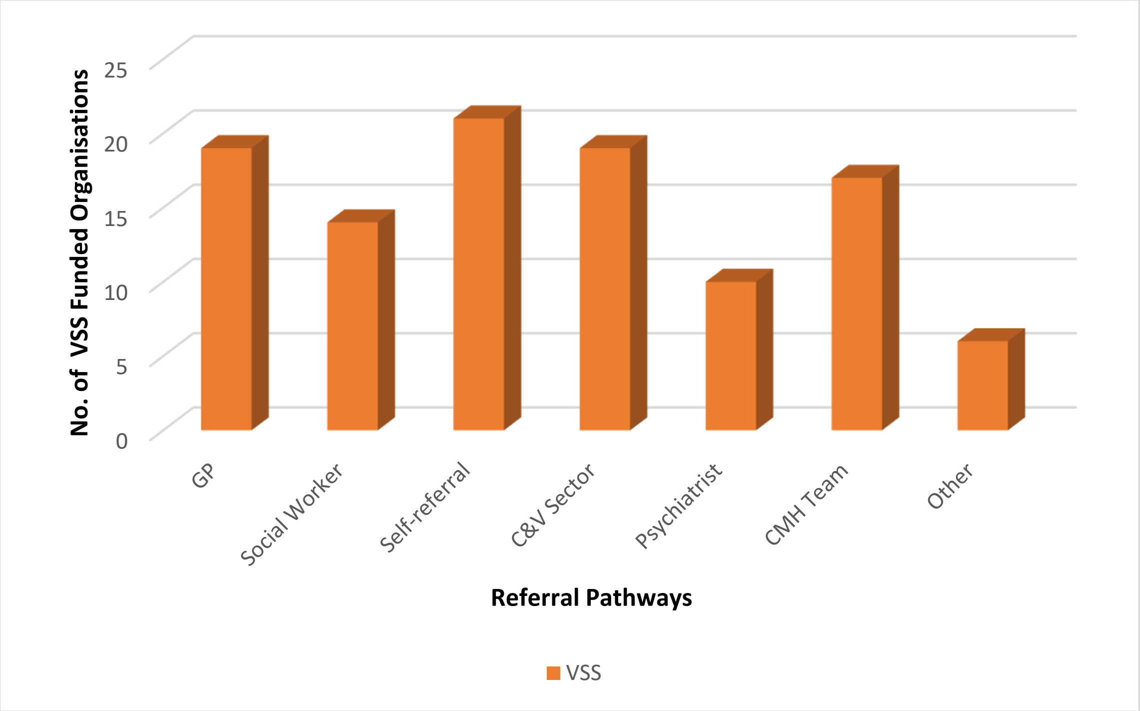


Chart 5.8b: Referral pathways to VSS funded organisations during 2017-2018



5.6 Outcome data Collection within VSS Funded Organisations

As explained earlier in the report, all VSS funded organisations are required to monitor their talking therapy outcomes on CORE Net and provide monthly and quarterly outcomes to the VSS. This requirement to monitor outcomes is an essential component to promote learning and growth, identify areas for improvement and continually increase the quality of care and services.

Below are additional data collection instruments used by some VSS funded organisations during 2017-18:

- Beck Depression Inventory, Beck Anxiety Inventory
- Child Outcome Rating Scales (CORS)
- Common Trauma Reaction Ratings Scale
- Clinical Impairment Assessment Questionnaire (CIA 3.0) and Eating Disorder Examination (EDE) Q 6.0 questionnaires
- Patient Health Questionnaire (PHQ-9) and General Anxiety Disorder (GAD) questionnaire
- Posttraumatic Stress Disorder Checklist (PCL-5)
- Impact of Event Scale-Revised (IES-R)

Fourteen VSS funded organisations reported data collection practices in addition to CORE Net, such as service evaluations to assess clients experience and qualitative feedback from workshops, and client feedback questionnaires. Over half (n=14) of VSS funded organisations used additional psychological outcome measurement tools, specific to clients' presenting problems. In Table 5.7 additional data collection tools used by some VSS funded organisations are listed.

5.7 Outcome data collection within the HSCTs

As discussed in Chapter one the use of outcomes measures varies across the region and between Trusts. Four HSCTs reported that standardised disorder-specific outcome measures, were routinely used including the PCL-5, PHQ-9, and the Traumatic Grief Inventory (TGI). Four HSCTs reported using other data collection methods, including the CORE Net paper version. Only the two specialist Troubles related trauma services and one generic psychological therapy service reported that specific outcome data for victims and survivors were collected.

In some Trusts this data is not centrally inputted into a computer system but retained on an individual basis, case by case in client's file, and as such is not in a format that is accessible to analyse pre-post outcome scores.

In Table 5.8 the data collection instruments used within the statutory sector are listed.

Table 5.7: Data collection in HSCTs during 2017-2018

Measure	Standardised measures	Core net	Trust specific	Troubles Related Traumas	Other
Number of Trusts	4	4	1	3	4

Those trusts that have an outcomes framework in place within generic psychological therapy services record data for patients with trauma-related disorders, but not specifically for Troubles related trauma. One HSCT reported using a trust specific outcomes framework and had a dedicated assistant psychologist to oversee the setup. The outcomes are benchmarked against The Improving Access to Psychological Therapies (IAPT) programme introduced in England in 2008 with a standardised outcomes framework that is centrally accessible for data comparison and analysis.

Key outcomes recorded include three clinical indicators:

1. Reliable recovery, as indicated by an improvement from a clinical range to a sub-optimal range,
2. Reliable significant improvement as indicated by enough improvement on relevant measures to indicate significant improvement, and
3. Reliable Clinical change – as indicated by 1 SD improvement.

This HSCT used a range of measures to monitor outcomes, including:

- CORE Net scores (CORE10/CORE34)
- The Work and Social Adjustment Scale (WSAS, Mundt et al., 2002)
- Service user Feedback Questionnaire
- Other disorder-specific measures for the main presenting problem i.e. PTSD, depressive episode etc.

One HSCT has been implementing a pilot for CORE NET which had just finished at the time of this study. However, the data is unlikely to adequately reflect the types of mental health problems presenting to the service as only a selection of clinicians were involved with the pilot and loaded cases on to the system. The Trust is hopeful that following a review of the outcome of the pilot there will be a greater accuracy in recording complexity of need, interventions and outcome for all patients.

5.8 Type of Outcome Data Collected by HSCT psychological therapy services

Three HSCT services collected a range of patient data with two Trusts collecting session-by-session and follow-up outcome scores. Similarly, several VSS funded organisations collected a range of client data, including session-by-session outcome scores. Only a small number of VSS organisations collected follow-up outcome scores. In Figure 5.8 the types of data collected are presented.

Figure 5.9a: Types of outcome data collected in HSCTs during 2017-2018

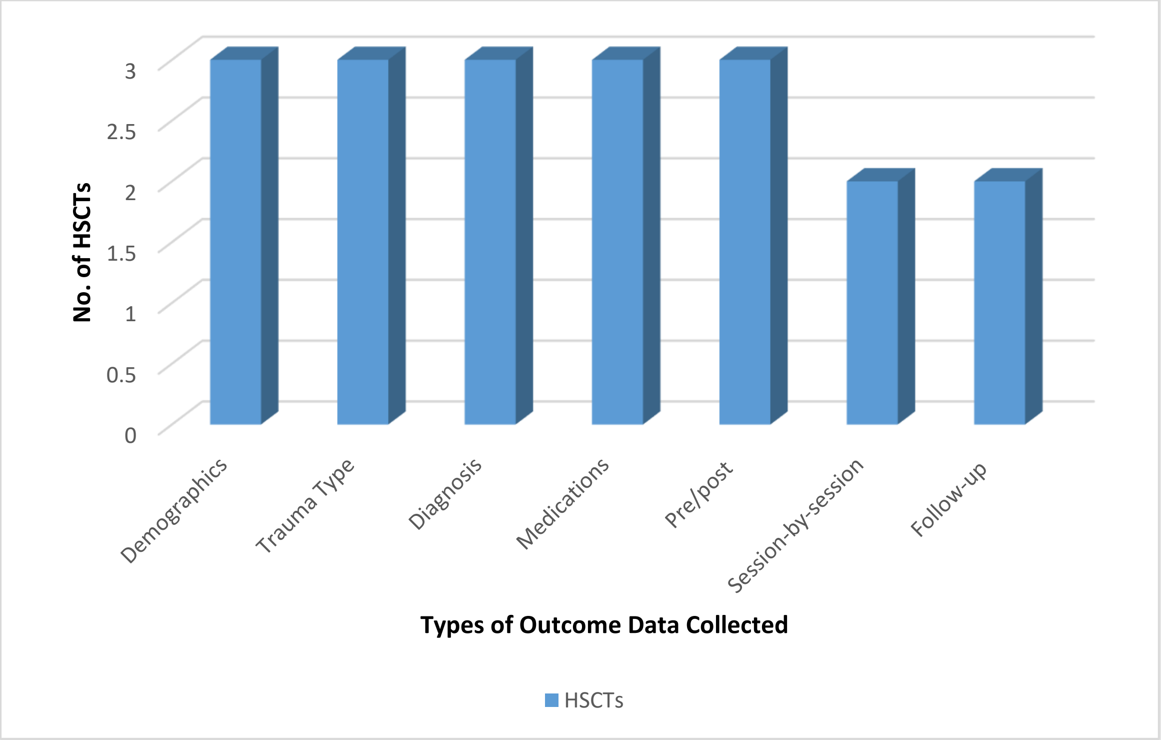
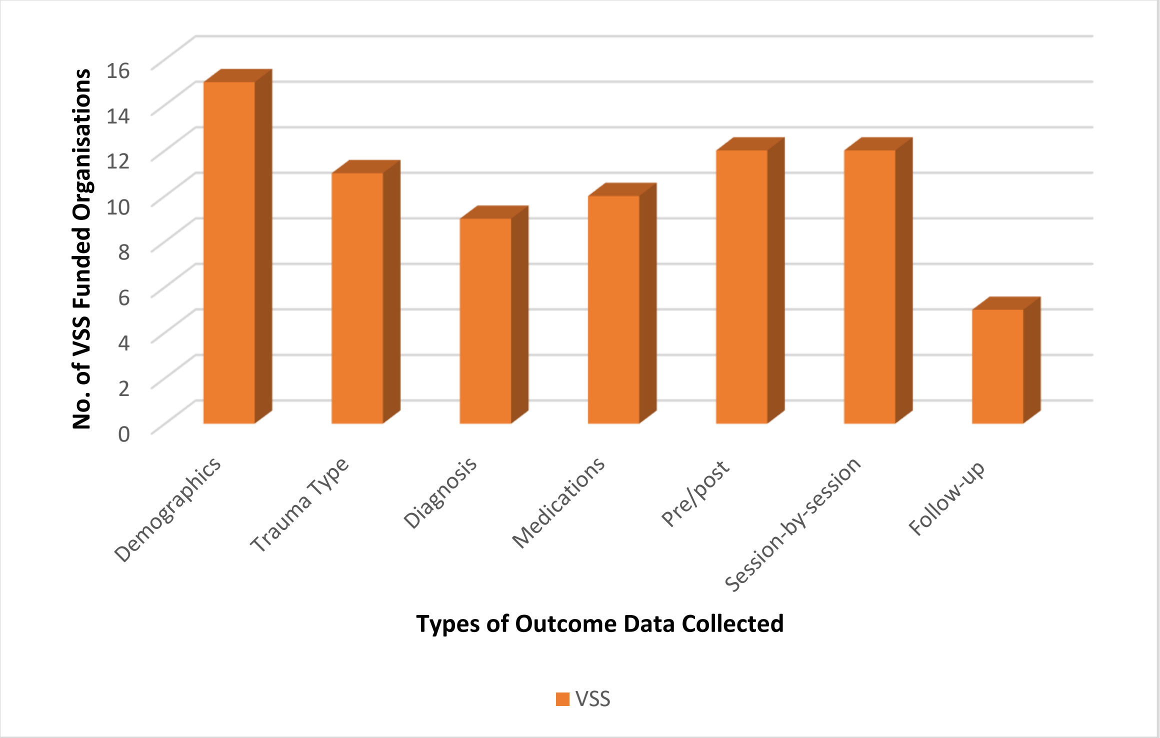


Figure 5.9b: Types of outcome data collected in VSS Funded Organisations during 2017-2018



NOTE

These illustrated results above are based on responses provided by the participating agencies, which did not provide answers to all questions. The VSS have explained that all the funded organisations are expected to collect pre- and post-outcome data.

5.9 Key findings from survey

1. Cases attending the specialist trauma centres in the statutory sector (SS) generally appear to have more challenging mental health problems compared with those cases presenting in the voluntary sector (VS) : diagnosis of PTSD (86% SS v 5% VS) (Substance Use Disorder (63% SS v 7% VS) Self-harm/suicide (41 SS v 10% VS). NOTE: *The VSS has explained that disclosure and reporting of mental health problems to the C&V sector may be limited and aligned to the services and support available in that setting*
2. The absence of a regional standardised outcomes framework across the statutory sector, that codes more specific details, limits the possibility of an accurate picture of types of mental health problems presenting, the severity and chronicity of psychological trauma presentations, the effectiveness of interventions provided and importantly the service demand from victims and survivors of the Troubles.
3. An outcomes framework has been introduced by the VSS across the non-statutory sector and as the system develops detailed data can provide a more accurate picture of specific presentations/conditions. *It is encouraging to note that, in January 2020, the VSS have set PTSD, Substance Use Disorders, and risk/history of Self-Harm/Suicide as mandatory data requirements from*

the VSS funded organisations. The VSS also report that refresher training was provided to organisations that had identified training needs in relation to data quality in January 2021.)

4. Only two HSCTs reported the use of session-by-session outcomes, limiting the potential to assess the effects of different therapeutic approaches in patients who do not complete therapy. There appears to be a lack of follow-up data across both statutory and non-statutory sectors to record longer term effects of different therapeutic approaches.

5. Within this survey's responses, the most commonly cited therapeutic approaches provided within statutory and non-statutory services mainly reflect the stepped care model employed across sectors, with non-statutory organisations providing mostly counselling for Step 1 and 2 care (mild to moderate mental health presentations), and statutory services providing evidence-based approaches at steps 3 – 5 for diagnosable conditions such as moderate to severe PTSD. There are exceptions to this pattern; for example, in the North Belfast Trauma Resource Centre most therapy was described as Person-Centred Counselling and there are examples of CBT and EMDR being offered by some non-statutory services.

6. There were differences in staff profiles across the statutory and non-statutory sector, in line with the Stepped Care Model employed across sectors. There was a higher proportion of practitioners with specialist training such as CBT Therapists and Clinical Psychologists responsible for treating moderate – severe Step 3-5 conditions such as PTSD in the statutory sector. The non-statutory sector, responsible for treating mild to moderate Step 1-2 client presentations, cited Counsellors as the most common profession. One notable exception to this pattern, however, was the staff profile in the statutory based centre where the majority of staff employed were described as counsellors with no staff defined as CBT therapists to provide TF-CBT.

7. One main difference between the statutory and non-statutory sectors was the high number of full-time staff employed in the statutory sector compared to the relatively small number of full-time staff employed within the non-statutory sector, which relied mostly on part-time or sessional staff. This was probably due to funding mechanisms.

8. A key gap/limitation identified across both sectors was the absence of psychiatrists embedded within psychological trauma services.

9. Long waiting times remain a problem within the statutory sector.

10. GPs were cited as a key point of referral to both statutory and non-statutory sectors.

11. HSCTs have reported challenges in installing an outcomes framework including however progress is being made in this respect and it is anticipated that the new Regional Trauma Network will help to introduce a standardised outcomes framework.

Section Two: Focus Groups and Interviews with Staff Members from HSC Trust Mental Health Teams and Community Voluntary Sector Organisations

In this section the results of focus groups and interviews with staff members from HSC Trust mental health teams, and Community Voluntary Sector organisations (VSS) funded groups will be presented.

6.1 The process

A total of four focus groups were conducted with senior mental health leads (n=19) in three HSCTs and the VSS (n=5). We conducted a one-to-one interview with a senior mental health lead in the remaining Trust. Four community and voluntary organisations offered to participate in a one-to-one interview.

These clinicians were invited to ensure a representative of clinicians and managers in both sectors were given the opportunity to participate.

Participant information sheets were attached to email invitations to all participants, and written informed consent was obtained. Each focus group and interview encouraged participants to engage in open discussion and debate, and provide qualitative feedback. Each semi-structured focus group and the interview lasted approximately 30 minutes to one hour. The focus group and interview topics included: partnership working, what is working well and what is not working so well, adequacy of services, service user engagement, and how the new Regional Trauma Network may help improve services (see Appendix 5 for the focus group and interview topic guide).

6.2 Data Analysis

Focus groups and interviews were audio-recorded and transcribed verbatim by a member of the research team. Data were then thematically analysed for both similar and differing patterns across all services i.e., successes and problems. In particular, data was used to identify any gaps/limitations in current psychological services for victims and survivors. This led to the identification of themes and sub-themes, which were checked for both reliability and validity. Table 6.1 presents these key themes and sub-themes.

6.3 Findings

Table 6.1: Thematic Analysis

OVERARCHING THEME	SUB-THEMES
Partnership Working	One-way referral system
	Communication and knowledge transfer

	Research gaps
	Joined up training
	Professional divide: Them and us
Barriers to the provision of effective psychological services	Resources
	Broken systems
	Co-morbidity
	Normalisation of the troubles
	Training gaps
	A complex client base
	Secondary gain
Facilitators to the provision of effective psychological services	Moving past victimhood: I'm a survivor
	Trust
	Wrap around support
Adequacy of services	Disparity of services
Victim and survivor engagement	Streamlined pathway
	Client choice
	Victim and survivor feedback
The new Regional Trauma Network	Hopes and fears:
	A niche service?
	Troubles related trauma has many faces

6.4 Overarching Theme 1 and sub-themes

Partnership Working

Partnership working appeared to be stronger within sectors than across sectors, with large variations in the level of partnership working across statutory and non-statutory sectors.

"I think it's (partnership working) very piecemeal in different parts of NI. The history of the X area has been that the community and voluntary sector, it has been difficult to penetrate into the statutory sector whereas it's commonplace in X." (VSS funded service)

"I suppose it's mainly within our own funded organisations that we would be making referrals. However, if there was someone that we thought needed a more specialised service through statutory services, we would be contacting their GP and encouraging them to go down that route, so currently it's just within VSS services." (VSS Case Manager)

Lack of a streamlined pathway

The key barrier to partnership working across sectors appeared to be the lack of a streamlined pathway. Participants reported a one way referral route from the statutory sector to the non-statutory sector, with no direct referral route onward from non-statutory to statutory services for clients with more complex presentations.

"Possibly at the end of a piece of work with somebody who has experienced trauma. I might be looking at all kinds of things that might help them reconnect with old values, and get more involved in their community, and pursue goals. So we might be looking at things like (VSS funded organization) up here, or the (VSS funded organization), and things that will get people social again, and get them out doing exercise, or maybe getting them back into employment. So we'd have links back and forth with those types of organisations, depending on referrals and waiting lists and so on." (HSCT Senior Manager)

"The only way is them (statutory sector) to us. And there's no way we can phone up the Clinical Psychology team and go, we've someone we want to refer to you. You can't do that." (VSS funded service)

Communication and knowledge transfer

A further barrier to partnership working across sectors was in relation to a lack of communication. This led to a lack of knowledge within the statutory sector around what psychological services were available in the community and voluntary sector. Some practitioners viewed the community and voluntary sector as only providing alternative therapies, or social support.

"And they obviously have groups for confidence building… they do, I think computer driving license, also photography courses, more vocational stuff… linking people into employment as well. So that's something we would use regularly for our clients down here." (HSCT Senior Manager)

Whereas other practitioners in the same trust were more aware of the additional psychological support the non-statutory sector could provide.

"Well, we would sometimes send people to floating support at the voluntary group. Also, if people are in need of systemic type interventions… we don't have specialists where we work, so we might refer people to (VSS funded organisation) for that." (HSCT Senior Manager)

Solutions to the apparent lack of communication and awareness of non-statutory services were put forward by a number of practitioners, such as increasing the presence of non-statutory organisations at statutory team meetings, and having accessible databases listing the non-statutory services available.

"We've had (a VSS funded organisation) come along to our Adult Mental Health Senior Management Team meeting and just talked about the services they (VSS funded organisations) offer. So, we do have links. It's just sharing information about their services, and we can then think about which fits best for the person, and which will they be able to access. If they're going to wait a

year for a service here, and they could access something out there quicker, then it's good for them to do that, if it's at the appropriate step of care." (HSCT Senior Manager)

"We also have a database of non-statutory and voluntary services that we've compiled, that all staff have access to, so that if a client comes in and they think they might need something beyond the remit of our service, there's a database that they can consult and link in with another organisation to support the client, and refer on if needs be." (HSCT Senior Manager)

Communication and raising awareness of the level of expertise within non-statutory services was also apparent for increasing statutory staff confidence in the standard of services provided, and in turn overcoming barriers to more joined-up working.

"Sometimes it's hard to know about the level of training that people might have. So there's some organisations where we do know it's of a high standard, but there can be other ones where it's less sure." (HSCT Senior Manager)

"People once they come to us, we don't refer them back out to community organisations for trauma focused work. I suppose part of that comes from, whilst people are saying they're providing trauma focused CBT, I have never been educated and informed, about well what was your training? So I don't know what's the level of training out there, to make a comfortable decision to refer somebody back out again." (HSCT Senior Manager)

Research Gaps

There were limited reports of joined-up research opportunities, with only one trust reporting research collaborations between statutory and non-statutory sectors.

"We've got two projects now that we are liaising with community and voluntary counselling organisations, so (VSS funded organization), and I can't remember the name of the other one that X is linking in with." (HSCT Senior Manager)

The majority of research appeared to be happening within sectors rather than across sectors, perhaps due to the different level of client needs being addressed across sectors. One of the HSCTs reported within sector multi-site research collaborations supported by Queen's University Belfast. Although it is encouraging that this trust is highly active in research, with 14 publications in relation to Mental Health and Trauma, there was a gap in relation to research on the efficacy of psychological therapies for Troubles-related trauma. This is a clear limitation with regards to determining whether existing psychological interventions are meeting the needs of victims of survivors, and severely limits the opportunity to share the wealth of experience that exists within Northern Ireland more widely. This is further emphasised in the following quote.

"And that was always my question, why go to America to learn? The dearth of research here, after 40 years of madness, is like criminal. We should be teaching them, because we actually have the practical experience of working with all these issues. So that's what we're trying to evidence." (VSS funded organization)

This non-statutory organisation reported a currently running research project in partnership with a local university to evaluate a psychological therapeutic intervention for police and their families who had experienced Troubles-related trauma, using standardised outcome measures to capture pre-, post-, end-of-therapy and follow-up outcomes.

A further gap identified in the research base for victims and survivors was in relation to veterans.

"The other thing where we've obviously pressed the Ministry of Defence and others on, is how we deal with veterans? The fact is we don't have a means of a census to record the context of former veterans, we don't have it. So in many ways people are able to pass off how serious the issue is, because the statistics are not able to be collected yet. They are done so in Australia, in Canada, in other Nations… so why not here?" (VSS funded organisation)

Joined up training

Both statutory and non-statutory sectors reported opportunities for joined-up training in relation to basic continuing professional development, but not for more skills-based educational qualifications.

"There is training that is available to either our staff or staff in the Community and Voluntary sector. There's been lots of different training over the years." (HSCT Senior Manager)

"I think the only joint training that I see happening is around things like mental health first aid, assist, you know, the bog standard training. The Trust runs them and everyone is open to go to them, but when it comes to higher level training, like qualifications and things like that, there's no joint training between Trust and community. It's all in-house." (VSS Case Manager)

Again, the key barrier appeared to be the different levels of client need catered for across sectors.

"But it's difficult to pitch that training at the right level. Because you've different professional backgrounds, different levels of experience or expertise." (HSCT Senior Manager)

However, there were reports of practitioners within the non-statutory sector working with clients presenting with more complex step 3 presentations.

"I work with complex PTSD. So policemen and soldiers who've been through nightmares for 20 years. PTSD is single incident. In NI you tend not to get single incident trauma, you get these multiple, complex traumas." (VSS funded organization, Therapist)

"What we've done, we've been very specific when we put the calls out… to develop the mental health team… we were specific that they were degree educated and above, that they have so many hours, had good experience of working with complex trauma. We ended up letting a lot of our step 1, step 2 counsellors go, because the demand wasn't there for them." (VSS funded organization, Director)

Professional divide: Them and us

Further barriers to partnership working included a sense of a ‘them’ and ‘us’ mentality between statutory and non-statutory sectors.

“You have these rigid lines, and it’s like, no, we’re all insiders, you’s are the outsiders.” (VSS funded organisation, Therapist)

“So that is a big barrier, is that ‘We are the specialists, you are providing a lesser service, or a less specialist service, so you have to go through the GP to refer to us.’” (VSS Health and Wellbeing Team)

Again, key recommendations for moving forward were offered.

“We need to have partnership agreements. And it’s a matter of having a good enough relationship with statutory services to be able to challenge that, and start breaking down those barriers, and breaking down misconceptions.” (VSS Health and Wellbeing Team)

Key observations related to partnership working

This section of the report highlights the need to foster a partnership approach between statutory and non-statutory sectors. Regular communication and awareness raising is essential to build up trust in each other’s abilities to deliver effective psychological services for victims and survivors. It was reported by respondents in this section that clients with step 3 level needs are seen within non-statutory services. It is suggested that more collaboration and joined up working is required where possible, for example in relation to; sharing knowledge and sharing trauma related training and education across both sectors.

Although there was some evidence of a research culture in both sectors, there is a need to direct the research focus on building and continually updating the evidence base on the most effective psychological interventions for those exposed to Troubles-related trauma, along with building up a database on veterans to help address their specific needs.

Finally, systems need to be in place to enable referrals onward from non-statutory to statutory services to facilitate a partnership approach between sectors and break down professional divides.

In summary the following priorities were identified:

- Building relationships and trust between statutory and non-statutory sectors.
- Awareness raising and knowledge transfer of key skills and services across both sectors.
- Stream-lined pathway to enable direct referral from non-statutory services to statutory services for those requiring step 4 and 5 psychological services.

- Joined up training and education available for those non-statutory organisations providing psychological services for step 3 clients i.e. specialist trauma qualifications.
- Joined up research on the effectiveness of different psychological interventions for Troubles related trauma for step 3 clients.

6.5 Overarching Theme 2 and sub-themes

Barriers to the provision of effective psychological services; Resources and Impact on waiting lists

Lack of resources was the most commonly cited barrier to effective psychological service provision, and the key contributor to lengthy waiting lists. Both statutory and non-statutory services reported a 25-30% increase in referrals over the past five years, year on year to mental health services, with additional funding requests to increase the number of therapists to match the growing demand.

"Well, waiting lists is not working well. And it's not just waiting lists within psychological therapy services. Access is a huge issue to statutory services at the minute. For both primary care, and then when you are assessed, referrals onto ourselves." (HSCT Senior Manager)

"The big issue for us is that we have a huge breach on our waiting lists. Our waiting lists are typically 9/10 months long, and that's just a combination of really… our referral rates have increased, the demand for our services has increased, and our complement of staff has not increased in proportion to that. And that's the story nearly everywhere, but that's where we're at." (HSCT Senior Manager)

Impact on key structures and processes

In relation to the statutory sector, huge funding problems exist. Inadequate funding impacts on the provision of key structures and processes, such as developing a standardised outcomes framework across all HSCTs.

"For the last year, we've been implementing CORE, manual CORE ourselves… it's very under resourced to be honest, to get somebody to come in and now start to look at that. We've been depending on charity… students… you know, psychology students looking to do a piece of…. So we have been gathering the information, we do CORE 10 at every session, but it's still kind of out there in the ether, it hasn't been… It needs to be all pulled together. We'd be very keen to do an outcomes study. Anecdotally we can see where people have grown and posttraumatic growth, you know, going back to work. We know all the stories but we've no evidence for the stories. Actually some of our clients are working in the trust now, but we've no research data to show, no outcome data to show the growth, but we know from our experiences." (HSCT 5, Specialist Troubles-Related Trauma Service, Senior Manager).

"I think a regionally, standardised, outcomes framework would be very important. It doesn't matter what our perceptions are. Our perceptions are whatever the objective figures are that are disseminated around" (HSCT, Senior Manager)

This is further supported by findings from the survey, where HSC practitioners reported difficulties with installing an outcomes framework across all the Trusts, as this would require extra resources to support it e.g. Band 4/5 staff to support set-up, and ongoing funding is essential. For example, maintenance requires £3-£4 per case, plus the extra workload incurred by staff to input the data on a regular basis.

Broken systems

Practitioners in both statutory and non-statutory sectors often referred to the Talking therapies and wellbeing primary care hubs as a key point of referrals. The hubs started out as a good idea for taking pressure off primary care in relation to streamlining patients presenting with mild to moderate step 1 and 2 difficulties into community services for social activities and low intensity counselling, rather than onto more specialist services in the trusts. However, reports from practitioners in both statutory and non-statutory services suggest that this system has broken down over time due to declining resources, with more and more patients being referred into community counselling services.

"The hubs just turned into another dumping ground for GPs to get people counselling. It was supposed to see something like 150 people per year… now it's seeing something like 600/800 people per year. It's just crazy. And I think this is what happens too often whenever the collaboration isn't as strong as it should be." (VSS Case Manager)

The ever-increasing pressure of waiting lists can result in clients not receiving the level of care they require.

"This is what's going on. You know the games. I eventually got a Consultant Psychiatrist. And I said, let me tell you what I think is going on. You guys in CAMHS and the mental health team are deliberately stepping clients down. You know they are step five and you are saying they're step three and passing them off to community organisations. And he said, I see that every week at multi-disciplinary meetings, so there's the reality." (VSS funded organisation)

The VSS have moved from a focus on waiting list numbers to a more outcomes-based approach.

"We have moved here in the VSS from this number head counting business to outcomes based… and I think that's the problem with these projects when they're set up as well, is that they're not outcomes based… it's how many people can we get through, can we avoid a waiting list, can we move the waiting list to the community so it doesn't look like we have the waiting list, which is what happened in the hubs… you've got a 1000 people through this year. Its 1000 people who probably didn't have a service that they actually could benefit from. Whereas if you got 100 people through who had absolutely the service that they required and move forward with their life… for me, I would take the 100 people every day, because the rest of those people, they will eventually get to them, and they'll have something meaningful. Whereas if you've got really heightened anxiety, anxious

people who are probably worse off after six sessions of talking about their trauma that they've had for 30 years, than people who get maybe, 20 sessions and feel extremely better after it." (VSS Case Manager)

As highlighted in earlier sections, the key problem appears to be the complexity of clients referred to community and voluntary sectors who require more high intensity and often longer-term therapeutic work.

"I think it touches more on about not just knowing what the level of qualifications are for people in community and voluntary organisations. But I get the sense that funding can change, so sometimes people might be allocated eight sessions, sometimes 16 sessions, sometimes they can only get four. Because you could be the best therapist, but if you're limited to four or six sessions, you're going to be very limited around what you can do." (HSCT Senior Manager)

"So if someone comes here and they only need talking therapy, we'd be more inclined to encourage them to go into the community. The difficulty with that is that the work in the community has become much shorter term. So we can't refer out as often as we used to. So if you've someone who needs a piece of long-term work, we have to keep them." (HSCT, Specialist Troubles Related Trauma Service)

"Six sessions… and then you're finished. If you're low to moderate that's fine, but for the more complex clients you might need 12, 18 sessions, and the hub can't offer it so you're taking a person in… starting a piece of work with them, and then dropping them again… so it's not ideal." (VSS Case Manager)

"Those people just keep coming back again." (VSS Case Manager)

Co-morbidity

As depicted in Figure 1, a further barrier to effective psychological services for victims and survivors, particularly in the statutory sector, was in relation to dealing with co-morbidities that those exposed to Troubles-related trauma present with.

"I mean ICD 11 has now brought in complex PTSD as a diagnosis and that's where there's a big overlap with personality disorder type stuff. So you've a lot of people coming through who you could say have emotionally unstable personality, among other things, a whole collection of problems, mood disorder, stress intolerance, can't cope, emotion regulation problems or whatever you want to call em… paranoia, anxiety, depression… but when you actually look at the bigger picture then trauma related to the Troubles may be there simply in the background and it's rarely picked up… but over the years has just embedded itself and its just continued on. They get labelled and referrals come through, and unless we pick it up…" (HSCT Senior Manager)

Current approaches to treating those with more complex needs within the statutory sector, such as Troubles-related cPTSD, actually marginalise those who present with substance abuse, despite the wide recognition within both statutory and non-statutory sectors of the high rate of co-morbid PTSD and addictions.

"I would say the co-morbidity with substance abuse. You know, we will not accept people who are using substances to a degree. And that already cuts a lot of people who would be coming through. They never get onto our waiting list. Obviously they go to addiction services, but it's whether or not they're ready to do that. Is it the chicken or the egg?" (HSCT Senior Manager)

There's barriers as well for people engaging with statutory services if they have an alcohol issue… those are the clients that the Trust will not deal with, and they will be put out into the community organisations. That's the reality. When people are heavily traumatised, they have PTSD or whatever, they are engaging in behaviours like drinking alcohol, they are under threat… there's this argument about mental health and addictions that still rages on in the Trust. You know, there would be a school of thought that says "You should be dealing with the trauma before you would deal with the addiction." But you have to stabilise someone before you can even contemplate therapy… so why you're not being able to run in tandem, I just don't get it. But it's just things that aren't done in the Trust. (VSS Case Manager)

Normalisation of the Troubles

Practitioners spoke of victims and survivors presenting with anxiety, which really masked previous exposure to troubles related trauma, making it more difficult to formulate the correct diagnoses, and as a result, limits the opportunity for patients to receive the appropriate psychological service.

"And there's a lot of normalisation of trauma as well within the Troubles, because you kind of grew up with it and everybody had it, so it didn't really have any relevance. So you see somebody coming through with an anxiety disorder, and you find out that their dad was a policeman, and they were a little child looking out the window waiting for dad not to come home, and they had to check under the car every morning, and you know… all that sort of stuff. And if you don't formulate properly, you're looking at anxiety, not PTSD, but it is Troubles-related." (HSCT Senior Manager)

The following quotes, and the language used further highlights the unique situation in NI where bombs and shootings have been viewed as the 'usual' stuff that happens.

"I remember it was… you could walk down the street and there were bombs going off and nobody ducked." (HSCT Senior Manager)

"We get some people coming through our books extremely paranoid, scared to leave the house, depressed, and then you look back at some of those sort of things and it's to do with Troubles-related issues, such as, the paramilitaries threatened them that if they didn't move their business they were gonna be shot… they've been shot at, witnessing people come into their house when they were kids and shooting people, the usual stuff." (HSCT Senior Manager)

Training Gaps; Specialist Trauma Practitioners; Reports from the statutory sector suggest that there are major gaps in relation to specialist training leading to a deficit in the number of highly skilled trauma specialists.

"I think we need to go back further and think about training. Where are the training organisations that train people to be psychologists, psychological therapists, CBT therapists? There really only is in NI Queen's that have the Doctorate… Queens have a CBT course, you know, I think that we need to

focus also on training, so that we do have a work force that can help fill these posts." (HSCT Senior Manager)

"And spread round the region as well. Other psychological leads have real issues trying to recruit for someone to work in Coleraine, or work in Ballymoney. Someone living in Rathlin, and they're traumatised, what are they going to do? There's very little around. UU is spread around, they've got lots of campuses, but not training that leads to a professional practice qualification. So it is quite Belfast centred." (HSCT Senior Manager)

A complex client base

The unique situation in NI, and the resulting unique barriers to effective psychological service provision was echoed throughout both focus groups and interviews. Mental health issues in NI are intricately linked to the political history, and as such cannot be treated in isolation.

"The problem with victims' work, it's always been very politicised… it should be a health issue, it's not a political issue, but here in NI it's a political issue." (HSCT Specialist Troubles Related Trauma Service)

"We see it in terms of our work here in terms of justice truth and accountability… and often down the years, people looked at these issues and tried to separate them from mental health, saying that they are two unique areas. And from day dot this organisation has said someone's mental health is related to their sense of injustice, and the sense that the pain and loss and harm that has been caused to them… there's been no account for it. And of course, there are other contributing factors in someone's mental health… but that question of injustice in palpable in this area where you've a 5% conviction rate, so 95% of crimes have gone unresolved. For people just to park that and to accept that's just the way it is… is very, very difficult." (VSS funded organization)

The unique situation in Northern Ireland means that mental health practitioners are dealing with a diversity of groups impacted by the Troubles, including:

1. Those physically injured, bereaved by perpetrators of the violence, and as a result struggling to deal with the resulting anger, loss, and sense of injustice.
2. Those who were the perpetrators of the violence, and as a result struggling to deal with the resulting fear, shame and guilt, as described in the following sub-theme.

Wall of silence

Some participants argued that a deep-seated fear and mistrust generated by the Northern Ireland Conflict was manifested in a wall of silence that severely compromised recovery from Troubles-related traumas. Specifically, for those who were involved in paramilitary activities, fear of retaliation for 'talking', and also fear of legal consequences.

"I think there's a big difficulty that arises in our own sort of historical, troubles- related stuff. And in my experience working clinically on the ground is that across the board you'll have people who've

been involved in sort of, historically, that fraction side of things. And they're only prepared to go so far, and they don't get into it. And I think there's a significant difficulty there, and I've had it quoted to me, that they're a civilian, and they're sworn to secrecy… there's military, and there's the Royal Navy, and there's… so there's all these different codes and they're bound to secrecy and can't discuss, because it would impinge on my safety. So there's only so far that some of these individuals can go. And as a result of that, the trauma piece is going to constantly reignite different problematic areas for them in their life, but they're never going to be fully prepared to address it. So therein lies, what I feel is a unique, almost like perfect storm, because we're never going to get to these guys to resolve all of their trauma issues. So a lot of these individuals are going to carry this to their grave" (HSCT Senior Manager)

"So how can you get full resolution from it? If you're trying to work through what you've been involved in but you can't go there, because if I wipe the slate here, and try to process this, it means then that the spotlight of the law is going to be on me" (HSCT Senior Manager)

"There's different issues you see, because with certain things people won't come forward for certain reasons, and I think there's barriers there such as people from certain communities coming forward and talking to a professional about troubles related stuff is actually seen as loose talk, and giving away information, and I've known cases where people have been visited afterwards about "what information have you given?". And I've been visited then to say "What information have you got?" (HSCT Senior Manager).

Secondary gain

Some participants suggested that the benefit system in NI, and VSS financial support for victims and survivors, also presented a barrier to effective psychological services. Disability based income depends on the individual remaining symptomatic, and as such is a major barrier to recovery.

"Because people don't want to be well if they lose their Personal Independence Payment (PIP) and they lose their VSS support, and it's very hard for people to be able to say I'm well. And some people will, and get jobs, and go back into training and volunteering, but some people just find it too hard. They don't want to let go of what they've got. We've the highest rate of people on PIP here. And it's very hard for us to support people's application. On the one hand you're trying to get them into some kind of stable life… on the other hand are you supporting them to be unwell? So it poses all kinds of dilemmas for you." (HSCT, Specialist Troubles Related Trauma Service)

Although this barrier appears to have been recognised within the non-statutory sector, the shift in focus from benefits to a holistic needs-based framework has not been an easy one for victims and survivors. However, the VSS are sensitive to the fact that recovery within the victims and survivors' context may not match traditional ideas around recovery where an individual is no longer physically or psychologically symptomatic. Instead, the focus is on improving quality of life.

"But recovery is about being as good as you can get. It's recovery to a certain extent. You're not going to take away all the pain, all the traumatic experiences, but you can make it good enough for you to live a higher quality of life. So it's trying to get that message across, that we're not taking

anything away from you. We're trying to improve your health and wellbeing." (VSS Health and Wellbeing staff member)

"Everything we do in here exists under the banner of "The living not existing project". And sometimes the most basic menial of tasks can be a huge undertaking. So that's not a life… that's an existence. So, what we try to do is work with them (victims and survivors) on a very individual level way looking at what are the areas they could unlock in a sense and enable them to have a quality of life again." (VSS funded organisation).

While there was recognition that full recovery, beyond improving quality of life may be unrealistic for the first generation of victims and survivors, practitioners strongly believed that things could be different for the second and third generations.

"But barriers as well… some people as well having put something into the Pandora's box… they're very, very nervous about opening all that up, all that exposure. Especially if they're people who have got to 70 years of age and they're thinking to themselves, I'm in my 70's and I'm getting by. I'm managing to live to some degree. There's an argument I've heard for first generation victims that it's almost too late. But without question for second generation and for the intergenerational issue it's not too late." (VSS funded organisation)

This hope for change is revisited in the following section in relation to facilitators to provision of effective psychological services.

Key observations related to breaking down barriers to the provision of effective psychological services:

- Adequate resources.
- Workforce matches increasing demand for psychological service provision.
- Number of therapeutic sessions matches client need.
- Standardised outcomes framework across all HSCTs needed to support. Research/evidence what is working/not working to inform effective psychological service provision for victims and survivors.
- Shift of focus in statutory sector to client 'outcomes' rather than waiting list targets.
- Need to address co-morbidities, especially substance use disorder, in the statutory sector.
- GP training – trauma aware as underlying Troubles related trauma often masked by anxiety, depression etc.
- Training and education needs.
- Specialist trauma practitioner qualifications.
- Creating a safe space to disclose Troubles-related trauma without fear of recrimination.
- Focus on improving quality of life (as opposed to full recovery) for first-generation victims and survivors.

6.6 Overarching Theme 3 and sub-themes

Facilitators to the provision of effective psychological services; Moving past victimhood: I'm a survivor

A number of participants discussed solutions to moving forward and breaking any transgenerational legacy of the Troubles. Building resilience in children and grandchildren of victims and survivors was seen as a key strategy for promoting hope and helping the next generation move beyond victimhood.

"So as a result of a young person's parents or grandparents being a victim or a survivor, then they are treated as a victim or a survivor themselves. And for me we have to start looking at things differently, and help them to build the resilience so they're not seen, not to be medicalising that. Because when do we break that cycle, and begin to promote the strength that is there in society. Encouraging wellbeing and responsibility, and change in our lives. And that needs to happen from a younger age, and as we move up through, or down through the generations, we need to begin to change that mind-set as well. So that we can encourage and treat the people that have difficult lived experiences, but to change the mind sets of the young people coming up so that they're not living in that memory, or by what's been fed down to them by those who've lived those experiences. I think there's a big piece of work in that!" (HSCT Senior Manager)

"What I've learned is that we need to help people learn not to be victims. Like another society. Victimhood. We need to be encouraging people that there's hope and you can, I've seen it, you can get your life back, and you can deal with the past in a way that's healthy, both mentally and psychically. I think we as a society need these people to be able to find a new way of living." (HSCT, Specialist Troubles Related Trauma Service)

As reported in section 1, some studies have reported that Northern Ireland has the highest rate of suicide in the United Kingdom with rates doubling in the past 10 years (NISRA, 2014; Snowcroft, 2013; Tomlinson, 2012). In a population of 1.7m, there were 305 suicides in Northern Ireland during 2017 (NISRA, 2018). As highlighted in previous studies, this increase in suicide rates appears to have come at a time when the Northern Ireland population is emerging from a 30-year period of civil conflict and violence and has in part been attributed to a legacy effect of the Troubles. (O'Neill et al., 2017). However, it is worth noting that these high rates have been questioned by recent analysis by NISRA that suggest that the method of recording suicide may have inflated the Northern Ireland rates. The 2019 provisional total (197) is a significant fall in previous years (2008 – 307) due to improvements in the statistical analysis of the data and collation of the suicide data at source. This has ultimately reduced the number of deaths coded with a finding of 'undetermined intent', while increasing the numbers coded as 'accidental' which fall outside the definition of suicide. [20]

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[20] https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/Guidance%20Note%20to%20Users%20on%20Suicide%20Statistics%20in%20Northern%20Ireland.pdf

Trust

The most commonly cited factor relating to engagement of effective psychological services was 'trust'.

"I suppose another way when we are working with someone who perhaps was a perpetrator of a particular activity or crimes. It's about being really clear from the outset what the limits of confidentiality are, and about just being really crystal clear about what our professional duty is, and what the protection is for them. And if they work within those limits, we can try and do as much work as we can. It's trying to be clear from the outset so there's no surprises for them. Building a trusting relationship with someone." (HSCT 3 Senior Management 4)

Likewise, for those who have been impacted by the violence, trust can be a major barrier to accessing help. One participant reported:

"What we hear from victims all the time is that "I don't go to my GP, I don't trust my GP, or I had a bad experience with my GP, I told them what happened to me and they didn't believe me", or its legacy based… back in the day they had issues, they experienced something, they were attacked or something happened to them, and they felt it was unsafe to go tell the GP, cause the GP was part of the statutory bodies and felt they couldn't tell them… 30 years later they're still living with the trauma. They don't trust the GPs." (VSS Case Manager)

"I think there's no short-term intervention… no short-term fix for the likes of the historical, Troubles related stuff. I think it's a much longer piece of work. I think primarily, early sort of therapy focuses heavily on the therapeutic alliance and developing that trust. And I've seen that from my own experience. You can't go anywhere near the trauma stuff until they really trust you" (HSCT 3 Senior Management 3)

Wrap around support

Wrap-around support was seen by some respondents in the non-statutory sector as a key facilitator to effective psychological services for victims and survivors, especially in recognition of the barriers that mistrust in traditional psychological interventions can introduce.

"We should be thinking wider than that, in terms of different interventions that we can apply… still psychological interventions, that maybe those trust issues wouldn't exist… like the equine therapy, or art, music therapy… you know, all those alternative things were people don't have to sit down one-to-one and say exactly what they did in the past, but they're still able to use the therapy to move forward in their own mind." (VSS Case Manager 2)

"I know there's been really positive outcomes from the XXX cultural piece of work. The Public Health Agency run a pilot, I think it ran for a year, two years? And the evaluation has been really, really positive, and some of the victims' groups were involved in that. It gives you the opportunity to do that therapeutic work, especially for men of a certain age, who have a certain experience, whether they were on one side perpetrating, they were in military, you know in some capacity… those men seem to respond really well to that type of treatment. Inadvertently they're talking about their issues, but they're not having to sit down in front of one person." (VSS Case Manager)

Practitioners in the statutory sector also felt that psychological therapy is not always the panacea for providing effective psychological services to victims and survivors. In the context of Troubles related trauma, multiple needs need to be addressed in addition to psychological therapies.

"I think as well though, communities need to be mindful that as much as they need to be aware of how much psychological therapy is available, that's not necessarily the answer either. We still live in a divided society, and there's lots of social and economic problems, and unless we collectively as a society are addressing those things, there's only so far that we can actually get with psychological therapy." (HSCT Senior Manager)

"Even on very practical levels as well, when you're considering stepping a client down from therapy, or what you're referring them onto, it's not necessarily more services doing the same thing, but it's actually services doing different things. More along the lines of, the buzz word these days is social prescribing. You know, what can we get someone into that is therapeutic, but not therapy. And that's what we really lack." (HSCT Senior Manager)

"As we've moved away from the older style model of things like day hospitals, long term supports, that's the type of thing that we are lacking. We don't have services that support people. And even the idea of support is an anathema currently, well that's institutionalisation and we're making them dependent. We can't refer onto any service with the mention of the word support because they'll instantly come back and say we don't do that. The service is an intervention. You have to do something and then pull out. It means there's a real lack of services that might be there for people across the longer term." (HSCT Senior Manager)

This final quote highlights the importance of a longer-term support plan that addresses the range of psychological needs, drawing on the specialist skills within both statutory and non-statutory sectors.

"Because to me it's not about them and us. It's about… it's like a puzzle, and we all have a place in the puzzle. So it's stepped care. So you have step 1, step 2 which is appropriate for a particular level of severity of condition. And then you have step 3 and above are the mental health services." (HSCT Senior Manager)

Key observations related to facilitating the provision of effective psychological services

- There is a need to understand and break a cycle of transgenerational trauma, through building resilience in second and third generation children and grandchildren of victims and survivors and promoting hope for mental health and wellbeing.
- More research is required to understand the concept of transgenerational trauma.
- More research is required to understand links between a post-conflict society and suicide rates.
- GPs, and other professional practitioners who care for victims and survivors, need to recognise the specific fears held by victims and survivors around disclosure, and clearly

outlining the limits to confidentiality and professional duties so that clients feel safe to open up about Troubles-related trauma.

- The psychological needs of victims and survivors cannot be met by psychological services in isolation, but require a holistic approach that addresses their biopsychosocial needs – drawing on the wide range of specialist skills and support structures across both statutory and non-statutory sectors.

6.7 Overarching Theme 4 and sub-themes

Adequacy of services

Senior managers in the statutory sector all believed their psychological services to be more than adequate for meeting the needs of victims and survivors. The key barrier to the adequacy of services always related to a lack of resources and long waiting lists.

"The problem is, it comes back to is the time span, the waiting list, resources. It's not questionable whether we have the staff to deal with trauma, and the skills to deal with trauma. It's just the waiting list." (HSCT Senior Manager)

"When we move up into the higher tiers, is it adequate, resource wise?" (HSCT 3 Senior Manager 2)

"The figures say no… the computer says no. We are just inundated with referrals, and the waiting lists are huge." (HSCT Senior Manager)

Similarly, the non-statutory sector believed their services to be working well based on the positive outcomes from their talking therapies. However, they also recognised the need to look at re-referral figures for a more accurate picture of what therapeutic approach is most effective, and the length of time required to facilitate recovery, so that clients do not get caught in the vicious cycle described earlier in this report.

Disparity of services

Practitioners in the statutory sector highlighted the disparity of services throughout Northern Ireland, with some areas providing more adequate psychological services to victims and survivors than others.

"Locally, it's better off for them because there's four or five of the services that actually receive the funding from the victims' service to do the trauma work for anybody affected by the Troubles. And depending on what kind of symptoms they're coming with, will depend on what type of therapy they're offered in that place. But they do have CBT, psychology, and some of them do have EMDR. Two centres have EMDR." (HSCT Senior Manager)

"Therein lies the problem really, because the higher populated areas… Belfast, Derry, do have a strong statutory and voluntary sector, whereas if you go to the outlying areas, it just doesn't happen… So, it means that a lot of it would fall back into our services, because people aren't able to get transport." (HSCT Senior Manager)

Key observations related to adequacy of psychological services

The first recommendation reiterates the key recommendations from the overarching theme 2: overcoming barriers to effective psychological services

- Adequate resources.
- Psychological services workforce matches increasing demand for psychological service provision.
- Type and number of therapeutic sessions matches client needs to decrease re-referrals.
- Greater parity of services for victims and survivors across Northern Ireland and the border regions.

6.8 Overarching Theme 5 and sub-themes

Victim and survivor engagement; Streamlined pathway

In addition to presenting barriers to partnership working within and between sectors, some practitioners also recognised the need for a more streamlined pathway between sectors to facilitate victim and survivor engagement with psychological services.

"The other thing as well, it's more innovative pathways access. You know, we're very stuck in the traditional GP referral within, and that doesn't suit certain… And some people still from the troubles who approaching their GP is seen as institutional and they're not likely to engage that way." (HSCT Senior Manager)

"The first thing I would say, is to improve the pathways and make it easier for the client to access the service, and that intervention, and for that to happen properly then, it does need to have a clear pathway between the community and statutory services." (VSS Case Manager)

Client Informed choice

Given the unique needs of victims and survivors, practitioners also highlighted the need for client choice to facilitate engagement with psychological services.

"I've seen it a few times, with veterans who want to seek treatment through somewhere that doesn't have any links to the military itself, and have asked for psychological therapies referral (statutory sector) rather than be referred in the direction of XX (VSS funded organisation)." (HSCT Senior Manager).

"Because it's such a small community. I remember seeing a young man who'd been traumatised, and the staff member who'd been allocated, I don't know, was she the sister of one of his

attackers… So if people have connections, bad connections within, they need to be given the option to say "Right, if this doesn't suit, for whatever reasons, here's where else you can go." (HSCT Senior Manager)

Victim and Survivor feedback

One practitioner put forward an important solution as to how to help engage victims and survivors in psychological services within the statutory sector; namely, asking those who are reluctant to engage, what the barriers are?

"For me what could probably work better is more service user feedback in terms of what they think of the services that are on offer. From being involved in the RTN, I know that there is a sense that there are a group of people out there that don't access statutory services. That they find it easier to go to the Community and Voluntary services. So I would really like to find out what the meat on the bones of that is. Are there a group out there, what size is that group, why… what makes it difficult to access statutory services? Because to me it's not about them and us. It's about… it's like a puzzle, and we all have a place in the puzzle, so it's stepped care. So you have step 1, step 2 which is appropriate for a particular level of severity of condition. And then you have step 3 and above are the mental health services. So if there's a group of people out there who are quite severe but aren't accessing specialist mental health services, I'd like to know why, and what we could maybe do about that." (HSCT Senior Manager)

Further solutions included reducing waiting times, reminders about appointments, and giving victims and survivors hope that they can have a better quality of life.

"Well I suppose one of the off-putting things for a lot of people is the waiting list. So if we could cut the time people have to wait. I always feel that it's very hard when you're doing an assessment and someone's very keen to work out what's going on for them, and you have to say, "look we've a bit of a waiting list. Maybe four or five months" so I think that can be very off putting, the length of time that people have to wait. So if people had easier access, I think they would engage easier." (HSCT, Specialist Trauma Service)

"We've also now set up a new system where people get a text message from the trust through our PARIS, through our activity recording system. We've noticed that our Do Not Attends have dropped quite dramatically. Because part of the trauma is memory and concentration. So, ways in which we are trying to help people engage is by initially sending them wee reminders, or following them up" (HSCT Specialist Trauma Service)

"And the way we need to help them engage is to give them hope. When somebody comes here for assessment, they'll be told, we are using a recovery model… we've started using that word. It's now become very bandied about, but we'd expect you'd get something from this service… like posttraumatic growth. So when people come, and they've been told "I'll never get over this" And some people don't. But I think people need to be in charge of what recovery is for them." (HSCT Specialist Trauma Service)

Key observations related to Victim and Survivor engagement

- The need for a streamlined pathway was reiterated in this section – enabling referrals onward from non-statutory services to more specialised statutory services to cut out the need for victims and survivors to go to their GP.
- Victims and survivors should be given a reasonable and informed choice of location options for the most appropriate psychological service.
- In general, there is a key need to reduce waiting times for psychological therapies.
- More research is required to determine what the barriers are to victims and survivor engagement.
- Practical steps, such as appointment reminders can help increase engagement.
- Finally, it is important to promote hope that a better quality of life is possible.

6.9 Overarching Theme 6 and sub-themes

The new RTN

Overall, the new RTN was seen as a positive way forward for improving psychological services for victims and survivors, in relation to streamlining services, increasing workforce capacity, and providing additional support for victims and survivors.

"Obviously there's going to be better networks through the RTN… the VSS will most likely be part of the team in a way… the Case Manager will be, because they'll be very present with the RTN. So there'll be good contact with them." (HSCT Senior Manager)

"I think it's going to increase capacity at the very basic level, increase capacity for people to actually access therapeutic services in the context of trauma. So I think that can only be a good thing when we look at the demand, capacity issues that we do have in statutory services." (HSCT Senior Manager)

"And we're very motivated by this new RTN, being a part of that… helping to establish that, and get it up and running and going, and seeing what comes out of the pilot. It's another aspect to try and support and help victims and survivors." (VSS Case Manager)

A Niche Service?

However, there were also concerns that the new RTN may become too niche in terms of therapeutic approaches, and as such not fit for purpose in relation to addressing all Troubles-related trauma presentations and co-morbidities.

"Because if you did a needs analysis, or needs assessment of the people, the full gamut of people in NI who've got Troubles-related trauma, then I'd imagine you'd probably have a massive breadth of issues that we see. But if it gets to narrowly defined, and sticks to one model. And it may do that because of the research base, the evidence base for what therapies do work, but I think it'll have to look at complex trauma using systemic approaches, all those sorts of things… family therapy." (HSCT Senior Manager)

This links in with additional concerns that if the new RTN focuses only on those with a diagnosis of PTSD, many patients with underlying Troubles-related trauma may be missed.

"That's where… any service that specifically defines and only narrows it to PTSD might miss an awful lot of what actually is happening in terms of what people are presenting to services." (HSCT Senior Manager)

Troubles-related trauma presentations may not always meet PTSD criteria.

Some practitioners stated that although patients with Troubles-related trauma may not present with a PTSD diagnosis, they may be suffering from trauma related problems although the primary presentation may be another mental health condition such as depression.

"I suppose the other issue is that many people present… the new trauma service obviously is for people who meet the threshold for PTSD, for troubles related PTSD and other forms of PTSD. But obviously we see a lot of people who have traumatic attachment problems, and trauma in other ways that may not meet a diagnostic threshold for PTSD." (HSCT Senior Manager)

"And that's where there's a big stumbling block, because a lot of people get referred to us, and they're not referred for trauma… but it's around, and nobody's maybe picked up the relevance of it. So you'll get someone referred for depression, alcoholism or whatever, and in the background, they've been shot years ago… or someone who presents with traumatic grief and maybe not presenting with PTSD classically." (HSCT Senior Manager)

"Myself and SM4, we specialise in psychosis, and the link between psychosis and trauma is actually stronger than between PTSD development and trauma or traumatic issues in itself. So, a lot of the patients we would see have trauma underlying as well in their psychosis development." (HSCT Senior Manager).

In summary, interviews relating to the RTN uncovered both high expectations plus reservations among practitioners in the statutory and non-statutory sectors: expectations for a more streamlined service, increased workforce capacity, and additional support for victims and survivors; reservations that the network may be too niche and miss a wide gamut of trauma presentations.

6.10 Section 2 - Concluding comments

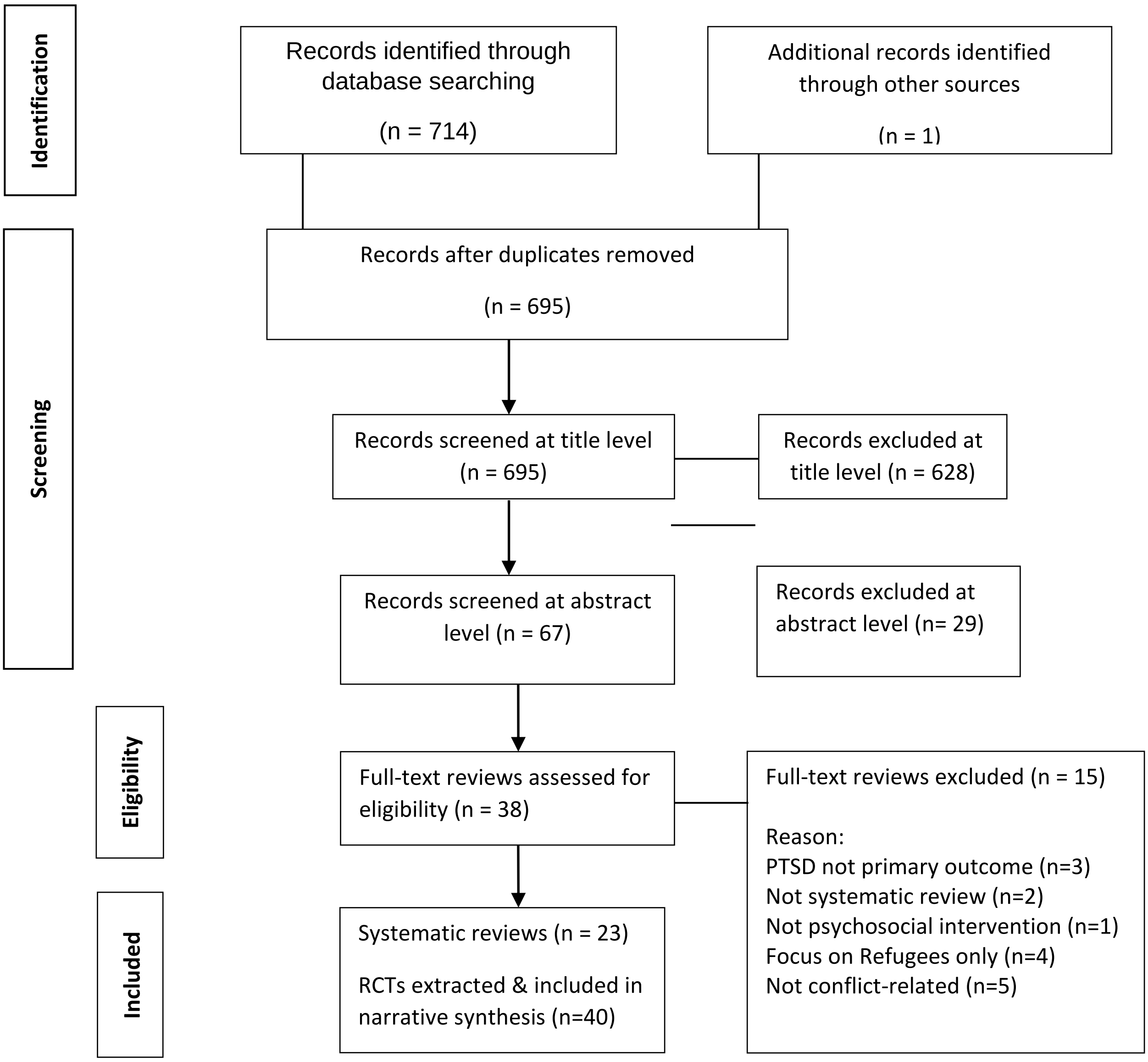
This section has captured themes and sub-themes using qualitative research methods and derived from interviews with individual clinicians and managers in both the statutory and voluntary sectors. The interviewees have provided responses based on their experience working in this sector and arguably can provide informed insights into how the services have been effective or can be improved.

References and appendices for Reports 1-5

Appendices to Literature reviews

Review 1- Psychological interventions for PTSD related to war, terrorism and civil conflict: An overview of systematic reviews

Flow diagram of review process for Review One -



Screening process

The review process and results are outlined in the PRISMA flow chart (appendices Figure 1). Reviews with clearly identifiable populations not specific to this review (e.g. natural disasters Road traffic incidents) or not addressing psychological treatments for PTSD (e.g. prevalence studies of

PTSD), were rejected at title screening by one review author (T.M.). Two authors (T.M. and M.D.) discussed and reviewed abstracts of all retrieved articles against the inclusion criteria. Any potentially relevant articles retrieved in full text were independently reviewed by the same two authors. Interrater agreement was 90 % and any disagreements were resolved by discussion with a third reviewer (C.M.) A record was kept of all excluded reviews along with the reason for exclusion.

The same rigorous screening process was used to identify individual RCTs from the selected systematic reviews. For this second stage, studies were included if a) the population of interest were people with a diagnosis of PTSD; b) studies included people exposed to war, civil conflict and terrorism, physical injury, combat, abductions, and torture; c) psychological interventions were evaluated using RCT's: d) psychological intervention were compared to another active psychological treatment, a wait-list control group or treatment/services as usual; e) standardised PTSD measures were used.

We did not apply any limits based on publication status or language of publication of studies. Studies focused on prevalence of PTSD only; refugee/asylum seekers only; sexual violence only, non-conflict-related trauma only, pharmacological treatments were excluded. Protocols and pilot studies were also excluded.

Data Extraction from individual RCTs

Any discrepancies in data extraction were discussed and resolved by two review authors (T.M. and M.D.). A data extraction table was developed to support the narrative synthesis of included RCTs, which comprised participant characteristics, trauma type (when available), description of the intervention and comparison, and the PTSD outcome measure(s) used.

Risk of Bias

Individual RCTs identified from the included reviews were assessed using the Cochrane Collaboration's 'Risk of bias' tool. Studies were assessed for risk of bias by two reviewers (T.M. and M.D.) on sequence generation, allocation concealment, blinding procedures, outcome data and reporting. RCTs assessed as having a low risk of bias were rated as high quality, those assessed as having an unclear risk of bias were rated as moderate quality, and those assessed as having a high risk of bias were rated as low quality.

As blinding of participants to intervention allocation is uncommon in psychological interventions, we used the following criteria from the Cochrane Collaboration's 'Risk of bias' tool to make a judgement on risk of bias for this domain "Either participants or some key study personnel were not blinded, but outcome assessment was blinded and the non-blinding of others unlikely to introduce bias". If the judgement was yes, the RCT was assessed as having a low risk of bias for this domain.

An example of part if the search strategy used in review 1

Setting: War/conflict, political violence (search string from Review 1 -therapies for PTD protocol

warfare OR "armed conflict*" OR war* OR warfare OR war-torn OR "war torn" OR warzone* OR post-war* OR postwar* OR (conflict adj1 (area or zone*)) OR post-conflict* OR postconflict* OR ((communal or violen* or political or military) adj2 conflict*)OR violence OR "exposure to violence" OR "ethnic violence" OR ((political* or military or communal or state) adj2 violen*) OR (ethnic cleansing or genocid*) OR terrorism OR Civil Disorder* OR "civil violence" OR "civil conflict" OR "civil disorder*" OR riot* OR terrorist* OR insurgen* Vetrans*

1 exp "warfare and armed conflicts"/

2 (war or wars or warfare or wartorn or war-torn or warzone$ or post-war$ or postwar$).tw,kw.

3 armed conflict$.tw,kw.

4 (conflict adj1 (area or zone$)).tw,kw.

5 (post-conflict$ or postconflict$).tw,kw.

6 ((communal or violen$ or political or military) adj2 conflict$).tw,kw.

7 violence/

8 exposure to violence/

9 exp ethnic violence/

10 ((political$ or military or communal or state) adj2 violen$).tw,kw.

11 ((communal or communit$ or ethnic$ or military or political$ or state) adj2 violen$).tw,kw.

12 (ethnic cleansing or genocid$).tw,kw.

13 exp terrorism/

14 exp Civil Disorders/

15 (civil violence or civil conflict or civil disorder$ or riot$).tw,kw.

16 (terrorist$ or terrorism or insurgen$).tw,kw.

17 or/1-16

Review 2

A Systematic Review of the Association between War Related Parental Post-Traumatic Stress on Family Functioning

Search Strategy

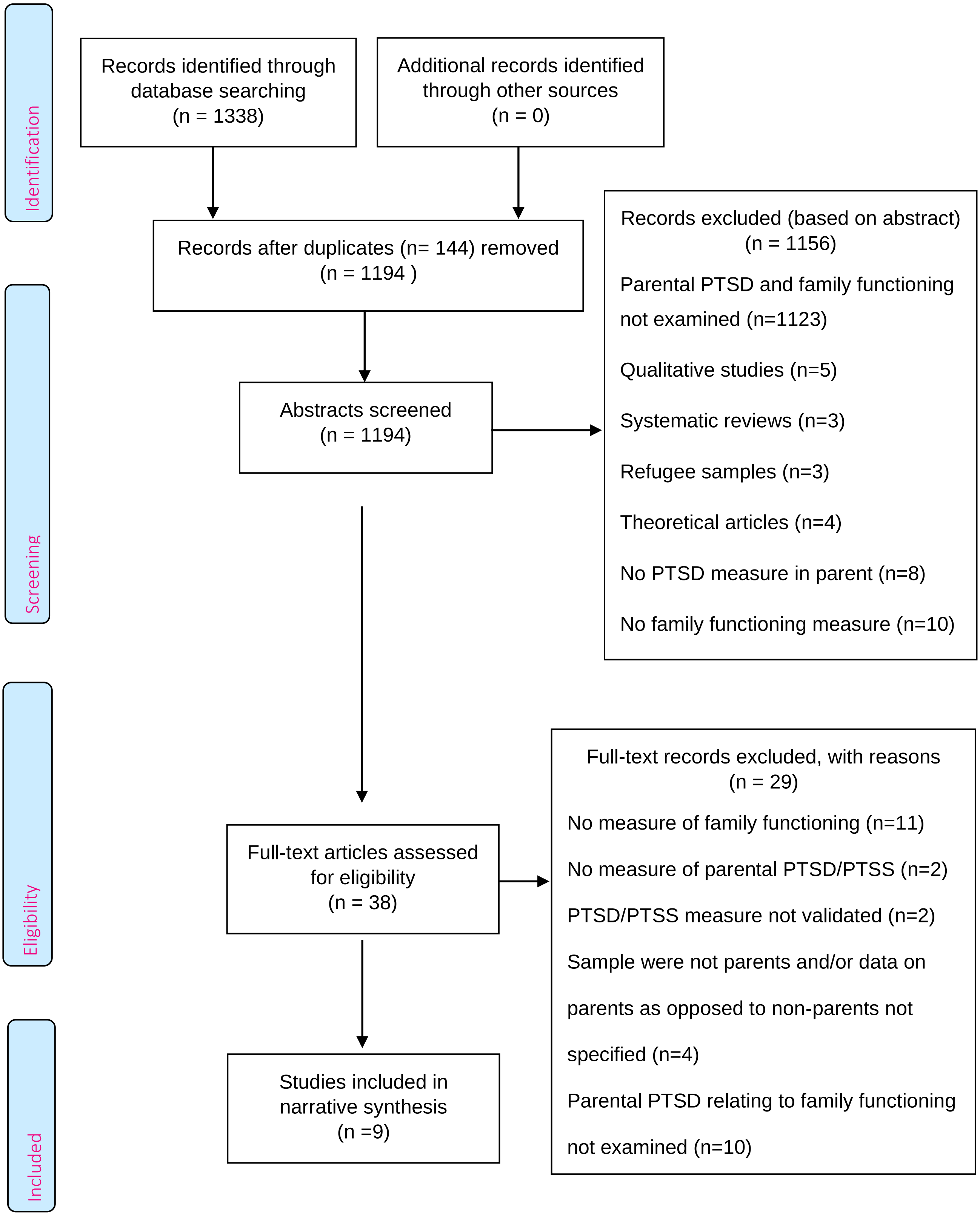
The current study protocol was registered on Prospero in January 2019 (CRD42019120169). The time period for the searches was from 1980 to January 2019 (PTSD was first introduced in 1980 following the publication of the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM-III; American Psychiatric Association, 1980)).

To meet the eligibility criteria, PTSD/PTSS must have been relating or stemming from civil conflict or war related trauma (as opposed to other types of trauma, i.e. sexual abuse) and defined by either a previously medically documented diagnosis of PTSD/PTSS or via a well-established measure of PTSD/PTSS. Examples of such measures include; The Mississippi Scale for Combat-Related PTSD (M-PTSD; Keane, Caddell & Taylor, 1988) and the Clinician-Administered PTSD Scale (CAPS; Blake et al., 1995).

Study Selection and Data Extraction

All identified studies were reviewed by the first author to determine eligibility. Studies were screened by title and abstract and irrelevant studies were excluded. The remaining studies were assessed via full text according to the inclusion and exclusion criteria by the first author and an independent reviewer. Relevant data was then extracted from each study including sample characteristics, PTSD and family functioning measure, participant(s), setting and relevant statistics regarding the association between parental PTSD and family functioning (e.g. effect sizes).

PRISMA Flow Diagram (Moher et al., 2009)



Quality Assessment

A quality assessment of the final studies was conducted by the first author and an independent reviewer using a 14-item quality assessment tool (The Quality Assessment Tool for Studies with Diverse Designs (QATSDD).

Each item is scored from 0 ('not at all') to 3 ('complete') on criteria including sample size and analytical technique employed with a total possible score of 42 (Sirriyeh, Lawton, Gardner & Armitage, 2011). Items 11 and 14 were excluded as these relate to qualitative studies only. The inter-rater reliability for assessment of the quality of the nine included studies was excellent (Intra Class Correlation =.91). All except two studies were assessed to reach above the recommended acceptable value of 60% (Sirriyeh et al., 2011). Low quality scores in these studies related to a lack of information regarding the aims of the study with no explicit hypotheses referred to in either paper (e.g. reference to broad aims only). This therefore reduced quality ratings on how the method of data collection and analytical methods were decided upon. Most studies made some reference to the psychometric properties of measures utilized as based on previous research (Davidson & Mellor, 2001; Marsanic, Margetic, Jukic, Matko & Grgic, 2014; Vukovic et al., 2015) while one study made no reference to reliability and validity (Westerink et al., 1999). Other studies tested the internal consistency of most measures utilizing their own data set (Al-Turkait, Smith, Iverson & Vogt, 2008; Harkness, 1990; Hendrix & Anelli, 1993; Jordan et al., 1992; Vaughn-Coaxum et al., 2015) and just one study considered the validity of two of their included measures (Al-Turkait et al., 2008). Only two of the aforementioned studies tested the internal consistency of family functioning measures with their own data set (Hendrix et al., 1993; Vaughn-Coaxum et al., 2015) highlighting the potential lack of psychometric data available on such instruments and the population in question.

Table 1 Studies included in *Systematic Review of the Association Between War Related Parental Post-Traumatic Stress on Family Functioning*

Study Name	War/civil conflict setting	Study design	Informants	No. of subjects (*n*)	Mean age (SD) of subjects	Gender	Recruitment setting	Comparison group	Quality score (QATSDD)
Al-Turkait et al. (2008)	Gulf War (Kuwait)	Cross-sectional	Veteran, s/p offspring	*n*=166 military father and *n*=166 mother pairs	Veteran; not specified	Veteran; all male sample	Records of the Ministry of Defense	Offspring were divided into groups according to father's level of combat exposure	71%
				Offspring, *n*=289	Offspring; (M^{age} = 13.6; SD=5.4)	Offspring; 48.9% (F)			
Davidson et al. (2001)	Vietnam War (Australia)	Cross-sectional	Veteran, offspring	Veterans, *n*=50, Civilian adults, *n*=33	Veterans; (M^{age}=51.6, SD=3.7)	Not specified	Vietnam veteran associations	Veterans with PTSD (*n*=30) compared with veterans without PTSD (N=20) and civilians (*n*=33)	64%
				Children of veterans (*n*=50) (sub-grouped according to their	Offspring; (M^{age}=23.4, SD=4.5);				

				fathers’ PTSD status) compared with civilian peers (*n*=33)					
Harkness (1990)	Vietnam War (U.S.A)	Cross-sectional	Veteran, s/p, offspring	Veterans, *n*=40 Offspring, *n*=85	Veterans; (M^{age}=40) Offspring; (M^{age}=11)	Veteran; all male sample Offspring; 47% (F)	Outreach services for veterans	Sample split according to PTSD severity (mild and severe)	74%
Hendrix et al. (1993)	Vietnam War (U.S.A)	Cross-sectional	Veteran	Veterans, *n*= 82	Veterans; (M^{age}=45, SD=3)	Veteran; 3% (F)	Vietnam veterans’ newsletter	No comparison group	61%
Jordan et al.(1992)	Vietnam War (U.S.A)	Cross-sectional	Veteran, s/p	Veterans with PTSD (*n*=319), veterans without PTSD (N=871) and corresponding	Veterans with PTSD; majority (47.7=7%) aged 37-39	Veterans; all male sample	Recruited from the National Survey of the Vietnam Generation	Veterans with PTSD and without PTSD	54%

				spouses/partners (*n*=376)	years.		(NSVG)		
Marsanic et al. (2015)	Homeland War ’91- ‘95 (Croatia)	Cross-sectional	Offspring	Clinically referred offspring of PTSD war veterans (*n*=122) and clinically referred offspring of veterans with no PTSD (*n*=122)	Adolescents; (M^{age} 15 years, SD=3.49)	Offspring; 53.2% (F)	Outpatient psychiatric hospital	Child of veteran father with PTSD and child of veteran father without PTSD	61%
Vaughn-Coaxum et al. (2015)	Iraq/Afghanistan wars (U.S.A)	Cross-sectional	Veteran	318 single (*n*=74) and partnered (*n*=244) veteran parents	*Parents*; Single (M^{age}=35.12, SD=8.50), Partnered (M^{age}=37.81, SD=8.68)	Parents; 44% (F)	Sample identified from a defence manpower data centre	Single and partnered parents	81%
Vukovic	Homela	Cross-	Offsprin	Clinically referred	Offspring;	Offspring	Outpatient	Offspring split according	70%

et al. (2015)	nd War ’91- ‘95 (Croatia)	sectional	g	offspring of PTSD war veterans; full PTSD=610, partial PTSD=108, no PTSD=633.	(M^{age}=15.2 years, SD=2.61)	(F=55.6%)	psychiatric hospital	to father’s level of PTSD (partial, full and no PTSD)	
Westerink et al. (1999)	Vietnam War (Australia)	Cross-sectional	S/p, offspring	Partners (*n*=31) and children (*n*=22), of treatment seeking Vietnam veterans	Veteran with PTSD partners; (M^{age}=28.1, SD=5.66) and children > 15 years, M^{age} =20.9, SD=4.56)	Partners; 100% (F) Offspring of veterans with PTSD; 72% (F)	Clinical setting; participants had contact with hospital.	Controlled comparison group	50%

Note. ‘sp’ indicates spouse/partner

Table 2. Overview of studies including their statistical analyses and key findings

Study Name	PTSD/ PTSS measure	Family functioning measure	Quality score	Statistical tests	Statistical associations	Key findings relevant to review

Al-Turkait et al. (2008)	CAPS (fathers) PTSD Checklist (mothers)	FAD; all subscales	30	Multiple regression analyses, T-tests, One-way ANOVA	Father PTSD on affective responsiveness: β = -0.17*, *t*=-2.7 Mother PTSD on FAD: *t* (276) = 2.2, *d* = 0.33*. Both parents' PTSD on communication; (M=2.0, SD=0.3, *p*<0.003), both parents PTSD on problem solving; (M=2.2, SD=0.1, *p*<0.04) controlled for age of parent and child and child's education level.	Father's PTSD symptom severity was significantly associated with poorer affective responsiveness. A significant difference between groups was observed where mother's with PTSD reported poorer family functioning scores. Children with parents who both had PTSD tended to have poorer family functioning scores in comparison to those where both parents had no PTSD. The differences were significant for the communication and problem-solving subscales.
Davidson et al. (2001)	M-PTSD	FAD; 6 subscales	27	Univariate, F-tests	*Parent report:* PTSD and affective involvement, F(2,80)=5.38, n^2=.12*; PTSD and affective responsiveness, F(2,80)=14.16, n^2=.26**; PTSD and communication, F(2,80)=10.46, n^2=.21**; PTSD and problem solving, F(2,80)=14.28, n^2=.26**; PTSD and behavior control, F(2,80)=0.13, n^2=.00; PTSD and roles, F(2,80)=2.04, n^2=.05 *Child report:* PTSD and affective responsiveness, F(2,80)= 4.02,	Parent veterans with PTSD rated their families as significantly less healthy than comparison groups on all subscales except for roles and behavior control. Compared with other children of veterans without PTSD and civilians, offspring of parents with PTSD had poorer functioning across all domains (except for behavior control) with a statistically significant difference observed in problem solving and affective responsiveness when compared with the civilian group.

					n^2=.09*; PTSD and problem solving, F(2,80)= 4.59, n^2=.10*, PTSD and affective involvement, F(2,80)= 0.13, n^2=.00; PTSD and behavior control, F(2,80)= 0.19, n^2=.01; PTSD and communication, F(2,80)= 1.24, n^2=.03; PTSD and roles, F(2,80)= 0.24, n^2=.01	
Harkness et al. (1990)	Diagnosis of PTSD according to DSM-III criteria	FACES; Cohesion, Adaptability & total score	31	T-tests	*Parents*: Severe PTSD group and Cohesion, *t* (77)=3.0**, *d* = .68; severe PTSD group and Adaptability, *t* (77)=1.3, *d*= .28; severe PTSD group and total family functioning score, *t* (77)=2.5*, *d* = 0.53. *Offspring*: Severe PTSD group and adaptability, *t* (462) =2.20*, *d* = .36; Mild PTSD group and adaptability, *t* (462) =2.308*, *d* = .38 (both compared to normative scale values).	There was a significant difference between the two parent groups in relation to cohesion; severe PTSD group reported feeling significantly less engaged from their families. Compared to the mild PTSD group, the severe PTSD group was significantly more likely to have overall lower functioning. Offspring; Significant differences found on adaptability between both PTSD groups and normative scale values.
Hendrix et al. (1993)	PPTSDS (veteran)	FACES; Cohesion & Adaptabili	26	Pearson correlation analysis using the 3 PPTSDS	PTSD (intrusion) and cohesion, *r*= -.27* and adaptability, *r*= -.32**; PTSD (avoidance) and cohesion, *r*= -.30* and adaptability, *r*= -	PTSD symptoms of intrusion and avoidance were significantly negatively associated with lower cohesion and adaptability. Global perception of distress was not significantly associated with

		ty subscales		subscales: intrusion, avoidance and global perception of distress	.33**; PTSD (global perception of distress) and cohesion, *r*=.00 and adaptability, *r*=.09.	cohesion or adaptability.
Jordan et al. (1992)	M-PTSD	FACES; Total score	23	Chi squared tests	*Veteran parent:* PTSD and family functioning total score; X^2 (1, *n*=785) = 109.7, *p* < .001). *Spouse/Partner*: X^2 (1, *n*=260) = 2.9, *p* < .088).	Veterans with PTSD reported significantly poorer family adjustment with 54% of participants reporting functioning in extreme ranges, compared to veterans without PTSD. Spouse/partners reported some tendency for families of theater veterans without PTSD to be better adjusted than those with PTSD.
Marsanic et al. (2014)	Previous diagnosis of PTSD	FAD; all subscales	26	Mann-Whitney U test	Parental PTSD and problem solving, MWU = 1989, *z* = -9.74, *r*=.62**; PTSD and communication, MWU = 2711.5, *z* = -8.40, *r*=.54**; PTSD and affective responsiveness, MWU = 1538.5, *z* = -9.54, *r*=.67**; PTSD and affective involvement, MWU = 2168.5, *z* = -9.54, *r*=.61; PTSD and total FAD score, MWU = 1928, *z* = -9.27, *r*=.59**	Children of veteran fathers with PTSD reported significantly worse functioning across all domains (except for roles and behavior control) compared to children of veteran fathers without PTSD.

Vaughn-Coaxum et al. (2015)	PPTSDS	DRRI-2 (Family functioning subscale)	33	Linear regression analyses	PTSD and family functioning, β = -.20*, *t*=-2.78 (partnered); PTSD and family functioning, β = -.11, *t*= -0.80 (single).	For partnered, but not single parents, higher post-traumatic stress symptom severity was associated with poorer post deployment family functioning.
Vukovic et al. (2015)	M-PTSD	FAD; total score	29	Multivariate Analyses of Variance (MANOVA)	Full PTSD group (*M*=2.72, *SD*=0.20, *p*<0.001), partial PTSD group (*M*=2.63, *SD*=0.24, *p*<0.001), no PTSD group (M=2.45, SD=0.27, *p*<0.001), *F* = 38.79**	Significant differences were found between groups on family functioning depending on PTSD status. Levels of family functioning were significantly lower in the full PTSD group than the partial PTSD group (*d*=.40) and significantly lower in the partial PTSD than the no PTSD group (*d*=.70).
Westerink et al., (1999)	CAPS	FES	21	T-tests	*Spouse/partner*: PTSD and cohesion; *t* (27) = - 3.08**; PTSD and expressiveness, *t* (27) = -3.50**; PTSD and conflict *t* (27) =5.68** *Offspring*: PTSD and conflict, *t* (27) = 3.53**; PTSD and cohesion, *t* (27) = - 2.05.	Veteran partners/spouses with PTSD rated their families as having less cohesion, less expressiveness and a higher degree of conflict compared to controls. Families of Vietnam veterans were rated by their children as being significantly higher in conflict and lower in cohesion compared to controls although this result did not reach statistical significance.

Note. **p* < .05, ***p* < .01 *PTSD/PTSS measures: CAPS; Clinician Administered PTSD Scale, M=PTSD; Mississippi Scale for PTSD, PPTSDS; Purdue Post-Traumatic Stress Disorder Scale *Family functioning measures: FAD; Family Assessment Device, FACES; Family Adaptability and Cohesion Scale, DRRI-2; Deployment Risk and Resilience Inventory-2, FES; Family Environment Scale.

Table 3. Strength of associations between parental PTSD and domains of family functioning.

	Author	*Affective Responsiveness*	*Affective Involvement*	*Problem Solving*	*Communication*	*Roles*	*Behaviour Control*	*FAD Total*
FAD	Al-Turkait et al. (2008) (parent)	Small*[a]	---	Medium*[b]	Medium**[b]	---	---	Small*[b]
	Davidson et al. (2000)	Medium** (parent)	Small* (parent)	Medium** (parent)	Small – Medium**(parent)	Small (parent)	Small (parent)	---
		Small* (offspring)	Small (offspring)	Small* (offspring)	Small (offspring)	Small (offspring)	Small (offspring)	---
	Marsanic et al. (2014) (offspring)	Large*	Large*	Large*	Large*	*Not reported*	*Not reported*	Large*
	Vukovic et al. (2015) (offspring)	---	---	---	---	---	---	Medium-Large*

FACES		*Adaptability*	*Cohesion*	*FACES Total*
	Harkness (1990)	Small (parent)	Large** (parent)	Medium* (parent)
		Small* (offspring)	Small (offspring)	---
	Hendrix et al., (1993)	Medium**	Medium*	---
	Jordan et al., (1992)	---	---	*Effect size not reported*
FES		*Cohesion*	*Expressiveness*	*Conflict*
		Effect size not reported	*Effect size not reported*	*Effect size not reported*
	Westerink et			

	al. (1999)	
DRRI-2		*Family Functioning Total Score (DRRI-2)*
	Vaughn-Coaxum et al. (2015)	Small* (partnered parents only)

Note. Effect sizes reported in Table 2 indicate all effects in Table 1, converted to Cohen's d effect sizes; the effect sizes for Al-Turkait et al. (2008) relate to fathers with PTSD only^a and relate to mothers with PTSD only^b

Review number 3

Psychological and Pharmacological Treatments for Comorbid PTSD and Substance Use Disorders Related to War and/or Civil Conflict: Systematic Review

Data Extraction

First step: Initial trawl of addiction literature to see if any papers related to trauma, and more specifically if any papers related to conflict related trauma

Search strategy: addiction AND “conflict related” AND trauma AND intervention AND treatment AND program* AND support AND service

See extraction table below for selected papers

Search string from PTSD & SUDs review - Interventions

pharmacotherapy OR pharmacologic* OR drug* OR medication* OR antidepressant* OR non?antidepressant* OR antipsychotic* OR anticonvulsant* OR "adrenergic-inhibiting agent*" OR alpha-antagonist* OR "opioid antagonist*" OR benzodiazepine* OR antianxiety OR antimanic agent* OR "mood stabili?er*" OR stimulant* OR treatment* OR psychotherapy OR psychotherapy* OR therapy OR social support OR education OR "mind-body therap*" OR "Mental Health Services" OR Biofeedback OR "Breathing Exercise*" OR hypnosis OR imagery OR meditation OR mindfulness OR Psychodrama OR "Tai Ji" OR neurofeedback OR Yoga OR "therapuetic touch" OR Aromatherapy OR Bibliotherapy OR Counsel?ing OR "Crisis Intervention" OR trauma-focus* OR ((Animal OR Art OR color OR colour OR dance OR gestalt OR laughter OR music OR narrative OR person-centred OR reality OR socioenvironmental) adj1 therap*) OR "Eye Movement Desensitisation and Reprocessing" OR EMDR OR psychotherap* OR psycho-therap* OR psychosocial OR psycho-social OR ((cognit* or behav* or psychol*) adj3 (intervent* or program* or therap* or treat*)

18 (pharmacotherapy OR pharmacologic* OR drug* OR medication* OR antidepressant* OR non*antidepressant* OR antipsychotic* OR anticonvulsant* OR adrenergic-inhibiting agent* OR alpha-antagonist* OR opioid antagonist* OR benzodiazepine* OR antianxiety OR antimanic agent* OR mood stabiliser* OR mood stabilizer* OR stimulant* OR treatment*)

19 exp psychotherapy/

20 psychotherap$

21 therapy.fs.

22 social support/

23 education/

24 exp mind-body therapies/

25 Mental Health Services/

26 (Biofeedback or Breathing Exercises or hypnosis or Imagery or Meditation or Mindfulness or Psychodrama or Tai Ji or neurofeedback or Yoga or therapuetic touch).tw,kw.

27 (Aromatherapy or Bibliotherapy or Counsel?ing or Crisis Intervention or trauma-focus$).tw,kw.

28 ((Animal or Art or color or colour or dance or gestalt or laughter or music or narrative or person-centred or reality or socioenvironmental) adj1 therap$).tw,kw.

29 ((Animal or Art or color or colour or dance or gestalt or laughter or music or narrative or person-centred or interpersonal or reality or socioenvironmental) adj1 therap$).tw,kw.

30 ((Eye Movement Desensitisation and Reprocessing) or EMDR).tw,kw.

31 (psychotherap$ or psycho-therap$).tw,kw.

32 (psychosocial or psycho-social).tw,kw.

33 ((cognit$ or behav$ or psychol$) adj3 (intervent$ or program$ or therap$ or treat$)).tw,kw.

34 or/19-33

Population

Post traumatic stress disorder OR posttrauma* OR post-trauma* OR (posttrauma*) OR (combat and disorder*) OR exp Substance Related Disorders/ OR (drug or substance$ or alcohol or opioid$ or amphetamine$ or cocaine or marijuana or cannabis or phencyclidine or benzodiaz$) adj2 (misuse or abuse$ or addict$ or depend$)).tw. OR (alcoholi$ or drinker$ or drinking$).tw. OR exp benzodiazepines/ OR (Post traumatic stress disorder) adj2 (comorbid*) adj2 ((drug or substance$ or alcohol or opioid$ or amphetamine$ or cocaine or marijuana or cannabis or phencyclidine or benzodiaz$) adj2 (misuse or abuse$ or addict$ or depend$))

35 Post traumatic stress disorder

36. posttrauma*

37. post-trauma*

38. (posttrauma*)

39. (combat and disorder*)

40. or/35-39

41. exp Substance Related Disorders/

42. ((drug or substance$ or alcohol or opioid$ or amphetamine$ or cocaine or marijuana or cannabis or phencyclidine or benzodiaz$) adj2 (misuse or abuse$ or addict$ or depend$)).tw.

43. (alcoholi$ or drinker$ or drinking$).tw.

44. exp benzodiazepines/

45. (Post traumatic stress disorder) adj2 (comorbid*) adj2 ((drug or substance$ or alcohol or opioid$ or amphetamine$ or cocaine or marijuana or cannabis or phencyclidine or benzodiaz$) adj2 (misuse or abuse$ or addict$ or depend$))

46. or/41-45

48. 17 and 18 and 34 and 40 and 46 and 47

Table **Psychological and Pharmacological Treatments for Comorbid PTSD and Substance Use Disorders Related to War and/or Civil Conflict: Systematic Review**

Authors	Design	Participants	Intervention	Clinical Outcomes	Clinical Scales	Clinical facility	Timeframe	Results	Limitations
Concurrent or integrated interventions for SUDs and PTSD									
Zandberg, Laurie J; Rosenfield, David; McLean, Carmen P; Powers, Mark B; Asnaani, Anu; Foa, Edna B;	RCT	Participants (n = 165) were adults meeting DSM-IV criteria for current AD and PTSD	165 adults were randomized to 1 of 4 groups for 24 weeks of: 1.naltrexone (NAL), 2. NAL and prolonged exposure (PE), 3.pill placebo, 4.pill placebo and PE.	PTSD predictors and moderators Drinking predictors and moderators	(Posttraumatic Stress Symptom Scale Interview; PSS-I) and AD percent days drinking from the Timeline Follow-Back Interview	Outpatient	During treatment, blind assessments and self-report questionnaires were completed every four weeks (from week 0 to week 24)	PTSD severity moderated the efficacy of PE on PTSD outcomes, such that the benefit of PE over no-PE was greater for participants with higher baseline PTSD severity. Baseline depressive severity moderated the efficacy of PE on drinking outcomes, whereby the benefit of PE over no-PE was greater for participants with higher depressive symptoms. NAL effects were most	Missing data: Several limitations should be noted. First, participants in the current study showed lower treatment attendance than is typical in PTSD treatment studies. Thirty two percent of the sample dropped out of the study, and the average number of sessions attended in PE was six out of a possible 18 sessions.

								beneficial for those with the longest duration of alcohol dependence.	
Luciano, Matthew T; McDevitt-Murphy, Meghan E; Acuff, Samuel F; Bellet, Benjamin W; Tripp, Jessica C; Murphy, James G;	Randomized Controlled Trial	Sixty-eight combat veterans (8.8% female; 27.9% African American)	1-session brief intervention that primarily targeted alcohol misuse but also included personalized feedback and psycho-education PTSD symptoms and coping. Participants were randomized to receive personalized written feedback either with or without a motivational interview.	PTSD symptom severity and diagnostic status	The Clinician-Administered PTSD Scale The AUDIT The Timeline Followback (TLFB)	outpatient	Participants completed follow-up assessments at two time points (6 weeks and 6 months after the intervention).	A mixed-model repeated measures analysis revealed that PTSD symptom severity was significantly lower at the 6-week (M = 41.47, SD = 28.94) and 6-month (M = 35.56 SD = 26.99) follow-up appointments relative to baseline (M = 51.22, SD = 26.67), F (2, 127.24) = 38.32, p < .001. Regression analyses demonstrated that the percent change in alcohol use was related to the change in PTSD severity. Further, results indicated that a motivational-	First, the causality between the intervention and reductions in PTSD symptomatology cannot be established, as the study did not include a no-treatment control group. Additional contextual factors, such as the passage of time or the comprehensive assessment process, may have contributed to a diminution in symptoms. Given that participants in the present study were

								interviewing-style counselling session accompanying the feedback was not significantly more efficacious than receiving feedback only.	engaging with VAMC services for the first time, it is possible that subsequent receipt of VAMC mental health services was associated with reduction in symptoms. It is also possible that change in PTSD occurred as a result of other unmeasured variables. Second, the small sample size limited statistical power
Back, Sudie E.; Killeen, Therese; Badour, Christal L.; Flanagan, Julianne C.; Allan, Nicholas P.; Ana, Elizabeth	**RCT**	Military veterans (N = 81, 90.1% male) with current SUD and PTSD	Groups were randomized to 12 sessions of COPE Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE) **or** Relapse	Reduced PTSD and Reduced substance use severity	Clinician Administered PTSD Scale (CAPS), PTSD Checklist-Military version (PCL-M), and the Timeline Follow-back	Outpatient	baseline, week 6, week 12, and 3- and 6-months follow-up	Several limitations sample size was small, which may have underpowered the analyses. Although the percentage of women in the study is representative of women in the U.S. military service	On average, participants attended 8 out of 12 sessions and there were no group differences in retention. Intent-to-treat analyses revealed that COPE, in comparison to RP, resulted in

Santa; Lozano, Brian; Korte, Kristina J.; Foa, Edna B.; Brady, Kathleen T.;			Prevention (RP)		(TLFB).			(Department of Defense (DoD), 2015), the small number of women limited our ability to evaluate gender differences.	significantly greater reductions in CAPS (d = 1.4, p < .001) and PCL-M scores (d = 1.3, p = .01), as well as higher rates of PTSD diagnostic remission (OR = 5.3, p < .01). Both groups evidenced significant and comparable reductions in SUD severity during treatment. At 6-months follow-up, participants in COPE evidenced significantly fewer drinks per drinking day than participants in RP (p = .05).
Psychological interventions for SUDs and PTSD									
Anke Köbach,	**Semi-Randomised Control Trial:**	98 male former	Narrative Exposure Therapy adapted for Forensic	PTSD, appetitive	Exposure to Violence	Out-patient	assessed prior to the	Mixed-model ANCOVA showed a significant interaction	The results are limited by the unnecessarily high

Susanne Schaal, Tobias Hecker and Thomas Elbert	Three phases of treatment delivery; each dissemination stage featured a balanced parallel group, semi-random design with a TAU control condition.	combatants	Offender Rehabilitation (FORNET) vs TAU (These participants assigned to TAU remained in the demobilization camp for 2–3 weeks or completed the usual programme in the local reintegration centre (1-year training in manual trades), respectively: in the demobilization camp, they received medical care and had access to psycho-social support (usually case-specific advice to the best of the advisor’s knowledge)	aggression, depression severity, drug dependence reintegration success which aimed at examining the course or reintegration (economic reintegration and connection with (para)military life; secondary outcome)	PTSD Symptom Scale-Interview Appetitive Aggression Scale		intervention and 6 and 12 months later; assessed reintegration success by assessing economic status and the participants connection with (para)military life.	of time × treatment (F (1, 92) =14.15, p ≤0.001, E 2 p=0.133, ε 2G =0.095), indicating greater PTSD symptom reduction in the FORNET group compared with TAU.	number of participants that were lost to follow-up, which was caused by the escalation of the conflict. This forced us to abandon matching dyads in the analysis to avoid further losses. With including participants that presented with only low symptom severities and excluding all participants that could not come for the follow-up assessment (instead of using intent-to-treat for instance), we chose a more conservative

									approach that may rather have underestimated the treatment effects.
Kendell L. Coker, Elina Stefanovics Robert Rosenheck	**Longitudinal study**: Data were drawn from administrative evaluation data collected by the VA's Northeast Program Evaluation Center (NEPEC) on all veterans who sought treatment from specialized intensive PTSD programs between 1993 and 2011.	12,270 dually diagnosed veterans	Specialized intensive Veterans Health Administration PTSD programs, characterized as one of four program types to which veterans were admitted: 1) Evaluation/Brief Treatment PTSD Units (EBTPUs), acute stabilization, PTSD evaluation, psycho-education, medical assessment, psychotropic medication and brief supportive psychotherapy; 2)	identify patient and program characteristics associated with improved outcomes for substance abuse.	Short Form of the Mississippi Scale for PTSD (MISS) Addiction Severity Index (ASI)	Out-patient	Outcomes were measured as changes from the admission assessment to four months after discharge based on continuous measures of substance use, PTSD symptoms and other clinical variables.	In comparison to the veterans in the short-term EBTPUs (the reference condition), veterans in the SIPUs (t= -3.91, β = -.031, p< .001) and in PRRPs (t= -3.57, β = -.032, p< .001) demonstrated significant relative improvements in ASI alcohol severity in bivariate analysis. Similarly, veterans admitted to SIPUs (t= -3.37, β = -.026, p< .001) and	First, the current data is associational and based on a specialized group. Thus we cannot ascertain whether the PTSD preceded the substance use or vice versa. However, prior research suggests that traumatized individuals may turn to illicit substances in an attempt to self-medicate due to the calming effects of the substances (Jacobsen et al., 2001; P. Ouimette

			Specialized Inpatient PTSD Units (SIPUs), with LOS of 28-90 days or longer which typically include acute hospital care, intensive trauma-focused evaluation, education, and intensive group and individual psychotherapy along with medical assessment and psychotropic medication; 3) PTSD Residential Rehabilitation Programs (PRRPs), with LOS similar to SIPUs but is less intensively supervised, and are less medically-oriented “halfway-house” settings					PRRPs ($t = -3.89$, $\beta = -.034$, $p < .001$) demonstrated significant relative improvements in ASI drug severity. With regard to discharge status, being transferred to another program was significantly associated with a reduction in ASI alcohol severity. In comparison to veterans who were discharged to another program or institution, veterans who were discharged to their own residence ($t = 5.95$, $\beta = .046$, $p < .001$) or to share someone else's residence ($t = 5.72$,	et al., 2010). et al., 2012).

			4) Day Hospital PTSD Programs, which are “therapeutic communities”					β $= .042$, $p < .001$) showed significant relative increases in ASI alcohol severity, possibly because they had more opportunities for alcohol use at those residences. The findings indicate that proper discharge planning in addition to intensity and duration of treatment for dually diagnosed veterans with severe PTSD may result in better outcomes.	
Robert J. Rotunda Timothy J. O’Farrell Marie Murphy Susan H. Babey	**Effectiveness study:** The sample was drawn from 122 consecutive couples who entered a Veterans Affairs (VA)	38 male substance abusing clients and their non-substance-abusing female Partners	Behavioral couples therapy (BCT)	increased relationship satisfaction reductions in drinking and negative consequences of	SUD and PTSD sections of the Structured Clinical Interview for DSM-III-R (SCID-P)	Outpatient	Each couple had assessment sessions at baseline, immediately after end of BCT, and quarterly in the year after BCT.	Small sample size may have limited power to detect differences between PTSD and non-PTSD groups, leading us to mistakenly accept the null hypothesis.	Thus each outcome showed improvement from before BCT to immediately after and 12-months after BCT; and extent of improvement and

	outpatient BCT program Nineteen clients who met DSM-III-R criteria for lifetime combat-related PTSD were matched on demographics with 19 other veterans who did not suffer from combat-related PTSD.			drinking, male-to-female violence psychological distress symptoms.	PTSD Checklist Military Version (PCL-M) Mississippi Scale for Combat-Related PTSD (M-PTSD) Combat Exposure Scale (CES) Timeline Followback Interview (TLFB; Sobell & Sobell, 1996) The Michigan Alcoholism Screening Test (MAST;			Second, we did not assess either group for traumatic events and symptoms that were not combat-related, and SUD-only clients were not interviewed using the PTSD section of the SCID at all, so undetected trauma symptoms may have affected study findings in unknown ways. Third, other Axis I disorders (anxiety, affective disorders) were not assessed in either sample, so their impact on study findings is unknown. Fourth, the study did not have a no-treatment control group so we cannot conclude that BCT caused improvements observed. Fifth,	pattern of change over time was similar for PTSD and non-PTSD clients. In terms of drinking, days abstinent increased and negative consequences of drinking decreased after BCT in both groups Figures: PTSD Checklist Military Version (PCL-M) a 48.8 16.7 19-83 r = .68 *** r = .44 * p < .001

					Seltzer, 1971) The Alcohol Dependence Scale (ADS; Skinner & Allen, 1982 The Drinker Inventory of Consequences (DrInC; Miller, Tonigan, & Longabaugh, 1995) The Dyadic Adjustment Scale (DAS; Spanier, 1976			nearly 60% of PTSD clients had current or recent VA counseling for PTSD, but the extent and the impact of this counseling is unknown. Sixth, although all had lifetime PTSD, only some had current PTSD with subthreshold symptoms for the remainder.	Mississippi Scale for Combat-Related PTSD (M-PTSD) b 97.4 10.0 80-120 -- r = .43 * p < .06 **Drinking and Related Variables** AND Relationship Functioning NOT STATISTICALLY SIGNIFICANT.

					The Conflict Tactics Scale (CTS; Straus, 1979) Total Score on the Symptom Checklist 90 - Revised (SCL–90–R; Derogatis, 1983)				
Monson, Candice M; Rodriguez, Benjamin F; Warner, Reid;	**Effectiveness study**: Assessing the effectiveness of PTSD treatment by examining different forms of CBT and the role of interpersonal	45 participants diagnosed with military-related PTSD	Trauma vrs skills-focused CBT	Reduction in PTSD symptom-atology, alcohol abuse, or violence perpetration	Mississippi Scale for Combat-Related PTSD (MISS) Addiction Severity Index (ASI) Four items	Outpatient	Measures were administered at admission and at four months post- treatment.	Limited by this study's design and size	Improvements in PTSD symptoms and alcohol abuse failed to meet statistical significance (PTSD: pre-treatment M=42.12, SD=4.10, post-treatment M=41.03, SD=5.01, Alcohol: pre-treatment M=.10,

	relationship functioning in those outcomes within a sample of veterans.				adapted from the National Vietnam Veterans Readjustment Study (Kulka et al., 1990).				SD=.12, post-treatment M=.16, SD=.18, p.10, There were no significant effects for treatment type or the time by treatment interaction (Wilk's .91, F=(3,41) 1.30, p.28, partial E=2.09, and Wilk's.94, F=(3,41) .81, p .49, partial E 2.06, respectively).
Roberts NP, Roberts PA, Jones N, Bisson JI	**Systematic Review:** Randomised controlled trials of individual or group psychological therapies delivered to individuals with PTSD and comorbid substance use, compared with waiting-	14 studies with 1506 participants	Effects of psychological therapies with a trauma-focused component and non-trauma-focused interventions against treatment as usual/minimal intervention and other active psychological therapies. Comparisons were	Reduction in PTSD symptom-atology, alcohol abuse and/or SUDs.	N/A	Mixed	3 to 4 and 5 to 7 months' follow-up.	We graded the quality of evidence as low to very low. This review includes a small number of studies. Some included studies were poorly designed, and most studies were small. very low-quality evidence).	Individual-based psychological therapies with a trauma-focused component plus adjunctive SUD intervention was more effective than treatment as usual (TAU)/minimal intervention for PTSD severity post-treatment (standardised mean difference (SMD) -0.41; 95%. Confidence interval

	list conditions, usual care, or minimal intervention or to other psychological therapies.		stratified for individual- or group-based therapies.							CI) -0.72 to -0.10; 4 studies; n = 405. PTSD severity following treatment completion As assessed by the CAPS, PSS-I, or IES-R. (High scores indicate greater symptom severity) SMD -0.41 (-0.72 to -0.1). Effect sizes of the range 0.2 to 0.5 indicate a small treatment Effect. Drug or alcohol use, or both following treatment completion As assessed by the TLFB or CIDI. High scores indicate

									greater symptom severity. SMD -0.13 (-0.41 to 0.15) Not significant
Kaysen, Debra; Schumm, Jeremiah; Pedersen, Eric R; Seim, Richard W; Bedard-Gilligan, Michele; Chard, Kathleen;	**Treatment outcome study**: study examines the effectiveness of CPT for veterans with PTSD and AUD, compared to veterans with PTSD only, who were enrolled in a VA outpatient treatment program as part of standard clinical services.	536 veterans diagnosed with PTSD who had received at least 1 session of CPT. The sample consisted of 482 males (90%) and 54 females (10%),	Cognitive Processing Therapy	Reduction in PTSD symptoms Reduction in Alcohol-use severity Reduction in Depression	Structured Clinical Interview for DSM–IV-TR, Non-Patient Version-I Clinician-Administered PTSD Scale PTSD Checklist – Specific Beck Depression Inventory-II	Outpatient	Participants completed the following measures at the initial diagnostic intake assessment and then within 2 weeks of completing CPT	Missing data was present on 11% of the values in the overall dataset. This included 67% of participants missing data on one or more variable, with missing values primarily occurring on post-treatment outcome measures.	Results from the mixed ANCOVA supported a significant decline in PCL scores, and a significant between groups effect of AUD diagnosis (see Tables 2 and 3). However, the AUD diagnosis by time interaction term was not significant (see Table 2). Post hoc Bonferroni comparisons revealed some support for our hypotheses. Those with past AUD were significantly

									different from those with no AUD. Independent samples t-tests showed that those with past AUD, had higher pre- but not post-treatment PCL scores when compared to those with PTSD only, pre-treatment pooled t (534) = 3.52, p < .001, d = .32, post-treatment pooled t (534) = 1.25, p > .22, d = .11
Norman, Sonya B; Trim, Ryan; Haller, Moira; Davis, Brittany C; Myers, Ursula S; Colvonen,	**RCT:** of 2 active treatments, I-PE and I-CS therapy, for PTSD and AUD	119 veterans	Integrated Exposure Therapy vs Integrated Coping Skills Therapy	PTSD symptoms and percentage of heavy drinking days	Clinician Administered PTSD Scale for DSM-5 the Timeline Follow-Back	Outpatient	before treatment, after treatment, and at 3- and 6-month follow-ups.	A limitation is that delivery of I-CS treatment in this study was different from how the SS treatment is typically delivered (in group or shorter individual	The I-PE arm had significantly higher rates of PTSD remission than the I-CS arm after treatment (8 of 36 [22.2%] vs 3 of 44 [6.8%]; χ

Peter J; Blanes, Erika; Lyons, Robert; Siegel, Emma Y; Angkaw, Abigail C; Norman, Gregory J; Mayes, Tina;								sessions). In general, group treatments for PTSD have lower effect sizes than individual treatments thus, current findings may not generalize to I-CS treatment delivered in group format. Other limitations of the study included a mostly male veteran sample, potentially limiting generalizability. Attrition was high (73.9% completed at least 1 posttreatment assessment), although comparable with other RCTs of I-PE treatment (eg, 48%-79% completing at least 1 post-treatment assessment).	^{2} = 3.96; P = .047) and 3-month follow-up (10 of 40 [25%] vs 2 of 33 [6.1%]; χ^2 = 4.72; P = .03)

Najavits, Lisa M; Krinsley, Karen; Waring, Molly E; Gallagher, Matthew W; Skidmore, Christopher;	RCT: to compare a new past-focused treatment (Creating Change; CC), to a well-established, evidence-based present-focused treatment for PTSD/SUD (Seeking Safety; SS), on symptoms of both disorders	Fifty-two male and female veterans with current PTSD/SUD	Past-focused treatment (Creating Change; CC) Vrs a well-established, evidence-based Present-focused treatment for PTSD/SUD (Seeking Safety; SS)	PTSD and SUD	Mini Neu-ropsychiatric Interview Addiction Severity Index-Lite (ASI) Beliefs about Substance Use The PTSD Checklist (PCL)	Outpatient	Assessments occurred at baseline, end-of-treatment, and 3-month follow-up unless noted otherwise.	A larger sample size would allow statistical power for subgroup analyses as well as to better understand assessment completion rates (for example, in this study fewer CC patients completed the follow-up but they also had more medical problems than SS patients, and those issues may be related).	Effect sizes were medium except for alcohol use, which was large. Change over time was primarily improvement from baseline to end-of-treatment, with gains sustained at follow-up, although for alcohol use there was continued improvement from end-of-treatment to follow-up. The majority of patients remitted on PTSD diagnosis: 57% at end of treatment and 63% at follow-up, with no differences by treatment condition. On three secondary

									measures no significant effects were found (Coping Self-Efficacy Scale; World Assumptions Scale; and Trauma Related Guilt Inventory [TRGI]). CC has promise as a PTSD/SUD therapy with strong public health relevance, given the results of this trial. We also did not have a solely treatment-as-usual or no-treatment control arm in this study.
Acosta, Michelle C; Possemato, Kyle; Maisto, Stephen A; Marsch, Lisa A; Barrie,	RCT: Veterans with PTSD/subthreshold PTSD and hazardous substance use were	Veterans with PTSD/subthreshold PTSD and hazardous substance	Web-Delivered CBT	PTSD, alcohol and other drug use, and quality of life	he Clinical Administered PTSD Scale (CAPS) The	Outpatient	Participants completed baseline and 4-, 8-, 12-, 16-, and 24-week follow-up assessments.	One limitation of the current study is the use of self-report data to assess our primary outcome of	Thinking Forward participants reported significantly greater declines in percent of heavy

Kimberly; Lantinga, Larry; Fong, Chunki; Xie, Haiyi; Grabinski, Michael; Rosenblum, Andrew;	randomized to primary care treatment as usual (TAU; n = 81) or to TAU plus a web-based CBT intervention called Thinking Forward (n = 81)	use were randomized to primary care treatment as usual (TAU; n = 81) or to TAU plus a web-based CBT intervention called Thinking Forward (n = 81).			Alcohol Use Disorders Identification Test (AUDIT) The Drug Abuse Screening Test-10 (DAST-10) The MINI International Neuropsychiatric Interview (MINI) The Timeline Follow-Back (TLFB) interview Medical Outcomes Study Social Support			alcohol and drug use (via TLFB). Finally, our study dropout may be seen as a limitation despite retaining the majority of our sample through the 3-month follow-up (76.5%). Over a third of participants (38.3%) completed all 11 core modules, which is consistent with other interventions of this type (e.g., Brief et al.,2013).	drinking days compared to TAU participants. (p= 0.125) after all mediators were included. Thinking Forward participants showed a greater decline in percent drug use days compared to participants in TAU, but the difference did not reach statistical significance. P=0.25 Regarding clinically significant change in PTSD symptoms, chi-square analyses did not reveal significant

					Scale (MOS-SSS) The Brief Situational Confidence Questionnaire (BSCQ The Future Scale readiness to Change Questionnaire (RTCQ) Connor-Davidson Resilience Scale (CD-RISC)				differences between treatment groups in the percent of participants who showed clinically meaningful improvement in PTSD symptoms on the PCL (i.e., N 10-point decrease) at either 12 weeks (TAU 31.3% vs. intervention 41.0% improved) or 3-month follow-up (TAU 29.7% vs. intervention 37.5% improved).
Brief, Deborah J; Rubin, Amy; Keane, Terence M; Enggasser,	RCT: to evaluate the efficacy of a newly developed, 8-module, self-	Six hundred participants, recruited through targeted Facebook	Initial Intervention Group (IIG;	Drinks per Drinking Day, Average Weekly Drinks,	The Alcohol Use Disorders Identification Test (AUDIT) The Quick	Outpatient	The AUDIT (eligibility) and CES-DRRI (baseline) were admin-	encountered high rates of attrition from the intervention (34% of IIG and 39% of DIG	IIG participants showed a significant decrease in DDD (B.504,SE.042,

Justin L; Roy, Monica; Helmuth, Eric; Hermos, John; Lachowicz, Mark; Rybin, Denis; Rosenbloom , David;	management web intervention (VetChange) based on motivational and cognitive-behavioral principles to reduce alcohol consumption, alcohol-related problems, and PTSD symptoms in returning combat veterans.	ads, were randomized to either an Initial Intervention Group (IIG; n = 404) or a Delayed Intervention Group (DIG; n = 196)	n 404) or a Delayed Intervention Group (DIG; n 196) that waited 8 weeks for access to VetChange.	Percent Heavy Drinking Days, and PTSD symptoms	Drink Screen (QDS; The Short Inventory of Problems (SIP) The Combat Experiences Scale of the Deployment Risk and Resilience Inventory (CES-DRRI) The PTSD Checklist–5 (PCL-5;		istered once. The QDS was administered at screening (eligibility) and all other assessment time points. The PCL-5 was administered at baseline, end of the intervention, and 3 months post-intervention. The SIP was administered at baseline and 3 months post-intervention	completed all eight modules). Although many web studies for problem drinkers fail to report completion rates, available data indicate that completion rates vary widely (e.g., 6% for a 6-week web intervention).	p.001), AWD (B .831,SE.067,p .001), PHDD (B .199, SE.017, p.001), and PTSD symptoms (B 8.182, SE 1.041,p .001) from Time 1 to Time 2. Between end-of-intervention and 3-month follow-up, all alcohol consumption variables (DDD [B.157,SE.047, p.01], AWD [B .452,SE.076, p.001], PHDD [B.096,SE.019,p.001]) continued to show a significant decrease. There were no further changes in PTSD

									symptom scores for IIG participants during this time period (B 1.199, SE 1.144, p .29).
Boden, Matthew Tyler; Kimerling, Rachel; Jacobs-Lentz, Jason; Bowman, Dan; Weaver, Christopher; Carney, Diane; Walser, Robyn; Trafton, Jodie A;	Randomized controlled effectiveness trial.	Ninety-eight male military Veterans with a SUD and co-occurring PTSD symptomatology.	Seeking Safety treatment and TAU VS TAU (at least three group therapy sessions, which focus on motivational enhancement and encouraging treatment engagement. Participants were recruited from these groups, and received full intake	drug and alcohol use severity and a secondary outcome was PTSD symptom severity.	The Addiction Severity Index (ASI) PTSD symptom severity was measured with the Impact of Events Scale—Revised Client Satisfaction Questionnaire Coping Responses	Out-patient Veterans Administration Health Care System SUD clinic.	Drug and alcohol use and PTSD severity, measured on the first day of treatment, and 3 (i.e. the planned end of SS sessions) and 6 months following the baseline assessment. Treatment attendance and patient satisfaction were measured following	First, although multiple clinicians delivered care within each treatment arm, the two treat- ments were delivered by different sets of clinicians with different training and levels of education. Thus, we cannot be certain that effects were due to the treatment rather than to the teams of clinicians.	S compared to TAU was associated with better drug use outcomes (P < 0.05), but alcohol use and PTSD severity decreased equally under both treatments (P's < 0.01). SS versus TAU was associated with increased treatment attendance, client satisfaction and active coping (all P's < 0.01).

			assessments and treatment program planning during this time. Participants then entered twice-weekly ‘recovery’ groups, focusing on building abstinence and, after approximately 90 days of therapy, focusing on maintaining abstinence. As needed, patients attended additional groups on smoking cessation, sobriety support, cocaine recovery, alcohol recovery, dual diagnosis recovery etc. . All patients were assigned a case manager, and case management and individual		Inventory		treatment (3-month follow-up). Active coping was measured at treatment intake and following treatment.	Secondly, this study included several participants who met only partial criteria for PTSD [7,20]. However, this limitation is tempered by the fact that inclusion of these participants increased the ecological validity of the study. homogeneous therapy groups from the effects of providing SS per se. Finally, our study only included male Veterans, thereby limiting generalization of results to females and non-veterans.	

			therapy were available as deemed appropriate.)						
Schumm, Jeremiah A; Monson, Candice M; O'Farrell, Timothy J; Gustin, Nancy G; Chard, Kathleen M;	uncontrolled trial	13 U.S. male military veterans and their female partners	Couples Treatment for Alcohol Use Disorder and Posttraumatic Stress Disorder	PTSD and heavy alcohol use), and veterans and partners would show im- provements on secondary outcomes (relationship adjustment and depression symptoms).	The Clinician-Administered PTSD Scale The PTSD Checklist-Specific The Timeline Followback Interview (TLFB Dyadic Adjustment Scale (DAS; The Beck Depression Inventory–II	Outpatient	Pretreatment assess- ment to confirm eligibility and approxi- mately 6–7 weeks after ending CTAP	There were 8 veterans who showed clinically reliable pre- to posttreatment reduction of PTSD outcomes. There were also significant group-level reductions in clinician-, veteran-, and partner-rated PTSD symptoms. CAPS (p=.028). veteran-reported PCL-S (p=.009, partner-reported PCL-S (p=.001) Most veterans showed clinically reliable reductions in percentage days of heavy drinking. Group-level reduction in veterans' percentage days of heavy drinking was	small sample size limited statistical power and may have yielded unstable parameter estimates. Second, the findings are limited to vet- erans with primary AUD and may not apply to veterans with primary substance use disorders other than alcohol, or to veterans whose partners also have AUD or PTSD. Third, the study was uncontrolled, making it impossible to make

								significant (p=.022) There were 4 veterans and 3 partners with clinically reliable reductions in depression, and group-level change was non significant for veterans (p =.482) and partners (P = .177)	causal inferences about the effects of CTAP.
Capone, Christy; Eaton, Erica; McGrath, Ashlee C; McGovern, Mark P;	Feasibility Study	12 eligible Veterans (attrition of 4) N=8	integrated cognitive behavioral therapy (ICBT) for co-occurring PTSD-SUD	focused on two feasibility outcomes: 1) acceptability; and 2) tolerability. We also examined clinically meaningful change in PTSD and depressive symptoms as a secondary aim.	Structured clinical interview for DSM-IV-TR, patient edition (SCID-I/P) Clinician administered PTSD scale (CAPS) Addiction severity index (ASI) Timeline followback (TLFB)	VA Medical Center (VAMC)	baseline assessment post-treatment follow-up assessment 3-month follow-up.	Eight participants had complete pre- and post-treatment data allowing for examination of clinically meaningful change. We examined CAPS and PHQ-9 total scores individually and found that 3 participants exhibited a meaningful decrease in PTSD symptoms and 2 showed a meaningful decrease in depressive	the current study lacks the experimental rigor associated with a randomized controlled trial. Also, our sample size was small and consisted solely of Caucasian male Veterans. Our use of a group format may be a potential limitation if it led to premature termination from the treatment, though we are

					Patient health questionnaire-9 (PHQ-9)			symptoms. It should be noted that two of the participants who demonstrated clinically noticeable change in PTSD symptoms at post-treatment were non-completers of ICBT.	unable to accurately determine this with these data.
Johnson, David Read; Fontana, Alan; Lubin, Hadar; Corn, Barbara; Rosenheck, Robert;	6-year longitudinal study	51 treatment-seeking male veterans	Comprehensive National Treatment Programme (in-patient treatment programme, no further details in publication)	Reduction in PTSD and psychiatric symptomatology, increase in social functioning, and program impact	War Stress interview follow-up Mississippi scale for PTSD, Revised Addiction Severity Index Brief Symptom inventory The combat Exposure Scale. Clinician administered PTSD scale (CAPS)	????	assessed at admission to an inpatient treatment program, at 18 months, and 6 years later	The sample showed an extremely high mortality rate of 17% over 6 years. The remaining veterans showed improvement in violence and alcohol and drug use, but an increase in hyperarousal symptoms and social isolation. Nearly three-fourths had had an inpatient hospitalization. Veterans' self-ratings, in contrast, indicated significant improvement in all areas of functioning	Sample small and lack of a control group any more detial

								except employment, as well as an overall positive view of the impact of the program on their lives. Results indicate that the majority of the veteran sample had experienced some improvement in their ability to cope with their chronic illness, decreasing their use of violence and substance abuse but still were experiencing high levels of symptomatology Any stats?	
Chermack, Stephen T; Bonar, Erin E; Goldstick, Jason E; Winters, Jamie; Blow, Frederic C;	Randomized controlled trial for aggression and substance use involvement among	N = 180; 165 males and 15 females	The E-TAU condition involved participation in standard treatment programs (e.g., individual and group CBT sessions)	Primary 12-month outcomes included physical aggression and injury to partners,	Conflict Tactics Scale-Structured Interview (CTS-SI) Timeline	Veterans Seeking SUDand/or mental health treatment at the AAVA and	Pre and Post; 3-,6-and 12-monthfollow-up assessments	findings showed significant reductions in aggression for all groups (MI-CBT,MI-CBT+CC,E-TAU),with potential modest support for the interventions	First, we did not meet the full recruitment goal (N=210), which limited statistical power. Second, as noted, all

Friday, Steven; Ilgen, Mark A; Rauch, Sheila A M; Perron, Brian E; Ngo, Quyen M; Walton, Maureen A;	Veterans		along with a single session that included brief advice to avoid interpersonal aggression, and a review of a printed referral booklet including information on community support groups VRS 6-session MI-CBT VRS 6-session MI-CBT plus subsequent Continuing Care (CC) involving 12 weeks of telephone monitoring/counsel	non-partners, and total aggression. Substance use outcomes included heavy drinking, marijuana use, cocaine use, and overall illicit substance use ??? re word	Follow-Back The Posttraumatic Checklist-Civilian (PCL-C)	affiliated community-based outpatient centers (CBOC		having a greater impact than standard care, supporting future research on these approaches. In terms of interpreting the findings, it appears that participants enrolled in standard VASUD or mental health treatment show significant declines in aggression and substance use and there may be some added benefit for the MI-CBT and MI-CBT+CC intervention approaches. Physical Aggression MI-CBT,MI-CBT+CC,E-TAU – p < .001); Injury MI-CBT p=0.01, MI-CBT+CC,E-TAU p < .001. Physical	participants had access and involvement with clinical programs using CBT and MI and this may have contributed to positive outcomes across all groups. Thus, it is possible that the findings may not generalize to other treatment settings due to participants possibly receiving MI and CBT outside of the study conditions.), the primary outcome measures here relied on retrospective self-report structured interviews that can be subject to recall and demand biases. Fourth, the study sample

			ing (MI-CBT+CC)					aggression (partner) MI-CBT p=0.001, MI-CBT+CC p=0.5,E-TAU p < .001. Physical aggression (non-partner) MI-CBT p=0.001, MI-CBT+CC p=0.5,E-TAU p < .001.	was somewhat older than some samples examining aggression out- comes for those with SUD problem
Pharmacological interventions for SUDs and PTSD									
Kachadourian, Lorig K; Gandelman, Erin; Ralevski, Elizabeth; Petrakis, Ismene L;	randomized, double-blind, placebo-controlled treatment study	Ninety-three Veterans	the efficacy of the alpha-adrenergic agonist prazosin	Reduction in hostility, covert hostility, and suicidal ideation Depression symptoms and PTSD symptom	The Buss – Durkee Hostility Inventory (BDHI) . PTSD Symptom Severity The Clinician Administered PTSD Scale for the DSM-IV (CAPS-IV)				

					Depressive Symptoms The Hamilton Depression Rating Scale (HDRS Suicidal Ideation/Suicidal Ideation Intensity The Columbia-Suicide Severity Rating Scale (C-SSRS;				
Batki, Steven L; Pennington, David L; Lasher, Brooke; Neylan, Thomas C; Metzler, Thomas; Waldrop,	**Pilot RCT:** Flexible-dose topiramate up to 300 mg/d in 30 veterans with PTSD and AUD	30 veterans with PTSD and AUD	Topiramate augmentation treatment vrs Placebo	Reduction in SUD, PTSD and Depression	Substance Use Disorders sections of the Structured Clinical Interview for DSM-IV-TR Clinician Administered	Outpatient	baseline, week 4, 8, and 12.	Limitations of the study include its sample size, consistent with the study's pilot nature, which may have decreased power to detect significant differences between	Univariate analysis revealed a significant reduction within TOP in PTSD symptom severity as measured by the PCL total score and all three subscale scores from

Angela; Delucchi, Kevin; Herbst, Ellen;					PTSD Checklist (CAPS) Beck Depression Inventory [BDI-II] PTSD Checklist [PCL] e Time Line Follow Back (TLFB; Obsessive Compulsive Drinking Scale (OCDS e Alcohol Use Disorders Identification Test (AUDIT)			topiramate and placebo despite there being large percent differences. Additionally, our small sample size did not allow for the examination of factors that may have influenced our outcomes, such as the moderating effects of concomitant treatment, genetics degree of motivation at study entry, or the presence of pretreatment abstinence. An additional limitation of this report is the reliance on self-report measures to assess drinking outcomes –	baseline through week 12. Between-group comparisons revealed a trend for a main effect of treatment on standard drinks per week (p=0.099, Table 2), with TOP having 55% fewer standard drinks during weeks 1-12 compared to PLA. There was a significant reduction in OCDS scores from baseline through week 12 within TOP [F(1,14)=15.17, p=0.002].

Petrakis, Ismene L; Poling, James; Levinson, Carolyn; Nich, Charla; Carroll, Kathleen; Ralevski, Elizabeth; Rounsaville, Bruce;	**RCT:** Randomization included (1) open randomization to disulfiram or no disulfiram; and (2) double-blind randomization to naltrexone or placebo.	Patients (n = 254) with a major Axis I psychiatric disorder and comorbid alcohol dependence	Effects of disulfiram and naltrexone on Reductions in SUDs and PTSD	Reduction in SUDs and PTSD	The Alcohol Dependence Scale (ADS) The Sub-stance Abuse Calendar, based on the Timeline Follow-Back Interview Obsessive Compulsive Drinking and Absti-nence Scale (OCDS) Clinician Administered PTSD Scale	3 Veterans Administration outpatient clinics.	SA measured used weekly visit to collect a detailed self-report of daily alcohol and other substance use throughout the 84-day treatment period as well as for the 90-day period prior to randomization. PTSD symptoms were assessed by the research staff at the baseline and biweekly during treatment	a predominately male VA sample, hence the results may not be generalizable to other clinical settings. Second, subjects were concurrently being treated with a variety of psychotropic medications, and the effect of specific interactions or combinations on alcohol use, an area of interest, could not be determined.	93 individuals (36.6%) met DSM-IV criteria for PTSD. Subjects with PTSD had better alcohol outcomes with active medication (naltrexone, disulfiram or the combination) than they did on placebo; overall psychiatric symptoms of PTSD improved. Individuals with PTSD were more likely to report some side effects when treated with the combination results ???

					(CAPS) Hopkins Symptom Checklist (HSCL)				
Ismene L; Desai, Nitigna; Gueorguieva , Ralitza; Arias, Albert; O'Brien, Erin; Jane, J Serrita; Sevarino, Kevin; Southwick, Steven; Ralevski, Elizabeth;	RCT: Prazosin for Veterans with Posttraumatic Stress Disorder and Comorbid Alcohol Dependence	Ninety-six veterans with PTSD and comorbid AD	randomized to receive prazosin (16 mg) or placebo	Reduction in symptoms PTSD, sleep disturbances , and alcohol use.	Structured Clinical Interview for DSM-IV (SCID)-I Alcohol Dependence Severity (ADS) CAPS for DSM-IV Obsessive-Compulsive Drinking Scale (OCDS) (Timeline Follow Back (TLFB)	Outpatient	Primary outcomes were measures of PTSD severity, alcohol use, and sleep disturbances assessed at baseline and every 4 weeks by the CAPS throughout the 84-day treatment period	Symptoms of PTSD improved over time, but contrary to the hypothesis, there was no medication effect on PTSD symptoms, or on sleep. Alcohol consumption also decreased over time, but there were no significant differences in outcomes between medication groups. Results statistics	Limitations include that the study was conducted with primarily male veterans and results may not be generalizable to other populations. Finally, and perhaps most importantly, a high percentage of subjects were in sober housing, and the percentages differed by site.
Verplaetse, Terril L; Ralevski, Elizabeth; Roberts, Walter;	RCT: Participants randomized to prazosin (16m) and Participants	Veterans with comorbid alcohol dependence and PTSD (n	prazosin for Veterans with alcohol dependence and comorbid PTSD Vrs placebo	Reduction in PTSD severity, sleep problems, or alcohol	Timeline Follow-Back (TLFB; Sobell and Sobell, 1992) and the	Participants were recruited from clinicians in the sub-	TLFB was adminis- tered weekly to collect a detailed self-report of daily	There was a main effect of alcohol abstainer status on symptoms of PTSD (p = 0.03), such that nonabstainers had	sample size was relatively small, primarily male, and consisted only of Veterans with alcohol

Gueorguieva, Ralitza; McKee, Sherry A; Petrakis, Ismene L;	randomised to placebo	= 96)		consumption	Clinician-Administered PTSD Scale (CAPS) for DSM-IV (Blake et al., 1995)	stance abuse and PTSD treatment programs at both sites and by advertisements at the VA facilities and in the communities.	alcohol use throughout the 84-day treatment period as well as for the 90-day period prior to randomization. Alcohol intake was confirmed using serum gamma-glutamyl transferase, collected 4 times during the study (baseline, weeks 4, 8, and 12). PTSD symptom severity was assessed every 4 weeks by the CAPS.	lower total Clinician-Administered PTSD Scale (CAPS) scores than abstainers. There was a significant treatment by alcohol abstainer status interaction (p = 0.01); specifically, among placebo-treated individuals, those who did not abstain from alcohol had lower total CAPS scores compared to alcohol abstainers. Within the prazosin-treated group, abstainers and nonabstainers did not differ on total CAPS scores. Results were similar for the avoidance (p = 0.02), reexperiencing (p = 0.01), and hyperarousal (p = 0.04) subscales, such that placebo-treated nonabstainers had lower CAPS scores overall	dependence and comorbid PTSD. Second, we collected data on PTSD symptoms at intervals, so we did not capture the interaction between PTSD symptoms and drinking in real time.

Flanagan, Julianne C; Allan, Nicholas P; Calhoun, Casey D; Badour, Christal L; Moran-Santa Maria, Megan; Brady, Kathleen T; Back, Sudie E;	RCT	67 male U.S. military veterans with current PTSD and AUD	Examined the effects of intranasal oxytocin (40 IU) as compared with placebo on stress reactivity (e.g., cortisol) as well as subjective alcohol craving in response to a laboratory stress task (Trier Social Stress Task).	Reduction in Stress Reactivity and Craving	The Mini-International Neuropsychiatric Interview (MINI; . The Clinician Administered PTSD Scale (CAPS-5; PTSD Checklist-Military version (PCL-M; Time Line Followback (TLFB; Alcohol Use Disorders Identification Test (AUDIT;	Outpatient	Baseline and 7 time points one day. Participants completed study procedures in a single 4-hr laboratory visit.	The findings revealed that oxytocin marginally attenuated cortisol reactivity in response to the stress task. Furthermore, oxytocin's effect was moderated by baseline cortisol level, such that oxytocin mitigated cortisol reactivity to a greater extent among participants with higher, as compared with lower, baseline cortisol. Oxytocin did not reduce craving.	One important limitation in the present study is the lack of a healthy control group. Incorporating a healthy control group is an important next step for future studies as is enrolling a sample capable of thoroughly examining sex differences.

Review number 4

The role of cognitive factors in the maintenance of complicated grief following conflict related bereavement

Search strategy

The search strategy for this study was conducted in two stages. The rationale for searching this way was to ensure that no key studies were overlooked. During the initial testing of the databases, our key terms were entered into the search together (Complicated Grief terms with Cogniti* and War/Conflict terms). However, this one strand approach returned only 3 articles, thus a two-stage search approach was decided upon. The first stage searched for studies which focused on CG and cognition, whilst the second stage searched for studies which had a focus on CG in the context of war and conflict. Search results were then combined before the screening process began (see *figure 1)*.

The search string for the stage 1 search consisted of a combination of subject headings (MeSH terms) with a wildcard term. Informed by the PICO approach (Sackett et al., 1997), keywords related to population ("prolonged grief" OR "complicated grief" OR "traumatic grief" OR "complex grief" OR "chronic grief") were combined with words related to indicator (cogniti* (Wildcard). The stage 2 search consisted of a combination of subject headings (MeSH terms) this time with a search string generated for "war/conflict". As in search 1, keywords related to population ("prolonged grief" OR "complicated grief" OR "traumatic grief" OR "complex grief" OR "chronic grief") were combined with a search string generated for war/conflict (warfare OR "armed conflict*" OR war* OR warfare OR war-torn OR "war torn" OR warzone* OR post-war* OR postwar* OR (conflict adj1 (area or zone*)) OR post-conflict* OR postconflict* OR ((communal or violen* or political or military) adj2 conflict*) OR violence OR "exposure to violence" OR "ethnic violence" OR ((political* or military or communal or state) adj2 violen*) OR (ethnic cleansing or genocid*) OR terrorism OR Civil Disorder* OR "civil violence" OR "civil conflict" OR "civil disorder*" OR riot* OR terrorist* OR insurgen*. The primary author (SM) independently performed both searches throughout the period of March-April 2019.

Study selection and data extraction

The review process and results are outlined in the PRISMA flow chart (*Figure* 1). The results from the database searches were imported to the screening tool Endnote (Clarivate Analytics) which is a software tool for publishing and managing bibliographies. Duplicates were removed before title and abstract screening commenced to identify potentially relevant studies. Studies with clearly identifiable populations not specific to this review (e.g. grief related to pet loss, financial loss or those focused on child/adolescent CG) or not addressing cognitive maintenance factors (e.g. prevalence studies of CG), were rejected at title screening by one review author (S.M.). Two authors (S.M. and S.D.) discussed and reviewed abstracts of all retrieved articles against the inclusion criteria. Any potentially relevant articles retrieved in full text were independently reviewed by the same two authors. Interrater agreement was 90 % and any disagreements were resolved by discussion with a third reviewer (M.D.) A record was kept of all excluded studies along with the reason for exclusion. The same rigorous screening process was used to identify individual studies from the selected relevant systematic reviews.

During the full text screening stage, studies were included if (a) they have been peer reviewed (b) the population of interest were adults with a diagnosis of CG; (c) studies which included people exposed to violent loss (e.g. suicide, accident, homicide, war or civil conflict;) (d) CG was assessed using a standardised validated measure; (e) studies reported on at least one cognitive maintenance factor related to the persistence of CG. No date limits were applied. Studies which have been excluded include those which focused on CG emerging from non-violent loss; the prevalence of CG only; epidemiology studies, single case study designs; those which look at CG only in bereaved infants/children/adolescents; populations consisting only of patients with a personality disorder; those where the trigger for grief is loss of property or finances; those in a language other than English, and studies where the data is incomplete.

The primary outcome of interest were cognitive factors which underpin CG. Subsequently, full texts of the promising studies were obtained, and their reference lists were examined by S.M.

A data extraction tool was developed to extract the key characteristics of included studies using the PICOS (Population, Intervention, Comparator, Outcomes and Study design) framework. Data extraction was conducted by S.M and checked by M.D and C.M.

Quality appraisal

The methodological quality of each included study was assessed using the proforma created by Kmet, Less and Cook (10). The proforma is designed to be comprehensive in evaluating quality research papers from a variety of fields. Criteria 5-7, applicable to studies assessing interventions, were removed, resulting in a reduced overall quality rating score out of 22. Articles were assessed for quality independently by S.M., results of the quality assessment are presented in the Supplementary Table 1.

Data analysis and synthesis

It had been anticipated that the cross-sectional design utilized predominantly in the study of CG would not provide sufficient statistical data to warrant a meta-analysis. Once the final studies had been located this was confirmed. Thus, the co-authors agreed that a narrative synthesis should be adopted (Popay et al., 2006).

***Figure 1.* PRISMA Flow diagram of review process**

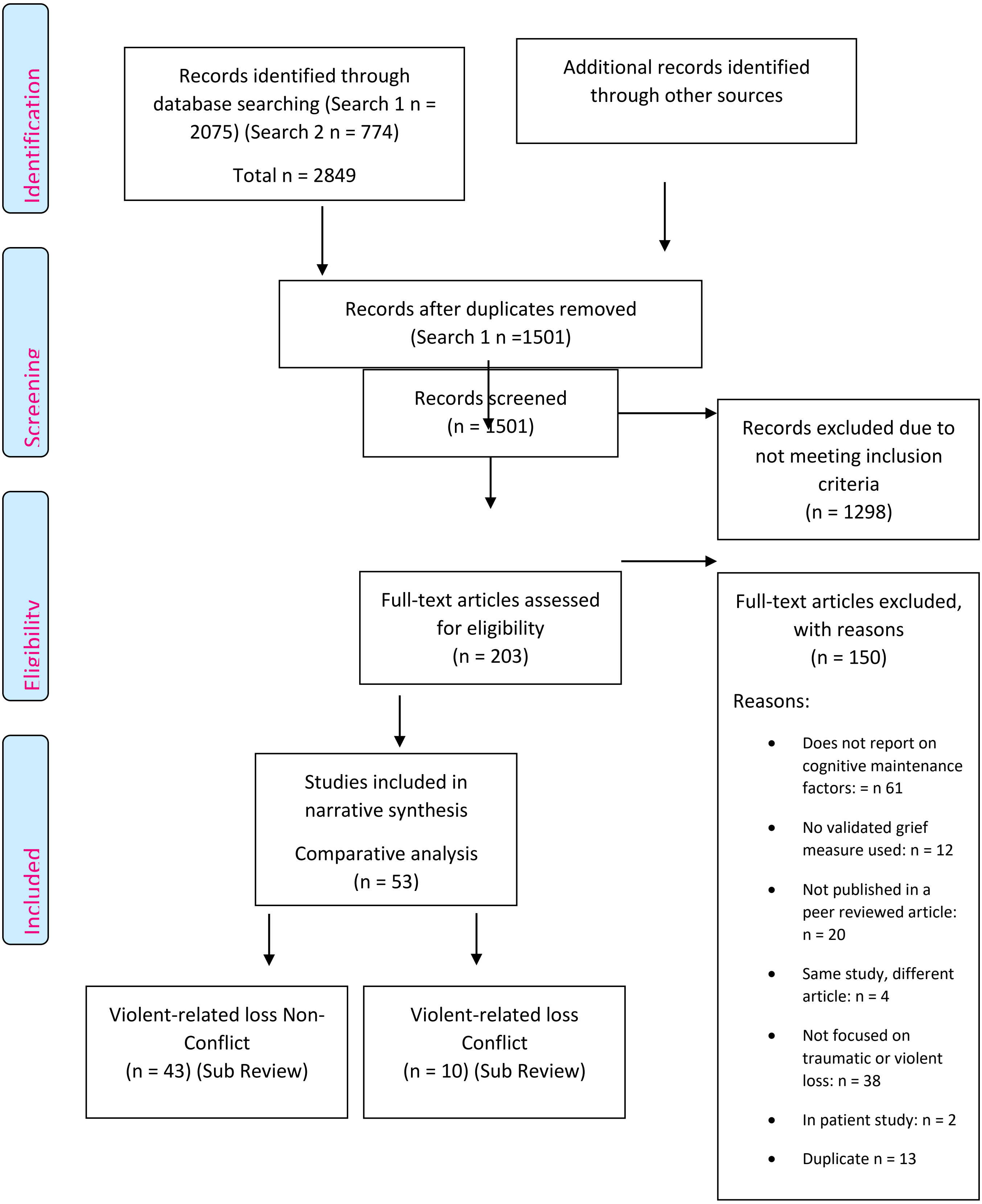


Table 1: Data extraction table	**The role of cognitive factors in the maintenance of complicated grief following conflict related bereavement**								
Study/Authors	Study Design	Participants	Procedure Data Collection	Clinical Outcomes	Clinical Scales	Clinical facility	Timeframe	Key Findings Quality Assessment Rating Score (QA)	Limitations
1 Prolonged grief disorder symptoms in bereaved internationally displaced Tiv persons in Nigeria: associations with rumination, rebirth concerns and	Cross Sectional Survey Design	(n = 379) individuals aged 12 and above who had lost at least one close relation in the attack. Participants (n = 165) were adults	Research assistants were recruited and trained to administer the questionnaires in each of the IDPs' camps.	Prolonged Grief Rumination -two forms Rebirth Concerns	The Prolonged Grief Scale (PGS). The seven-item Rumination Scale. Concerns about the rebirth status	Internally displaced persons (IDPs) camps.	Data collected at one time point. There are no clear details as to the time frame post loss, however	QA Score: 22/22 High intrusive rumination and high deliberate rumination were associated with increased CG symptoms in males and females. Rebirth concern was associated with high PGD symptoms in males	The use of self-report measures. The one-item measure of rebirth concern. The

gender. Chukwuorji et al., (2018)					of the deceased was assessed using a single item		as the PGS was used we can presume that it was 6 months post loss as this is a prerequisite to using this scale.	but not in females. Findings highlight the need for socio-culturally informed screening/intervention in the wake of conflict-related bereavement.	multiplicity of the bereavement in the violent attack made it difficult to analyse based on the relationship with the dead person(s) (e.g., partner, child, parent, or sibling).

2 The loss of a fellow service member: Complicated grief in post-9/11 service members and veterans with combat-related posttraumatic stress disorder. Simon et al., (2017)	Cross Sectional Survey Design: Sample drawn from an existing RCT	(n 160) bereaved veterans, predominantly (n=male, 88.75%) and White (55.97%) Black (32.08%). Mean age of 35.03 years (Range: 20–61).	Trained certified Raters.	Prevalence of CG by loss type Prevalence of co-occurring conditions Trauma-related guilt cognitions Psychosocial functioning Suicide severity	Standard assessment of demographics and type of military service, Structured clinical interview with the MINI international neuropsychiatric interview (MINI) for DSM-IV version 5.0 (Sheehan et al., 1998). The clinician-	One of four sites: The VA Ann Arbor Healthcare System, University of Michigan; Massachusetts General Hospital; Ralph H. Johnson VA Medical Centre, Medical University of South	Data collected at one time point. >6 months post loss	QA Score: 22/22 This study found that exposure to the loss of a fellow service member occurs commonly and is associated with CG amongst service members and veterans with combat-related posttraumatic stress disorder (PTSD). Further, the presence of CG was associated with more severe PTSD, guilt and lifetime suicide attempts, as well as poorer function.	Self-report measure ICG. CG was not confirmed using a structured clinical interview in this study. The study did not collect specific date of loss (only year) and thus, were unable to determine the precise time since the loss. Although a subset of the sample (n =40) had experienced

					administered PTSD scale (CAPS) PTSD checklist-specific stressor version (PCL-S). 19-item inventory of complicated grief (ICG). Trauma-related guilt inventory (TRGI). Inventory of psychosocial functioning (IPF). Columbia suicide severity	Carolina; VA San Diego Healthcare System, University of California San Diego.			a loss in the past year, it is possible that this loss occurred less than 6 months prior to assessment of grief symptoms for some. The study did not provide details regarding the precise nature of the death to examine factors such as whether the loss was due to combat, suicide, or natural causes, or occurred

					rating scale (C-SSRS).				while the veteran was deployed.
3 Prolonged Grief in Cambodian Refugees Following Genocide: Rebirth Concerns and Avoidance of Reminders. Hinton et al., (2013).	Cross Sectional Survey Design	(n = 100) treatment-seeking (adult) Cambodian refugees (n= 35 men), (n=65 women). Mean age of the sample was 54.2 years (SD = 7.5).	All participants were interviewed by either a psychiatrist fluent in Khmer (first author) or a clinical psychologist (second author) with the aid of a translator.	Distinction between PTSD and CG. Centrality to CG of "avoidance of reminders of the deceased" as compared to "rebirth concerns". Functional impairment	Prolonged Grief Scale 13 (PG-13). PG-13 Addendum Item. Culturally Sensitve Measure of Grief-Related Distress (CSM-G). PTSD Checklist (PCL).	All participants attended a clinic specializing in the treatment of Southeast Asian refugees in Lowell, Massachusetts.	Data collected at one time point. >30 years post loss.	QA Score: 22/22 The PG-13 significantly predicted over and above PTSD severity both the severity of a culturally sensitive measure of grief-related distress and the presence of grief-related functional impairment. They found those surveyed to have low rates of CG: 8% They found that the PG-13 addendum item (rebirth concerns) was more correlated than	They did not assess other types of psychopathology, thus we cannot evaluate the distinctions between CG and other relevant disorders. The one-item cultural measure of grief-related distress has not been validated by other studies.

								one of the PG-13 items (avoidance) to grief-related distress as assessed by the PG-13 and a culturally sensitive measure (CSM-G). In the analysis assessing various types of predictive power of the PG-13 items and its addendum item, two items performed best, rebirth concerns and bitterness over the loss, both of which had high sensitivity, specificity, and positive and negative predictive power	This population had many losses occurring approximately 30 years before, so applicability to acutely bereaved populations is unclear.
4 Peace, Reconciliatio	Cross Sectional Survey	(n = 21) Israeli Jews and	Structured face-to-face	The grieving process	A structured interview.	All interviews were	Data collected at one	QA Score: 15/22 The most prominent finding of study is that	This work is a pilot study, and the small

n and Tolerance in the Middle East. Weder et al., (2010)	Design- Interview face to face.	Palestinians. 13 were members of PCFF (PC group) and 8 are not (non-PC group).	interviews were conducted by a mental health professional in either English, when the interviewed participants were fluent, or with the help of a translator when necessary.	and Emotional well-being Positive attitudes and emotions toward the opposing groups.	Beck Depression Inventory (BDI). Prolonged Grief Disorder Scale (PG-13). The Global Severity Index (GSI) of the Symptom Checklist 90 (revised; SCL-90-R).	conducted in the participant's home for his or her comfort.	time point. Time since loss: PC Group M =16.08, (Years) SD = 4.817 Non-PC Group M = 13.25, (Years) SD = 4.039.	some attitudes (e.g., a positive attitude toward peace, being hopeful about the future, the ability to forgive the opposing group) can be considered protective factors associated with CG. People-to people peace building initiatives, such as the Parent Circle–Families Forum, reinforce these factors. Furthermore, they provide their members with social support and a strong sense of mutual commitment and responsibility, facilitating their grieving process, and emotional well-being. The participants in the non-PC group reported more cognitive,	sample size should be taken into consideration. Thus, these findings must be interpreted with care.

								emotional, and behavioural symptoms (e.g., difficulty accepting the loss, bitterness or anger related to the loss, difficulty moving on with life, numbness; feeling that life is empty).	

5 Dreams of the Dead Among Cambodian Refugees: Frequency and Phenomenology, and relationship to Complicated and Posttraumatic Stress Disorder. Hinton et al., (2013)	Cross Sectional Survey Design	(n = 100) treatment-seeking (adult) Cambodian refugees (n= 35 men), (n=65 women). Mean age of the sample was 54.2 years (SD = 7.5).	All participants were interviewed by either a psychiatrist fluent in Khmer (first author) or a clinical psychologist (second author) with the aid of a translator.	Dreams of the deceased CG PTSD	The Dream Frequency Scales. The Prolonged Grief-13 (PG-13). The PTSD Checklist (PCL).	All participants attended a clinic specializing in the treatment of Southeast Asian refugees in Lowell, Massachusetts.	Data collected at one time point. >30 years post loss.	QA Score: 20/22 Symptoms of CG were common among the study participants and having dreams of the deceased was significantly associated with the severity of CG symptoms. The current article suggests a key role of bereavement-related dreams in perpetuating distress among Cambodian refugees. By way of contrast, among most native English speakers a nightmare of the deceased may be upsetting but is not thought to reflect the spiritual status of the deceased or to be	Not reported.

								dangerous concerns about the spiritual status of the deceased: Negative appraisals that the deceased is in a negative liminal state.	

6 Rumination and Avoidance as Predictors of Prolonged Grief, Depression, and Posttraumatic Stress in Female Widowed Survivors of War Morina et al., (2011)	Cross Sectional Survey Design- Interview Format.	(n= 100) bereaved mothers. Mean age of 50.1 (SD, 7.9) years	The survey was carried out by five master's degree level psychology students who had gathered experience in conducting clinical interviews in a previous project (Priebe et al., 2010a). All instruments were completed in an interview format by	Rumination Experiential avoidance CG	First part of the Harvard Trauma Questionnaire (Mollica et al., 1992). Prolonged Grief Disorder Interview (PGD-I). The Patient Health Questionnaire (PHQ). Posttraumatic Stress Diagnostic Scale (PDS).	Not Reported, possibly at the participants own home.	The survey was conducted in 2009 (i.e., ten years after the war in Kosovo) All participants reported the killing of the husband during the war in 1998 and 1999.	QA Score: 22/22 Results showed that both rumination and experiential avoidance significantly predicted the symptom severity of CG, depression, and posttraumatic stress. Furthermore, rumination accounted for additional variance above and beyond experiential avoidance and vice versa. Finally, the interaction of rumination and experiential avoidance did not provide significant explanatory power over and above the individual main effects.	The cross-sectional design precludes any conclusions about causality. Rumination was measured with four items only. Furthermore, the PHQ, PDS, AAQ-II, and CERQ were administered in an interview format although they were designed to

			the interviewer, and all data were completed at the same time.		Acceptance and Action Questionnaire YII (AAQ-II). The Cognitive Emotion Regulation Questionnaire (CERQ).			These findings suggest that rumination and experiential avoidance may be significant factors in understanding and treating psychological distress following exposure to potentially traumatic events and loss due to violence.	be self-administered and their use in an interview format still has not been examined. In addition, no power analysis was conducted before the study, and some of the analyses might be underpowered.

7 Identifying a Combined Construct of Grief and Explosive Anger as a Response to Injustice Amongst Survivors of Mass Conflict: A latent class analysis of data from Timor-Leste. Rees et al., (2017)	Cross Sectional Survey Design	(n = 2964) (men, n = 1451) 49%; (women, n = 1513) 51%). Mean age was 36.4 years (SD = 14.4).	The team included 18 Timorese field workers with prior survey experience and/or psychology / public health degrees. They conducted a survey of all adults, 18 years and older, living in every household in two	Explosive anger Grief	The 17 conflict-related traumatic events (TEs) listed in the Harvard Trauma Questionnaire (HTQ). An inventory of daily adversities was developed. Preoccupations with injustice. Respondents were asked to identify and describe the worst	One-hour long interviews were conducted in participants' homes or another location if preferred by respondents, the procedure ensuring maximal privacy and confidentiality.	>6 months post loss.	QA Score: 22/22 Reported a model comprised three classes: grief (24%), grief-anger (25%), and a low symptom group (51%). Persons in the grief and grief-anger classes experienced higher rates of witnessing murder and atrocities and traumatic losses, ongoing poverty, and preoccupations with injustice. Implicates a pre-occupation with injustice which may have existed before the loss with elevated levels of CG.	Caution needs to be exercised in inferring causal relationships from cross-sectional data.

			administrative villages (sucos), one in Dili, the capital, the other, a rural site an hour's drive away.		human rights violation or other event associated with injustice. Community measure of explosive anger was developed. *Used own 4 item pool to assess CG* PTSD: Assessed - Harvard Trauma Questionnaire (HTQ).				

8 Traumatic Bereavement and Terror: The Psychosocial Impact on Parents and Siblings 1.5 Years After the July 2011 Terror Killings in Norway. Dyregrov and Kristensen, (2015).	longitudinal and non-experimental survey design. Three measurement points (18, 28, and 40 months following the terror attacks).	Bereaved parents (n =67) and siblings (n = 36). Three groups are studied: (a) bereaved parents, (b) bereaved siblings, and (c) bereaved close friends.	Names of (step)parents and (step=half-) siblings of the deceased, public records of the deceased were linked to the National Population Register. The recruitment began in February 2013, when bereaved parents and siblings were sent an	CG PTSD Psychological Distress	The General Health Questionnaire (GHQ-12). The Impact of Event Scale-Revised (IES-R). The Inventory of Complicated Grief (ICG). The Work and Social Adjustment Scale (WSAS).	Own Homes.	1.5 years after the attack at three time points (18, 28, and 40 months.	QA Score: 20/22 Findings showed a high prevalence of CG in parents and siblings (82% vs. 75%), posttraumatic stress reactions (63% vs. 72%), and general psychological distress (88% vs. 75%) 1.5 years after the killings. There were significant gender differences, and the loss had a substantial negative impact on parents' and siblings' work and school situations. Found that bereaved parents and siblings were struggling with a	Data being based on self-reported questionnaires. Cross-sectional data, which hinders the possibility of making causal inferences. Small sample size, particularly in some of the subsamples, yielded low statistical power in some of the analyses.

			information letter regarding participation in the study. Those individuals who wanted to participate returned their informed consent and then received the questionnaire.					persistent and intense longing and yearning for the deceased, combined with intrusive thoughts and images of the killings, as well as reactivity in response to reminders of the event. Additionally, the results showed that both siblings and parents oscillated between an anxious preoccupation with and avoidance of memories of their dead sibling or child. Implicates Yearning, Avoidance and Intrusions with elevated CG.	In addition, no baseline data existed prior to 1.5 years after the terrorist attack.
9 Factorial Structure of Complicated	Cross Sectional Survey Design	(n=230) West Papuan adults	Interviews were conducted by West	Examines the factor structure of CG and	CG assessed using a culturally adapted	The study sample comprised West	>6 months post loss.	QA Score: 20/22 The sense of injustice	Not Reported.

Grief: Associations with Loss-related Traumatic Events and Psychological Impacts of Mass Conflict Amongst West Papuan Refugees Rates and Risks for Prolonged Grief Disorder in a Sample of Orphaned and Widowed Genocide Survivors. Tay et al., (2016).		(men n= 137), 59.5 %; women (n= 93), 40.4 %). mean age of 37 (SD = 9.80) years.	Papuan refugees who received 3 weeks' intensive training under supervision of a bilingual clinical psychologist (AT).	broader effects of conflict.	checklist comprising core items (rated as absent or present) of the DSM-5 (PCBD) and proposed ICD-11 symptoms (PGD). The complicated grief interview, The pool of items demonstrated a high level of internal reliability with a KR20 of 0.94. Exposure to conflict- and	Papuan refugees participating in a community survey undertaken across six settlements in Port Moresby, Papua New Guinea (PNG). Interviews were conducted in a private location or within the home of the participant, depending on their preference.		associated with traumatic losses appeared to be of key importance to the manifestations of CG. Lack of access to justice arising from human rights violations was strongly associated with the CG domains of anger/negative appraisal in addition to yearning/preoccupation and shock/ disbelief. Confirmatory factor analysis yielded a novel dimension of confusion/diminished identity. A Multiple Indicators Multiple Causes (MIMIC) model revealed that traumatic loss and the sense of injustice each were associated with the unitary construct of CG	

					loss-related traumatic events (TEs) The ADAPT index of the psychosocial impacts of conflict and displacement			and its subdomains of yearning/preoccupation shock/disbelief;anger/negative appraisal (exclusive to injustice); and estrangement from others/social impairment (exclusive to TE domain of conflict and loss). Implicates Injustice and Diminished Identity with elevated CG.	

10 Rates and Risks for Prolonged Grief Disorder in a Sample of Orphaned and Widowed Genocide Survivors. Schaal et al., (2010)	Cross Sectional Survey Design	(n=351) women (87.7%) and (n=49 men) (12.3%). Mean age was 37.18 years (SD = 16.73, range 18-97 years).	Diagnostic interviews were carried out by 15 Master level psychologists and psychology students (7 female and 8 male) from the National University of Butare, Rwanda.	Rates and Risks related to development of CG	Assessed the importance of religious/spiritual beliefs on a 4-point Likert scale from 0 (not at all important) to 3 (very important). *<u>PG-13</u>* PTSD Symptom Scale-Interview (PSS-I)	The study was conceived as a community-based study with a house-to house survey.	Time frame > 16 years since the loss.	QA Score: 20/22 Risk factors associated with CG included loss to violent circumstances, PTSD symptom severity, years passed since the loss and importance of religious/spiritual beliefs. Implicates Religious Beliefs.	Cross sectional and retrospective nature of the design. Thefocus of the present study was on women (who outnumbered men approx. 7:1). The evaluation has been based exclusively on subjective assessment by the bereaved themselves.

Review number 5 – a rapid review of the management of comorbid chronic pain and PTSD linked to war, conflict and injury

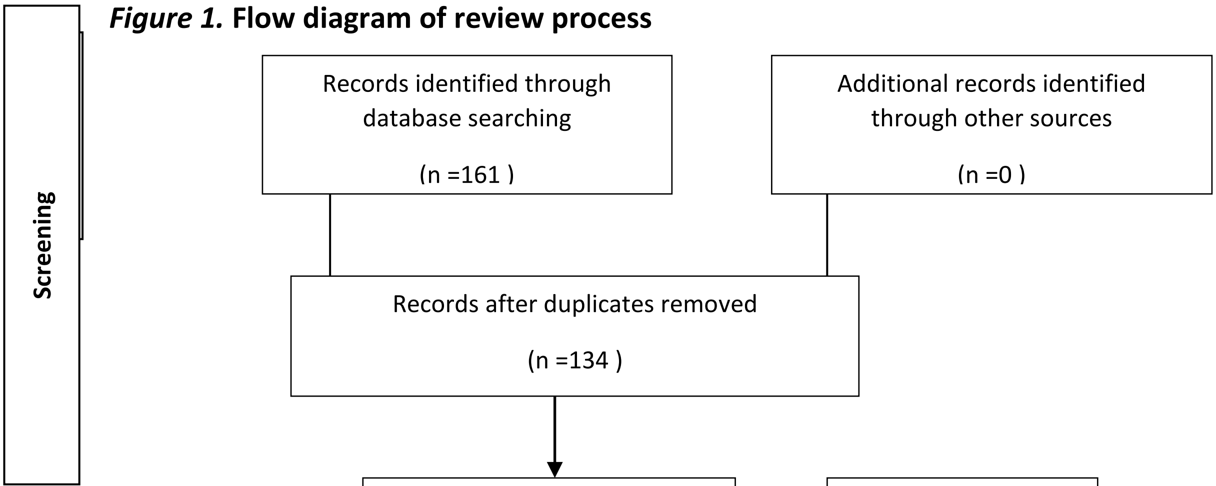
The Search terms that were included were Chronic Pain, Post Traumatic Stress Disorder and PTSD. Search terms included (Post Traumatic Stress disorders or PTSD) and (Chronic pain or Intractable pain). Limits of (English language and humans and yr="1994 -Current") as well as ("all adult (19 plus years)" and journal article) were applied. See supplementary Table 1 for the full Medline search strategy. Resultant articles were then hand searched to identify those which pertained to available treatments.

With regards to the PICOS criteria for eligibility, the population of interest included, all individuals suffering from PTSD (as defined by the DSM-5 criteria) that also had a concomitant diagnosis of CP (as defined by the IASP); no inclusion restrictions were applied to treatment strategies; comparison groups included active and wait-list controls; and the primary outcome was improvement in PTSD and chronic pain symptoms.

Exclusion criteria included individuals aged under 18 years; study protocols, editorials and book chapters; studies not published in English; and studies that did not focus on chronic pain in those exposed to war and/or civil conflict-related trauma.

The search strategy is presented below in the flow chart (fig 1) and selected papers are included in the data extraction table below (table 5)

Figure 1. **Flow diagram of review process**



Full-text reviews excluded (n = 24)

Reason:

Medical treatment n=1

Animal study n=2

Recognition of PTSD/Chronic Pain Association=10

PTSD substance abuse n=5

Sexual Trauma n=1

Other sources of trauma n=6

Table 5 – Data Extraction Table - Studies included in the review of the management of comorbid chronic pain and PTSD linked to war, conflict and injury: a rapid review of the literature.

Study name	War/civil conflict setting	Study Design	Informants	No. of subjects (*n*)	Mean age (SD) of subjects	Gender	Recruitment setting	Comparison group	Quality score (QATSDD)
Trevino et al (2020)	Hospital	PTSD/CP screening. Randomised to SoC or TQOL. Comparison made using Injured Trauma Survivor Score	Civilian Trauma victims	n=649 screened. n=36 randomised to SOC or TQOL		Male and Female	Level 1 Trauma Centre	SoC Vs TQOL	
Feinburg et al (2017)	Hospital	Prospective. Longitudinal Study	Civilian MVC	n=10,629 screened n=948 enrolled	Civilians (M^{age}=33)	Male and Female	Presenting to ED	Patients followed up immediately post discharge, 6 weeks, 6 months and 1 year after initial presentation	
Bartoszek et al(2017)	(Korea, Vietnam Persian Gulf)	Longitudinal	Veterans	n=99		Male and Female	Archival data of US military veterans	Veterans with conflict related trauma and non-conflict	

								related trauma
Phillips et al (2016)	Iraq, Afghanistan	Cross-sectional analysis	Veterans	n=359	(M^{age}=35.1)	Male and Female	OIF/OEF/OND registry	Veterans screened for the presence of pain and psychiatric co-morbidities.
Cook et al (2015)	Iraq, Afghanistan	Longitudinal Study	Veterans	n=177	(M^{age}=37.4)	Male and Female	OEF/OIF veterans enrolled at the Central Texas Veterans Health Care System (CTVHCS)	Veterans screened for the presence of PTSD and Pain acceptance. Pain acceptance as a potential model for therapy
Moeller-Bertrram et al (2014)	Iraq/Afgahnistan	Prospective observational study	Veterans	n=21		Male	Outreach services for veterans	Veterans reporting conflict related trauma were compared to combat veterans in painful response to IM capsaicin
Dunne et al (2012)	Emergency department	Prospective observational	Civilians	N=26		Male and Female	Follow up from	Randomly allocated to

	study	presentation at ED	waiting list or early TF-CBT

Note : SoC means Standard of Care, TQOL means Trauma Quality of Life, MVC means Motor Vehicle Collision, ED means Emergency Department, IM means Intra-muscular, TF-CBT means Trauma Focused Cognitive Behavioural Therapy

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