COMMISSION for VICTIMS and SURVIVORS

QUEEN'S UNIVERSITY BELFAST

4

Conflict, Trauma and Mental Health

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

Interviews with Victims and Survivors | Report 4 of 5

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

Report Number Four

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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).

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