DOCTOR OF PHILOSOPHY

Trauma-informed practice
Principles and attrition

Mitchell, Sinead

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Part 1
Section 1: Systematic literature review

Effects of baseline psychological symptom severity on dropout from trauma-focused cognitive behavior therapy for posttraumatic stress disorder: A meta-analysis

Sinéad Mitchell ¹, Ryan Mitchell ², Ciaran Shannon ³, Martin Dorahy ⁴ & Donncha Hanna ¹

¹ Department of Clinical Psychology, Queen’s University, Belfast, BT9 5BN, Northern Ireland

² Southern Health and Social Care Trust, Moylennn House, 21 Legahory Centre, Craigavon, BT65 5BE, Northern Ireland

³ IMPACT Research Centre, Gurteen House, 60 Steeple Road, Antrim, BT41 2RJ, Northern Ireland

⁴ School of Psychology, Speech, and Hearing, University of Canterbury, Private Bag 4800, Christchurch, 8140, New Zealand

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Corresponding Author: Donncha Hanna, Department of Clinical Psychology, Queen’s University Belfast, BT9 5BN, Northern Ireland. Email: donncha.hanna@qub.ac.uk
Abstract

A meta-analysis was conducted to explore the impact of baseline psychological symptom severity on treatment dropout among adults administered Trauma-Focused Cognitive Behavior Therapy (TF-CBT) for Posttraumatic Stress Disorder (PTSD). Literature on how baseline psychological symptom severity influences attrition has produced inconsistent findings. No review to date has analyzed outcomes across studies. This meta-analysis compared baseline severity scores of, a) clinician-rated PTSD symptoms, b) self-report PTSD symptoms, and c) comorbid psychological symptoms, between TF-CBT completers and dropouts. Eligible studies were peer-reviewed, original outcome research of TF-CBT trials with adults meeting diagnostic criteria for PTSD. Data included standardized and quantitative baseline scores of clinician-rated and/or self-report PTSD and comorbid psychological symptom severity for treatment completers and dropouts. Searches were conducted of PsycINFO, Web of Science and SCOPUS and resulted in the identification of 12 studies with data received for 881 adult participants with a primary diagnosis of PTSD. Nine Randomized Control Trials (RCTs) and three non-RCTs were included. The interventions in the studies were guideline-recommended and evidence-based treatments of Prolonged Exposure, Cognitive Processing Therapy and Cognitive Behavioral Therapy for PTSD. Findings revealed participants dropping out of treatment had higher clinician-rated PTSD symptom severity at baseline than those who completed, with a significant and moderate effect size observed (g = -.50, 95% CI [-0.95, -0.04], p < .05). No other findings were significant. The implications of inconsistent definitions of treatment dropout in included studies are discussed.

Keywords: CBT, dropout, posttraumatic stress disorder, symptom severity
Effects of baseline psychological symptom severity on dropout from trauma-focused cognitive behavior therapy for posttraumatic stress disorder: A meta-analysis

The diagnostic criteria for Posttraumatic Stress Disorder (PTSD) stipulate the presence of symptoms of re-experiencing the trauma, avoidance of trauma reminders, altered arousal, and changes in mood and cognition following exposure to a traumatic event (American Psychological Association, 2013). Fundamental components of standard PTSD therapy include psychoeducation of symptoms and common reactions to trauma, breathing retraining, and recounting the traumatic memories through imaginal exposure or reliving (Hembree et al., 2003). Trauma-Focused Cognitive Behavior Therapy (TF-CBT) combines behavioral approaches of exposure to the trauma memory or trauma stimuli, and cognitive techniques including cognitive restructuring of trauma-based thoughts and appraisals (Watkins, Sprang & Rothbaum, 2018).

CBT has been described as an effective treatment for both acute and chronic PTSD among individuals exposed to a range of trauma experiences (Kar, 2011; Harvey, Bryant & Tarrier, 2003). Trauma-focused interventions within a CBT framework demonstrate higher efficacy in the reduction of PTSD symptom severity (Bisson, Roberts, Andrew, Cooper & Lewis, 2013), PTSD-specific and trauma-related distress (Powers, Halpern, Ferenschak, Gillihan & Foa, 2010), and trauma-related cognitions (Diehle, Schmitt, Daams, Boer & Lindauer, 2014). Such interventions have resulted in high remission rates (Springer, Levy & Tolin, 2018). The effectiveness of individualized TF-CBT for reducing trauma symptoms has been reported in the treatment of survivors of childhood abuse (Ehring et al., 2014), those with coexisting alcohol-use disorders (Sannibale et al., 2013), and those attending National Health Service outpatient clinics, where depression and anxiety have also shown marked reductions following treatment (Ehlers et al., 2013). National Institute for Health and Care Excellence (NICE) guidelines (2018) recommend individual TF-CBT for adults presenting...
with a diagnosis of PTSD, or clinically associated symptoms. Recommended interventions are CBT, Cognitive Therapy (CT), Cognitive Processing Therapy (CPT), Prolonged Exposure (PE) and Narrative Exposure Therapy (NET).

Despite evidence for the efficacy of TF-CBT, attrition rates are problematic (Wamser-Nanney & Steinzor, 2017), as they are for other treatment modalities. A recent meta-analysis identified an average dropout rate of 16% across a range of psychological therapies for PTSD (Lewis, Roberts, Gibson, & Bisson, 2020), consistent with previously reported rates of 18% (Imel, Laska, Jakcupcak & Simpson, 2013). Attrition rates as high as 41% have been recorded in individual studies (Schottenbauer, Glass, Arnkoff, Tendick & Gray, 2008) with indications that clinical settings may report higher rates still (Paintain & Cassidy, 2018; Najavits, 2015). These findings could generate resistance among clinicians in the implementation of evidence-based therapies (Zayfert et al., 2005). However, a comparison of CBT or psychodynamic therapy for PTSD demonstrates similar dropout rates (Paintain & Cassidy, 2018). Psychological therapies with a trauma-focus were recently shown to be significantly associated with greater dropout (Lewis et al., 2020); yet, some previous reviews do not support this finding (Imel et al., 2013; Hembree et al., 2003).

The impact of baseline psychological symptom severity on dropout from CBT for PTSD has produced inconsistent findings. Participants dropping out of treatment have been shown to endorse higher scores of pre-treatment PTSD symptom severity than those who complete (Chard, 2005; Zayfert et al., 2005; Marks, Lovell, Noshirvani, Livanou & Thrasher, 1998). Individuals with co-occurring major depressive disorder were nine times more likely to dropout of PE (Markowitz et al., 2015), and higher levels of depression were noted in a clinical sample of patients dropping out of CBT for PTSD (Zayfert et al., 2005). Female survivors of childhood sexual abuse who dropped out of CBT had significantly greater anxiety and depression at baseline than treatment completers (McDonagh et al., 2005). More
severe anxiety also predicted dropout from PE in a clinical population (Van Minnen, Arntz & Keijsers, 2002). Conversely, differences in baseline scores of PTSD symptom severity between completers and dropouts were shown to be nonsignificant (Belleau et al., 2017; Zandberg, Rosenfeld, Alpert, McLean, & Foa, 2016; Eftekhari et al., 2013; Rizvi, Vogt & Resick, 2009; Van Minnen et al., 2002). No association was found between baseline depression (Rizvi et al., 2009; Taylor et al., 2001; Marks et al., 1998) or other comorbidity and dropout (Belleau et al., 2017). Furthermore, among a large sample of adults in a private setting, those dropping out of CBT presented with lower depression than completers (Zieve, Persons, & Yu, 2019). Due to the breadth of diversity in existing literature, the current review sought to consolidate and analyze findings across studies.

Recent work suggests young children may not have developed the complex cognitive capabilities required to engage meaningfully in trauma-focused treatment aligned with the cognitive appraisal model of PTSD (Dow, Kenardy, Long & Le Brocque, 2019; Mitchell, Brennan, Curran, Hanna, Dyer, 2017). This model proffers that idiosyncratic negative appraisals of the trauma and/or its sequelae create a sense of serious current threat (Ehlers & Clark, 2000). While a positive association between negative appraisals of the trauma and posttraumatic stress symptoms was identified in children and adolescents, this relationship was not found among younger children (Mitchell et al., 2017). Furthermore, the role of wider systemic factors may influence treatment completion among children. Presence of an additional nonprimary caregiver was associated with increased likelihood of completion (Celano, NeMoyer, Stagg & Scott, 2018), while in-session caregiver avoidance significantly impacted dropout (Yasinski et al., 2018). A focus on adults can provide an assessment of psychological factors associated with dropout less impacted by these additional variables.

To date, no review has analyzed baseline psychological symptom scores between TF-CBT treatment completers and dropouts across studies. Furthermore, PTSD symptom
severity has been assessed using clinician-rated and/or self-report measures, with no previous study examining if outcomes alter based on assessment methods. To elucidate and synthesize understanding, separate analyses were conducted to assess baseline, a) clinician-rated PTSD symptom severity, b) self-reported PTSD symptom severity and, c) comorbid psychological symptom severity, and their impact on dropout from TF-CBT. Findings aim to bridge a gap in knowledge surrounding psychological factors which may influence therapeutic engagement with trauma-focused interventions for PTSD.

Method

Sample

Potential studies were identified by searching three electronic databases (PsycINFO, SCOPUS and Web of Science) using the following search terms: (cognitive behav* therapy OR CBT) AND (posttraumatic stress disorder OR post-traumatic stress disorder OR PTSD) AND (adult* OR over 18). Reference lists of identified papers were screened for additional articles. Articles included for review were assessed by two reviewers (redacted for peer review). The meta-analysis focused on reported baseline scores of psychological symptom severity among adults with PTSD who either completed or dropped out of TF-CBT. Factors of population, intervention, comparison and study design were used to determine the inclusion criteria. Articles were included if they met the following criteria: a) A trial using TF-CBT for the treatment of PTSD; b) Included adult participants aged 18 years or older who met the diagnostic criteria for PTSD; c) Reported a standardized quantitative measure of clinician-rated and/or self-report PTSD symptom severity at baseline; d) If comorbid psychological symptom severity at baseline was reported, measures were quantitative and standardized; e) Evidenced treatment dropout; f) Where dropout occurred, more than one
participant had dropped out of the intervention; g) Were peer-reviewed, original studies; h) Were published in the English language.

Comorbid symptoms may have included, but were not restricted to, anxiety and depression. Eligible TF-CBT interventions were those recommended for the treatment of PTSD for adults in accordance with NICE guidelines. Crucially, treatment must have involved elaboration and processing of trauma memories through exposure (NICE, 2018). Studies which reported the integration of added elements to standard treatment manuals were excluded. Such additions may negatively impact treatment as often original components are reduced to accommodate new concepts (Resick et al., 2008). In the event that a clinical trial or Randomized Control Trial (RCT) compared treatment modalities, at least one treatment condition must have included an eligible TF-CBT intervention. Where additional treatment conditions occurred, data pertaining to the TF-CBT intervention only was included. Full articles for papers meeting the eligibility criteria were obtained and screened for the required baseline data. If pre-treatment data was not available, this was requested from the corresponding author by email. Studies where only one participant dropped out of treatment were excluded as no standard deviation was available for the calculation of estimation of variance in the analysis. Qualitative studies and those involving participants under 18 years were excluded. Studies which included participants who did not meet the diagnostic criteria for PTSD were excluded.

A total of 1352 articles were identified following the completion of the search strategy. After the removal of 192 duplicates, 1160 articles were screened by abstract and title by the first two authors independently. From these, 946 were excluded as they did not meet the eligibility criteria. The remaining 214 articles were full text screened. Data was requested from 30 papers and received for eight studies. If requested data could not be obtained the study was excluded. Following full text review 202 papers were excluded (see Figure 1). A
total of 12 studies (N = 902 participants) were included in the analysis (Table 2). Agreement between the two raters after full text review \((n = 214)\) was high \((k = .83)\). Disagreement \((n = 12\) studies) was resolved by discussion and consensus.

![Flowchart of the review and selection process](image)

**Figure 1.** Review and selection of articles (PRISMA)

Of the 12 studies included in the meta-analysis, the data for eight \((1, 5, 6, 7, 8, 9, 10, 11)\) came from corresponding authors, while data for the remaining four \((2, 3, 4, 12)\) was sourced within the studies. The definition of dropout varied across studies therefore extracted data
conferred to the definition and corresponding dropout rate reported by each study. One study (Galovski, Blain, Mott, Elwood & Houle, 2012) described two completer samples. Each completer group was analyzed separately against the study’s dropout sample.

The Cochrane Quality Assessment Tool was completed for included RCT studies \( (n = 9) \). Outcomes showed papers were of high quality with bias determined to be predominantly low or unclear (Table 1). Quality assessment for non-RCTs was conducted using the ROBINS-I tool (Sterne et al. 2016). Non-RCTs were judged as having a moderate risk of bias due to clinicians choosing different TF-CBT interventions based on patient need (Garcia et al., 2011), and missing data (Zayfert et al., 2005). Among included studies (Table 2) high levels of therapist adherence and fidelity to the delivery of the TF-CBT model were described \( (1, 2, 3, 6, 7, 8, 9, 10, 11) \). This ranged from therapists receiving regular supervision \( (1, 3, 6, 7, 8, 9, 10, 11) \), to the random selection of video or audiotaped sessions where independent clinicians assessed adherence and competence \( (2, 7, 8, 9, 10) \). Additional and specialized training was provided on the therapeutic models delivered in seven studies \( (1, 2, 3, 7, 8, 9, 10) \).

To assess publication bias, a funnel plot was constructed for each outcome of interest. Visual inspection showed some evidence of publication bias (Figure 2). Findings are likely to be due to high levels of heterogeneity among the included studies based on sample variation. Visual inspection of funnel plots for each outcome produced similar findings.

**Participants**

A total of 374 from 902 participants dropped out of their respective TF-CBT interventions. Between 520 and 528 were reported as treatment completers. This variability related to participants in the Galovski et al. (2012) study where two completer samples were described. In this study, completers had achieved end-state criteria of self-report PTSD severity in the moderate range, mild depression, and negative PTSD diagnostic status.
Table 1. Quality assessment of included randomized control trials.

<table>
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<th>Random Sequence Generation</th>
<th>Allocation Concealment</th>
<th>Blinding Participants &amp; Personnel</th>
<th>Blinding Outcome Assessment</th>
<th>Incomplete Outcome Data</th>
<th>Selective Reporting</th>
<th>Other Bias</th>
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*Baseline measures symbols indicate the following: * = Clinician-rated PTSD symptom severity measure, ** = Self-report PTSD symptom severity measure, *** = Depression measure, **** = Anxiety measure. BAI = Beck Anxiety Inventory; BDI = Beck Depression Inventory; CAPS = Clinician Administered PTSD Scale; HAM-A = Hamilton Rating Scale - Anxiety; HAM-D = Hamilton Rating Scale - Depression; IES-R = Impact of Events Scale Revised; MMPI-2 = Multiphasic Personality Inventory, MMPI-D = Depression scale; MMPI-A = Psychasthenia, or Anxiety scale (Garcia et al. 2011); PCL = PTSD Checklist (M= Military); PDS = Posttraumatic Diagnostic Scale; PHQ-9 = Patient Health Questionnaire; PSS = PTSD Symptom Scale; PSS-SR = PTSD Symptom Scale Self-Report; STAI = Spielberger Trait Anxiety Inventory; E = Early Completers, L = Long Completers (Galovski et al. 2012 study)

†Studies are referred to in the current article by the use of the allotted study number in superscript
Figure 2. Funnel plot of baseline clinician-rated PTSD symptom severity scores

Criteria were met by what the study called “early completers” (n = 29) prior to session 12, or by “long completers” (n = 21) beyond session 12. Dropout rates ranged from 9% to 72.2%.

Participants with chronic and complicated PTSD most commonly comprised the clinical presentations in the meta-analysis (see Table 2). Common interventions were PE, CBT and CPT, delivered to participant samples including those diagnosed with severe mental illness, those with chronic PTSD, and individuals who experienced a single incident trauma (referred to as Type I trauma) in adulthood. Such variability within sample populations was taken into consideration in the conduct of the data analysis.

Measures

Clinician-rated PTSD symptom severity.

The Clinician-Administered PTSD Scale (CAPS; Blake et al., 1995, Blake et al., 1990; CAPS-IV, Blake et al., 1997; CAPS-5, Weathers et al., 2015) was administered at baseline in 10 papers (2, 3, 5, 6, 7, 8, 9, 10, 11, 12). The CAPS semi-structured interview calculates the intensity and frequency of PTSD symptoms, providing a total score of PTSD symptom severity. The CAPS total mean, standard deviation and number of treatment completers and dropouts were obtained for each study (Table 3).
Self-report PTSD symptom severity.

Standardized self-report measures of PTSD symptom severity were reported by nine studies (1, 2, 3, 4, 6, 7, 8, 9, 11). These included: versions of the PTSD Checklist (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993); the Posttraumatic Diagnostic Scale (PDS; Foa, Cashman, Jaycox & Perry, 1997); and the PTSD Symptom Scale (PSS; Foa, Riggs, Dancu, & Rothbaum, 1993). Higher scores on each scale indicated higher levels of PTSD symptom severity. In two cases (1, 6), more than one self-report measure was administered to study participants. Only one PTSD self-report measure per paper was analyzed, with the PDS and PSS-SR selected, respectively. These measures determine PTSD diagnostic status as well as assessing symptom intensity. The number of study completers and dropouts, the mean, and standard deviation of baseline scores are presented (see Table 4).

Co-morbid psychological symptom severity.

Nine studies assessed baseline measures of depression (2, 3, 4, 6, 7, 8, 9, 11, 12). The most commonly used tool was the first or second edition of the Beck Depression Inventory (BDI; Beck, Ward, Mendelsohn, Mock & Erbaugh, 1961; BDI-II, Beck, Steer & Brown, 1996). Other studies reported baseline depression scores using the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001), the Hamilton Rating Scale for depression (HAM-D; Hamilton, 1959) or the Multiphasic Personality Inventory-2 depression scale (MMPI-2; Butcher, 1990). Table 5 shows the baseline scores for treatment completers and dropouts for these studies. Four studies (2, 4, 6, 9) reported pre-treatment assessment of anxiety symptoms using a variety of measures (Table 6). Self-report measures were commonly applied, with the exception of the Hamilton rating scales used in two studies (2, 6). If more than one measure of depression and anxiety were reported (6), scores from instrument with
greater validity and reliability were analyzed, in this case the BAI and BDI. No other baseline
comorbidities were commonly measured.

**Data Analysis**

Analyses were performed using Review Manager 5.3 from the Cochrane
Collaboration (RevMan 5.3) attending to each of the three study questions. Analysis
compared baseline differences of, a) clinician-rated PTSD symptom severity, b) self-report
PTSD symptom severity, and c) depression and anxiety severity, between TF-CBT treatment
completers and treatment non-completers. Random effects were computed. Hedges \( g \) was
used for the estimation of the standardized mean difference. Using guidelines proposed by
Cohen (1988), effect sizes were interpreted as small (0.2), moderate (0.5), or large (0.8).
Heterogeneity was calculated using the Chi\(^2\) statistic (\(\chi^2\)) computed in RevMan 5.3. This
calculation assesses whether observed differences in results are compatible with chance alone
(Deeks, Higgins & Altman, 2011). Large values indicate the presence of heterogeneity along
with a \( p \) value which determines the statistical significance of intervention effects. Based on
this calculation, \( I^2 \) was computed. This provided information on the variation in effect
estimates due to heterogeneity. Cochrane report heterogeneity can range from unimportant (\( I^2 \)
of 0 - 40%) to considerable (\( I^2 \) of 75% - 100%), depending on the magnitude and direction of
the effect and strength of evidence based on statistical significance (Deeks et al., 2011).

**Results**

**Clinician-rated PTSD symptom severity**

Findings for 10 studies (2, 3, 5, 6, 7, 8, 9, 10, 11, 12) showed a standardized mean difference in
baseline clinician-rated PTSD symptom severity between treatment completers (\( n = 432 \)) and
dropouts (\( n = 271 \)). Participants dropping out were assessed by clinicians to have
significantly higher PTSD symptom severity at baseline than completers, with a moderate
effect size, \( g = -0.50, 95\% \text{ CI } [-0.95, -0.04], p = .03. \) Heterogeneity was significant, \( \chi^2(9) = 61.64, p < .001, \) with \( I^2 = 85\%. \) Effect sizes ranged from 0.31 to -3.68. Seven papers reported dropouts as having higher baseline PTSD symptom severity than completers (Table 3 and Figure 3). Findings revealed that Galovski et al.’s (2012) early completers (Table 3) had substantially lower baseline PTSD symptom severity than dropouts.

Subgroup analysis was completed. When Galovski et al. (2012) long completers (\( n = 424 \)) replaced early completers, slight differences were observed in the overall effect size, but this remained significant, \( g = -0.43, 95\% \text{ CI } [-0.82, -0.04], p = .03. \) Long completers had substantially lower baseline scores than dropouts, \( g = -2.89, 95\% \text{ CI } [-3.81, -1.98]. \) Comparisons between baseline CAPS scores in RCTs (3, 5, 6, 7, 8, 9, 10, 11) and non-RCTs (2, 12) found similar effect sizes irrespective of study design. One study defined treatment dropout as occurring when pre-defined treatment goals had not been met (Zayfert et al., 2005). Subgroup analysis found a slightly larger effect size within this sample, \( g = -0.70, 95\% \text{ CI } [-1.10, -0.03], p < .001, \) but subgroup differences were not significant.

![Figure 3](image-url) **Figure 3.** Significant standardized mean difference in baseline clinician-rated PTSD symptom severity
Table 3. Significant effect of baseline clinician-administered PTSD scale on treatment dropout

<table>
<thead>
<tr>
<th>Study</th>
<th>Treatment Completers</th>
<th>Treatment Dropouts</th>
<th>Weight</th>
<th>Std. Mean Difference IV, Random, 95% CI</th>
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<td>Total</td>
<td>Mean</td>
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<td>Frueh et al., 2009</td>
<td>65.08</td>
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<td>71.43</td>
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<td>Galovski et al., 2012</td>
<td>67.86</td>
<td>3.54</td>
<td>29</td>
<td>82.42</td>
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<tr>
<td>Miles et al., 2015</td>
<td>76.85</td>
<td>14.31</td>
<td>53</td>
<td>83.64</td>
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<tr>
<td>Paunovic &amp; Öst, 2001</td>
<td>96.75</td>
<td>20.14</td>
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<td>90.25</td>
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<tr>
<td>Resick et al., 2002</td>
<td>74.44</td>
<td>18.49</td>
<td>109</td>
<td>74.03</td>
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<td>Resick et al., 2008</td>
<td>66.89</td>
<td>15.97</td>
<td>27</td>
<td>75.82</td>
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<tr>
<td>Schnurr et al., 2007</td>
<td>77.27</td>
<td>17.25</td>
<td>88</td>
<td>78.15</td>
</tr>
<tr>
<td>Sloan et al., 2018</td>
<td>36.73</td>
<td>9.41</td>
<td>37</td>
<td>37.96</td>
</tr>
<tr>
<td>Thorp et al., 2019</td>
<td>67.43</td>
<td>14.27</td>
<td>30</td>
<td>64.11</td>
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<tr>
<td>Zayfert et al., 2005</td>
<td>67.00</td>
<td>19.50</td>
<td>30</td>
<td>83.20</td>
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<tr>
<td>Total (95% CI)</td>
<td></td>
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<td>432</td>
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</tr>
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Self-report PTSD symptom severity

Baseline self-report PTSD symptom severity scores were available for nine included studies (1, 2, 3, 4, 6, 7, 8, 9, 11) comprising treatment completers (n = 405) and dropouts (n = 230). A small to moderate effect size was observed which trended towards significance, $g = -0.38, 95\% \text{ CI } [-0.81, 0.05], p = .08$ (Figure 4). Effect sizes ranged from -2.31 to 0.38. Heterogeneity was significant, $\chi^2(8) = 38.61, p < .001$, and $I^2 = 79\%$. Six papers (1, 2, 3, 4, 7, 8) showed baseline PTSD symptom severity was lower among completers. Early completers in the Galovski et al. (2012) study reported substantially lower baseline PTSD symptom severity than dropouts (Table 4). Yet, long completers had slightly higher scores than dropouts, $g = 0.08, 95\% \text{ CI } [-0.55, 0.70]$. When long completers were substituted, findings remained nonsignificant, $g = -0.15, 95\% \text{ CI } [-0.35, 0.06], p = .16$. Substantial differences were noted in effect sizes based on study design. Dropouts from non-RCTs (2, 4) had higher baseline PTSD severity with a moderate effect size, $g = -0.60, 95\% \text{ CI } [-0.96, -0.24], p = .001$. One study defined dropout as occurring when treatment goals had not been achieved (4). In this study, higher symptom severity was observed with a moderate effect size, $g = -0.61, 95\% \text{ CI } [-1.01, -0.22], p = .002$. No subgroup differences were found when dropout was defined as non-completion of the intervention (1, 2, 3, 6, 7, 8, 9, 11). A subgroup using this definition showed a small but nonsignificant effect when Galovski et al. (2012) early completers were included, $g = -0.34, 95\% \text{ CI } [-0.84, 0.15], p = .17$, and a smaller effect size was calculated when long completers where analyzed, $g = -0.03, 95\% \text{ CI } [-0.23, 0.17], p = .77$. 
Figure 4. Standardized mean difference in baseline self-report trauma symptom severity
Table 4. Baseline self-report PTSD symptom severity

<table>
<thead>
<tr>
<th>Study</th>
<th>Treatment Completers</th>
<th>Treatment Dropouts</th>
<th>Weight</th>
<th>Std. Mean Difference IV, Random, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Butollo et al., 2016</td>
<td>28.96</td>
<td>10.14</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Frueh et al., 2009</td>
<td>56.00</td>
<td>13.62</td>
<td>13</td>
<td>-0.52 [-1.46, 0.41]</td>
</tr>
<tr>
<td>Galovski et al., 2012</td>
<td>28.62</td>
<td>1.76</td>
<td>29</td>
<td>-2.31 [-3.07, -1.56]</td>
</tr>
<tr>
<td>Garcia et al., 2011</td>
<td>55.81</td>
<td>13.94</td>
<td>38</td>
<td>-0.61 [-1.01, -0.22]</td>
</tr>
<tr>
<td>Paunovic &amp; Öst, 2001</td>
<td>38.63</td>
<td>7.84</td>
<td>16</td>
<td>0.38 [-0.73, 1.48]</td>
</tr>
<tr>
<td>Resick et al., 2002</td>
<td>29.30</td>
<td>8.60</td>
<td>109</td>
<td>-0.02 [-0.39, 0.35]</td>
</tr>
<tr>
<td>Resick et al., 2008</td>
<td>28.00</td>
<td>8.70</td>
<td>27</td>
<td>-0.31 [-0.92, 0.30]</td>
</tr>
<tr>
<td>Schnurr et al., 2007</td>
<td>58.33</td>
<td>12.38</td>
<td>88</td>
<td>0.03 [-0.31, 0.38]</td>
</tr>
<tr>
<td>Thorp et al., 2019</td>
<td>58.07</td>
<td>13.40</td>
<td>29</td>
<td>0.11 [-0.67, 0.89]</td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td></td>
<td></td>
<td>405</td>
<td>-0.38 [-0.81, 0.05]</td>
</tr>
</tbody>
</table>
Co-morbid symptom severity at baseline

Baseline depression scores were available for nine included papers (2, 3, 4, 6, 7, 8, 9, 11, 12) reporting treatment completers (n = 376) and dropouts (n = 293). Findings revealed a small to moderate effect size but no significant difference (Figure 5) between participant groups, g = -0.36, 95% CI [-0.80, 0.08], p = .10. Heterogeneity was significant, \(\chi^2(8) = 45.25, p < .001\), with \(I^2 = 82\%\). Participants who dropped out had higher baseline depression scores than completers in five studies. Galovski et al. (2012) early completers (Table 5) had substantially lower scores of depression than participants who dropped out. Such notable differences were not observed between long completers and dropouts, g = -0.28, 95% CI [-0.91, 0.34].

Long completers were substituted leading to a reduction in the completer sample (n = 368). A smaller and nonsignificant effect size was reported, g = -0.19, 95% CI [-0.42, 0.04], p = .11. Non-RCTs (2, 4, 12) had substantially different effect sizes from RCTs (3, 6, 7, 8, 9, 11). Dropouts from non-RCTs had higher depression scores than completers with a moderate effect size, g = -0.53, 95% CI [-0.87, -0.19], p = .002. Seven studies (3, 6, 7, 8, 9, 11) defined dropout as non-completion of the intervention. A small effect size was noted when the subgroup included Galovski et al. (2012) early completers, g = -0.28, 95% CI [-0.87, 0.31], p = .35. A smaller effect size was observed when the subgroup comprised long completers, g = -0.04, 95% CI [-0.25, 0.16], p = .68. Study dropouts who failed to achieve their treatment goals (4, 12) endorsed higher baseline depression than completers with a moderate effect size, g = -0.59, 95% CI [-0.99, -0.18], p = .004. No differences in effect size were observed when self-report depression measures (3, 4, 6, 7, 8, 9, 11, 12) were analyzed, g = -0.38, 95% CI [-0.85, 0.09], p = .11. One study included a clinician-administered scale (2) with no significant difference found between completers and dropouts, g = -0.13, 95% CI [-1.05, 0.79], p = .78.
Figure 5. Standardized mean difference between baseline scores of depression
<table>
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<th>Study</th>
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<th>Mean</th>
<th>SD</th>
<th>Total</th>
<th>Weight</th>
<th>Std. Mean Difference IV, Random, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frueh et al., 2009</td>
<td>24.39</td>
<td>13.63</td>
<td>13</td>
<td>26.14</td>
<td>10.79</td>
<td>7</td>
<td>8.9%</td>
<td>-0.13 [-1.05, 0.79]</td>
</tr>
<tr>
<td>Galovski et al., 2012</td>
<td>26.93</td>
<td>2.00</td>
<td>29</td>
<td>32.61</td>
<td>2.54</td>
<td>19</td>
<td>10.0%</td>
<td>-2.51 [-3.29, -1.73]</td>
</tr>
<tr>
<td>Garcia et al., 2011</td>
<td>75.26</td>
<td>14.00</td>
<td>38</td>
<td>80.73</td>
<td>13.51</td>
<td>79</td>
<td>13.2%</td>
<td>-0.41 [-0.79, -0.01]</td>
</tr>
<tr>
<td>Paunovic &amp; Öst, 2001</td>
<td>38.00</td>
<td>10.22</td>
<td>16</td>
<td>34.00</td>
<td>14.26</td>
<td>4</td>
<td>7.6%</td>
<td>0.35 [-0.75, 1.45]</td>
</tr>
<tr>
<td>Resick et al., 2002</td>
<td>23.35</td>
<td>9.27</td>
<td>108</td>
<td>22.91</td>
<td>10.12</td>
<td>35</td>
<td>13.2%</td>
<td>0.05 [-0.34, 0.43]</td>
</tr>
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<td>Resick et al., 2008</td>
<td>28.41</td>
<td>11.00</td>
<td>27</td>
<td>27.76</td>
<td>11.72</td>
<td>17</td>
<td>11.4%</td>
<td>0.06 [-0.55, 0.66]</td>
</tr>
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<td>Schnurr et al., 2007</td>
<td>24.69</td>
<td>9.53</td>
<td>88</td>
<td>26.43</td>
<td>9.34</td>
<td>53</td>
<td>13.5%</td>
<td>-0.18 [-0.52, 0.16]</td>
</tr>
<tr>
<td>Thorp et al., 2019</td>
<td>12.87</td>
<td>5.93</td>
<td>30</td>
<td>9.86</td>
<td>9.51</td>
<td>7</td>
<td>9.6%</td>
<td>0.44 [-0.39, 1.27]</td>
</tr>
<tr>
<td>Zayfert et al., 2005</td>
<td>21.40</td>
<td>8.00</td>
<td>27</td>
<td>29.30</td>
<td>10.20</td>
<td>72</td>
<td>12.7%</td>
<td>-0.81 [-1.27, -0.35]</td>
</tr>
<tr>
<td>Total (95% CI)</td>
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<td></td>
<td></td>
<td>293</td>
<td></td>
<td></td>
<td>100.0%</td>
<td>-0.36 [-0.80, 0.08]</td>
</tr>
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</table>
Data was available for four studies (2, 4, 6, 9) which assessed anxiety at baseline (Table 6). The standardized mean difference was calculated to compare baseline anxiety scores between treatment completers (n = 155) and treatment dropouts (n = 143). While three studies (2, 4, 6) showed participant dropouts had higher scores, no significant differences were found, \( g = -0.11, 95\% \text{ CI} [-0.35, 0.13], p = .39 \) (Figure 6). Effect sizes ranged from -0.34 to 0.10. Tests of heterogeneity were not significant, \( \chi^2 (3) = 2.87, p = .41 \), with \( I^2 = 0\% \).

Differences in study design showed a small to moderate effect in non-RCTs (2, 4), \( g = -0.32, 95\% \text{ CI} [0.67, 0.04], p = .08 \). Dropout definition differed in one study (4) with a small to moderate effect size that trended towards significance, \( g = -0.34, 95\% \text{ CI} [-0.73, 0.05], p = .09 \). No change in effect size was observed in self-report anxiety scales (4, 6, 9), \( g = -0.12, 95\% \text{ CI} [-0.44, 0.21], p = .48 \); a clinician-administered measure (2) showed a small but nonsignificant effect size, \( g = -0.20, 95\% \text{ CI} [-1.13, 0.72], p = .66 \). Based on wide variability within the participant samples, classification of PTSD, and an inability to extract specific data relating to years since and type of trauma, no further subgroups were found to be viable.

![Figure 6. Standardized mean difference between baseline anxiety scores](image-url)
Table 6. Baseline scores of anxiety between treatment completers and dropouts

<table>
<thead>
<tr>
<th>Study</th>
<th>Treatment Completers</th>
<th>Treatment Dropouts</th>
<th>Weight</th>
<th>Std. Mean Difference IV, Random, 95% CI</th>
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<td>SD</td>
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<td>Mean</td>
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<td>Frueh et al., 2009</td>
<td>17.39</td>
<td>9.92</td>
<td>13</td>
<td>19.29</td>
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<td>17.09</td>
<td>38</td>
<td>80.78</td>
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<td>Paunovic &amp; Öst, 2001</td>
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<td>10.88</td>
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<td>Schnurr et al., 2007</td>
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<td>12.77</td>
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<td>51.32</td>
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<tr>
<td>Total (95% CI)</td>
<td>155</td>
<td>143</td>
<td>100.0%</td>
<td>-0.11 [-0.35, 0.13]</td>
</tr>
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</table>
Discussion

Findings from the meta-analysis show higher clinician-rated PTSD symptom severity at baseline had a significant and moderate effect on dropout from TF-CBT interventions for PTSD. No significant differences were found between completers and dropouts on baseline scores of self-report PTSD symptom severity, or symptoms of depression, or anxiety. While previous evidence has been conflicting, the current review analyzed findings across studies. The meta-analysis answered three distinct questions surrounding baseline factors of clinician-rated PTSD symptom severity, self-report PTSD symptom severity, and comorbid psychological symptom severity which may be implicated in completion or dropout from TF-CBT.

Clinician-rated PTSD symptom severity.

The moderate effect size for participants who dropped out based on higher clinician-rated PTSD symptom severity was similar to effect sizes found regardless of study design, but the definition of treatment dropout impacted findings. A slightly larger effect size was observed in a single study where individuals may have received further treatment sessions yet were coded as dropouts if they continued to meet the diagnostic criterion of reexperiencing (Zayfert et al., 2005). The authors described this definition as conservative but in-keeping with clinical decision-making. Variability and diversity among participant samples and intervention type may have accounted for the high levels of heterogeneity observed.

Outcomes support previous findings of higher pre-treatment CAPS scores among treatment dropouts (Chard, 2005; Marks et al., 1998). Three out of seven studies included in the analysis commented on higher baseline CAPS scores among treatment dropouts within the discussion of their findings (3, 5, 12). More clarification is required in future studies to support
or refute evidence of clinician-rated PTSD symptom severity scores and its association with dropout from TF-CBT interventions.

*Self-report PTSD symptom severity.*

Baseline PTSD symptom severity fell marginally short of differing between TF-CBT treatment completers or non-completers. Nonsignificant effects were also evident in previous studies among participants with substance use disorders (Zandberg et al., 2016), combat histories (Eftekhari et al., 2013), and those with chronic PTSD (Van Minnen et al., 2002). This outcome altered substantially by study design. In non-RCT studies, dropouts presented with higher baseline symptom severity. Participants who dropped out endorsed more severe baseline symptoms when dropout was defined as leaving treatment prior to no longer meeting the diagnostic criteria for PTSD or experiencing a significant reduction in PTSD symptoms (Garcia et al., 2011). The majority of included studies measured PTSD symptom severity using both clinician-rated and self-report measures (2, 3, 6, 7, 8, 9, 11), three applied the CAPS only (5, 10, 12), while two included self-report measures only (1, 4).

Findings from the meta-analysis suggest differences may exist between baseline self-report and clinician-rated measures of PTSD symptom severity, and their association with dropout from TF-CBT. Clinician-administered measures have been described having more PTSD diagnostic sensitivity (Weathers et al., 2018; Foa et al., 1993), with the possibility that the clinical interview may prompt individuals to report avoidance symptoms that they may be less aware of in the completion of self-report instruments (Weathers et al., 2018). Self-report measures have been suggested as potentially overestimating the prevalence of PTSD (Griffen, Uhlmansiek, Resick & Mechanic, 2004; Stevens, Fabra, Thies, 2013); validation of diagnosis with clinician-administered assessment has been encouraged. Among studies in the meta-analysis, Paunovic & Öst (2001) described the application of additional and longer therapy
sessions (120 minutes) due to the extreme trauma experienced by their sample. Baseline clinician-assessed PTSD symptom severity was higher among treatment completers in this study. Longer duration of manualized therapy sessions may reduce dropout among those with more severe baseline PTSD symptoms, while additional sessions could lead to improved and longer-term symptom reduction (Forbes et al., 2019); however further research is warranted in this area. Outcomes from the analysis suggest clinician-rated measures may be more sensitive in determining PTSD symptom severity associated with dropout. Findings recommend the administration of both clinician-rated and self-report measures to further understand the impact of higher baseline symptom severity on dropout from TF-CBT.

Co-morbid psychological symptom severity.

No significant difference was found in baseline depression scores between TF-CBT treatment completers or dropouts. This was consistent with previous literature (Belleau et al., 2017; Eftekhari et al., 2013; Taylor et al., 2001). A larger effect was observed in non-RCT studies (2, 4, 12) where dropouts presented with higher depression scores. Dropout definition led to a slightly larger effect size when participant dropouts included those who had not achieved their pre-treatment goals (4, 12). Significant differences in baseline depression between completers and dropouts had been reported in both publications (4, 12). Differences in baseline scores of anxiety among treatment completers or dropouts were also not significant. Outcomes do not support previous findings (McDonagh et al., 2005; Van Minnen et al., 2002). Little change in effect size was observed based on study design or dropout definition. Anxiety measures used, including the Hamilton rating scales and Spielberger state anxiety inventory, have been criticized due to their limited ability to discriminate between symptoms of anxiety and depression (Grös, Antony, Simms & McCabe, 2007; Riskind, Beck, Brown & Steer, 1987). Caution is therefore required in the interpretation of this outcome.
Findings demonstrated variability in the measurement, reporting and discussion of baseline psychological symptom severity implicated in dropout from TF-CBT. More consistent measurement and reporting is encouraged prior to the initiation of psychological interventions for PTSD. In addition, given clinician-rated measures of PTSD were more sensitive to dropout than self-report measures, clinician-administered baseline assessment of depression and anxiety should be trialed to see if they increase the capacity to detect those vulnerable to leaving treatment early. Findings could enhance understanding and evidence factors that may lead to dropout from TF-CBT.

**General discussion**

The average dropout rate across included studies (41.5%) was similar to higher rates previously reported (Schottenbauer et al., 2008), but much higher than evident in other meta-analytic work across all PTSD treatment types (e.g. 16%; Lewis et al., 2020). Studies have suggested that clinical settings tend to report higher dropout rates than RCTs (Paintain & Cassidy, 2018) as RCTs often exclude patients with major complications, including severe mental illness (Najavits, 2015). Findings from the meta-analysis suggest that dropout definition rather than clinical setting may be attributable to higher observed rates. While a number of RCT studies comprised the current analysis, just two samples were more actively recruited from a metropolitan area (Galovski et al., 2012; Resick et al., 2008); among the remaining studies participants were treatment-seeking adults recruited from clinical settings. Across all included studies, a majority comprised participants presenting with more complicated PTSD diagnoses. Two studies described substantially higher dropout rates of 67.5% (Garcia et al., 2011) and 72.2% (Zayfert et al., 2005) and were distinct in the use of an alternative dropout definition. Forbes and colleagues (2019) recommend clear consensus is essential to understand what constitutes treatment success, failure, and non-response in PTSD. Attention must be paid to the particular dropout definitions used in the interpretation.
of findings, particularly when informing clinical decisions on the application of TF-CBT treatments.

Outcomes from the analysis encourage clinician assessment of PTSD symptom severity to inform judgements on the selection of appropriate and empirically supported TF-CBT therapies. While studies in the meta-analysis included participants with chronic PTSD and those with complex PTSD presentations, a lack of diagnostic criteria available at the time studies took place means outcomes cannot be generalized to this population. Currently no specific treatments exist for those with complex PTSD and unified, validated assessment tools are in their infancy (Karatzias & Cloitre, 2019). In applying a phased approach to trauma-focused treatment, and prior to the initiation of trauma-processing, participants with more severe baseline PTSD symptom severity may benefit from stabilization and psychoeducation (McFetridge et al., 2017; though see De Jongh et al., 2016).

Included studies were of a high standard and demonstrated high fidelity and adherence to the treatment models to which they were aligned. Furthermore, CAPS reliability through an assessment of recorded interviews (2, 3, 5, 7, 8, 11) or completed by clinicians independent of the study (9, 10) ensured robust scores were analyzed. Sample populations were broad and diverse based on gender, age group, and the range of trauma experience types. All participant samples had a primary diagnosis of PTSD, with many including chronic and complicated PTSD presentations. Findings may contribute to clinical decision-making regarding the initiation of TF-CBT for PTSD within this population.

Some limitations of the meta-analysis were noted. Baseline and attrition data are not regularly reported in psychotherapeutic studies (Fernandez, Salem, Swift & Ramtahal, 2015). While the current analysis addressed this challenge with the inclusion of any study which evidenced dropout, data was unobtainable for 30 eligible papers. Additionally, among
included studies, not all baseline data was available. In the Zayfert et al. (2005) paper, data was missing for a large proportion of treatment dropouts \((n = 19)\) but fewer completers \((n = 2)\). The authors highlighted that discrepancies were due to difficulties in adherence to structured assessments in clinical settings. More routine inclusion of baseline data in future research is encouraged, particularly in the context of analyzing or reporting factors implicated in treatment dropout. Studies predominantly comprised participants from the USA \((n = 10)\); findings may not be generalizable to other cultural settings. Finally, figures calculated in the meta-analysis relate to the published and reported dropout rate for each included study. Caution must be exercised in the interpretation of results of PTSD treatment completion and dropout, with readers attending to the specific definition used.

The meta-analysis reported that higher clinician-rated PTSD symptom severity at baseline had a significant and moderate effect on treatment dropout from TF-CBT interventions for PTSD. Baseline scores of self-reported PTSD symptom severity, depression and anxiety did not impact treatment dropout. Findings highlighted variability within the definition of treatment dropout, urging caution in the interpretation of wider research. Future studies should aim to gain consensus on a definition of dropout to provide opportunities for more consistent reporting and evidence to inform best practice. Future outcomes studies may heighten sensitivity to those potentially at risk of early withdrawal from treatment by using clinician-administered measures of PTSD.
References


www.training.cochrane.org/handbook


### Summary Tables

<table>
<thead>
<tr>
<th>Critical Findings</th>
<th>Implications for Practice, Policy &amp; Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Significantly higher baseline clinician-rated PTSD symptom severity was found among TF-CBT treatment dropouts with a moderate effect size.</td>
<td>• Close attention must be paid to the completion and dropout definitions used among studies reporting results from TF-CBT treatments.</td>
</tr>
<tr>
<td>• No other significant differences in baseline psychological symptom severity were found between treatment completers and dropouts.</td>
<td>• Regular reporting of baseline psychological symptom severity scores between treatment completers and dropouts is encouraged, along with routine assessment and discussion of dropout.</td>
</tr>
<tr>
<td>• Variation in the definition of dropout had an impact on findings.</td>
<td>• Future studies should aim to reach agreement on the definition of dropout from TF-CBT for PTSD.</td>
</tr>
<tr>
<td>• Consensus on the definition of treatment dropout in PTSD is required.</td>
<td></td>
</tr>
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</table>
Section 2: Instructions for Authors: Trauma, Violence and Abuse (TVA)

TVA accepts comprehensive reviews of research or legal reviews that address any aspect of trauma, violence or abuse. Reviews must be based on a sufficient number of studies to justify synthesis. Reviewed literatures may come from the social or behavioral sciences or the law.

Each manuscript must:

- be prepared using APA style, and be no longer than 40 double-spaced pages, including references, tables, and figures;
- include an abstract of up to 250 words describing the topic of review, method of review, number of research studies meeting the criteria for review, criteria for inclusion, how research studies were identified, and major findings;
- begin with a clear description of the knowledge area that is being researched or reviewed and its relevance to understanding or dealing with trauma, violence, or abuse;
- provide a clear discussion of the limits of the knowledge that has been reviewed;
- include two summary tables: one of critical findings and the other listing implications of the review for practice, policy, and research;
- include a discussion of diversity as it applies to the reviewed research.*

All manuscripts are peer reviewed and should be submitted with a letter indicating that the material has not been published elsewhere and is not under review at another publication. Manuscripts should be submitted electronically to http://mc.manuscriptcentral.com/tva where authors will be required to set up an online account on the SAGE Track system powered by ScholarOne. Inquiries may be made by email at jiv@u.washington.edu.

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Please note:

Reviews of issues related to trauma, violence, and/or abuse are not appropriate for TVA unless they are based on a comprehensive review of research. TVA does not publish case studies or reports on individual research studies.
TVA does not respond to author inquiries regarding the interest of the journal in their manuscript or on the suitability of their manuscript for TVA. The mission and parameters of TVA are clearly stated above and TVA assumes that authors are in the best position to know if their work is consistent with the aims and scope of the journal.

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TVA requires all submissions to include a discussion of diversity as it applies to the reviewed research (e.g., nature of the sample, limitations of the measurement). The discussion should address the body of knowledge reviewed as it addresses or fails to address issues of diversity. Diversity concerns are not a criteria for publication but must be addressed. The nature of the discussion and amount of space devoted to the discussion is the responsibility of the author(s).

TVA understands diversity to include all aspects of human differences such as socioeconomic status, race, ethnicity, language, nationality, sex, gender identity, sexual orientation, religion, geography, ability, age, and culture.

Diversity as a core value embodies inclusiveness, mutual respect, and multiple perspectives and serves as a catalyst for expanding knowledge and practice with all human beings. While science seeks knowledge that can be generalized, it must appreciate that specific findings, while important in understanding the unique experiences of individuals or groups, are not necessarily applicable to all.

**Manuscript Preparation**

Manuscripts should be prepared using the APA Style Guide, and should be no longer than **40 double-spaced pages, including references, tables, and figures**. Text must be in 12-point Times New Roman font. Block quotes may be single-spaced. Manuscripts must include margins of 1 inch on all sides and pages must be numbered sequentially. All files should be in Word (.docx or .doc).

The manuscript should include five major sections (in this order): Title Page, Abstract, Main Body (blinded, with all author names and identifying information removed for peer review), References, and Author Biographies.
Sections in a manuscript may include the following (in this order): (1) Title page, (2) Abstract, (3) Keywords, (4) Text, (5) Notes, (6) References, (7) Tables, (8) Figures, (9) Appendices, and (10) Author Biographies.

1. **Title page must be uploaded as a separate file. Please include the following:**

   - Full article title
   - Acknowledgments and credits
   - Each author’s complete name and institutional affiliation(s)
   - Grant numbers and/or funding information
   - Conflict of interests, if any
   - Corresponding author (name, address, phone/fax, e-mail)

2. **Abstract.** Copy and paste the abstract (150 to 250 words) into the space provided, headed by the full article title. Omit author names. Abstract must describe the topic of the review, method of review, number of research studies meeting the criteria for review, criteria for inclusion, how research studies were identified, and major findings.

3. **Keywords.** 5-7 keywords must be included in the manuscript.

4. **Text.** Begin text headed by the full article title. Text must be blinded, with all author names and other identifying information removed, for peer review.

   **a. Headings and Subheadings.** Subheadings should indicate the organization of the content of the manuscript. Generally, three heading levels are sufficient to organize text.

   - Level 1: centered, boldface, upper & lowercase
   - Level 2: flush left, boldface, upper & lowercase
   - Level 3: indented, boldface, lowercase paragraph heading ending with a period
   - Level 4: indented, boldface, italicized, lowercase paragraph heading ending with a period
   - Level 5: indented, italicized, lowercase paragraph heading ending with a period
b. **Citations.** For each text citation there must be a corresponding citation in the reference list and for each reference list citation there must be a corresponding text citation. Each corresponding citation must have identical spelling and year. Each text citation must include at least two pieces of information: author(s) and year of publication. Following are some examples of text citations:

(i) **Unknown Author:** To cite works that do not have an author, cite the source by its title in the signal phrase or use the first word or two in the parentheses. For example, “The findings are based on the study of students learning to format research papers” ("Using XXX," 2001)

(ii) **Authors with the Same Last Name:** Use first initials with the last names to prevent confusion. For example, “L. Hughes, 2001; P. Hughes, 1998.”

(iii) **Two or More Works by the Same Author in the Same Year:** For two sources by the same author in the same year, use lowercase letters (a, b, c) with the year to order the entries in the reference list. The lower-case letters should follow the year in the in-text citation. For example, “Research by Freud (1981a) illustrated that…”

(iv) **Personal Communication:** For letters, e-mails, interviews, and other person-to-person communication, citation should include the communicator’s name, the fact that it was personal communication, and the date of the communication. For example, E. Clark, personal communication, January 4, 2009. Do not include personal communication in the reference list.

(v) **Unknown Author and Unknown Date:** For citations with no author or date, use the title in the signal phrase or the first word or two of the title in the parentheses and use the abbreviation "n.d." (for "no date"). For example, “The study conducted by the students and research division discovered that students succeeded with tutoring” (Tutoring and APA, n.d.).

5. **Notes.** If explanatory notes are required for your manuscript, insert a number formatted in superscript following almost any punctuation mark. Footnote numbers should not follow dashes (—), and if they appear in a sentence in parentheses, the footnote number should be inserted within the parentheses. The footnotes should be added at the bottom of the page after the references. The word “Footnotes” should be centered at the top of the page.

6. **References.** Basic rules for the reference list:
• The reference list should be arranged in alphabetical order according to the authors’ last names.
• If there is more than one work by the same author, order them according to their publication date – oldest to newest (therefore a 2008 publication would appear before a 2009 publication).
• When listing multiple authors of a source use “&” instead of “and.”
• Capitalize only the first word of the title and of the subtitle, if there is one, and any proper names – i.e., only those words that are normally capitalized.
• Italicize the title of the book, the title of the journal/serial and the title of the web document.
• Manuscripts submitted to TVA should strictly follow the current APA style guide.
• Every citation in text must have the detailed reference in the Reference section.
• Every reference listed in the Reference section must be cited in text.
• Do not use “et al.” in the Reference list at the end; names of all authors of a publication should be listed there.

Here are a few examples of commonly found references. For more examples, please check the APA style guide:

Books:


Periodicals:


Journal article – 8 or more authors: Crooks, C., Ameratunga, R., Brewerton, M., Torok, M., Buetow, S., Brothers, S., … Jorgensen, P. (2010). Adverse reactions to food in New Zealand

**Internet Sources:**


**Examples of various types of information sources:**


*Brochure / pamphlet (no author): Aging well: How to be the best you can be [Brochure].* (2009). Wellington, New Zealand: Ministry of Health.


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7. **Tables.** They should be structured properly. Each table must have a clear and concise title. When appropriate, use the title to explain an abbreviation parenthetically, for example, Comparison of Median Income of Adopted Children (AC) v. Foster Children (FC).

8. **Figures.** They should be numbered consecutively in the order in which they appear in the text and must include figure captions. Figures will appear in the published article in the order in which they are numbered initially. The figure resolution should be at least 300dpi at the time of submission.

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9. **Appendices.** They should be lettered to distinguish from numbered tables and figures. Include a descriptive title for each appendix (e.g., “Appendix A. Variable Names and Definitions”). Cross-check text for accuracy against appendices.

10. **Author Biographies.** Author(s) are required to send a 40-60 word biography for publication at the end of the article. A sample biography is given below:

**Jessica Shaw, PhD,** is an Assistant Professor in the School of Social Work at Boston College. Her research focuses on community responses to sexual assault and emphasizes improving community systems through collaborative, multidisciplinary efforts. She is interested in using evaluation as a tool to initiate and support policy-level change and improvement and in identifying mechanisms to translate research into practice.
Part 2
Section 3: Research Paper

Reaching consensus on the principles of trauma-informed care in early intervention psychosis services: A Delphi study

SHORT RUNNING TITLE: Trauma-informed care in early intervention

Sinéad Mitchell ¹, Ciaran Shannon ², Ciaran Mulholland ², ³ & Donncha Hanna ¹

¹ Department of Clinical Psychology, Queen’s University Belfast, Northern Ireland

² STEP Team, Northern Health and Social Care Trust, Antrim, Northern Ireland

³ School of Medicine, Dentistry and Biomedical Sciences, Queen’s University Belfast, Northern Ireland
Abstract

Aim: The current study sought to conceptualise and reach consensus on the principles of trauma-informed care in early intervention psychosis services.

Methods: A three-phase Delphi method was employed in this study. Experts included researchers, service providers and Experts by Experience in the area of early intervention in psychosis. In the initial qualitative phase, an expert panel (n = 57) shared their views on the constituents of trauma-informed care in early intervention psychosis services. Thematic analysis led to the generation of statement items. The expert panel were asked to rate the extent to which each statement item was an essential principle of trauma-informed care, leading to consensus of endorsed principles.

Results: Qualitative analysis of the first phase data led to the identification of 185 distinct statements which were compiled into an online questionnaire for the panel to rate in Phase 2. The Phase 2 questionnaire was completed by 42 experts, with the endorsement of seven principles. In Phase 3 the panel were invited to re-rate 24 statements. This phase was completed by 39 panel members, with the acceptance of a further nine principles. Consensus was achieved resulting in the endorsement of 16 essential principles of trauma-informed care.

Conclusions: The study offers novel understanding of the conceptualisation of trauma-informed care in early intervention services and suggests principles which are widely agreed by experts in the field. The recommendations may inform the adoption of consistently delivered trauma-informed care in early interventions in psychosis and facilitate the evaluation and development of services.

Keywords: Delphi Technique, Early Intervention, Psychosis, Trauma-Informed
Reaching consensus on the principles of trauma-informed care in early intervention psychosis services: A Delphi study

Introduction

Research findings point to a significant and predictive relationship between childhood trauma and psychosis risk (Varese et al., 2012; Traulesen et al., 2015). Childhood trauma has been found to be a causal factor for command hallucinations and voice hearing (Read, Van Os, Morrison & Ross, 2005; Dorahy et al., 2009), and associated with increased severity of hallucinations and delusions (Bailey et al., 2018). High prevalence of childhood trauma has been reported among those experiencing first episode psychosis (Conus, Cotton, Schimmelmann, McGorry & Lambert, 2010; Bendall, Alvarez-Jimenez, Hubert, McGorry & Jackson, 2012), therefore the impact of trauma has been described as integral to understanding the development of psychosis (Toner, Daiches & Larkin, 2013).

Early Intervention Services (EIS) facilitate prompt access to high-quality care following first episode psychosis (MacDonald et al., 2018). EIS have demonstrated reductions in rates of relapse, suicide risk, hospital admissions, crisis contacts, and led to improved outcomes in employment and education, social functioning, and quality of life (Adamson et al., 2018). However, trauma and adversity have been found to predict poorer treatment outcomes in those accessing EIS (Jones et al., 2019), with individuals demonstrating a more severe clinical profile, lower remission rates and poor treatment compliance (Schäfer & Fisher, 2011).

The clinical implications of such findings have resulted in practitioners being called on to understand “the critical and primary role of trauma and fundamentally change their practice as a result” (Sweeney, Clement, Filson & Kennedy, 2016, p.185). It has been recommended that secondary prevention of the effects of childhood trauma requires
recognition of its occurrence and understanding of the behavioural strategies adopted by individuals to reduce the emotional impact of their experiences (Felitti et al., 1998). Trauma survivors could struggle to feel the safety and trust required for effective therapeutic relationships (Fallot & Harris, 2009) impacting their engagement with services (Mihelicova, Brown & Shuman, 2018). This could delay access and uptake of important early interventions for those experiencing first episode psychosis. Practitioner training and more consistent assessment and treatment of trauma have been encouraged within EIS (Peach et al., 2020); however, limited guidance on how to address trauma in this setting has been noted (Walters, Hogg & Gilmore, 2016).

The adoption of practices aligned with the principles of Trauma-Informed Care (TIC) could be valuable in the development of a coordinated approach to working with trauma in EIS. Services integrating TIC are those where all members of an organisation understand the impact of trauma, aiming to promote recovery through each interaction (Elliott, Bjelajac, Fallot, Markoff & Reed, 2005), and to limit the potential for re-traumatisation (Johnstone & Boyle, 2018). A review of TIC demonstrated benefits for service users in reduced posttraumatic stress and general mental health symptoms, enhanced coping skills, and greater treatment retention (Sweeney et al., 2016).

In the development of guidelines for organisations interested in adopting a trauma-informed model of service, five foundational principles of safety, trustworthiness, choice, collaboration and empowerment were proposed (Fallot & Harris, 2009). Studies in homelessness populations (Hopper, Bassuk and Olivet, 2010) and working with women accessing human services (Elliot et al., 2005) have extended the principles of TIC to incorporate service-specific practices of: promoting recovery from trauma, emphasising strengths and resilience, and cultural competence. Furthermore, the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) in the United States, supported the
inclusion of additional components of peer support and cultural, history and gender issues. Services have been encouraged to tailor the foundational principles to their specific context (Kezelman & Stavropoulos, 2012), yet a lack of consensus on what constitutes TIC within services for people with a psychotic illness has been acknowledged (Bloomfield et al., in press).

Due to the high levels of childhood trauma experienced by those accessing early interventions for psychosis (Bendall et al., 2012), studies have called for the adoption of a trauma-informed approach within these services (Coates et al., 2019). The integration of TIC in EIS could facilitate enhanced understanding of trauma, reduce re-traumatisation, and lead to positive outcomes for both service users and staff. To date, no consensus exists surrounding the principles of a trauma-informed approach within EIS. The current study aimed to address this gap, inviting experts in the field of early psychosis to comment and reach agreement on the principles of TIC in EIS using a Delphi approach. Findings aim to provide conceptualisation and more consistent understanding of TIC across EIS settings.

**Methods**

**Participants**

Participants were recruited by contacting publishing authors in the area of early psychosis and through the International Early Psychosis Association (IEPA). Corresponding authors who had published in Early Interventions in Psychiatry with a focus on early intervention for psychosis, or who had published first-person accounts of the experience of psychosis in Schizophrenia Bulletin, between January 2017 and July 2019 were contacted. A personalised invitation containing a link to a study website (www.traumainformedcare.org) was emailed to 119 corresponding authors (Appendix 1) and 34 EIS (Appendix 2) listed on the IEPA website with available email addresses. Snowball sampling resulted in the
identification of further experts, including those co-authored on journal articles. A reminder email was sent one month after the initial invitation with a final reminder emailed two weeks prior to Phase 1 closing. The study website and a blog written for the IEPA by the first author were shared with international psychosis organisations via social media. Recruitment ran from May 2019 to October 2019. Registering participants were provided with an information sheet (Appendix 3) and a link to Phase 1 of the study. Informed consent was provided by ticking an electronic box before beginning Phase 1. The study was granted ethical approval by the Faculty Research Ethics Committee at Queen’s University, Belfast.

**Design**

The Delphi method structures a communication process, enabling a group of individuals to collectively deal with a complex issue (Linstone and Turoff, 1975). It involves the gathering of expert opinion and inviting an expert panel to independently rate statements to reach consensus on these views. Feedback is provided through a statistical summary of the group’s ratings. The process results in statements for which there is considerable agreement among the panel (Langlands, Jorm, Kelly & Kitchener, 2008). Online methods facilitate opportunities for global experts to contribute to the process.

The current Delphi study was structured in three phases. In the first, an online panel of experts were asked: “What are the principles of trauma-informed care in early intervention psychosis services?” Panel members were encouraged to reflect on principles each regarded as best practice, including those they currently deliver or aspire to deliver, or those considered important in EIS. A first-phase qualitative round has been described as optimal as it provides an opportunity to expand current knowledge (Iqbal & Pipon-Young, 2009). Analysis of qualitative responses led to the generation of distinct statement items. In the second phase, the expert panel was asked to rate each of the items (from Essential to Should
Responses were analysed to calculate the aggregated percentage rating of each item. Items were endorsed if they were rated *Essential* by over 80% of the panel. Items were re-rated if they were rated *Essential* by 70-79% of the panel. Those not meeting either of these criteria were rejected as they were not perceived to be essential principles by the panel. In the final phase, the panel re-rated a shorter list of statements to reach consensus on the essential principles of TIC in EIS.

**Results**

**Phase 1**

*Expert panel.*

Phase 1 included a questionnaire to gather information about the participant, and a qualitative section asking each individual to share their views on the principles of TIC in EIS. In this Phase, 57 participants completed a demographic questionnaire to identify their age, gender, country of residence, experience in EIS, and professional role (see Table 1). The expert panel were involved in EIS in various ways: through working in a service ($n = 31$, 54.4%), conducting research ($n = 19$, 33.3%) or as a service user in the past ($n = 7$, 12.3%). Professional roles included: 20 (35.1%) Clinical Psychologists, 16 (28.1%) Academic or Clinical Researchers, eight (14%) Psychiatrists, five (8.8%) Nurses and eight (14%) other professionals (Peer Counsellors, Experts by Experience, Peer Support Workers and Practice Leads). Most commonly, participants resided in the UK though there was worldwide representation. On average, the expert panel had over 10 years’ experience in early interventions in psychosis.
Table 1. Participant demographics

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
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<tr>
<td>Female</td>
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</tr>
<tr>
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<td></td>
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<tr>
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<td>3.5</td>
</tr>
<tr>
<td>India</td>
<td>2</td>
<td>3.5</td>
</tr>
<tr>
<td>Other†</td>
<td>3</td>
<td>5.2</td>
</tr>
<tr>
<td><strong>Mean (years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>40.75</td>
<td>9.49</td>
</tr>
<tr>
<td>Duration of service</td>
<td>10.40</td>
<td>7.59</td>
</tr>
</tbody>
</table>

†Other countries of residence included New Zealand (n = 1), Mexico (n = 1), and one individual currently travelling.
**Qualitative data.**

In the qualitative section, participants shared views on the principles of TIC in EIS. All qualitative data was combined, and individual contributions were not identifiable.

Thematic analysis was conducted using Braun and Clarke’s (2006) six-step process. These included: familiarisation with the data; generation of initial codes; searching the text for themes; reviewing themes; defining themes; and writing the report. To enhance support for outcomes derived from the thematic analysis, the report (see Appendix 4), anonymised data, and preliminary statement items were circulated to authors (redacted for peer review) and an independent Expert by Experience. A total of 185 statement items (Appendix 5) were generated from the qualitative analysis. These were grouped into seven core themes (see Table 2) which provided structure for the Phase 2 questionnaire.

### Table 2. Phase 1 themes and number of statement items in each theme

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number of items</th>
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<tbody>
<tr>
<td>Adopting individualised trauma-informed care in early intervention psychosis services</td>
<td>34</td>
</tr>
<tr>
<td>Trauma-informed principles of care in early intervention psychosis services</td>
<td>43</td>
</tr>
<tr>
<td>The wider role of a trauma-informed early intervention psychosis service</td>
<td>15</td>
</tr>
<tr>
<td>Beliefs and values of a trauma-informed early intervention psychosis service</td>
<td>35</td>
</tr>
<tr>
<td>The trauma-informed environment of the early intervention psychosis service</td>
<td>9</td>
</tr>
<tr>
<td>Knowledge of trauma-informed care among staff in the early intervention psychosis service</td>
<td>24</td>
</tr>
<tr>
<td>Supporting staff in a trauma-informed early intervention psychosis service</td>
<td>25</td>
</tr>
</tbody>
</table>
Phase 2

In Phase 2, the panel was invited to assess the relevance of statement items arising from the qualitative analysis, rating how essential each item was as a principle of TIC in EIS. One participant requested to withdraw from the study following Phase 1, resulting in 56 participants invited to rate the Phase 2 items. A questionnaire was developed using an online survey platform (Qualtrics). Participants were asked to rate if each of the 185 statements were Essential, Important, Unimportant or Should not be included as a principle of TIC. A don’t know/depends option was not included due to difficulties in the interpretation of such rated items (Morrison & Barratt, 2010). In addition, a glossary of terms (see Appendix 6) was provided defining less familiar concepts (for example, the “Double Empathy Problem” or “small ‘t’ and large ‘T’ traumas”) with definitions sourced from representative bodies; additional clarifying information is consistent with Delphi methodology (Jorm, 2015).

Of the maximum Phase 2 panel \( n = 56 \), 42 individuals rated the 185 statement items. Some participants did not fully complete this phase \( n = 15 \). Among those who did not complete, nine did not begin the questionnaire and six questionnaires were partially completed. Partial responses were excluded from analysis and members who did not complete this phase were excluded from subsequent phases. Responses to the Phase 2 statement items were analysed to determine expert consensus. Items receiving a rating of Essential by at least 80% of the panel were endorsed as principles. Seven items met this criteria in Phase 2. Items rated Essential by 70-79.9% of the panel would be re-rated in Phase 3. There were 24 items to be re-rated in the next phase. Items not meeting either of these criterion were rejected \( n = 154 \) as they were not deemed to be essential principles by the expert panel.
Phase 3

In Phase 3, the panel were invited to re-rate a reduced list of statements to reach agreement on the essential principles of TIC. Participation was requested from those who had completed Phase 2 \((n = 42)\). Participants received a table (see Appendix 7) outlining each of the 24 statement items to be re-rated, the group aggregated Essential percentage rating of each item, and a personalised column showing how they rated items in the previous phase. In accordance with Delphi methodology, experts could consider their original response in the context of the group rating and had the opportunity to revise their view (Jorm, 2015).

Participants received a copy of the essential items which had been endorsed in Phase 2 along with the group percentage rating (see Appendix 8). Out of a maximum panel of 42 members, 39 participants completed Phase 3 (92.9%). This was 68.4% of the original expert panel \((n = 57)\). Based on the pre-defined criteria, a further nine statements were endorsed as principles in this phase. A total of 16 statement items were rated Essential by at least 80% of the panel. These constitute the recommended principles of TIC in EIS (see Table 3).
### Table 3. The principles of trauma-informed care in early intervention psychosis services

<table>
<thead>
<tr>
<th>Statement Item†</th>
<th>Group Rating ‘Essential’ %</th>
<th>Phase Endorsed</th>
</tr>
</thead>
<tbody>
<tr>
<td>A trauma-informed early intervention psychosis service will work to protect the service user from ongoing abuse.</td>
<td>89.7</td>
<td>3</td>
</tr>
<tr>
<td><strong>Staff within a trauma-informed early intervention psychosis service...</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>are trained to understand the link between trauma and psychosis.</td>
<td>85.7</td>
<td>2</td>
</tr>
<tr>
<td>will be knowledgeable about trauma and its effects.</td>
<td>84.6</td>
<td>3</td>
</tr>
<tr>
<td><strong>A trauma-informed early intervention psychosis service...</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>seeks agreement and consent from the service user before beginning any intervention.</td>
<td>84.6</td>
<td>3</td>
</tr>
<tr>
<td>will build a trusting relationship with the service user.</td>
<td>84.6</td>
<td>3</td>
</tr>
<tr>
<td>will provide appropriate training on trauma-informed care for all staff.</td>
<td>84.6</td>
<td>3</td>
</tr>
</tbody>
</table>
will support staff in delivering safe assessment and treatments for the effects of trauma. 84.6 3
adopts a person-centred approach. 83.3 2
will maintain a safe environment for service users. 83.3 2
will have a calm, compassionate and supportive ethos. 82.1 3
is trustworthy. 82.1 3
will acknowledge the relevance of psychological therapies. 82.1 3
will be sensitive when discussing trauma. 81.0 2
is empathetic and non-judgemental. 81.0 2
will provide supervision to staff. 81.0 2
will provide regular supervision to practitioners who are working directly with trauma. 81.0 2

†Sentence stems are represented in italics with the statement item completing this stem.


**Discussion**

Expert consensus was reached on 16 principles of TIC in EIS. This is the first study to our knowledge to provide consensus on the conceptualisation of trauma-informed practice in this setting. Outcomes show high agreement in the endorsement of the principles which extend on foundational concepts of TIC including providing safety, increasing choice and empowerment, and reducing re-traumatisation (Johnstone & Boyle, 2018; Hopper et al., 2010; Fallot & Harris, 2009; Elliott et al., 2005).

The trauma-informed components of safety and trustworthiness were described in the essential principles of: protecting service users from ongoing abuse; consent-seeking from service users prior to the introduction to interventions; development of trusting therapeutic relationships; sensitivity when discussing trauma; and values of being trustworthy, empathetic and non-judgemental. The panel agreed strongly that those accessing EIS are protected from ongoing abuse. TIC encompasses the prioritisation of emotional and physical safety (Sweeney et al., 2016) with services encouraged to offer safety planning (Elliott et al., 2005) and to recognise common trauma reactions that individuals may adopt to cope with the emotional impact of ongoing abuse (Hopper et al., 2010). Among those accessing EIS, perceptions of safety and validation within the therapeutic relationship have been found to facilitate disclosure of significant trauma experiences (Jansen, Pedersen, Hastrup, Haahr & Simonsen, 2018). Findings demonstrate the need for trauma-sensitive practices which promote service user choice and control in trauma disclosure (Tong, Simpson, Alvarez-Jimenez & Bendall, 2018) and may lead to the identification of appropriate trauma-focussed treatments (Schäfer & Fisher, 2011). TIC has been shown to enhance treatment retention (Mihelicova et al., 2018); therefore, with outcomes in EIS strongly linked with engagement (Jones et al., 2019) the adoption of more consistent TIC practices could increase opportunities for service users to avail of positive outcomes of EIS (Adamson et al., 2018).
Panel members agreed on the importance of trauma-informed training, knowledge and supervision for staff within EIS. The development of a trauma-informed culture has been suggested to be contingent on staff competence in understanding the impact of trauma on their clients (Muskett, 2003). Enhanced knowledge and increased confidence in the delivery of trauma assessment and treatment was shown among EIS staff who received trauma training (Walters et al., 2016). Training could support the adoption of more consistent childhood trauma assessment in EIS (Peach et al., 2020; Read et al., 2005). Experts highlighted the importance of regular supervision among staff, particularly those delivering trauma treatments. To reduce the impact of vicarious trauma and decrease burnout and staff turnover (Sweeney et al., 2016), additional resources to establish regular clinical supervision may be required (MacDonald et al., 2018). While the expert panel acknowledged the relevance of psychological therapies, the treatment of trauma among individuals with psychosis has been described as greatly under-researched (Bloomfield et al. in press). Further work in this area is warranted to identify evidence-based therapies for the treatment of trauma among those experiencing psychotic illness.

While the study demonstrated high agreement among experts on the endorsed principles of TIC in EIS, limitations were noted. First, the study was conducted in English-language which may have restricted participation from experts whose first language was not English. Second, while Experts by Experience contributed to findings, this sample was small in number and not all were retained throughout the Delphi phases. The inclusion of Experts by Experience would be recommended in the integration of the principles of TIC to EIS. Such approaches have been encouraged, particularly in the assessment and evaluation of the trauma-informed culture of the service (Fallot & Harris, 2009).

Study outcomes provide the first consensus-achieved conceptualisation of trauma-informed practice within EIS. Expert agreement led to the identification of 16 essential
principles of TIC and may facilitate the implementation of consistently delivered trauma-informed practice in this setting. The incorporation of these practices could result in positive benefits for those providing and accessing early psychosis care. The principles consolidate specialist knowledge and may act as a framework for the evaluation and enhancement of a trauma-informed EIS.

**Acknowledgements**

The authors wish to thank all the participants who contributed their time, knowledge and expertise to this study. We would also like to thank our independent Expert by Experience, for their time and reflections.

**Conflict of Interest**

The authors have no conflicts of interest to declare.

**Data Availability Statement**

Data available on request from the authors.
References


Coates, D., Wright, L., Moore, T., Pinnell, S., Merillo, C., & Howe, D. (2019). The psychiatric, psychosocial and physical health profile of young people with early
psychosis: Data from an early psychosis intervention service. *Child & Youth Services, 40*, 93-115. doi: 10.1080/0145935X.2018.1553613


http://dx.doi.org/10.1080/17522439.2015.1131324
**Section 4: Technical Appendix**

Appendix 1: Invitation email for individual prospective participants

To [Title and Name of Expert],

My name is Dr Sinéad Mitchell and I am conducting research to reach consensus surrounding the principles of Trauma-Informed Care within Early Intervention Psychosis Services.

Based on your experience within this field, I would like to invite you to join our panel to contribute perspectives of what the principles of trauma-informed care are, or should be within early intervention services.

The study will use the Delphi technique to reach agreement among the panel. You will be asked to participate in three online 20 minute-phases of the study, taking place once every three months.

The phases include:

- **Phase 1**) A brainstorming exercise in which you will describe your perspectives of trauma-informed care within early intervention psychosis services.

- **Phase 2**) You will receive a survey of statements based on the outcomes of analysis from phase one. You will be asked to rate the relevance of each statement for its inclusion as a principle of trauma-informed care.

- **Phase 3**) You will be asked to rate a refined list of statements.

Following analysis, you will receive the final agreed consensus reached among the panel.

Details, including participant information, can be found on our study website: [http://traumainformedcare.org](http://traumainformedcare.org)

Should you have any questions please do not hesitate to contact me.

Kind regards,

Dr Sinéad Mitchell
Trainee Clinical Psychologist
Queen's University, Belfast
School of Psychology
David Keir Building
18-30 Malone Road
Belfast
BT9 5BN

Email: smitchell26@qub.ac.uk
Website: [www.traumainformedcare.org](http://www.traumainformedcare.org)
Appendix 2: Email to early intervention psychosis services

To [Name of Service],

My name is Dr Sinéad Mitchell and I am conducting research to reach consensus surrounding the principles of Trauma-Informed Care within Early Intervention Psychosis Services.

We are hoping to recruit an online panel of participants who work in, research, or are experts by experience within early intervention psychosis services. I would like to invite individuals from [Name of Service] to join our panel to contribute perspectives of what the principles of trauma-informed care are, or should be within early intervention services.

The study will use the Delphi technique to reach agreement among the panel. Each participant will be asked to take part in three online 20 minute-phases of the study, taking place once every three months.

The phases include:

   Phase 1) A brainstorming exercise in which you will describe your perspectives of trauma-informed care within early intervention psychosis services.

   Phase 2) You will receive a survey of statements based on the outcomes of analysis from phase one. You will be asked to rate the relevance of each statement for its inclusion as a principle of trauma-informed care.

   Phase 3) You will be asked to rate a refined list of statements.

Following analysis, you will receive the final agreed consensus reached among the panel.

Details, including participant information, can be found on our study website: http://traumainformedcare.org

Should you have any questions please do not hesitate to contact me.

Kind regards,

Dr Sinéad Mitchell
Trainee Clinical Psychologist
Queen’s University, Belfast
School of Psychology
David Keir Building
18-30 Malone Road
Belfast
BT9 5BN

Email: smitchell26@qub.ac.uk

Website: www.traumainformedcare.org
Appendix 3: Participant Information Sheet

Dear Participant,

Thank you for your interest in taking part in this research study. The research aims to reach consensus surrounding “What are the principles of trauma-informed care in early intervention psychosis services?” While the links between trauma and psychosis have been evidenced within existing literature, little is known of the conceptualisation of trauma-informed care in early intervention services. The findings of this research aim to address this gap by providing a consensus of the principles of trauma-informed care in early intervention services.

The current research will use a Delphi approach. This is a phased approach to data collection culminating in agreement among participants. The expert panel will be comprised of researchers, experts by experience, and service providers of early interventions for psychosis. The study will initially ask an open-ended question about your perspectives of trauma-informed care in early intervention services. The lead researcher (Sinéad Mitchell) will analyse responses and generate a series of statements based on the outcomes of the perspectives provided. These statements will be distributed to all participants and you will be asked to rate your perception of the importance of each statement relative to trauma informed care in early intervention. Statements will be rated using a Likert scale. Outcomes of this analysis will identify those statements that need to be re-rated in order to gain consensus among the panel. You will be asked to re-rate the statement items. For each phase of the research, you will be asked to return your responses by a specified date to allow for the analysis and redistribution of the next questionnaire.

The lead researcher will be in contact on a quarterly basis (once every three months). You will be initially asked to brainstorm what trauma informed care is in early intervention (open-ended question). Three months later, you will receive a link to a questionnaire which will ask you to rate a range of statements using a Likert scale. Three months after this, you will receive another link to a questionnaire to repeat this process. At the final stage of the research, you will be provided with the panel-agreed principles of trauma informed care in early intervention.

The expert panel will be anonymous to one another, and the panel will not be able to access the responses of other members prior to the final agreed consensus. Your data will be accessible only by the research team. All data will be stored on a password protected file. You can withdraw from the research at any time, however the data you have contributed up to this point cannot be removed from the study as perspectives you have provided will have informed subsequent phases of the research. The data may be used for the inclusion in journal articles and reports. Your responses will be anonymised, and you will not be personally identifiable.

Thank you for taking the time to read this information. Should you have any questions, please do not hesitate to contact the lead researcher Sinéad Mitchell (smitchell26@qub.ac.uk) or research supervisor Donncha Hanna (donncha.hanna@qub.ac.uk).
Appendix 4: Phase 1 Thematic Analysis Report

Qualitative analysis of the principles of trauma-informed care in early intervention psychosis services

This report provides an analysis of outcomes of Phase 1 of the Delphi study which aimed to gain consensus surrounding the principles of Trauma-Informed Care (TIC) in Early Intervention Services (EIS) for psychosis. A total of 57 participants registered for this phase of the study. Participants were asked to share their views on: “What are the principles of trauma-informed care in early intervention psychosis services?” A free-text space was provided so experts could share their opinions. Thematic analysis was conducted on the obtained participant responses using Braun and Clarke’s (2006) six step process. These included: familiarisation with the data; the generation of initial codes; searching the text for themes; reviewing the themes; defining the themes; and finally, writing up the report. The current report focuses on the qualitative analysis of Phase 1 data.

Themes

Superordinate themes (n = 7) were identified surrounding the principles of TIC in EIS for psychosis. These were: adopting individualised trauma-informed care in EIS; trauma-informed principles of care in EIS; the wider role of a trauma-informed EIS; beliefs and values of a trauma-informed EIS; the trauma-informed environment of the EIS; knowledge of TIC among all staff in EIS; and, supporting staff in a trauma-informed EIS. Within each theme, a series of subthemes were identified which have been outlined in this report. Each theme will be discussed in turn along with accompanying subthemes and direct quotes obtained from the original data. Themes and subthemes were used to develop the statement items in Phase 2 of the study (Appendix 5), where the 57 members of the expert panel were asked to rate the relevance of each statement and its inclusion as a principle of TIC in EIS.
Theme 1: Adopting individualised trauma-informed care in early intervention psychosis services

The participant panel described the importance of person-centred and individualised care within the EIS. Individual participants commented on: relevant person-centred care practices; an EIS ethos of collaboration, choice and autonomy; the importance of obtaining consent from service users; generating opportunities to facilitate alternative communication methods; the involvement of family members within a service users’ care; peer support; and, the impact of wider systemic influences on the service user.

**Person-centred care practices.**

The panel shared a need to create “personalised services that fit the service users’ needs”. Comments emphasised the matching of interventions to what practitioners feel may encompass what the “individual finds helpful”. Importantly, panel members demonstrated the individuality of service users within their care, and the need to provide space and time for the exploration and activation of support-seeking in relation to their experiences:

“The importance of recognising that different people will experience trauma and post-trauma symptoms/experiences differently and will need different things to help them through their experiences.”

“...people with significant histories of trauma should be given an opportunity to talk about and develop an understanding of the ways in which their trauma history has influenced their current symptoms...”

Person-centred care within EIS would seek to explore the experience of the individual, their experiences of trauma, and how they cope and/or are challenged by the impact of their trauma history. Psychological formulations would recognise and keep the impact of trauma “at their centre”:
“Importance of working at clients’ pace, and how this may progress and regress at times however the importance of understanding this as part of the picture of trauma.”

“Going at a slow pace, attuned to the individual's emotional experience and past relationships particularly parental figures.”

The panel acknowledged the importance and relevance of evidenced-based therapies within the EIS. They reported the requirement of trauma assessments and to identify appropriate interventions based on the needs of the individual:

“If the patient is not able to relate the PTSD-related symptoms to or a specific traumatic event (for example in individuals with longstanding neglect, abandon or who denies or have forgotten previous more intrusive traumatic events…), the application of TICBT [Trauma-Focused CBT] addressing the PTSD related symptoms might not be useful or even possible.”

_Ethos of collaboration, choice and autonomy._

The expert panel suggested that the EIS should adopt a common approach that would ensure collaboration with service users in all aspects of TIC. Factors were identified including treating the “client as a partner” and ensuring service users have a “say in the treatments they want and receive”. Reported benefits of this ethos included the respect, increased sense of control, safety and empowerment of service users:

“Patients are involved in their treatment process and intervention to increase feeling of control and safety.”

“Collaboration with them (if appropriate /helpful) and co-authored formulations to empower them as a service user...”
The benefits of collaboration would lead to a shared understanding, increasing the acceptability of the therapeutic process:

“Intervention should be patient-led and paced appropriately to feel manageable...”

“Using the language of the individual client to develop a shared understanding of their experience.”

A collaborative approach would allow service users to make choices surrounding their disclosure of, and support with, trauma experiences:

“Individuals should be...given control on whether they choose to address trauma or not.”

“The choice of any of these different assessment options should be the object of a discussion with the patient in the early stages of the treatment.”

A collaboratively focused EIS could “build strengths” of the individual leading to a trauma-informed culture of safety, respect, choice and inclusiveness.

*Permission seeking and obtaining consent.*

Linked with the ethos of collaboration, individuals considered working with other services a service user may be involved with. This could lead to more “joined up” care, but required the full consent of each service user:

“...it might be helpful to share this information [trauma experience] with the other involved services...However, this would need to be done very carefully and sensitively, and with the full understanding and permission of the patient.”
Seeking permission was felt to provide safety and promoted choice and respect for service users. Safety was felt to be the foundation upon which trauma-informed therapeutic support could be established:

“Once the person feels an internal safeness then other work can be put into motion - with their agreement.”

*Facilitating alternative communication.*

Panel members acknowledged the barriers to engagement with the EIS. One area was communication. One participant suggested non-verbal communication could be integrated during assessment:

“As part of the intake, a chart with symptoms might be used, to make it easier for the client, for example, to point to an item, rather than having to speak to communicate the idea. This strategy allows non-verbal communication to have a greater role in the process, and that may be of benefit for a client with trauma.”

Additionally, questionnaires could be used at the assessment to support service users in disclosing sensitive and painful trauma histories:

“For some patients a self-report can be useful (for example the CTQ, for those for whom the direct assessment must be distressing and who tend to defend themselves from this kind of assessments); or an interview like the CECA can also be good if a more unstructured method confronts the patients to highly distressing emotions.”

*Family involvement.*

The panel identified that TIC in EIS should incorporate support for family members. Individuals stated the requirement of service user consent and maximisation of choice to share information prior to involving family members and carers in their care:
“Carers should be better informed and involved while not breaking the confidentiality of patients.”

“...involving family members and friends in the care planning if this is what the service user wants...”

TIC would include the recognition that the wider family may be affected by trauma. Experts noted that the trauma-informed EIS needed to offer support and deliver effective skills to the family system:

“Involve the closest family members to share the common conflict.”

“...a focus on family support and interventions which enable families to work through trauma, loss and grief, and help support family environments to become more supportive rather than potentially negative/traumatising for the young people recovering from psychosis.”

Others felt peer support should be included “from the outset” in a trauma-informed EIS.

*Impact of wider systemic influences on the individual.*

The expert panel recognised a range of systemic factors that could impact experiences of psychosis and care within EIS. TIC in EIS needed to consider these factors and their implications for each individual:

“The need to reflect on the wider social circumstances, and the role that these can play in people's experiences.”

“The broader context of an individual should be taken into consideration (life experiences, cultural background, social background, relationships with family and friends).”
A trauma-informed EIS should be involved in engaging with systems surrounding the client, and consider the impact of symptoms and triggers of psychosis that may present here for the client:

“Family/systemic influences are a focus too re the symptoms or triggers of psychosis.”

“A service that works with the systems that surround their clients.”

Summary.

Findings point to the importance of an individualised and person-centred care plan for service users who access a trauma-informed EIS. The service should ensure individuals are “partners” in their care and aim to create a therapeutic environment built on safety, trust, respect and choice. With permission, service users may wish to involve family members and other services in their care to allow for a more holistic and systemically-informed approach. Family members may benefit from involvement in the service user’s care, gaining an understanding of the impact of trauma and developing skills to enable this network to effectively support the service user. A trauma-informed EIS would acknowledge the wider systemic influences and facilitate alternative forms of communication to fully support each individual who seeks care from the service.

Theme 2: Principles of trauma-informed care in the early intervention psychosis service

The second theme outlined the principles of TIC that the expert panel felt should be adopted within the EIS. These included: the assessment and shared understanding of the impact of trauma in psychosis for service users; transparency, continuity and consistency in care provided; delivering supportive, sensitive, appropriate and flexible care; multi-disciplinary and holistic care; the provision of evidence-based and effective care; and providing safety.
Assessment and shared understanding of the impact of trauma in psychosis.

Panel members highlighted that assessment of trauma should be routine practice within EIS. This included the screening for trauma at the assessment stage, assessing for consequences of trauma including Posttraumatic Stress Disorder (PTSD), and how this may relate to psychotic symptoms:

“Being trauma informed must involve directly asking about and offering patients a chance to talk about their traumas.”

“...exposure to trauma is very frequent among psychosis patients and that this should be explored when assessing a new patient.”

“Exploration of how (or indeed if) previous trauma relates to psychotic symptoms.”

Assessment of trauma afforded the opportunity to educate service users on the relationship between trauma and psychosis:

“Offering support to understand the links between trauma and psychotic experience.”

Experts described the importance of recognising and adapting to the needs of the individual during their early engagement with the EIS. For example, one panel member reported the need of services to assess trauma in the context of the “Double Empathy Problem”. The National Autistic Society states that the Double Empathy Problem can occur when individuals with very different experiences of the world interact, leading to challenges in empathising with one another. The panel member suggested:

“Assess experiences of trauma in the context of the Double Empathy Problem, including those not typically regarded as traumatising.”

Another member acknowledged the importance of communicating with the service user, even if they appear not to respond:
“Use the intake as an opportunity to describe the symptoms you're seeing, and let the client know how these fit in with the diagnosis, even if the patient appears not to respond to the conversation.”

These comments outlined the importance of recognising the different presentations and reactions of service users. A trauma-informed EIS should aim to reach shared understanding of the impact of trauma on each individual’s experience of psychosis.

_Transparency, continuity and consistency in care provided._

Panel members suggested a trauma-informed EIS should be open in the care they provide to service users and describe “all the steps they are doing and what they see”. The panel reported that a trauma-informed EIS would provide continuity of care from practitioners and offer consistency and predictability in access to the service:

“Consistent, predictable contact from the service in a timely manner (re scheduling of appointments, and information regarding what to expect from appointments, being notified about being referred to the service and information about the service being provided).”

“Where possible appointments conducted in the same room consistently with the same staff in order to facilitate consistency and build trust.”

The impact of providing this care was felt to offer safety and trust for service users. Clarity from the service could reduce uncertainty for service users who are accessing care in relation to their early experiences of psychosis.

_Supportive, sensitive, appropriate and flexible care._
Experts suggested that the care provided by the EIS should be sensitive to the needs of the service user. This included awareness of the cultural background and beliefs of the service user and providing practical support through access to interpreters:

“How having the necessary cultural support available for clients who have experienced trauma, where this may be impacted by their cultural or ethnic background.”

“Ensuring that practical resources are available such as interpreters to do trauma focused work, but ensuring that these practitioners too, are adequately supported to do this work.”

A core theme among the responses was a need for the EIS to be inclusive and sensitive to the trauma that may have been experienced by service users:

“Sensitive assessment of trauma and its effects (e.g. PTSD, dissociative symptoms).”

“There is a risk that a history of severe trauma could be treated in the same way as a diagnosis of personality disorder is often treated - i.e. as an exclusion criteria or ‘black mark’.”

Care should be built on the foundations of a relationship of trust with the care provider, and a need to be sensitive and considerate in moving towards therapeutic interventions:

“...a trauma-informed treatment will ensure that the service provider is providing a supportive personal space foremost, and that any other agenda is secondary to this.”

“Giving the client time to build a therapeutic relationship before asking them to go into details of trauma experiences.”

“I believe that assessing the history of early adversity based on a trusting relationship between patient and carer (his psychiatrist, care coordinator, case manager etc…) might be the best option.”
Multi-disciplinary and holistic care.

A trauma-informed EIS was suggested to be one in which care was provided by a Multi-disciplinary Team (MDT). This was felt to lead to “more effective and holistic care”. Panel members proposed the sharing of service user information among professionals with the permission of service users, to provide more collaborative care:

“...it would be helpful to discuss information sharing with patients, so that care could be more 'joined up'... However, this would need to be done very carefully and sensitively, and with the full understanding and permission of the patient.”

“Facilitate more collaborative work amongst professionals and less redundancy and overlap in targets of work in different services.”

For others, working with the MDT would provide assessment of comorbidities and enable the integration of care practices:

“Management of co-morbidities resulting from or connected to previous trauma (e.g. PTSD, depression).”

“Do a thorough physical screening, to rule out any underlying medical conditions which may be causing psychiatric symptoms.”

“I would tend to link in with other MDT members such as OT to help with building emotional regulation skills and incorporate these into the work.”

Evidence-based, effective care.

The panel identified a need for a trauma-informed EIS to practice evidence-based care. These included using particular trauma-focused treatments including Cognitive Behaviour Therapy (CBT) and Eye Movement Desensitisation Reprogramming (EMDR), and early interventions to support emotional regulation and stabilisation:
“There should be implementation of evidence-based interventions for trauma. E.g. trauma focused CBT and EMDR should be widely available as a fundamental part of interventions, to help people address their trauma pre-psychosis, during and following psychosis.”

“Focus on stabilisation and on emotional regulation.”

“Peer support and normalising…”

Individuals commented on reducing the use of medication and using a multi-modal approach to provide optimum care for service users:

“Minimal use of medication used especially for sedation.”

“Drawing from a number of models/practices/professions in order to provide optimum care for clients, rather than a uni-modal approach which may not flexibly meet the needs of a diverse range of clients.”

“Youth at clinical high risk (CHR) for psychosis are often able to complete trauma-focused treatments with less initial preparation, youth with first-episode psychosis (FEP) often require more stabilization which may include medication.”

Another participant suggested that EIS should incorporate “educational and employment support” within their services.

*Providing safety.*

Safety was described by participants as being a key objective within EIS. These included establishing safety for the service user from ongoing abuse, providing information on the help available if the service user in in crisis, and relapse prevention planning. Others stated that effective relationships with the service were key to enhancing perceptions of safety.
Summary.

The findings of this theme point to the important attributes that a trauma-informed EIS should adopt in order to consistently deliver TIC. Factors included offering routine assessment, tailored communication, and promoting engagement for all individuals referred to the service. TIC within EIS would work to increase understanding of the impact of trauma among individuals experiencing psychosis. MDT work was described as facilitating the application of evidence-based holistic care, and providing safety for service users.

**Theme 3: The wider role of a trauma-informed early intervention psychosis service**

Panel members reported that the principles of TIC in EIS would include wider roles of the service in liaison and advocacy, influencing practice, suicide prevention, and service development and research. The service was noted to have a role in liaising with other mental health services and in advocating for EIS service users within these settings. Panel members said other services may use restrictive practices that can be re-traumatising for service users experiencing early psychosis, both prior to their engagement with EIS and following discharge:

“Staff to be able to liaise with other services around circumstances that may be re-traumatising for clients (such as hospital admissions), and if required advocate for the client.”

“To minimise the use of coercion and restrictive interventions throughout their journey with the EIS to empower the person.”

“...advocating for better/trauma-informed services which clients may be discharged to following early intervention in psychosis.”
Within this role, experts suggested that EIS could influence the prevention of additional traumatising treatment, wherever possible.

**Influencing practice.**

Participants saw the EIS as having a role in influencing practices and policies across all mental health settings. These included actions to reduce re-traumatisation and strategies that could lead to perceptions of more respectful and appropriate TIC:

“Try and get some food or drink into the person and wait a bit before considering giving psychiatric drugs. Many people who are psychotic may not have eaten nor drunk anything for hours or days. Improvement may occur simply by allowing for food and drink, and the practice will be seen by the client as being much more respectful than the immediate administration of drugs.”

“Having a role in the consideration of inpatient units and how these are set up, the use of seclusion and restraint practices, the management of risk on wards etc.”

Individuals suggested that the EIS played a key role in challenging “the traditional medical model of psychosis and schizophrenia” and should develop trauma-informed thinking in wider systems and communities. Panel members felt the EIS should support policies that maximise service user autonomy and agency. The panel felt the EIS played a pivotal role in suicide prevention, particularly on mental health wards, and advocating for access to supervision to prevent suicide within these settings.

**Service development and research.**

The panel advocated for the role of EIS in the development and provision of trauma-specific psychotherapies for those experiencing a first-episode psychosis. Additionally, participants felt opportunities should be taken to develop peer-based approaches alongside
more traditional EIS interventions. Others recommended the consideration of trauma when drafting new policies and procedures within the service.

Summary.

The wider role of the EIS included liaison and advocacy for service users affected by trauma and psychosis in a range of settings. Better information and informed care practices could reduce the risk of re-traumatisation and work to empower service users in these areas. Equipped with an understanding of trauma, TIC within EIS could facilitate the development of enhanced therapies for service users.

**Theme 4: Beliefs and values of a trauma-informed early intervention psychosis service**

The panel identified a range of values and beliefs of the EIS, including: a client-centred approach; trust and respect; prioritising the therapeutic relationship; offering containment and providing hope; being creative and open to alternative treatment; and adopting a strengths-based approach.

*Client-centred.*

Participants noted that the EIS should prioritise the needs and goals of the service user, delivering compassionate care which does not try to “fix or problem solve” the service user’s experience of trauma. Service users should be a collaborative partner in their treatment plan and therapeutic interventions, and proceed when they feel ready to do so:

“Specific trauma or therapeutic interventions are considered after the individual is able to engage in them...”

“...if someone is feeling disconnected from their care plan or they feel that treatment is being done to them instead of for them, there is a problem.”
Panel reflections stated services should be mindful of delivering the “right intervention at the right time”, ensuring phase-based treatment is not linear, but instead considers the client experience and stage of the therapeutic process:

“These phases (of trauma informed care) should not be delivered in a linear fashion and for some clients’ intervention will only involve stabilisation and formulation before a period of consolidation if addressing the trauma feels too overwhelming.”

**Trust and respect.**

The panel members noted the negative impact of labelling and a need to be more sensitive in considering “the story” of individuals accessing EIS:

“Service users need to be listened to more fully and attentively and not labelled as mad/ ill/ psychotic.”

“Moving away from labels and understanding the story of how this has come to be - essentially the assessment phase is key.”

Participants reiterated the importance of sensitivity and in particular treatment which is “sensitive to the gender, culture and sexuality of clients”. For some it was important to reduce the use of terms for service users such as “patient” and “psychiatric patient” for someone who may be “at risk of psychosis”.

**Therapeutic relationship.**

The therapeutic relationship was described as a priority for many participants, referred to as the “foundation for everything else that comes next” in the service user journey. This foundation could help the client alter their relationship with their trauma:

“...the repairing effect of the therapeutic alliance is really the aspects that changes their relationship with the trauma most.”
This relationship is based on trust, with EIS being honest, providing boundaries and respecting service users:

“To build trust - being honest when things don’t go well, showing up when you should, and approach work in a truly collaborative way, offering possible choices based on discussion and respecting choice.”

Offering containment and providing hope.

The service was viewed as holding “a holistic concept of recovery” for service users and “providing hope that trauma responses can be helped”. The service was seen as needing to reassure the client and to provide feedback with caution, “not to overwhelm”. Many participants noted that the EIS should empower service users through providing control. It was suggested that increasing service user participation in organisational and management structures could promote the sense of empowerment among service users.

Creativity and alternative treatment and perspectives.

The panel noted problems that are characteristic of a diagnosis of psychosis and a need to be more informed about different approaches including the Power Threat Meaning Framework (Johnstone & Boyle, 2018):

“Knowledge and implementation of the Power Threat Meaning Framework is an aspirational goal, and something that I think it very important to embed within early intervention services, not rejecting the role for medication or hospital based interventions, but not having such a steadfast use of the medical model without also acknowledging the problems and powers that exist within it.”

“There are problems inherent in this diagnosis, and we need to be more informed about different approaches (e.g. the Power threat meaning framework), and
experiences/formulations that might lead someone to be presenting with unusual/‘psychotic’ experiences.”

Others recommended the provision of alternative interventions to support clients who may benefit from these. The panel felt it was important for EIS to move away from practices such as emphasising “drug compliance” and instead focussing on “healthy lifestyle activities which a client might do”. Values included a systemic approach to supporting service users and reiterating the importance of client-centred care.

**Strengths-based approach.**

Panel members noted the need to build upon the “skills and strengths” of service users, but also the importance of having a “familiarity with the concepts of post-traumatic growth and resilience...in the context of trauma work”. Practitioners should acknowledge the positive factors within the individual and appreciate the patient’s openness.

**Summary.**

The values of TIC within EIS would adopt a client-centred approach to care, recognise alternative therapy models and approaches, and contain, empower and provide hope to service users. The TIC service would build trusting and safe therapeutic relationships and acknowledge the strengths of the individual.

**Theme 5: The trauma-informed environment of the early intervention psychosis service**

The panel observed the importance of both the emotional and physical environment of the service for clients and service users. EIS should be a place where young people “can talk about and receive treatment for the effects of trauma” while also being a service that is aware of possible barriers to engagement. The demeanour of staff could be implicated in perceptions of safety for the service user:
“When staff appear worried, anxious, frightened, or angry, this violates the most important principle of safety.”

Panel members described a range of attributes of being “calm, compassionate, understanding and supportive” as well as showing empathy and being non-judgemental. It was felt the culture of the service should be stigma-free, transparent and promote inclusion. EIS should be “flexible to responding to need”, de-stigmatise psychiatric care, and be transparent “if we are going to ask a question that might be seen as invasive”.

Experts recognised factors in the physical environment of the service that could maintain safety and confidentiality for service users. Participants also noted the impact of other settings that could affect the client’s perception of care (e.g. wards):

“Consider the environmental, sensory and communication context (e.g. of wards).”

“Safe, welcoming, soundproofed, appropriate environment free from obvious potential trauma triggers (anything potentially threatening).”

“It is crucial that a person who presents with psychosis for the first time should arrive in a building which through its design and maintenance feels safe, first and foremost.”

Summary.

The trauma-informed EIS should provide a safe and confidential emotional and physical environment for service users. The service should endeavour to minimise the risk of re-traumatisation and create space which is considerate and compassionate to the needs of those accessing care.

**Theme 6: Knowledge of trauma-informed care among all staff in early intervention psychosis services**
Staff knowledge was an important principle of TIC. Subthemes included: knowledge of the links between trauma and psychosis; recognition and appropriate assessment of trauma; staff training in intervention strategies to support service users; facilitating access to EIS and promoting retention in care; and understanding the impact of negative experiences and re-traumatisation within mental health services.

*Understanding the links between trauma and psychosis.*

Panel members felt that education on the links between trauma and psychosis was “foundational”, with all staff in the service “knowledgeable about trauma and its effects”. Participants felt staff should receive training in the impact of trauma, symptoms that may present in someone who has experienced trauma, and compassionate understanding of adaptations that individuals experiencing psychosis may use to cope:

“...being more aware of symptoms of dissociation and dissociative disorders and having awareness of the models of structural dissociation and complex trauma, as well as diagnoses such as BPD [borderline personality disorder], and how these can fit together in a broader picture which also may include psychosis experiences.”

“Recognition that psychosis and associated emotional/social/interpersonal difficulties are often an adaptation to difficult life experience including adversity and trauma (focus needs to be on what's happened to you).”

“Using trauma informed principles to understand the full range of experiences/symptoms that someone may present to our services with, from psychosis symptoms themselves, to emotional dysfunction, substance abuse, interpersonal difficulties etc.”

Panel members believed staff needed to “consider trauma in causation of early psychosis” and were aware of the prevalence of trauma within EIS. Others suggested models including...
the stress-vulnerability model to develop understanding, as well as being aware of big ‘T’ and little ‘t’ traumas and how these may be appraised by the individual. Staff should have awareness of the ways that “adverse experiences can and do manifest in the form and content of psychosis” particularly surrounding the content of what voices may say and “who or what they represent”. Trauma history was felt to impact on service users’ access to care:

“Recognise the impact a history of trauma can have on people- on how they seek help, how they access care, how they engage in care, how it impacts on their expectations of us and our expectations of them.”

“Principles of TIC include having an awareness and understanding of the impact of trauma on people's communication, self-worth, identity, actions, thoughts and feelings about themselves, the world, the future and trust in themselves and others.”

Participants noted that psychosis can be perceived as an additional traumatic experience for the individual:

“Recognition that psychosis in and of itself can often be experienced as traumatic.”

*Recognising and appropriate assessment of trauma.*

The panel felt that all staff should be trained to “recognise the signs and symptoms of trauma”, offering opportunities for “patients to talk about their traumas”. Experts believed trauma should be discussed in the clinical assessment with trauma-related factors included in the formulation:

“Trauma-informed care relates to the fact that exposure to trauma is very frequent among psychosis patients and that this should be explored when assessing a new patient.”

*All staff trained in intervention strategies to support those experiencing trauma.*
The panel described a trauma-informed EIS as one where all staff were trained to support those experiencing trauma. This included staff having “good understanding of the needs of patients and relatives”, but also skilled in the delivery of basic intervention strategies:

“Ensure that all staff are aware of trauma informed care so that a consistent approach is used.”

“Staff...having basic intervention strategies available to support people experiencing trauma such as grounding strategies.”

The panel commented on the use of a phase-based approach to treatment, initially beginning with “stabilisation and emotional regulation”:

“…for the phase based approach care would include grounding and stabilisation skills development to support clients to develop coping strategies that are effective…to assist them to manage high levels of emotional arousal in a healthy way, supporting them to build distress tolerance strategies in addition to confidence in their ability to cope with heightened emotional arousal.”

Following this trauma-focused therapy, such as CBT, could be provided to “reduce some of their symptoms, suffering and transition risk”.

Facilitating access to EIS and promoting retention in care.

Similar to the emotional and physical environment of EIS, staff were required to be knowledgeable in supporting care access and treatment. Participants noted the importance of staff being empathetic, non-judgemental and demonstrating active listening skills and awareness of potential triggers. Prompt access to services was felt to be a principle of a trauma-informed service:
“Access to psychological therapies needs to be more widespread and quicker to access.”

Safety was described as key, along with adequate pacing for the service user:

“Sometimes I spend a while just talking to them about the immediate present, or even their interests/hobbies, before they feel talking about other stuff. And that's okay.”

“...need safety first and before further work, otherwise people will not feel safe in relationships and if completing further work e.g. disclosure, reprocessing.”

*Understanding the impact of negative experiences and re-traumatisation within mental health services.*

The expert panel commented that a trauma-informed EIS would recognise “the traumatic potential of psychiatric care in early phases of psychosis”. Individuals described a range of experiences that a service user may have encountered prior to their engagement with the service:

“...with things like substitute decision makers, community treatment orders, forced medications, and forced hospitalizations...”

“Being aware of the trauma of the experiences of psychosis themselves and the experiences of 'so-called-treatments' for those experiences, which some people will find very traumatic.”

A trauma-informed EIS is one which would reflect “on our own use of implicit powers” and to acknowledge “the trauma [service users] may have endured at the hands of services”. Such experiences were described as leading to “disempowerment” of service users.

*Summary.*
TIC within EIS would be comprised of staff who are trained, knowledgeable about the links between trauma and psychosis, and have basic intervention strategies, such as grounding, to support service users. The EIS would promote access to care but also recognise the preceding mental healthcare experiences of service users, understanding how these may act as a barrier to availing of care.

Theme 7: Supporting staff in a trauma-informed early intervention psychosis service

The final theme related to supporting staff in the delivery of effective TIC within the service. Subthemes included: supporting staff to deliver effective treatment; providing psychological support to staff; acknowledging the personal trauma experiences of staff; and adequate resourcing of all EIS.

Supporting staff to deliver effective treatment.

Participants felt that staff should receive training in trauma and have an ability to handle “mass trauma”. They described factors required to support staff in the delivery of TIC:

“Organisation should support staff in delivering safe and acceptable assessment and treatment for the effects of trauma.”

“Staff team must also feel safe and have trusting supportive relationships to remain working in this way.”

Safety of staff was felt to be an important component in the principles of TIC in EIS.

Providing psychological support to staff.

The panel acknowledged the impact of working with trauma on staff and made suggestions to promote safe and supportive working within EIS. Reflective practice, debriefing, and supervision were described as developing “compassion and understanding” among staff allowing them to “better support patients”: 
“A service that acknowledges the impact of working regularly with trauma has on its staff and which puts a high level of support in place for its staff through supervision, reflective practice, CPD (continuing professional development) opportunities and regular team building.”

Support was felt to equip staff with knowledge and awareness of the powerful psychological dynamics and consequences of working with trauma:

“The importance of the right supervision, support and training structures…so that they [staff] can be supported to work with trauma, in a way that is safe, effective and helps to protect themselves from vicarious traumatisation or difficult-to-manage transference and countertransference experiences.”

“Such approaches also promote understanding and curiosity relating to barriers to engagement that can occur as a result of mismatches between the attachment style of the patient and clinician or as a result of providing care to people who have experienced disruptions to attachment through trauma.”

Ultimately, opportunities to avail of psychological support would facilitate the delivery of enhanced care:

“Regular supervision is required in order to explore such dynamics and encourage open discussion of ‘stuckness’ to help improve confidence and knowledge of working in an often challenging but highly rewarding field.”

*Acknowledging the personal trauma experiences of all EIS staff.*

Panel members identified that often staff working within EIS have experienced their own levels of trauma:
“...it is important to acknowledge that staff are humans, likely with their own trauma histories.”

Such factors are imperative in the EIS setting to ensure staff feel adequately supported to work with trauma. Recommendations included an ability to recognise how personal trauma experiences may be triggered and to promote the practice of self-care:

“The importance of reflective practice, and practitioners being aware of their own potential trauma experiences and how these may be triggered in working with our clients.”

“The team need to have a shared understanding...about the impact of trauma on themselves and to practice self-care.”

It was also noted that other professionals who are entering the service need to be supported also to do this work, for example, interpreters.

_Adequate resourcing of EIS._

Finally, participants noted that a trauma-informed service would be adequately resourced to facilitate effective relationships with service users. This included having appropriate staffing levels:

“Services must ensure that staffing levels are sufficient to prevent burnout and provide enough cover to allow staff to develop meaningful compassionate therapeutic relationships with patients.”

_Summary._

Supporting staff within EIS would acknowledge the potentially challenging dynamics within the therapeutic relationship and offer support to overcome such difficulties. TIC in EIS would recognise the impact of vicarious trauma and offer psychological support for all staff.
Effective psychological support and adequately resourcing services could result in optimal care for service users.

**Conclusion**

The current report described findings from a thematic analysis of the perceived principles of TIC in EIS among an online expert panel. Outcomes identified seven overarching themes which attended to trauma-informed principles that impact staff, service users and wider systems surrounding individuals experiencing psychosis. These core themes will be used in the generation of statements derived from the panel’s responses. Direct quotes and statements from panel members will be used in the development of statements. In subsequent phases of the Delphi study, the panel will decide which statement items should be included as a principle of TIC in EIS. This will be completed through the rating of statements presented on an online questionnaire. Experts will be asked to rate to what extent each item is an essential principle of TIC for EIS using a Likert scale. Analysis will determine the acceptance, rejection and statements which will require re-rating in further phases of the Delphi study.

**References**


Appendix 5: Phase 2 Statement Items

Note: Ratings of each statement were made using the following format, however on Qualtrics this was represented by an option box where participants indicated their choice.

<table>
<thead>
<tr>
<th>Essential</th>
<th>Important</th>
<th>Unimportant</th>
<th>Should not be included</th>
</tr>
</thead>
</table>

Phase 2 Delphi Study: What are the principles of trauma-informed care in early intervention psychosis services?

Please consider each statement and rate if it is Essential, Important, Unimportant or Should not be included as a principle.

Each theme starts with a sentence stem which is written in bold at the beginning of the new theme (e.g. 'A trauma-informed early intervention psychosis service...'). The statement items complete this stem with the core details of the principle.

Please rate all statements included in this questionnaire.

Thank you for your time.

Theme 1: Adopting individualised trauma-informed care in early intervention psychosis services

For each statement please consider the following question:

How important is it to adopt this statement as a principle of trauma-informed care in early intervention psychosis services?

A trauma-informed early intervention psychosis service...

1. adopts a person-centred approach.
2. recognises that different people will experience trauma differently.
3. recognises that people will experience post-trauma symptoms differently.
4. recognises that service users will need individualised support to help them through their experiences.
5. gives service users an opportunity to talk about their trauma.
6. helps service users to develop an understanding of how their trauma history has influenced their current symptoms.
7. allows service users to reveal their trauma narratives at their own pace.
8. recognises that some trauma therapies may not be the best treatment for traumatised individuals who present with psychosis or other severe mental illness.
9. is attuned to the service user’s emotional experience.
10. assesses the service user’s past relationships.
11. is guided by the service user’s formulation.
12. holds the impact of the service users’ trauma at the centre of their formulation.
13. responds to trauma on an individual basis.
14. routinely assesses trauma and adversity.
15. collaborates with the service user, treating them as a partner in the treatment process.
16. offers service users a choice of assessment options (including self-report questionnaires, or clinical interviews).
17. provides choice to service users in the treatments they want and receive.
18. aims to empower service users.
19. puts the service user in control of their own care.
20. lets service users decide whether they choose to address their trauma or not.
21. respects the choices made by the service user.
22. uses the language of the service user to develop a shared understanding of their experience.
23. seeks agreement and consent from the service user before beginning any intervention.
24. provides alternative forms of communication (such as a symptom chart) to facilitate non-verbal communication.
25. provides self-report questionnaires for those who may find direct assessments to be too distressing.
26. involves family members in care planning with the consent of the service user.
27. provides psychoeducation to family members and carers.
28. offers family support.
29. provides interventions for families to work through trauma, loss and grief.
30. helps families to become more supportive rather than potentially negative or traumatising for service users who are recovering from psychosis.
31. offers peer support.
32. offers peer support from the outset of the service users’ involvement with the service.
recognises that family and wider social systems can impact or be a symptom or trigger of psychosis.

acknowledges the impact of a service users’ previous, and potentially negative, experience with mental health treatment.

**Theme 2: Principles of trauma-informed care in the early intervention psychosis service**

A trauma-informed early intervention psychosis will...

35. educate service users on the links between trauma and psychotic experience.
36. routinely screen for experiences of childhood adversity.
37. routinely assess for consequences of trauma, including Posttraumatic Stress Disorder (PTSD).
38. be sensitive when discussing trauma.
39. assess trauma in the context of the Double Empathy Problem.
40. describe the symptoms they see in the service user and explain how these fit with the diagnosis.
41. consistently describe and explain the symptoms of psychosis at assessment, even if the service user does not appear to respond to the conversation.
42. provide continuity of care from service practitioners.
43. offer consistent and predictable contact from the service in a timely manner.
44. provide information to service users about what to expect from appointments.
45. conduct appointments in the same room where possible.
46. ensure all staff are aware of trauma informed care so that a consistent approach is used.
47. describe all the steps involved in the care provided to service users.
48. provide a supportive personal space for the service user.
49. build a trusting relationship with the service user.
50. build a therapeutic relationship with the service user before asking them to share details of their trauma experiences.
51. **not** exclude service users who have a history of severe or complex trauma.
52. offer a phase-based approach to the delivery of care to clients.
53. be sensitive to the cultural and ethnic background of the service user.
54. ensure interpreters are available to support the delivery of trauma focused work.
acknowledge the experiences of refugees and migrants who have experienced psychosis.

recognise the health and social disparities experienced by marginalised groups.

be multidisciplinary and acknowledge the multiple ways of working with trauma across professions.

sensitively share information with other professions with the full understanding and consent of service users.

incorporate strategies from members of the multidisciplinary team to provide holistic care.

complete a thorough physical assessment to rule out underlying medical conditions which may be causing psychiatric symptoms.

complete a thorough dietary screen to rule out dietary sensitivities that may be causing mental illness.

offer treatment and management of other co-morbidities arising from trauma (e.g. PTSD, depression).

assess levels of loneliness in service users.

provide educational and employment support.

use evidence-based interventions for trauma (e.g. trauma-focused CBT and EMDR).

use the British Psychological Society/Division of Clinical Psychology publication on understanding psychosis to inform their practice.

adopt SAMHSA’s six principles that guide a trauma informed approach.

aim for the minimal use of medication.

normalise the experience of psychosis.

monitor trauma related outcomes (e.g. PTSD).

provide psychotherapy which will help service users to identify and name their emotions.

work to protect the service user from ongoing abuse.

provide information on help available in crisis to service users.

promote risk reduction through relapse prevention planning.

see no distinction between “trauma-induced psychosis” and “real psychosis” when individuals have a clear, disclosed trauma history.
not dismiss the content of an individual’s psychotic beliefs or experiences as “delusional memories”, but instead recognise that these may link with traumatic memories.

give psychological therapy the same focus as medical interventions.

Theme 3: The wider role of a trauma-informed early intervention psychosis service

A trauma informed early intervention psychosis service will...

promote reduction in the use of restrictive interventions in other mental health settings.

advocate for trauma-informed care in other services where service users may access care.

work to address policies and practices that may be re-traumatising for service users.

advocate for better trauma-informed services which service users may be discharged to following early intervention.

help other services to recognise the impact of restrictive interventions, breaches of trust and power imbalances on service users.

support policies and practices that maximise service user autonomy and agency.

support practices such as providing food and drink to patients presenting at inpatient wards, rather than the immediate administration of medication.

have a role in the consideration of inpatient units and how these are set up.

challenge the traditional medical model of psychosis and schizophrenia.

help to develop trauma-informed thinking in wider systems and communities.

advocate for supervision to prevent suicide among individuals experiencing severe symptoms of psychosis.

develop trauma-specific psychotherapies for people with first-episode psychosis.

develop peer-based interventions.

consider trauma when drafting policies and procedures in the early intervention psychosis service.

seek to enhance awareness that trauma can become manifested in response to stimuli unrelated to past traumatic experiences.
Theme 4: Beliefs and values of a trauma-informed early intervention psychosis service

A trauma-informed early intervention psychosis service...

93. will prioritise the service user’s own goals for health.
94. will be sensitive to the fact that service users may have had negative and traumatic experiences in the context of their psychotic episodes.
95. will not try to fix or problem-solve traumatic experiences.
96. will support the service user to maintain social networks.
97. will recognise that the service user may not be ready for trauma-focused interventions.
98. will ensure service users feel treatment is being done for them, not to them.
99. will acknowledge that the phases of trauma treatment are not delivered in a linear fashion but will attend to the phase that is most appropriate to the needs of the service user.
100. will endeavour to deliver the right intervention at the right time.
101. will not label service users as “mad”, “ill” or “psychotic”.
102. will be sensitive to the gender and sexuality of service users.
103. will not use terms such as “patient” or “psychiatric patient” for someone who is at risk of psychosis.
104. will be honest when things do not go well.
105. will ensure practitioners acknowledge the importance of being on time for appointments.
106. will have a calm, compassionate and supportive ethos.
107. will include services users in organisational and management structures.
108. will have knowledge of the Power Threat Meaning Framework.
109. will not reject the medical model but should acknowledge the problems that exist within it.
110. will include creative therapies alongside traditional psychological interventions.
111. will consider the physiological and neuro-biological impact of trauma in addition to the psychological impact.
112. will have familiarity with concepts of posttraumatic growth and resilience.
113. will recognise strengths and positive attributes of the service user.
114. will identify and build on the skills and strengths of the service user.
recognises that the therapeutic alliance can help to repair the service user’s relationship with their trauma.

is empathetic and non-judgemental.

believes the therapeutic relationship is the foundation of trauma-informed care.

is trustworthy.

is stigma-free and destigmatises psychiatric care.

recognises that trauma-informed care should be embedded in each aspect of early intervention.

believes that long term recovery is possible.

validates what has happened to the service user.

is sensitive when providing feedback to service users and is cautious not to overwhelm the individual.

does not emphasise drug compliance as a counselling strategy.

understands the service user in the context of their life experiences, not from a diagnosis perspective.

values a systemic approach to working with the service user and wider systems.

appreciates the service user’s openness.

**Theme 5: The trauma-informed environment of the early intervention psychosis service**

**A trauma-informed early intervention psychosis service...**

will be aware of potential barriers to service engagement.

will maintain a safe environment for service users.

is a place where young people can talk and receive treatment for the effects of trauma.

recognises that worried, anxious, frightened or angry staff will violate the important principle of providing safety.

will recognise the sensory environment of other mental healthcare settings, such as inpatient wards.

will be a welcoming physical environment.

will provide soundproofed consultation rooms.

will offer an environment which is free from potential trauma triggers.

is designed with safety in mind.
Theme 6: Knowledge of trauma-informed care among all staff in early intervention psychosis services

Staff within a trauma-informed early intervention psychosis service...

137. are trained to understand the link between trauma and psychosis.
138. understand that associated emotional, social and interpersonal difficulties are often an adaptation to difficult life experiences, including adversity and trauma.
139. will be knowledgeable about trauma and its effects.
140. will acknowledge the relevance of psychological therapies.
141. will be aware of symptoms of dissociation.
142. will be understanding of the experiences and symptoms that service users may present to the service with including emotional regulation difficulties, substance use, and interpersonal difficulties.
143. will be familiar with the concepts of large ‘T’ trauma and small ‘t’ trauma.
144. will understand single incident traumas and complex trauma.
145. will be aware that a large proportion of service users may have been exposed to childhood trauma.
146. will have training in basic intervention strategies to support service users experiencing trauma e.g. grounding strategies.
147. will be aware of different presentations of psychosis.
148. will recognise that psychosis itself can be experienced as traumatic.
149. will incorporate trauma when creating the complex care plan.
150. will regularly assess risk.
151. will focus initially on stabilisation and emotional regulation for the service user.
152. will support service users to manage high levels of emotional arousal through distress tolerance strategies.
153. will establish a therapeutic alliance and safety before beginning trauma-focused therapy.
154. will acknowledge that service users may feel disempowered within mental health services.

For the next statement items, consider the following sentence stem:

A trauma informed early intervention psychosis service...
will have a trauma-informed protocol for the treatment of psychosis.
will increase trauma awareness through staff training.
will promote widespread and quick access to psychological therapies.
will acknowledge power as it manifests within the practitioner-service user relationship.
will acknowledge the traumatic potential of psychiatric care (e.g. mental health orders, forced hospitalisation, forced medications).

Consider the following statement as a standalone item (separate from the previous sentence stem):

Practitioners within a trauma-informed early intervention psychosis service will understand concepts of working within a service user’s window of tolerance.

Theme 7: Supporting staff in a trauma-informed early intervention psychosis service

A trauma informed early intervention psychosis service will...

provide appropriate training on trauma informed care for all staff.
support staff in delivering safe assessment and treatments for the effects of trauma.
train staff to treat complex trauma.
ensure staff feel safe and have trusting and supportive relationships within the service.
offer debriefing to staff.
provide supervision to staff.
provide regular supervision to practitioners who are working directly with trauma.
routinely offer reflective practice sessions for all staff.
support staff to protect themselves from vicarious trauma.
support staff to discuss their own emotions.
support staff to develop compassion and understanding of themselves.
offer continuing professional development (CPD) for staff.
offer regular team building for staff.
help staff to understand the powerful dynamics that can be projected into them by service users, families and the surrounding systems.
support staff to understand transference and countertransference experiences.

encourage open discussion of feeling ‘stuck’ in the therapy process.

help to improve staff confidence.

be aware that staff may have personal trauma experiences.

support staff to be aware of their personal trauma experiences and how these may be triggered when working with service users.

encourage staff to practice self-care.

ensure that practitioners who provide input to the early intervention psychosis service (e.g. interpreters) are adequately supported to do this work.

ensure staffing levels are sufficient.

recognise that adequate resourcing of the service is important to prevent burnout.

recognise the impact of attachment within the therapeutic relationship.

be understanding and curious about mismatches in attachment style between the practitioner and service user.

Thank you for taking the time to complete this questionnaire. Please save, attach and return your completed questionnaire to Sinéad (smitchell26@qub.ac.uk).
Appendix 6: Glossary of Terms used in Phase 2 Statement Items

**Glossary of Terms**

This glossary identifies some of the terminology used within the statement items. This list is not exhaustive, therefore if you have any questions please get in touch. Terms have been researched within the literature surrounding trauma, psychology, and governing bodies. Terms have been arranged in alphabetical order.

**A**

Attachment: the emotional bond between a human infant or a young nonhuman animal and its parent figure or caregiver; it is developed as a step in establishing a feeling of security and demonstrated by calmness while in the parent’s or caregiver’s presence. Attachment also denotes the tendency to form such bonds with certain other individuals in infancy as well as the tendency in adulthood to seek emotionally supportive social relationships. (Source: American Psychological Association)

Attuned: the matching of affect between infant and parent or caregiver to create emotional synchrony. The parent’s response can take the form of mirroring (e.g., returning an infant’s smile) or be cross-modal (e.g., a vocal response “uh oh” to the infant’s dropping cereal on the floor). Attunement communicates to the infant that the parent can understand and share the infant’s feelings. In psychoanalysis, misattunement describes a lack of empathy by a therapist or analyst toward a patient. (Source: American Psychological Association)

**B**

British Psychological Society/ Division of Clinical Psychology document ‘Understanding Psychosis and Schizophrenia’: This Report describes a psychological approach to experiences that are commonly thought of as psychosis, or sometimes schizophrenia. The full text can be accessed by emailing Sinéad Mitchell at smitchell26@qub.ac.uk (Source: British Psychological Society)

**C**

CBT: Cognitive Behaviour Therapy is a form of psychotherapy that integrates theories of cognition and learning with treatment techniques derived from cognitive therapy and behaviour therapy. CBT assumes that cognitive, emotional, and behavioural variables are functionally interrelated. Treatment is aimed at identifying and modifying the client’s maladaptive thought processes and problematic behaviours through cognitive restructuring and behavioural techniques to achieve change. (Source: American Psychological Association)

Complex Trauma: Complex trauma refers to a type of trauma that occurs repeatedly and cumulatively, usually over a period of time and within specific relationships and contexts. (Source: Courtois, 2008)

Continuing Professional Development (CPD): Continuing professional development (CPD) is the professional and work-related aspect of lifelong learning. It is an integral part of the process of adapting to change, and essential for maintaining and enhancing professionalism and competence. (Source: British Psychological Society)
Countertransference: the therapist’s unconscious (and often conscious) reactions to the patient and to the patient’s transference. These thoughts and feelings are based on the therapist’s own psychological needs and conflicts and may be unexpressed or revealed through conscious responses to patient behavior. (Source: American Psychological Association)

Debriefing: Psychological debriefing is broadly defined as a set of procedures including counselling and the giving of information aimed at preventing psychological morbidity and aiding recovery after a traumatic event. (Source: Kenardy, British Medical Journal, 2000)

Distress Tolerance Strategies: some treatments (e.g. Dialectical Behavior Therapy) are designed in part to raise an individual’s level of distress tolerance by habituating him or her to the experience of adapting to distress and other negative emotions. (Source: American Psychological Association)

Double Empathy Problem: the theory of the double empathy problem suggests that when people with very different experiences of the world interact with one another, they will struggle to empathise with each other. This is likely to be exacerbated through differences in language use and comprehension. (Source: National Autistic Society)

Drug compliance: (or Drug Adherence) Adherence to medicines is defined as the extent to which the patient’s action matches the agreed recommendations. (Source: National Institute of Health and Care Excellence/ NICE)

EMDR: Eye-Movement Desensitization and Reprocessing is a treatment methodology used to reduce the emotional impact of trauma-based symptoms such as anxiety, nightmares, flashbacks, or intrusive thought processes. The therapy incorporates simultaneous visualization of the traumatic event while concentrating on the rapid lateral movements of a therapist’s finger. (Source: American Psychological Association)

Emotional Regulation Skills: the ability of an individual to modulate an emotion or set of emotions. (Source: American Psychological Association)

Formulation: the summation and integration of the knowledge that is acquired by the assessment process. This will draw on psychological theory and research to provide a framework for describing a client’s needs. (Source: British Psychological Society)

Grounding Strategies: Grounding is a particular type of coping strategy that is designed to "ground" you in, or immediately connect you with, the present moment. Grounding is often used as a way of coping with flashbacks or dissociation when you have post-traumatic stress disorder (PTSD). (Source: verywellmind.com)
Large ‘T’ Trauma: A large-T trauma is distinguished as an extraordinary and significant event that leaves the individual feeling powerless and possessing little control in their environment. Such events could take form as a natural disaster, terrorist attack, sexual assault, combat/war zone, car or plane accident, etc. (Source: Barbash, E. 2017, Psychology Today)

**M**

Multidisciplinary team: a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients. (Source: National Health Service, NHS)

**P**

Phase-based treatment: The phase-based model, originally proposed by Herman (1992), involves three overlapping phases of treatment, which may be cyclical. The individual may need to return to earlier phases as therapy progresses:

- **Phase one:** stabilisation (establishing safety, symptom management, improving emotion regulation and addressing current stressors)
- **Phase two:** trauma processing (focused processing of traumatic memories)
- **Phase three:** reintegration (re-establishing social and cultural connection and addressing personal quality of life). (Source: McFetridge et al. 2016, UK Psychological Trauma Society)

Posttraumatic Growth: Posttraumatic growth is the experience of positive change that occurs as a result of the struggle with highly challenging life crises. This change, or growth, is manifest in a stronger sense of self, richer relationships with others, and changes in life philosophy that often include a radically altered priorities (Calhoun & Tedeschi, 2001, 2006; Joseph & Linley, 2008). (Source: Maitlis, 2012)

Power Threat Meaning Framework: an over-arching structure for identifying patterns in emotional distress, unusual experiences and troubling behaviour, as an alternative to psychiatric diagnosis and classification. (Source: British Psychological Society)

Projection: in psychoanalytic and psychodynamic theories, the process by which one attributes one’s own individual positive or negative characteristics, affects, and impulses to another person or group. This is often a defense mechanism in which unpleasant or unacceptable impulses, stressors, ideas, affects, or responsibilities are attributed to others. (Source: American Psychological Association)

Psychoeducation: Psychoeducational interventions are interventions in which education is offered to individuals with psychological disorders or physical illnesses. These interventions can vary from the delivery of materials such as single leaflets, emails or information websites to active multi-session group-intervention with exercises and therapist-guidance. (Source: Donker et al. 2009, BMC Medicine)
Reflective Practice: One of the key processes that should be encouraged for psychologists is having a complex understanding of self in the context of others. Psychologists should be aware of the possibility that they may be influenced by considerations which are not driven by professional knowledge, skills or experience. Maintaining awareness of these biases is important when trying to think through dilemmas. (Source: British Psychological Society)


Self-care: how staff can maintain their own wellbeing. (Source: British Psychological Society)

Self-Report: a statement or series of answers to questions that an individual provides about his or her state, feelings, thoughts, beliefs, past behaviors. Self-report methods rely on the honesty and self-awareness of the participant and are used especially to measure behaviors or traits that cannot easily be directly observed by others. (Source: American Psychological Association)

Small ‘t’ trauma: Small ‘t’ traumas are events that exceed our capacity to cope and cause a disruption in emotional functioning. These distressing events are not inherently life or bodily-integrity threatening, but perhaps better described as ego-threatening due to the individual left feeling notable helplessness. (Source: Barbash, E. 2017, Psychology Today)

Stabilisation: establishing safety, symptom management, improving emotion regulation and addressing current stressors (See Phase 1 of Phase-based treatment above)

Supervision: The objectives of supervision are: to provide practitioners with consultation on their work with clients; to enhance the quality and competence of practice offered to all clients; to offer psychologists intellectual challenge enabling reflection, transformational learning and psychological support to maximise their responsibility for appropriate self-care; and to contribute to the CPD of both psychologist and supervisor by developing competence in the use and practise of supervision. Supervision is not personal therapy and nor is it a form of, or substitute for, line management or appropriate training. (Source: British Psychological Society)

Systemic Approach: concerning or having impact on an entire system. (Source: American Psychological Association)

Transference: in psychoanalysis, a patient’s displacement or projection onto the analyst of those unconscious feelings and wishes originally directed toward important individuals, such as parents, in the patient’s childhood. The term’s broader meaning—an unconscious repetition of earlier behaviors and their projection onto new subjects—is acknowledged as applying to all human interactions. (Source: American Psychological Association)
Vicarious Trauma: Vicarious traumatisation refers to the cumulative transformative effects upon the identity, world view, psychological needs, beliefs and memory system of the trauma therapist as a result of working with survivors of traumatic life events. (*Source: McFetridge et al. 2016, UK Psychological Trauma Society*)

Window of Tolerance: A person’s window of tolerance is sculpted by their early attachment relationships. A person’s window of tolerance narrows as a consequence of repeated trauma and influences, resulting in: reduced emotion regulation abilities; reduced relational capacities; reduced capacity for attention and consciousness; negative influence on belief systems; increased somatic distress or disorganisation. Treatment of complex posttraumatic stress disorder builds emotional resilience and integrative capacity, which can only happen with an increased window of tolerance. (*Source: McFetridge et al. 2016, UK Psychological Trauma Society*)
### Appendix 7: Phase 2 response tables circulated to Experts in Phase 3*

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Statement</th>
<th>Group Rating</th>
<th>My Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Theme 1: Adopting individualised trauma-informed care in early intervention psychosis services</strong>&lt;br&gt;“A trauma-informed early intervention psychosis service...”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>recognises that different people will experience trauma differently.</td>
<td>71.4</td>
<td>Essential</td>
</tr>
<tr>
<td>14</td>
<td>routinely assesses trauma and adversity.</td>
<td>71.4</td>
<td>Essential</td>
</tr>
<tr>
<td>15</td>
<td>collaborates with the service user, treating them as a partner in the treatment process.</td>
<td>76.2</td>
<td>Essential</td>
</tr>
<tr>
<td>23</td>
<td>seeks agreement and consent from the service user before beginning any intervention.</td>
<td>78.6</td>
<td>Essential</td>
</tr>
<tr>
<td></td>
<td><strong>Theme 2: Principles of trauma-informed care in early intervention psychosis services</strong>&lt;br&gt;“A trauma-informed early intervention psychosis service will...”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>build a trusting relationship with the service user.</td>
<td>78.6</td>
<td>Essential</td>
</tr>
<tr>
<td>51</td>
<td>not exclude service users who have a history of severe or complex trauma.</td>
<td>76.2</td>
<td>Important</td>
</tr>
<tr>
<td>53</td>
<td>be sensitive to the cultural and ethnic background of the service user.</td>
<td>73.8</td>
<td>Important</td>
</tr>
<tr>
<td>72</td>
<td>work to protect the service user from ongoing abuse.</td>
<td>78.6</td>
<td>Essential</td>
</tr>
<tr>
<td>73</td>
<td>provide information on help available in crisis to service users.</td>
<td>71.4</td>
<td>Essential</td>
</tr>
<tr>
<td>77</td>
<td>give psychological therapy the same focus as medical interventions.</td>
<td>71.4</td>
<td>Essential</td>
</tr>
<tr>
<td></td>
<td><strong>Theme 4: Beliefs and values of a trauma-informed early intervention psychosis service</strong>&lt;br&gt;“A trauma-informed early intervention psychosis service...”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>will be sensitive to the fact that service users may have had negative and traumatic experiences in the context of their psychotic episodes.</td>
<td>76.2</td>
<td>Important</td>
</tr>
<tr>
<td>106</td>
<td>will have a calm, compassionate and supportive ethos.</td>
<td>71.4</td>
<td>Important</td>
</tr>
<tr>
<td>113</td>
<td>will recognise strengths and positive attributes of the service user.</td>
<td>73.8</td>
<td>Important</td>
</tr>
<tr>
<td>114</td>
<td>will identify and build on the skills and strengths of the service user.</td>
<td>73.8</td>
<td>Essential</td>
</tr>
<tr>
<td>118</td>
<td>is trustworthy.</td>
<td>73.8</td>
<td>Essential</td>
</tr>
<tr>
<td>122</td>
<td>validates what has happened to the service user.</td>
<td>76.2</td>
<td>Essential</td>
</tr>
<tr>
<td></td>
<td><strong>Theme 6: Knowledge of trauma-informed care among staff in early intervention psychosis services</strong>&lt;br&gt;“Staff within a trauma-informed early intervention psychosis service...”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>138</td>
<td>understand that associated emotional, social and interpersonal difficulties are often an adaptation to difficult life experiences, including adversity and trauma.</td>
<td>71.4</td>
<td>Important</td>
</tr>
<tr>
<td>139</td>
<td>will be knowledgeable about trauma and its effects.</td>
<td>76.2</td>
<td>Important</td>
</tr>
<tr>
<td>140</td>
<td>will acknowledge the relevance of psychological therapies.</td>
<td>71.4</td>
<td>Important</td>
</tr>
<tr>
<td>156</td>
<td>A trauma-informed early intervention psychosis service will increase trauma awareness through staff training.</td>
<td>73.8</td>
<td>Important</td>
</tr>
<tr>
<td></td>
<td><strong>Theme 7: Supporting staff in a trauma-informed early intervention psychosis service</strong>&lt;br&gt;“A trauma-informed early intervention psychosis service will...”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>161</td>
<td>provide appropriate training on trauma-informed care for all staff.</td>
<td>78.6</td>
<td>Important</td>
</tr>
<tr>
<td>162</td>
<td>support staff in delivering safe assessment and treatments for the effects of trauma.</td>
<td>71.4</td>
<td>Important</td>
</tr>
<tr>
<td>182</td>
<td>ensure staffing levels are sufficient.</td>
<td>71.4</td>
<td>Important</td>
</tr>
<tr>
<td>183</td>
<td>recognise that adequate resourcing of the service is important to prevent burnout.</td>
<td>76.2</td>
<td>Important</td>
</tr>
</tbody>
</table>

*42 individual tables were created and sent to each panel member to support decision-making of statement items in Phase 3. Each panel members’ table was unique to them based on their Phase 2 responses. The statement items and group aggregated percentage ratings were the same.
Appendix 8: Endorsed Phase 2 items circulated to Experts in Phase 3

**Phase 2 Findings: Essential principles of trauma-informed care in early intervention psychosis services**

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Statement</th>
<th>Group Rating ‘Essential’ %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A trauma-informed early intervention psychosis service adopts a person-centred approach.</td>
<td>83.3</td>
</tr>
<tr>
<td>38</td>
<td>A trauma-informed early intervention psychosis service will be sensitive when discussing trauma.</td>
<td>81.0</td>
</tr>
<tr>
<td>116</td>
<td>A trauma-informed early intervention psychosis service is empathetic and non-judgemental.</td>
<td>81.0</td>
</tr>
<tr>
<td>129</td>
<td>A trauma-informed early intervention psychosis service will maintain a safe environment for service users.</td>
<td>83.3</td>
</tr>
<tr>
<td>137</td>
<td>Staff within a trauma-informed early intervention psychosis service are trained to understand the link between trauma and psychosis.</td>
<td>85.7</td>
</tr>
<tr>
<td>166</td>
<td>A trauma-informed early intervention psychosis service will provide supervision to staff.</td>
<td>81.0</td>
</tr>
<tr>
<td>167</td>
<td>A trauma-informed early intervention psychosis service will provide regular supervision to practitioners who are working directly with trauma.</td>
<td>81.0</td>
</tr>
</tbody>
</table>
Section 5: Instructions for Authors: Early Interventions in Psychiatry

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In contrast with mainstream healthcare, early diagnosis and intervention has come late to the field of psychiatry. Early Intervention in Psychiatry creates a common forum for researchers and clinicians with an interest in the early phases of a wide range of disorders to share ideas, experience and data. This journal not only fills a gap, but also creates a new frontier in academic and clinical psychiatry.

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Articles reporting original work that embodies scientific excellence in psychiatry and advances in clinical research (maximum word count for text 3000; abstract 250);

Reviews which synthesize important information on a topic of general interest to early intervention in psychiatry. (maximum word count for text 5000; abstract 250);

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important topics (maximum word count for text 1500; abstract 150);

*Early Intervention in the Real World*, a special features section which focuses on issues such as service descriptions and delivery, and clinical practice guidelines (maximum word count for text 3000; abstract 250);

*Editorials or New Hypotheses.* Please contact the editorial office before writing an Editorial or New Hypotheses article for the journal (maximum word count for text 1000);

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v. Abstract and keywords;

vi. Main text;

vii. Acknowledgements;

viii. Conflict of interest statement;

ix. References;
x. Tables (each table complete with title and footnotes);  
xi. Figure legends;  
xii. Appendices (if relevant).  

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Five key words, for the purposes of indexing, should be supplied below the abstract, in alphabetical order, and should be taken from those recommended by the US National Library of Medicine’s Medical Subject Headings (MeSH) browser list at [http://www.nlm.nih.gov/mesh/meshhome.html](http://www.nlm.nih.gov/mesh/meshhome.html).  

**Text**  

Authors should use the following subheadings to divide the sections of their manuscript: Introduction, Methods, Results and Discussion.  

**Acknowledgments**  

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A sample of the most common entries in reference lists appears below. Note that for journal articles, issue numbers are not included unless each issue in the volume begins with page one, and a DOI should be provided for all references where available.  

**Journal article**  


**Book**  

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.
Internet Document


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Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

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Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

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9. **EDITORIAL OFFICE CONTACT DETAILS**

Professor Patrick McGorry, Editorial Office, *Early Intervention in Psychiatry*
C/O Wiley
155 Cremorne St
Richmond, Victoria, 3121
Australia
Email: [eip.eo@wiley.com](mailto:eip.eo@wiley.com)

*Author Guidelines updated 18 March 2019*
Section 6: Ethics and Governance Approval

Date: 29 January 2019
To: Dr Donncha Hanna
Faculty REC Reference Number: EPS 19_05

Full Title: Towards a consensus of the principles of trauma-informed care in early intervention psychosis services: a Delphi approach

Decision: APPROVED

Thank you for your application which was reviewed by the EPS Faculty Research Ethics Committee (Faculty REC) in accordance with the Proportionate Review process.

Your application was considered and some clarification and revisions were requested on 11 January 2019. You submitted the requested information on 20 January 2019.

The clarification and revisions have been reviewed and deemed satisfactory. The application has been approved.

Conditions of the Approval

The Faculty REC approval is subject to the following conditions:

(i) The study must be conducted in accordance with all relevant legislation. All relevant management approvals from organisations involved in the research must be obtained.
(ii) When the research involves human volunteers the study must be entered on the University’s Insurance Database.
(iii) Monitoring and auditing process must be complied with including submission of annual progress reports to the Faculty REC.

It is the Chief Investigator's responsibility to ensure the study is conducted in accordance with the conditions stipulated.

Any future changes to any part of the submitted application, protocol or supporting documentation must be notified to the Committee prior to these changes taking place.

Approved Documents

The documents approved by the Faculty REC are listed in the table below.

<table>
<thead>
<tr>
<th>Documentation Received</th>
<th>Version</th>
<th>Date</th>
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<tbody>
<tr>
<td>Application Form (Revised)</td>
<td></td>
<td>Received 20 January 2019</td>
</tr>
<tr>
<td>Covering Letter addressing Reviewer concerns</td>
<td></td>
<td>21 January 2019</td>
</tr>
<tr>
<td>Research Protocol</td>
<td>1</td>
<td>Received 08 January 2019</td>
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<tr>
<td>Participant Invitation Email</td>
<td>1</td>
<td>Received 08 January 2019</td>
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<tr>
<td>Participant Information Sheet</td>
<td>1</td>
<td>Received 08 January 2019</td>
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<tr>
<td>Statement of Consent</td>
<td></td>
<td>21 January 2019</td>
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<tr>
<td>Participant Demographics Questionnaire</td>
<td>2</td>
<td>Received 20 January 2019</td>
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<tr>
<td>Peer Review</td>
<td></td>
<td>21 December 2018</td>
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</table>
If you would like to discuss this further please contact the Research Ethics Officer, Miss Kathryn Taylor, at facultyreceps@qub.ac.uk or by telephone on 028 90972529.

Yours sincerely

[Signature]

pp Dr Brendan Murtagh
Chair, EPS Faculty REC
Date: 13 May 2019
To: Dr Donncha Hanna
Faculty REC Reference Number: EPS 19_05 – Amendment received 16 April 2019
Full Title: Towards a consensus of the principles of trauma-informed care in early intervention psychosis services: a Delphi approach
Decision: AMENDMENT 1 - APPROVED

Thank you for your request for an amendment to the above study, received on 18 April 2019. A signed Notification of an Amendment Form was received on 03 May 2019.

The amendment proposes a change to this exclusion criteria to allow individuals who may be accessing Early Intervention Psychosis Services to share their views on what they believe are, or should be, the principles of trauma-informed care in these services.

The Chair has considered your proposed amendment and is content to give an approval.

The following study documents have been reviewed as part of this amendment and approved for use:

<table>
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<tbody>
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<td>Received 18 April 2019</td>
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<tr>
<td>Notification of an Amendment Form – Amendment 1</td>
<td></td>
<td>02 May 2019</td>
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<tr>
<td>Research Protocol</td>
<td>2</td>
<td>Received 18 April 2019</td>
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<tr>
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</table>

If you would like to discuss this further please contact the Research Ethics Officer, Miss Kathryn Taylor, at facultyreceps@qub.ac.uk or by telephone on 028 90972529.

Yours sincerely

Kathryn Taylor

pp Dr Brendan Murtagh
Chair, EPS Faculty REC
Section 7: Reflective Appendix

The completion of this thesis offered an opportunity to enhance skills in research, methodological procedures, data analysis, critical assessment of the literature, and communication. It also developed personal skills in resilience and maintaining effective working relationships.

I was initially daunted by the task of beginning the large-scale research study as it applied a methodological approach which I was previously unfamiliar with. This required support from my research team and self-directed learning in understanding the conduct, analysis and outcomes of Delphi studies in the context of mental health. In the early stages, skills in organisation, planning, and the development of an effective recruitment strategy to engage global participation were required. A strength of this work was the recruitment and retention of experts in the field, with early planning stages crucial in securing these participants. The outcomes provided the first consolidated and agreed conceptualisation of trauma-informed care in early intervention psychosis services. I had hoped to recruit more Experts by Experience to the study. This was addressed in the article, with recommendations emphasising the inclusion of Experts by Experience in the adoption and integration of the agreed principles. Future research, particularly in a service evaluation of the adopted principles, would be of value in this area.

The systematic review identified a novel and innovative research question of relevance to psychological research and clinical practice. The process required competence in review and synthesising psychological knowledge within the area of CBT for PTSD. Critical assessment led to the identification of gaps in understanding surrounding dropout from such interventions. The meta-analysis aimed to provide new understanding of the psychological factors that may be implicated in dropout from trauma-focused interventions for PTSD. Skills
were developed in choosing, applying and interpreting the results of the statistical analysis employed in the study. I am so grateful to the research team: to Ryan for his time, patience and commitment to the identification and review of articles, and Donncha for supporting me with the analysis and signposting to the appropriate resources to enhance my understanding of the outcomes. This experience will help shape my clinical practice, particularly in the critical review of evidence, knowledge of the efficacy of trauma-focused treatments, and to explore and understand factors which may impact therapeutic engagement.

The completion of both studies facilitated an exploration and critical analysis of existing literature, with a review of outcomes enhancing my understanding of trauma-informed practice. The experience has strengthened confidence in my ability to critically assess research which will enrich my future practice as a qualified clinical psychologist. I would like to thank Donncha Hanna and Ciaran Shannon for sharing their knowledge and skills to facilitate the completion of both studies, and for their unwavering support, guidance and encouragement. I would also like to thank Ryan Mitchell, Ciaran Mulholland and Martin Dorahy for their valuable expertise and contributions to this research.