

**The Role of Cognitive Behaviour Therapy in Mitigating  
the Impact of Post-Traumatic Stress Disorder in Northern  
Ireland**

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## Abstract

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This paper deals with an understanding of how cognitive behaviour therapy plays a role in alleviating PTSD in Northern Ireland. The paper starts with a definition of PTSD and the problems that are prevalent in Northern Ireland as a result of PTSD. The methodology that is used here is qualitative in nature where five practitioners from the area were considered with regards to their response to open ended questions regarding PTSD, treatments, as well as the impact that the disorder has on Northern Ireland. Six key themes were mined from the interview data.

The study notes that there is a pervasive impact of PTSD on families where the impact is expected to last for nearly 30 to 40 years after the conflicts end. Moreover, it was noted that CBT is an effective short term treatment which is suitable for some, but for some patients longer term treatments are required. Interventions proposed to bring down the level of PTSD in the region are education in order to remove the stigma attached to PTSD, and a better role for the government which will be essential in supporting and funding the treatments.

## Chapter One: Introduction

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Northern Ireland faced ‘Troubles’<sup>1</sup> over three decades. These armed conflicts killed nearly 3500 people as the Catholic nationalist minority struggled to gain a political foothold in the Protestant-led government and police force of Northern Ireland.

The protest was led by the Catholic community in a bid to end job and housing allocation discrimination as well as discrimination in the police force, which was 90 per cent Protestant, and cited to be brutal as far as minorities were concerned. These troubles led to a prevalence of Post-Traumatic Stress Disorder (PTSD) in the population that suffered during and in the aftermath of the conflict.

According to a 2011 report on the prevalence of PTSD in the region, it was indicated by the World Mental Health survey that it costs the country £175m in one year, to cater to the needs of 18,000 people who are suffering from PTSD in the region (BBC.com, 2011). The survey that was carried out by researchers from the University of Ulster and Omagh-based trauma treatment experts was conducted over a four-year period, (2004-2008) on 4,340 adults. (University of Ulster, 2011)

Events relating to the conflict, such as the violent death of a near one, witnessing a violent death, kidnapping, mugging or serious injury, led to the highest incidence of PTSD at 18.6 percent, where Ferry, Bunting, Murphy, O’Neill, Stein & Koenen (2014) indicated that there

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<sup>1</sup>‘The Troubles’ is the common name for the conflict in Northern Ireland. The main participants in the Troubles were Irish republican paramilitaries such as the Provisional Irish Republican Army (IRA) and the Irish National Liberation Army (INLA); Ulster loyalist paramilitaries such as the Ulster Volunteer Force (UVF) and Ulster Defence Association (UDA); British state security forces, the British Army, and the Royal Ulster Constabulary (RUC); and political activists and politicians.

is a likelihood that the prevalence of PTSD might be higher in the population compared to the sample studied.

Projections of the sample results also revealed that nearly 40 per cent of the population had suffered PTSD due to the conflict. The prevalence of PTSD in the region, therefore, is irrefutable but the high incidence of this disorder is also expected to take a toll on other aspects of the country. PTSD prevalence is also expected to lead to further violence in the form of spouse or child abuse, as patients with PTSD are prone to indulge in such kind of behaviour (Ferry *et al.*, 2014).

In this paper, the role that cognitive behaviour therapy has played in mitigating the impact of PTSD in Northern Ireland will be explored. The key themes of the paper are to explore PTSD and how it can be alleviated with the help of Cognitive Behaviour Therapy (CBT). It has to be noted here, that the paper will take the viewpoint of a psychotherapist, where the focus of the paper will be to explore the issue in greater depth in order to get to understand how CBT works and how effective it has been in alleviating the impact of PTSD in patients. This will be done through a qualitative research that will follow the views of five psychotherapists who will be interviewed for their insights regarding the topic.

The insights of the psychotherapists will be compared with the secondary research literature that is available on the topic so that an analysis can be made of how effective CBT is and in what cases CBT works best. This paper aims to assess the effectiveness of CBT as well as the methods that are used in alleviating PTSD in comparison to other methods of treatment such as drug therapy and exposure therapy.

Even though the conflict may have been resolved politically, people who have gone through the trauma and relive it each day and are incapacitated in the presence of these memories they then have to be dealt with as a direct result of the ‘Troubles’. The research objectives of this paper, following through with the main purpose, explore the prevalence of PTSD and how it can be resolved on a wider scale using CBT.

- To understand what constitutes PTSD and the events that lead to PTSD
- To understand CBT and its effectiveness
- To evaluate which PTSD symptoms are most easily eliminated by CBT
- To evaluate exposure therapy and drug therapy effectiveness in mitigating PTSD
- To understand psychotherapists’ perceptions regarding CBT effectiveness in treating PTSD and propose recommendations that could help alleviate the problems faced by individuals suffering from PTSD

The structure of this report will be based on four consecutive parts. The first part of the report will review existing literature and published studies on the topic of PTSD and the role that CBT has played in alleviating PTSD. The literature review will also help in formulating the methodology of the paper, and will help inform the findings and analysis that will be consequent parts. The conclusion will enlist recommendations and a discussion and synthesis of findings and results.

## Chapter Two: Literature Review

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Post-traumatic stress disorder (PTSD) has a pervasive impact on the individual that it victimizes. For a country such as Ireland, where there are multitudes of affected people. The bearing that PTSD has had on individual lives, is manifest in the statistics. They indicate that 26 per cent of PTSD can be attributed to the Troubles. Each year Northern Ireland spends around 1.4% of the entire expenditure on Health and Social Care budget (2008 figures) on treating PTSD. The paper seeks to study how PTSD is caused, and the role that CBT has played in treating the disorder in the Northern Irish population. The effectiveness of CBT will be identified using the literature that is available on the topic. Moreover, the literature review is intended to assist in developing an interview for understanding the perceptions regarding PTSD and CBT as a treatment option from a sample selected by Psychotherapists in Northern Ireland.

### 2.1 Definition of PTSD

Post-traumatic stress disorder (PTSD) is a mental health condition that is created due to anxiety, which is caused after an individual is exposed to a traumatic event in his or her life. Although there are descriptions of the disorder impacting individuals prior to a formal definition of the disorder, PTSD was recognized as a treatable disorder in the Diagnostic and Statistical Manual of Mental Disorders volume III (DSM III)<sup>2</sup>, which was published in 1980. The World Health Organization recognized PTSD in 1993 as a disorder that afflicted people worldwide. This means that although the disorder has been prevalent historically, official recognition of the disorder has been recent (Jones & Wessely, 2005). However, intensive

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<sup>2</sup>*Diagnostic and Statistical Manual of Mental Disorders* is the standard classification of mental disorders used by mental health professionals. DSM V is the current edition.



work on this has been carried out, due to the fact, that it is pervasive, and in the recent years, with terrorist attacks and conflicts on the rise, PTSD is a serious issue to be dealt with (Bisson, 2007).

Some of the characteristic symptoms that define PTSD are:

- Recurrent disturbing dreams and recollections of the event
- Acting or feeling as if the events are recurring.
- Physiological reactions to stimulants in the environment that trigger memories of the event.
- Avoidance of thoughts or feelings.
- Numbing of feelings and emotions.
- Detachment.
- Sleep disorders.
- Hyper-vigilance and concentration difficulties (Bisson, 2007).
- In addition to these symptoms, feelings of helplessness and horror are generic problems that are categorical of PTSD.

## **2.2 Psychotherapist's Definition of PTSD**

Individuals who are part of the military are exposed to frequent traumatic events, where they are faced with recurrent danger and combat situations, which could trigger PTSD in the aftermath of the incident. There are millions of stories of war veterans who were incapacitated in their ability to lead normal lives once the war had ended (Maguen, 2008). Shira Maguen, an eminent psychologist in the Post-Traumatic Stress Disorder Clinical Team

at the San Francisco VA Medical Centre, indicated that PTSD can occur when the individual's life is in danger, and can occur in a combination of ways for different people.

Individual responses to traumatic events can differ, where not all people who face traumatic events suffer from PTSD. Response mechanisms, apart from PTSD manifestation, include the initial onset of trauma receding into forgetting the event, and sufferers going back to leading their normal life. Other responses include the feeling of mild trauma, which cannot be diagnosed as PTSD as the individual's condition does not check all the boxes for the disorder (Maguen, 2008).

As far as the prevalence of PTSD in Northern Ireland is concerned, nearly a third of the population has experienced some kind of trauma, and this has led to a larger exposure to PTSD (BBC.com, 2011). However, the lack of awareness regarding treatment modalities, as well as the lack of acceptance of mental illnesses as real illnesses, has led to a lack of treatment and prevalence of the disorder in the country (BBC.com, 2011).

The main option in the way that PTSD is treated is through Cognitive Behaviour Therapy (National Center for PTSD, 2013). There are two treatments, which fall into this category. These are Cognitive Processing Therapy and Prolonged Exposure Therapy. An alternative treatment is Eye Movement Desensitization and Reprocessing, which teaches control of eye movements in stressful situations (US Department of Veteran Affairs, 2016).

### **2.3 Role of Psychotherapists in PTSD**

Psychotherapists play a role in alleviating problems associated with PTSD through a counselling approach and other techniques, which involve a study of the patient's life events, in order to treat them and where the treatment lasts over long period of time (Therapy Works Private Ltd, 2013).

### **2.4 Current Debates on PTSD**

Recent studies have suggested that while there are a vast number of people who may be exposed to traumatic events, the recovery for a majority of these people is spontaneous. The example of USA and South Africa is cited, where it was indicated that 50 per cent of Americans and nearly 67 per cent of South Africans have been exposed to traumatic events in the past, only 7.8 percent and 2.3 per cent of the people respectively were diagnosed as suffering from PTSD in the two countries (Eagle & Kaminer, 2015, p. 27). Debate has therefore arisen on the issue that, while PTSD was thought to be a common response to the occurrence of a traumatic event, the incidence of PTSD is much lower than expected.

These figures and studies explain that PTSD is not a common occurrence globally but when compared to the situation in Northern Ireland, it can be seen that Northern Ireland has one of the highest rates of PTSD in the world (Eagle & Kaminer, 2015, p. 27).

One reason that may contribute to the high incidence of PTSD is that the continuing exposure to trauma could have led to a higher incidence of the condition where an isolated past event could have been the starting point of the disorder. It makes sense, therefore, that the violence, which spanned thirty years and even after that, there were incidences of violence that led to the high occurrence of PTSD in the region (Eagle & Kaminer, 2015).

## **2.5 Transgenerational Trauma**

Transgenerational trauma is transferred across generations and impacts children who have seen their parents suffer through a traumatic event or death. Transgenerational trauma is another theme in PTSD, where children might be traumatized due to the incidents in their parents' lives. An alarming increase in the rates of suicide has been reported in men who were young at the time of the worst stages of the Troubles. McNally (2014) states that the experience of bereavement at a young age can re-emerge at an older age. When the grief of young people has not been adequately addressed, it has the potential to lead to an obsession with the suffering that their parents have faced. This obsession can lead to extreme actions being taken by individuals which can include suicide or suicide attempts (McNally, 2014).

The severity of this issue is intense, as the impact that conflict has on children is not fully understood and therefore, not enough attention is paid to their feelings and their emotions are not adequately addressed by those around them. However, it has to be noted that conflict tends to have a long-lasting effect, especially as the children grow up with their mental state impacted by the unaddressed trauma that they have experienced (McNally, 2014).

## **2.6 Gender Differences**

Gender differences have been observed in handling trauma and the occurrence of PTSD. It was noted that while 9.7 percent of women suffer from PTSD among the adults and adolescents of the USA, approximately half that number – 3.6 percent of males suffer from the disorder (Gaidos, 2016). Studies reported that males and females have biological differences in how they respond to stress. It was noted that there is a special chemical process in the brain called Corticotrophin-Releasing Factor (CRF) that creates the response of the body to stress, where in males, CRF tended to move away from the internal parts of the

brain to the outer part, signalling that they were able to cope better with similar stress in the future. On the other hand, in females, CRF stayed in the same vicinity of the brain, creating similar levels of stress in like situations (Ferry *et al.*, 2014).

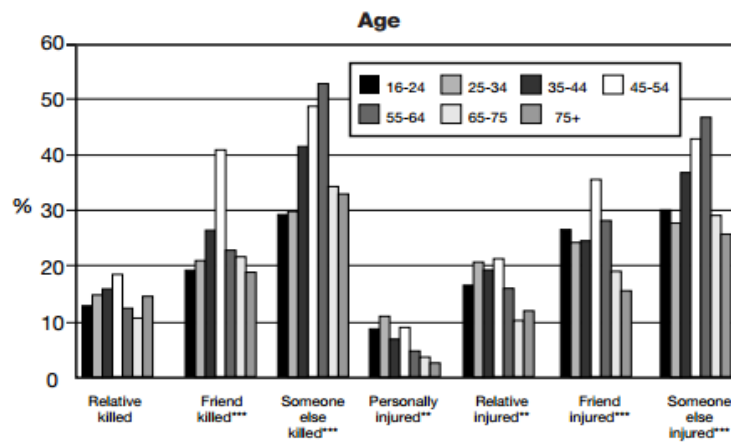
For psychotherapists dealing with PTSD, considerations of gender have to be kept in mind. The gender differences in the occurrence of PTSD have been supported by a report on trauma, health and conflict in the country, where it has been noted that females are twice as likely to develop PTSD, both from groups that have been exposed to trauma, as well as from the general population (Ferry *et al.*, 2014).

## **2.7 Impact of the Conflict on Northern Ireland**

It has been estimated that approximately 3,500 people have died and 35,000 have been injured in over thirty years of conflict that has afflicted the region of Northern Ireland. Many incidents of trauma are a result of witnessing approximately 34,000 shootings and 14,000 bombings (Hillyard, Rolston & Tomlinson, 2005). PTSD affects nearly 12 percent of the population of Northern Ireland, while reports also suggest that the entire nation has been deeply affected due to the conflict pervading all aspects of their daily lives. Statistics indicate that approximately 49 percent of the population had known someone who had been killed in the conflict. Of this, 14 percent had lost a close relative. The impact of the conflict was present also on the economic circumstances of the people, where 8 percent were forced to leave their homes and jobs to move to safer areas due to the threat of sectarian violence close to their areas of residence. (Hillyard, Rolston & Tomlinson, 2005).

The chart below indicates the age profile of people who had witnessed some sort of conflict-related violence according to data collected in 2002/2003 that has been quoted in Hillyard, Rolston & Tomlinson (2005 p. 132).

**Figure 1: Incidence of people knowing someone killed due to the conflict - age breakup**



Northern Ireland has not been able to cope effectively with PTSD due to the fact that the society as a whole has been in denial of the after effects of the ‘Troubles’ (Kapur, 2001). This has led to people suffering PTSD and feeling isolated, as they have been unable to share their distress. The long-term impact of PTSD has been only recently realised, where alarming figures about the high incidence of the disorder in the country, has led to a call for action (Kapur, 2001).

## 2.8 Solutions to PTSD

Some solutions that have been recommended for addressing the widespread problem of PTSD include mass education regarding the disorder and an awareness of coping mechanisms. However, this will be more effective when it is done in a psychosocial context, where family members, as well as friends, are involved and informed about how to deal with a person suffering from PTSD (McNally, 2014).

It has to be acknowledged that PTSD is a chronic illness and takes up an uncertain duration of time in a person's life. For that reason, it would be useful for the research to be longitudinal in nature so that patterns and trends can be studied. This would allow studies to suggest better ways of coping with PTSD, based on how the disorder progresses or digresses over a period of time (Jayawickreme & Blackie, 2014). This longitudinal study of the disorder is also important as there are different symptoms which manifest and different treatments have to be prescribed at different stages. Symptoms can include hyperarousal in transgenerational trauma where individuals are reliving their parent's lives. Gender differences have also to be considered when PTSD solutions are proposed, as it has been indicated by research that females tend to be more prone to having the disorder when compared to males. Psychotherapists propose three main ways of treating PTSD, which include:

- Trauma Focused Cognitive Behaviour Therapy (CBT): Where the therapist helps change the way that people think about the trauma. (Eagle & Kaminer, 2015).
- Exposure Therapy where the patient is taught to have less fear about their memories. This therapy uses desensitization techniques, where good thoughts are talked about before bad ones, so that the association of the bad thoughts with stress triggers, is lessened (US Department of Veteran Affairs, 2015).
- Eye Movement Desensitization and Reprocessing (EMDR) integrates components of cognitive-behavioural therapy with eye movements or other forms of rhythmic, left-right stimulation, such as hand taps or sounds. These work by "unfreezing" the brain's information processing system, which is disturbed in times of extreme stress.

However, the current methods of dealing with PTSD have been met with suggestions of further improvement in a report on PTSD in Northern Ireland (Hillyard, Rolston, & Tomlinson, 2005). Some of the people, who have gone through PTSD treatment, indicated that due to the widespread prevalence of the disorder in the region, general physicians should also be aware of the treatment options available for PTSD and should be in a position to guide patients in the correct course of action. Psychotherapy as a treatment takes time to manifest results, as it does not include the use of medication to treat patients. This means that the sooner the disorder is diagnosed, the earlier the treatment for the disorder can start. For this reason, if general physicians are able to diagnose the disorder in Northern Ireland, treatment for patients can start sooner and could likely involve fewer sessions, as the disorder would not have progressed to more complex stages.

## **2.9 Effectiveness of CBT**

CBT refers to the treatment of post-traumatic stress disorder through changing thinking about the trauma and understanding the thoughts that trigger stress so that these can be consciously managed (US Department of Veteran Affairs, 2015). There are two main treatments that fall under the broad umbrella of CBT, which are Prolonged Exposure CBT and Trauma-focused CBT (Makinson & Young, 2012).

Under the prolonged exposure approach, the two factor theory of learning forms the premise of the understanding of PTSD symptoms. This theory indicates that fear and avoidance are learnt through classical and instrumental conditioning, where trauma is linked with similar stimuli, which cause anxiety, and this then becomes learnt behaviour. The therapy session for PE is traditionally 90 minutes and goes on for nine to twelve sessions, where the initial



sessions are devoted to relaxation followed by sessions where cognitive control is taught (Makinson & Young, 2012).

As far as Trauma focused CBT is concerned, the therapy uses attachment, family and person therapy in order to treat patients, where identification and control of cognitions is carried out in order to control the symptoms of PTSD. The goal of this therapy is to identify and change negative personal meanings through updating, where feelings, during the height of distress are explored, and are then updated, with the new information that the patient knows, in order to take the stress from the situation. Another goal of this therapy is to break the link between the trauma and the traumatic feelings, while the final goal is to identify the cognitive behaviours and to change them so that stress is not created (Makinson & Young, 2012).

CBT has traditionally been used as a therapy for dealing with PTSD, and among children, it was noted that in cases which were not responsive to CBT that trauma-based CBT and Eye Movement Desensitization and Reprocessing tend to work. A study reported that comorbid depression and hypersensitivity in children reduced as a result of these treatments (Diehle, Opmeer, Boer, Mannarino, & Lindauer, 2015).

Research on group sessions of CBT noted that group sessions were effective in reducing PTSD symptoms. The symptoms included alcohol misuse, anxiety, depression and quality of life, which were all reported as improved. This is important in the study of the effectiveness of group CBT sessions as it was longitudinal in nature, where data was collected quarterly for nine years and where the participants were Australian combat veterans who took part in a six week long CBT group session. (Khoo, Dent, & Oei, 2011). However, the findings of Khoo, Dent, and Oei (2011) were contradicted by two meta analyses papers focusing on group

sessions for the treatment of PTSD. The Sloan, Feinstein, Gallagher, Beck, & Keane (2013) and Sloan, Bovin, & Schnurr (2012) reviews of group treatment for PTSD, concluded that the effect size of the treatment was lower with a correlation of 0.24 in comparison to the effect size of individual therapy sessions (Bradley, Greene, Russ, Dutra, & Westen, 2005).

Always include a short chapter summary pulling the main points together.

## **2.10 Summary**

The literature defines PTSD symptoms and details the role that psychotherapists and the CBT treatment have to play in mitigation of this disorder. Various aspects of PTSD and its prevalence in Northern Ireland have been explored where gender differences and in particular transgender differences are discussed. It has been seen that Gender plays a strong role in how PTSD impacts victims. Transgenerational PTSD is also seen to be a cause of alarm as the impact indicates how each generation is impacted after the subsequent one due to secondary exposure to trauma. The solutions to PTSD as provided in academic articles are also discussed.

## Chapter Three: Methodology

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### 3.1 Aim of the Study

The aim of the study is to understand the role of that CBT has had to play in alleviating the symptoms of PTSD in Northern Ireland.

### 3.2 Research Design

The research ideology that forms the premise of this paper is interpretivist where the researcher will be using his sensory experiences to understand the truth of the situation. It has to be borne in mind that the paper is exploring the role of cognitive behaviour therapy through the use of an inductive approach (Neuman, 2005). An ethnographic strategy has been adopted here where the researcher has relied on in-depth interviews with the target group, and has augmented field notes and observations in order gain more information about the topic being explored. A mono-method qualitative study has been used in a cross sectional time frame here, where the justification for the methodology, design and strategy can be found in the suitability of the choices to the research aim (Malhotra, 2008).

Foremost, an interpretivist approach is necessary for a psychological exploration of this nature, as an experimental or realist ideology, would not have uncovered the insights needed and the profound understanding of the issue at hand. Secondly, a deductive approach is not suitable, due simply to the fact, that this is an exploration, rather than a document, required to prove or disprove an already established proposition (Saunders, Lewis, & Thornhill, 2011).

The choices of a mono-method qualitative option are suitable, as this is an exploratory study, which is looking to gain insights. Therefore, given the design of the research, expert opinion is necessary in order to gain a deeper perspective on the issue, where the target group for seeking further information is:

- Professional psychotherapists treating PTSD patients with CBT
- Professional psychotherapists treating PTSD patients with alternative methods

The first target group is a means to attaining information regarding the impact that CBT has had on treating individuals with PTSD. The second group is a means of understanding general perceptions regarding alternative therapies to treat PTSD in order to understand the difference in the two treatments.

### **3.3 Methodological Approach**

The method that is being used here is termed as CQR or Consensual Qualitative Research where the method uses a semi structured instrument, with open-ended questions, that allows researchers to explore the multifaceted issue of PTSD without any restricting bias or constraints (Hillyard, Rolston & Tomlinson, 2005). This allows the characteristics of the disorder to come to life so that understanding the impact of treatment therapies on alleviation of PTSD can be considered.

### **3.4 Research Questions**

The research questions sought to be answered require information that will be gathered from consenting participants through the use of the following questions that will be asked from them during the interview. These are as attached in the Appendix (Appendix 2: Interview Questions).

### **3.5 Procedure**

The procedure for the interview was that the researcher printed out forms with spaces between each of the questions that were to be asked of the interviewee. While the questions were asked, the researcher made notes on this form. In addition to this, a tape recorder / mobile-phone was used to record the interview which allowed any gaps in note taking to be filled, and the interview to be refreshed for better data and content analysis.

The recordings were listened to as soon as the interview was over, so that there would be things that could be taken a note of, while the memory of the researcher was fresh. The recordings were then transcribed and the contents of the interview were analysed.

### **3.6 Data and Content Analysis**

Coding was developed for the interview guidelines, where major trends and ideas that the interviewees spoke about were noted and a coding was developed in order to understand how many times that trend or phrase appeared in the interview. This was useful as it helped to evaluate and categorize the information so that an analysis with existing literature and published studies could be carried out (Hill, Knox, Thompson, Williams, Hess, & & Ladany, 2005).

While individual interview analysis was carried out immediately after the interview was over, a synthesis of the interviews and their analyses were carried out at the content analysis stage where all interviews were combined together and then examined for important information.

### **3.7 Ethics**

An introductory letter to the interviewee was prepared along with a consent form as attached in Appendix 1: Letter of Consent. The duration of the interview was one hour. The psychotherapists were updated about the situation of PTSD in the country. They were apprised of the fact that the information collected from them during the interview would be used for academic purposes only and that their names would be kept confidential. The letter and the interview questions will be attached in the appendix.

### **3.8 Recruitment of Participants**

The psychotherapists shortlisted for interview were:

1. Interviewee 1: Ann
2. Interviewee 2: John
3. Interviewee 3: Colm
4. Interviewee 4: Noel
5. Interviewee 5: Helen

The respondents were contacted through a mutual contact person. They were emailed a brief about the interview and a follow up call was made to fix an interview at their premises.

The background information of the interviewees reveals that they are all qualified to talk about the subject and are in a position to offer opinions which are valid for the purposes of this research. Data collected from the interviews enabled the researcher to categorise the material into six main themes. The themes explored are:

- PTSD constituents and causes
- Optimal course of action for PTSD
- Gender differences in PTSD
- Impact of family on PTSD
- CBT and its role in PTSD Alleviation
- Intervention

## Chapter Four: Findings

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The findings have been categorized into 6 main themes. Before proceeding to analyse the findings of the interview, it is important to note the profile of the respondents. The first respondent gained Psychotherapeutic experience while training at Business School for a degree in Psychotherapy. The respondent went on to obtain a Master's in Organizational Psychology. However she does not practice the EMDR treatment.

The second respondent was an accredited as a therapist in 2006 and has a Degree in Psychology, a Master's Degree in Trauma Management, Psychology with Trauma Management and an Advanced Diploma in Integrative Therapy and an Advanced Diploma in CBT. The second respondent practices EMDR.

The third interviewee is a psychotherapist as well as a counsellor since 2009. Colm has been trained in an integrative model -the Egan Model, as well as CBT - both person centered and psychodynamic.

The fourth interviewee is a Clinical Director who has been managing a team of counsellors, psychotherapists, psychologists. The interviewee used a holistic model approach, where he leads a team of twenty-five specialists. His background in the field is as a psychologist.

The fifth respondent, Helen has been counselling since 1997 and has received basic training when she was with an institution known as Cruise Bereavement Care. She is now a full-time counsellor with a Diploma in person-centred counselling, and also has a level five diploma in CBT and EMDR.



#### 4.1 PTSD Constituents and Causes

TSD is defined as a traumatic event, where the constituents are physical and psychological arousal/ stress, trauma – which can be single or multiple event, where anxiety, uncertainty feelings, hyper vigilance, disconnectedness and depression are all manifested in the sufferers' behaviours. One of the respondents used the acronym HARM: hyper vigilance, avoidance, re-experiencing, mood (low) to define the symptoms, while another indicated that one of the main manifestations of the onset of PTSD is the feeling of disconnectedness or apathy that the person has with other people as well as with their life events. Another respondent also found it necessary to indicate that the DSM5 defines PTSD as a disorder where normal ways of coping are overwhelmed and there is no control of the victim over environment. Feeling disconnected and helpless, according to another respondent was a coping mechanism where the therapist stated that it is normal to experience trauma.

As far as the link of the incidence of PTSD to the Troubles in Ireland was concerned, a transgenerational trend could be observed, where the respondents indicated that there are many psychological disorders among adults and youth which are due to the trauma faced by a person close to them - parent or grandparent. Unresolved traumas from the Troubles are explicitly present, where quite often; exploration of the history of the patient reveals that the problem is related to the Troubles related. According to respondent John:

*“In victims of the church it was largely hidden for a long-time, em, victims of the Troubles, during the Troubles and when the Troubles actually ended, em, a lot of unresolved traumas which didn't go and many people in Belfast still have unresolved traumas from it.”*

The impact has also been indicated to be present especially among people who lived during the early 70s, according to Ann, these people have a sense of threat or fear that someone will die, and there is a general sense of paranoia among them. She said:

*“I mean just to give you an indication I had these guys in a room. We were doing some focus groups and I brought some of these guys, they were very, very senior guys into a room and what we found was that like the very first thing they did when they came into the room was they stood up on top of tables and they checked the room for devices.”*

The worse thing is not that the trauma is related to the Troubles; it is that the people are leading damaged lives where multiple traumatic incidents are prevalent as the conflicts are still on-going. The Troubles are a recurring theme among people where discoveries of paramilitary sexual trauma are common. In some cases there are also incidences of people abusing their own children.

One of the phrases that stood out during the interviews was the culture of silence. This was cultivated during the times of the Troubles, as any person feared to be communicating with people from the other group was regarded as a traitor and had to suffer severe consequences as a result. PTSD was recognized as a medical condition which impacts the body as well as the mind, and the effects need to be known, a book that was suggested as a means of educating people was 'Sky before the storm'.

#### **4.2 Impact of Family on PTSD**

Interviewees noted that there was a large influence of families on the prevalence of PTSD among people and that family is exposed to trauma in a secondary manner, where the members see the patient suffering through various moods and through depression. This then evokes a variety of responses from the families where four of the interviewees have indicated

that family can also be a hindrance. One of the respondents indicated that families do not understand why their dear ones are behaving in the fashion that they are, and hence tend to be overbearing, which in turn results in suffocating the victim. Moreover, some of the people are influenced by the parents or their grandparents who pass on certain stereotypes regarding various aspects to their children who in turn follow the behaviour without understanding the logic behind their actions. As Ann reported,

*“You have a sixteen or seventeen year old who comes to you from the Shankill and then you meet somebody who comes to you from the Falls and they have this conversation and you’re asking them why are you throwing petrol bombs across the wall at your man? And they’re kind of going just because like they’re Catholic or just because they’re Protestant but they don’t understand the actual, what’s actually happened. So, it’s actually, it’s a really, really big issue because the more you get into it they just kind of go well it’s actually, it’s because me da told me and it’s not even because me da told me, it’s because me grandad told me. It goes back and back and back and back.”*

Moreover, according to one of the therapists from the interview, guilt and anxiety also plays an important role in shaping and changing relationships among family members, who might blame them for the victim’s situation. The respondents further elaborated that relationships breakdown as a result of apathy and disconnectedness, where drinking and self-medication can lead to hyper vigilance. They reported that this is exacerbated by the feeling of disconnectedness and that no one understands.

The phrase ‘culture of silence’ again came up in the interview, where non-communication among families leads to children not being able to understand what is going on, and they mirror the symptoms of parents. Traumatic bereavement was one of the terms used to describe the situation with families.

Transgenerational impact of families on PTSD among members has been seen, and was explored briefly in the previous theme. Interviewees noted that the impact lasts anywhere between 30 to 40 years where one of the respondents likened it to the effect of the World Wars, where the impact of the Second World War can be seen till today. One interviewee alluded to the fact that people have started drinking at a younger age, as they have seen their elders trying to cope with PTSD through drinking. The children in the house having observed this adopt it at a younger age and eventually it becomes socially acceptable. It takes three generations for the impact of PTSD to be eliminated where the drug culture is a symptom of this. Moreover, parenting, socialization and beliefs are all impacted due to PTSD.

Family can become overly emotional and hinder the therapeutic process. Need to be made to understand that the patient needs space. Need to tell patient they are there without being overly involved. One of the key aspects that were considered important was that in order to be a support to the patient, parents and families should be able to provide a sense of belonging to and provide a safe haven for the victim.

### **4.3 Gender Differences in PTSD**

For some of the respondents, there were no real gender differences that could be seen in the symptoms or reactions to trauma. It was noted by the first interviewee that there were more differences in how people reacted to PTSD on the basis of their emotional intelligence, more so than there were differences with regards to gender. Ann illustrated by saying that Emotional Quotient Intelligence (EQI) might be more prominent as a determinant as compared to gender

*“So I actually think it may not be gender, it’s actually more to do with EQI and how developed that is in the individual. So if the person is more, em, is higher on the EQI spectrum the reality is they’re more attuned to what’s going on.”*

Other respondents noted that women generally tended to seek treatment earlier as compared to males, where males tended to have ego issues with regards to consulting a therapist for their problems. One therapist used the term: ‘big boys don't cry’ to indicate the ego problems that males have with regards to seeking treatment or talking about the disorder. According to her women tend to be more resilient. Noel seconded these views to indicate that:

*“Females are more in touch with their feelings. Macho culture as if men do not feel things. It is part of the man's training, while females are expected to talk to friends and express themselves.”*

A contradictory statement was made by a therapist when he indicated that while women are more willing to reach out for help, they are more vulnerable to PTSD due to them being more exposed to the risks of rape and sexual assault.

#### **4.4 Optimal Course of Action for PTSD**

According to the participants the correct treatment for PTSD starts with a proper diagnosis. While some of the respondents had a problem with the label of PTSD, which according to them could be a burden for the patient, others recognized that while PTSD was a label, a diagnosis enabled the patient to understand what was wrong with him or her, and in that they knew there was a solution to their problem. The participants explained that many people felt relieved that they had a disorder and that they were not going mad. Moreover, for therapists also, the diagnosis of PTSD gave them something specific to work with, increased awareness and allowed for the following of correct evidence-based procedures.

The course of action for PTSD has been described by some of the respondents as occurring in three stages where the first stage is to create a safe environment, or providing psychological first aid, followed by the intervention phase, with the later stage being group or family therapy. The importance of providing a safe haven for treatment has been considered as important by respondents as starting treatments means that the patients are generally isolated and starting treatment would mean that they are now open to all the flashbacks. This makes them vulnerable therefore there is a need to make the patients feel safe.

Some of the therapies that are used are psychotherapies, education, and medicine to help them understand their condition. The average number of sessions that the therapists quoted as sufficient was 12-14. Respondents also implied that there were cultural issues present in the situation where the people considered it a stigma, and according to therapists it is important to alienate this stigma in order for the treatment to be effective.

Colm indicated that he preferred a person-centric approach and is quoted as follows:

*“Em, optimal I think again it depends the person. Some people are going to fit that CBT sort of structure then it’s going to work brilliantly for them. That educational side going things like, going through things like reframing exercises are absolutely brilliant. Other people are going to may be benefit more from a person centred approach. They just want to be able to talk about their experience.”*

#### **4.5 CBT and its Role in PTSD Alleviation**

The role of CBT in alleviating PTSD has been considered as debatable. All of the respondents believed that CBT is an effective treatment, but that its effectiveness depends on the patient’s needs. One of the respondents indicated that CBT is structured so it could work well for people who are used to structure such as soldiers. For others who are not as accepting of

structure, a non-directive, person-centric, Gestalt approach can work. The crux of the responses was that *'One size does not fit all'*.

When asked which form of CBT – trauma focused or prolonged exposure was more relevant, all respondents indicated a preference for trauma focused CBT. The duration of treatment for prolonged exposure was 8-11 weeks whereas for Trauma focused is 6 weeks. One of the respondents shed light on this preference by indicating that while therapies are person dependent, trauma focused CBT is preferred as it's comfortable for client, while prolonged exposure is more taxing.

One of the respondents reflected on the fact that there is a difference in how the treatments are perceived in the North and the South of Ireland. In the North, CBT is considered very effective and pragmatic, while in the South there is a higher preference for psychoanalysis and is a non-directed approach.

CBT and other therapies have advantages and disadvantages where an integrated approach is generally preferred. Apart from CBT approaches that have been noted to work are the Humanistic approach works as well as EMDR.

However, according to the respondents there were two widely differing perceptions regarding CBT effectiveness among the therapist communities where one school of thought perceived CBT as a patch job as it doesn't go deeper. Colm indicated regarding CBT that

*"Some people say to the doctor and they say it hurts when I do this and the doctor says well stop doing that. Do that instead."*

It was acknowledged that there is a lot of scepticism from counsellors where some people hate it as they consider it to be overwhelming for a patient who has had little schooling. Those who are in favour state that CBT can be useful for people who are busy with work, as it is a quick treatment that does not delve deeper.

In order to measure the effectiveness of the CBT treatment, there are a variety of tools that are used. These include Beck's depression scales which are used in a before and after manner in order to gauge the progress of the patient. One popular method that was recorded in at least three of the interviews was that of Core<sup>3</sup>. Core measures person's psychological state at the start of the treatment, where the scale has 34 items on a 0-4 score scale. This is augmented by normality and balance measurements as well as personal care questions. Tangible differences in demeanour measured through these allow the therapist to gauge progress. Mood diaries are another effective way which allows for a narrative to be built and a structure for the thoughts and images. Anecdotal evidence of the progress is also a useful measure, but is constrained in that it is limited by self-reporting.

One issue that was identified with the excessive use of PTSD is the fact that companies send their employees suffering from PTSD for short term CBT therapies where the therapy puts a patch on things. This is regardless of the fact that the person might need long term counselling as there are budget considerations by companies who are simply trying to fulfil a long term requirement. One form of CBT that was highly recommended by one of the respondents was that of compassion focused CBT where it is highly effective when there are guilt and anger around the events which are dealt with.

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<sup>3</sup> Core measures person's psychological state at the start of the treatment, where the scale has 34 items on a 0-4 score scale. This is augmented by normality and balance measurements as well as personal care questions. Tangible differences in demeanour measured through these allow the therapist to gauge progress.



On the topic of CBT, it was noted that in most cases an integrated approach drawing on different disciplines is highly relevant where motivational interviewing as well as rewind technique - revisiting the situation and reframing it causes desensitization for the patient but it works for some and does not work for others.

#### **4.6 Intervention**

There were various solutions that were provided by the therapists when considering interventions for CBT. Foremost is that long term counselling sessions might be needed for some of the patients and that companies which are sending their employees might not be doing good by their charges. Secondly, one recurring aspect that came to light was that there is a need for the victims to find compassion for themselves, as they need to be told that they are not to blame for their condition.

Perhaps one thing that was repeatedly mentioned in all the interviews was that people considered a stigma to be attached to seeking treatment for PTSD. The intervention recommended by all the therapists in this regards has been that of education with regards to psychology and the fact that while people are suppressing the issues but they need to talk about it and they need to know that it's okay to talk about it. There is no need for PTSD to be labelled as a disorder, as it tends to prevent treatment. Ann said that,

*“So firstly, I think, that there needs to be, em, less of a stigma attached to going to therapy and I think that, em, the more we talk about it and we talk about what therapy is. It’s amazing, the amount of clients that have said to me they were putting off coming for months and months and months on end was incredible and then because they had this preconceived notion of what it was to come to a talking therapy or what CBT was.”*

Respondents stressed that in order to reduce the stigma, the policy-makers need to take it to rural level, where John metaphorically said: *'make it like going to a dentist'*.

While the long term solution to the Troubles has been touted as a means of ending PTSD, there is an acknowledgement that PTSD will prevail as the upcoming generations are carrying the conflict forward. Therefore for both aspects continuing education is needed where there is a need to validate the victim's experiences and there is a need to have people who acknowledge it. In that education is needed for people, government, church, and police. There was also a call made for more funding, more understanding, and increased awareness from statutory services - government, and General Physicians.

Moreover, a cohesive partnership of voluntary and statutory services was hinted at by Noel where the interviewees stated that the effectiveness could be gauged due to it being a ripple effect of making one person better. Cultural issues and landmark dates such as the Annual Protestant parade on the 12<sup>th</sup> of July were classified as reminders of the horrid past, where a respondent claimed that *'[it] makes everyone go back'*.

Professional development is important according to John where PTSD is not easily diagnosed or labelled so that while medication was not commented upon as all of them claimed that they were not trained in prescribing medication, Noel claimed their disdain for medication by quoting that:

*"Medication does not get to the root of the problem. It leads to more medication. So you know they will come in with a list of the medication that they're on. They get a tablet to deal with the problem and then they get something else to deal with the side effect. Then it's another drug to deal with the side effects and so it goes on and the list gets longer and longer."*

## Chapter Five: Discussion

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The six themes that have been identified here find support in the literature that has been presented above. The five themes have been developed based on the data collected from the interviews with respondents whose answers enlightened the research to the various practical aspects of PTSD that are present in the region of Northern Ireland. These six themes, as discussed in the findings include the constituents and the causes of PTSD, impact of family, gender differences, optimal courses of action, CBT and Role in PTSD alleviation, and finally intervention. The first theme used content from answers 1 and 2, the second theme was based on answers from questions 4, 7 and 17, while the third used material from question 4. The optimal course of action category was explored through questions 3, 8, 9, and 10 while CBT and its role in PTSD alleviation was mentioned in questions 10-14. The interventions were mined from answers to questions 15 and 16.

Amalgamating the primary research findings with those from the secondary sources reveals some important insights regarding the research problem: “The Role of Cognitive Behaviour Therapy in Mitigating the Impact of Post-Traumatic Stress Disorder in Northern Ireland.”

PTSD has been an on-going concern for Northern Ireland where alarming statistics have been found in published material. For instance, data from the BBC website noted that 26 per cent of the occurrence of PTSD is due to the Troubles, where 1.4 per cent of the budget of the country was spent in dealing with this problem (BBC.com, 2011). As far as the interviews with the therapists and counsellors are concerned, the findings indicate that all respondents held that most of the people who came in for therapy had psychological issues that were troubling them in the present, but that a majority linked back to the Troubles. The Troubles

have had a pervasive impact on Northern Irish society as a whole. Therefore this high number that has been reported can be validated as PTSD having a direct link with the Troubles.

The interview findings also suggest that the word Troubles was referred to by the respondents a total of 26 times. This indicates the importance of Troubles in the discussion of PTSD in context of Northern Ireland. Quoting four of the five respondents on their allusion to the Troubles, Ann said that: *“so there was always something that came back to what had happened previously during the Troubles.”*

While John said:

*“Victims of the Troubles, during the Troubles and when the Troubles actually ended, em, a lot of unresolved traumas which didn’t go and many people in Belfast still have unresolved traumas from it.”*

Noel indicated that:

*“I think, the majority of my clients have lost children in the Troubles, em, you know, so a mixed bag of Trouble related trauma but where they lived it would have been long-term trauma.”*

Helen added to the discussion on Troubles by saying that:

*“One of the statistics that came out recently, more people have died by suicide since the end of the Troubles than were killed in the Troubles. So that’s what we’re dealing with.”*

It has to be noted here that some recent studies have claimed, in the context of the USA, that while 50 per cent of the population of the USA has gone through some sort of Trauma, only 7.8 per cent of those people have suffered from PTSD (Eagle & Kaminer, 2015, p. 27).

However, in case of Northern Ireland, the reason for the high incidence of PTSD can be linked to the fact that the conflict is still on-going and that the trauma that the nation has collectively faced is severe and has a far reaching impact, where a majority of the people have known someone who was killed in the conflict personally (Eagle & Kaminer, 2015). Helen reported that:

*“I mean you’re dealing with on-going troubles like, you know, the disappeared, the people looking for the truth.”*

Moreover, there is a transgenerational impact that has been mentioned in the literature (McNally, 2014), as well as repeatedly by therapists who have said that the impact will take at least 30-40 years to be alleviated.

John, to this effect said that:

*“I think it will take another thirty or fifty years for it to clear through in the way of the effects of the First and Second World War still existed twenty/thirty years later because my generation and the generation before were affected.”*

In addition to this, there has also been an indication that the stereotypes and the behaviours are being carried down from one generation to the next, where children have been picking up the behaviours and attitudes from their parents and grandparents without really understanding the rationale or the logic behind this (McNally, 2014).

Ann illustrated this point by saying that:

*“They don’t understand it. They just know that this is the way they need to be.”*

Moreover, there is also a pervasive impact of even one person in the family having been exposed to trauma. Parents, when they suffer from PTSD tend to send out cues to their children. This in conjunction with the general culture of non-communication, or the 'culture of silence' as it is termed, is the reason why many people fell out of the habit of sharing their traumas, and this in turn has led to a more severe impact of PTSD, which pervades most of the Irish society today. Addition it has led to many of the children's grief not being addressed (Kapur, 2001).

Noel gave a highly perceptive response as follows:

*“Within conflict related trauma there was very much a culture of silence. So it wasn't something that, things weren't spoken about and there's various reasons for that but that had an impact on young people in the family for instance not working out, not being able to work out what was happening and why their parents were behaving the way they were, you know, and children learn most effectively from observation.”*

This eventually manifests in the children's behaviour, even when they reach adulthood. Children who have either been abused by psychologically disturbed parents, or have seen the parent or an elder suffer or change as a result of that trauma grow up with unanswered questions that lead to problems later in the lives of those children. That is the reason why some of the respondents indicated that there were clients who had some minor psychological issues such as eating disorders, which, on further psychoanalysis were linked to the trauma that they had faced when the client was 18 months old. Ann narrated the incidence as follows:

*“And then we did a lot of body work and we did a lot of mindfulness and we did an awful lot of that and also she got really into yoga and transcendental meditation and it just unlocked something and then something came back to her and when that came back to her it was just like, it was like a bolt out of the blue and this woman was like mid-thirties and this had happened when she was probably about eighteen months old.”*

This incidence illustrates the point that researchers as well as therapists are making about the transgenerational and pervasive impact that PTSD has. The transgenerational impact is one impact which is an alarming indicator of what conflict can do to the prosperity of a region. Conflict not only impacts the generation which is exposed to the conflict but also impacts subsequent generations who have been exposed to the trauma through the eyes of their parents (McNally, 2014). Elaborating more on the culture of silence that is present in Northern Ireland especially with regards to the Troubles indicates that it could be the reason why PTSD has been diagnosed in such a large population. The culture of silence has led to a general denial of the Troubles and the after effects that it has had on society in general. The culture of silence is indicative of a dangerous cultural tradition in the area, where a lack of communication has led to PTSD being such a widespread problem. This is because, people who were scared of sharing their traumas were not able to be diagnosed or seek treatment as no one knew nor understood what was going on with the patient (Hillyard, Rolston & Tomlinson, 2005).

Ann narrated this by saying that:

*“Let’s say they were involved in or they witnessed a bombing and they saw people being killed or whatever and, em, they may be lost a friend as a result. The impact then on the family is that the family is trying to deal with this and process what’s going on, the significant loss that their close family member is having to deal with and process.”*

Gender differences is a topic in the context of PTSD that has been contradictory in terms of primary and secondary findings. Research based on the population of the USA revealed that there are gender differences in the occurrence of PTSD, where there were 9.7 percent of women and 3.6 per cent of men who were diagnosed with PTSD (Gaidos, 2016). In addition to this, research also reported that there are biological differences which account for the

higher occurrence of PTSD in women as compared to men, where the reason was given as a different processing of trauma among males as compared to females (Ferry *et al.*, 2014). The respondents; held contradictory views regarding the role of gender in PTSD.

Noel was of the view that:

*“Women, I think, by nature tend to talk to their friends and it’s expected that women will be, eh, will expression emotions. So I think there is a slight difference there.”*

However, Ann was of the view that there were no real gender differences for PTSD, where she said that:

*“So I actually think it may not be gender, it’s actually more to do with EQI and how developed that is in the individual.”*

While Noel’s view concurred with the literature available on the issue, Ann’s view was diametrically opposed. Some of the contradiction between respondent data and the literature can be partially reconciled with the fact that the higher occurrence of PTSD reported in the USA for females could be due to the fact – as supported by respondents, that females were more likely to seek treatment as compared to males. Also conditioning differences could account for the figure for men being lower, where the ego issues of men could have prevented them from going for a diagnosis of their problems in the first place (Eagle & Kaminer, 2015).

Another reason that has been supported by literature with regards to the prevalence of PTSD in the country is that there is a lack of general awareness regarding PTSD and that people do not know that it is a mental illness that can be cured (Bisson, 2007). The interviewees also echoed this same problem where for their suggestions to alleviate the levels of PTSD in the



country indicated that there is a stigma associated with PTSD and mental illnesses in the country that needs to be eliminated through education.

Ann, John and Colm referred to the stigma related to PTSD. Jon's quote summarises the general perception in the following words:

*"I think easier access to therapies for trauma therapies, em, and for the stigma around therapy to be reduced both North and South and in the border areas as well. A lot of rural areas are still a lot more masculine."*

As far as the diagnosis and the treatment of PTSD is concerned, while the research studies indicated that early diagnosis of PTSD was important for getting treatment sooner (Makinson, 2012), the interviewees indicated that the PTSD label had advantages as well as disadvantages. The advantage was that the label allowed for the correct therapies to be used.

Colm said,

*"Now sometimes it can be a helpful label I think if something has a term, it has a label you know exactly what they're doing with you."*

However, the disadvantage that Ann and John particularly marked was that the label carried a stigma which could hinder the patient from seeking treatment.

The role of CBT in the treatment of PTSD has been acknowledged by academics as well as the practitioners, albeit with some limitations (Eagle & Kaminer, 2015, p. 27). While CBT exposure therapy has been recommended in theory (Makinson, 2012), respondents in Northern Ireland believe that trauma focused is a preferable means as it is shorter and is more comfortable as compared to prolonged exposure.

Noel indicated his preference for Trauma focused CBT by answering that:

*“Trauma focused.... That’s preferred that’s what has the best evidence for clients”.*

The reason for this could be the fact that there are many PTSD patients in the country and that many could likely to go back to their high functioning lives if the simple and short therapy was given. Helen said:

*“Again I think it goes back to how people manage their lives. You know, high functioning people CBT is great”.*

Moreover, it works to help people go back to their normal lives, and hence was preferred. Only where it was not working could the therapists seek a longer term option.

The number of sessions required for an ideal CBT treatment was prescribed by academicians an respondents as 9-12 sessions (Makinson & Young, 2012)., where the initial sessions were important in making the patient feel comfortable and secure in order for the treatment to be effective.

Ann explained the sessions break up for the initial sessions by stating that:

*“There’s the initial stage, there’s the middle stage and then there’s the later stage. So there are three stages when it comes to dealing with PTSD. So the initial stage is very much, it’s making it a safe environment for the individual so it’s all about, em, you know, it’s actually very humanistic. It’s just about exploring. It’s about being gentle. It’s about making it, ensuring that they feel that it’s a safe place to be able to disclose.”*

As far as the exploration of group therapy as a part of CBT treatments is concerned the literature has contradictory results. Bradley, Greene, Russ, Dutra, & Westen (2005) noted that group therapy with friends and family was effective, while Sloan, Feinstein, Gallagher, Beck, & Keane (2013) and Sloan, Bovin, & Schnurr (2012) noted that group therapy was less effective as compared to individual treatment. The latter result is the one that is echoed by respondents who have indicated that while family support can be a positive thing, family tends to be a hindrance for the recovery of their members. One of the top reasons for this was the lack of understanding that well-intentioned family members have, in that they may get overly involved and would not be able to understand the disconnect that PTSD patients feel towards them. Therefore all therapists interviewed here were wary of involving family in the treatment, except for asking them to support the victim after educating them about the need for the patient to be given personal space to get better.

Ann stated her opinion in the following words:

*“The family although they have the individual and the best interest of the individual at heart, sometimes they can become because they’re overly emotional and they’re so involved and so embroiled and enmeshed in what’s going on, that can sometimes hinder the therapeutic process because they may be overly influenced by what the family member is saying.”*

John also proposed a solution alongside stating his view on enlisting family support during treatment by saying that:

*“I find that it can be very difficult for spouses or loved ones to understand PTSD, so what I do with my clients is get them to get their partner or family members to study PTSD”*

Colm was more positive about the role that family has to play and stated that:

*“Again I think it depends on the person but I think that connectedness again, I suppose. That sense of belonging, that somewhere to feel safe can play a big part.”*

Noel noted that if family understood the patient’s problems it would lead to better recovery for the patients. He said that:

*“You know if families understand what the person is going through and what’s happened to them in their lives then they’re better able to help and in turn they’re better able to alleviate the person’s symptoms”.*

Helen in contrast to all the other respondents was most in favour of support not only from family, but also from friends as well as the community in general. She said that:

*“I would say not just family support. I would say support is great”*

## Chapter Six: Conclusion

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This study looks at how CBT can be effective in alleviating PTSD in Northern Ireland. The methodology used to explore the topic was qualitative where five interviews with respondents from the psychotherapist school of thought, as they were practicing in the region were carried out. The six themes have been discussed in relation the findings from the interview data as well as in the context of the literature.

The respondents were able to shed light on all six themes of the study scope, where some of the incidents that were narrated, illustrated and illuminated understanding on a variety of concepts that would not have been addressed through any other research methodology. That is the reason why an interpretivist approach to the research was taken and an exploratory stance was taken in order to develop and add colour to the observations on this topic (Saunders, Lewis, & Thornhill, 2011).

The literature that is available so far on the topic has dealt with the problem area of PTSD in a distinct way, while this research focuses on a highly specific treatment of Cognitive behaviour therapy for the alleviation of PTSD. The interview information indicated that while CBT is considered to be a method of simply putting a patch on the ailment, rather than addressing the root cause, it is a preferred method of treatment as it allows people to return to their lives faster. Nearly all the respondents in this paper were pro-CBT therapy, but at the same time they also indicated that in some cases CBT was simply a means for corporation to do the needful in order to meet regulatory requirements (Makinson, 2012). In some cases there were more intensive treatments that were needed, which included the use of counselling in the long term. Another effective treatment that was mentioned in the study was EMDR,

which is a more technical and an equally effective manner – according to interview respondents of dealing with PTSD. It can be said that with the limited number of economic resources that the conflict-ridden region has, CBT can prove to be effective in at least getting the population to its feet so that constructive work towards the progress of the nation can be carried out (Eagle & Kaminer, 2015).

The study notes that while CBT is considered to be effective for the short term, especially in context of Northern Ireland, the preferred approach is a Gestalt or a person-centric approach as each person has a unique set of problems, and that therapists need to integrate various methods in order to alleviate PTSD. Having said this, it is important to note that CBT is effective in getting the victims back to normal life within 9-12 sessions, and that this can prove to be an effective intervention for the country as a whole for the short term. However, one alarming fact that came to the fore through this study was that the Troubles have had a long lasting impact on people in the country, and that the Troubles as an on-going problem are likely to continue to impact the lives of the people for a further 30-40 years by manifesting across generations. The transgenerational impact has been studied rarely in existing literature, but all the respondents realized the seriousness of the situation, where the conflicts, which are still on going, can continue to hinder the progress of the country and its people (Hillyard, Rolston, & Tomlinson, 2005).

The impact on families is something that has been causing the conflict to continue, and it is this impact that has also caused PTSD to become such a largely prevalent problem for the country. It was studied that while there is a large and pervasive impact on children with regards to observing their parents go through PTSD, there is also the fact that in some cases families – no matter how well meaning, do not have any idea about what their loved one is

going through (McNally, 2014). That is the reason why that the findings reveal that the respondents were ambivalent about the role of families in helping during treatment. This problem is further exacerbated by the prevalence of the ‘culture of silence’ in Northern Ireland. This culture has prevailed through the Troubles as a means of oppressing the general population from speaking out against the conflicts. This culture, alarmingly, has pervaded the society where a lack of communication breeds misunderstanding and a further stronghold of PTSD (Ferry *et al.*, 2014).

Among some of the solutions suggested are that education and awareness needs to be created in the country with regards to PTSD and that the stigma that is attached to it, especially in the context of the ‘Culture of Silence’ in the country should be eliminated.

There are some limitations to this study, where the interviews of only five respondents have been considered. However, some recurring themes in the data led the research towards an understanding of PTSD and some of the prevailing problems that have caused Northern Ireland to suffer through many decades. Taking this study a step further would mean elaborating on the views of the PTSD patients as well as their families in order to validate the responses analysed here, and in order to understand the problem from a holistic perspective.

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## Appendix 1: Letter of Consent

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As part of my BA in Counselling and Psychotherapy in Dublin Business School which is IACP accredited, I am presently conducting a study into the impact of the “Troubles” in Northern Ireland. My research methodology is purely qualitative and I am engaging in five in-depth interviews with representatives from two groupings: professional psychotherapists treating PTSD clients with CBT and professional psychotherapists treating PTSD clients with alternative methods. Having spoken with other therapists in Northern Ireland. You/your organisation has been recommended as influential in the treatment of trauma resulting from the “Troubles”.

The interview should take no longer than an hour and your anonymity is assured with your name or identifying features not being disclosed in the thesis. Please note that the information from the interview that you provide will be shared among my colleagues and with anyone who wishes to read this Thesis. However your personal information will remain anonymous and no one will be able to trace the information back to you.

You can also freely withdraw from this research at any time. All information provided will be stored securely under the Data Protection Act. Please sign below if you give consent for the interview to occur and we can arrange a time and date that suits you.

Thank you very much for your time. I really appreciate it.

The questions are set out below so you can prepare in advance to our meeting in March.

## DECLARATION

I have read this consent form and have had time to consider whether to take part in this study.

I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research.

I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant (in block letters) \_\_\_\_\_

Signature \_\_\_\_\_

Date    /    /

## Appendix 2: Interview Questions

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1. What are the events that lead to PTSD?
2. What are the constituents of PTSD?
3. How important is PTSD diagnosis for recovery?
4. Do you think gender differences play a role in the incidence of PTSD?
5. How does PTSD affect the patient's family?
6. What should be the course of action taken once PTSD has been diagnosed?
7. How does family support alleviate PTSD?
8. What is the optimal therapy for PTSD?
9. What is EMDR and how does it work?
10. Is EMDR a better approach as compared to CBT?
11. How relevant do you feel that CBT is in the treatment of PTSD?
12. What are psychotherapists' perceptions regarding CBT usage and scenarios where it is applicable?
13. How should the effectiveness of CBT be evaluated?
14. Which CBT therapy is preferred? Prolonged Exposure or Trauma focused?
15. What three things do you consider most important for people in general to know about PTSD in Northern Ireland?
16. What more can be done to bring down the level of PTSD in the country?
17. What is the impact of trans-generation PTSD on the current situation in Northern Ireland?

### Appendix 3: Category of Coding

Category	Code
PTSD Constituents and Causes	Physical
	Psychological
	Importance of diagnosis
	PTSD and Troubles
Gender Differences	Yes
	No
Impact of Family	Social process
	Transgenerational
	Relationship impact
	Family support
Optimal Course of Action	CBT
	Gestalt/holistic
CBT and its role in alleviating PTSD	CBT is effective
	CBT is a patch (hate it)
	Measuring effectiveness
	Prolonged versus trauma focused CBT
Intervention	Education to remove stigma
	Funding

### Appendix 4: Coded Transcriptions

Category	Code	Transcription interview 1	Transcription interview 2	Transcription interview 3	Transcription interview 4
PTSD Constituents and Causes	Physical	I suppose both psycho and physiological arousal. So all of the things that you would ultimately associate with the stress response per say. Ln 152-153			
	Psychological	There's a diminished sense of self-control that can happen as a result of it too, em, hypersensitivity can also occur, em, and I think also, em, excessive, em, with OCD type tendencies occurring and emerging ln 150-151		So trauma if you think at the very heart of that, you've no control environment, feeling uncertain. a feeling and I'm so aware I might be making a word here (laughs) disconnectedness ln 1292	acronym HARM so, em, the symptoms. There needs the event itself that leads to the traumatic event. In terms of the symptoms there's... HARM is, 'H' is hypervigilance, 'A' is avoidance, 'R' is re-experiencing and 'M' is mood so low mood ln 1955

	Importance of diagnosis		Strangely enough I'm not a great believer in a label. It is a label as such and I'm not... People have trauma, you know, for me trauma is trauma In 946	Now sometimes it can be a helpful label I think if something has a term, it has a label you know exactly what they're doing with you. You know, you're in a better place to do something but it's just whenever use the word disorder, In 1267	people use the term I'm going crazy and losing their mind and it provides a context and information, clear information as to what has happened to them and how if they follow, you know, correct evidence based procedures then there's an opportunity for them to recover as well In 1973
	PTSD and Troubles	You could spend all day on that question but it's a massive question. I mean it impact significantly because it goes back to the whole secondary, tertiary trauma piece In 255			Here is Belfast its primarily conflict related so and now they can be very, very early into the... way back in terms of the years so it can be very early in the conflict and you know, early seventies is still a high proportion of our referrals and you know, they could be, em, on the basis of PTSD In 1891

Gender Differences	Yes		Well I do know women are a lot quicker to come for therapy, em, there is still a masculine trait of big boys don't cry so men are quite reluctant to come for therapy. Ln 967		They do, em, well they do in the sense that there's more people, when people experience trauma there's a higher incidence of females who go on to develop PTSD. They sort of, there's a lot of evidence that still, a lot of research that's still ongoing in that area. Some researchers found that higher incidences because of the great vulnerability to sexual assault, high rate of sexual assault leading to higher rates of PTSD In 2004
	No	Would I think gender or would I say it's more to do with levels of emotional intelligence line 219		I haven't found that and that that it isn't that it might but I haven't experienced it In 1333	



Impact of Family	Social process			<p>Em, the article I wrote and you can have a look at yourself but what it is saying in it is at that time people generally dealt with trauma with drink. Now there's nothing wrong with drink and I would never say to someone don't drink because I don't think it's my place to say that but what I do ask people to do is monitor what they drink because it a depressant, you know. In 1790</p>	<p>transgenerational trauma and one of the areas that focuses on in this part of the world is the <i>culture of silence</i> within families. Ln 2032</p>
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	Tans generational	Oh yeah because they're Catholic and you're kind of going yeah but why? Why are they different to you? I don't really know. So it's like, you know, that intergenerational thing is there. Like they don't understand it. They just know that this is the way they need to be. In 280	Very much so, em, I think it will take another thirty or fifty years for it to clear through in the way of the effects of the First and Second World War still existed twenty/thirty years later because my generation and the generation before were affected. In 1171		It's massive. There's a very good study that's just been completed and I could actually point you in the direction of that study. It would relate to that culture of silence I mentioned, em, there's a lot a little bit more reference to an epigenetic transfer, em, of trauma, not direct genetic transfer but, em, a physical process as well as a social process. In 2342
	Relationship impact	Because what it does is they're wacked with guilt because they're going I shouldn't have left my twenty-one year old go away, em, in the first place and allow them to be exposed to that so there's guilt but then there's also this anxiety that's kind of manifests and that in turn can also kind of cause that level of nearly depression. In 292	Greatly, it really does affect the family. You can lose a loved one basically to the trauma, em, you can't understand their moods, behaviours and all the other stuff that goes with PTSD like avoidance, not wanting to go out and withdrawing into oneself In 985	Of course it does yeah and again I suppose as marriages and relationships breakup it kind of reinforces that feeling of no connection, no one understands	

	Family support	can hinder	. It can help and hinder. The reason I say that is that the family although they have the individual and the best interest of the individual at heart, sometimes they can become overly emotional and they're so involved and so embroiled and enmeshed in what's going on, that can sometimes hinder the therapeutic process In 390	I find that it can be very difficult for spouses or loved ones to understand PTSD In 1013 Again I think it depends on the person but I think that connectedness again, I suppose. That sense of belonging, that somewhere to feel safe can play a big part. Ln 1428	the family unit is really important as a platform for how people engage with others in society so it's not just as an effective, you know, cohesive, communicative family then that helps the person feel supported and you know, it's very much a process as well. In 2127
Optimal Course of Action	CBT	So the CBT strategies are the one that I would kind of be trained in myself and would be kind of what I would find principally to be the most effective			
	Gestalt/ holistic			a gentler kind of non-directive may be a person centred approach or even like a Gestalt approach In 1404	On PTSD, so the NICE guidelines would recommend either the trauma focused CBT or EMDR the best methods of intervention. This is after a diagnosis when a traumatic event is experienced there's essentially psychological first aid at that early stage. Ln 2081

CBT and Role in alleviating PTSD	CBT is effective	Yeah, I think it's definitely cognitive behavioural from me personally having utilised it. Ln 417			
	CBT is a patch		J I'm would EMDR over CBT but both work so I don't think you can...Ln 064	I think CBT it's a bit like, em, you know, some people say to the doctor and they say it hurts when I do this and the doctor says well stop doing that. Do that instead. Ln 1608	
	Mixture of various theories	, I think some people are very for it. Some people are very against it. I think it really divides the camp, em, CBT actually. I think, you know, for me when I worked up Ln 518	I use well CBT if clients are suitable for it. I also use an integrative approach if clients are suitable for it and I use EMDR if clients are suitable for it. Ln 1020 So some psychotherapists are against CBT, some CBT therapists are against any other approach. I don't go down that road. Each to their own because both work. Ln 1103	Because I work in a very integrated way I suppose for me its drawing on the different disciplines Ln 1456	It's one or the other. Its trauma focused CBT or EMDR but I guess what I was explaining there that there's a limit to that in relation to particular environments such as this whereby there's a broader approach that's needed so I think the best approach is an evidenced based approach within a psychosocial framework. Ln 2153
	Measuring effectiveness	Beck's depression inventory or the anxiety inventory which we normally start off with, em Ln 456	I use core at the start and at the end and that will show, em, to the client and to yourself how much the symptoms have been alleviated Ln 1122	I use core but not in every session but, em, I would use them quite a lot  why I put a mood diary against its tapping into that sense of autonomy. You're mood diary its showing evidence. It's your handwriting. How can you argue with it Ln	We use core evaluation and it's an online system we use, em, I think you're looking at yeah pre and post outcomes, em, you're looking at measuring, measurements at each session but you're also looking at client feedback and follow-up feedback Ln 2254

				1592	
	Prolonged versus trauma focused CBT	I don't know which one would be my preference. I think its very client dependent. Ln 641	Trauma focused ln 1136	Again I think it depends on the person and the event. I don't think it's a one size fits all. Ln 1669	Trauma focused ln 2277
Intervention	Education to remove stigma	So firstly, I think, that there needs to be, em, less of a stigma attached to going to therapy and I think that, em, the more we talk about it and we talk about what therapy is ln 716	J That it can be resolved would be the first one. Ln ln 1147	This is the stigma? C Yeah. It's not to say that there isn't a disorder. I think it's whenever it becomes so intense that the quality of life and everything is affected thus why they've got a disorder. First of all it's perfectly normal, it's just that our normal ways of coping, ln 1698	

		there's a lack of education that goes with that too, em, which does definitely impact on and also this sense of respect and understanding, you know and then there's also what happens as well is that they kind of, they actually purposely set out to annoy each other pg 823	J Education, education, education. Get it out there. Get it more acceptable that it's not something to be ashamed of or to be hidden away from. That it is just the same as going to the doctor or dentist. Ln 1160	C I think education is a good place to start. The old saying knowledge is power. ln 1753	
	Funding				More funding for one and more understanding of the work that's completed in, the high quality work that's completed ln 2297