Submitted in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology,
May 2014

Doctoral Thesis:

Exploration of how children and young people self-construe following a traumatic experience

Amy D’Sa

Doctorate in Clinical Psychology

Division of Health Research

Lancaster University

Word Count

	Main Text	**Appendices (including abstract, tables, figures and references)**	**Total**
Thesis abstract	298		298
Literature Review	7,993	6,948	14,942
Research paper	7,974	7,214	15,187
Critical Review	3,999	479	4,478
Ethics Section	5,989	10,753	16,742
Total	26,253	25,394	51,647

Abstract

Trauma experience influences an individual’s emotional wellbeing, self-concept and relationships (e.g., Beck, Grant, Clapp, & Paylo, 2009) as well as increasing their risk of experiencing trauma in the future (Copeland, Keeler, Angold, & Costello, 2007). Accordingly clinical guidance for trauma presentations recommends treatment to alleviate distress and improve emotional wellbeing (van der Hart et al., 2006). Correspondingly, a literature review, using a meta-synthesis design, explored how adults experience talking therapies for complex trauma. From this, two themes were identified which noted that, in contrast to remaining detached from the trauma and associated difficulties as a means of surviving, adults were able to access therapy and instead reconnect with their trauma experience, others, and importantly self. This finding highlighted that exploring the impact of trauma on self is important and underrepresented in literature.

Given research exploring self and trauma remains limited to adults, the research paper explored how children and young people self construe following a traumatic event(s). Seven young people completed a Trauma Symptoms Checklist Children – Alternative (TSCC-A) measure. Following this a pictorial self characterisation (Kelly, 1955; Ravenette, 1996), based on personal construct psychology, was used to encourage a creative and developmentally appropriate exploration of how they construed. These included four overarching themes which were developed using thematic analysis (Braun & Clarke, 2006): The Inferior Self, The Misfortunate Self, The Protective Self and The Enhanced Self. The clinical implications of this suggest that working therapeutically with the metaphor “self as community” (Mair, 1977) offers powerful opportunities to explore and understand different selves, reduce vast differences between selves, and to develop healthier core constructs. Future specialist trauma interventions should emphasise the importance of exploring self

from the perspective of the individual (e.g., Ronen, 1996). Finally the critical appraisal provides reflections on the limitations and strengths of this research.

Declaration

This thesis records work undertaken for the Doctorate in Clinical Psychology at the Division of Health Research at Lancaster University from August 2013 to May 2014.

The work presented here is the author's own, expect where due reference is made. The work has not been submitted for the award of a higher degree elsewhere.

Name: Amy D'Sa

Signature:

Date:

Acknowledgements

I would like to start by thanking the children and young people who took part in my study, and who allowed me the privilege of hearing about their experiences and inner worlds. I hope this thesis does justice to your incredible resilience.

A huge thank you to my field supervisor, Dr Joanne Robinson, who has been an incredible source of support and enthusiasm throughout my training and, in particular, for helping me in completing this thesis to the best of my ability.

To my academic supervisors, Dr Pete Greasley and Dr Jane Simpson, who have supported me in developing my skills as a researcher.

To my fellow trainees without whose support, humour and incredible skills I would not have developed into the trainee I am today. Thank you for making training an unforgettable and rewarding experience!

Finally and most importantly to my family and friends, who have tirelessly supported and encouraged me. Your belief in me has helped me work through the challenges of training and emerge from the other side! Thank you.

Contents Page

Section One: Literature Review

Section Two: Research Paper

Section Three: Critical Review

Section Three: Critical Review

Section Four: Ethics Documents

Section One: Literature Review

Adult experiences of talking therapies following complex trauma: A meta-synthesis

Word Count: 7,993

Amy D’Sa

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Amy D’Sa
Doctorate in Clinical Psychology
Furness College
Lancaster University
Lancaster
LA1 4YT
a.dsa@lancaster.ac.uk

Prepared for Journal of Psychological Trauma: Theory, Research, Practice, and Policy

---

[1] See Appendix 1-A for ‘Notes to Contributors’

Abstract

This meta-synthesis explores adults' experience of talking therapies provided to address the impact of interpersonally generated, cumulative and repeated complex trauma experience (Courtois, 2008). A systematic search of research literature explored client experience and perception of the value of such interventions. Noblit and Hare's (1988) meta-ethnographic approach was used to synthesise nine qualitative papers published between 2006 and 2013. Papers were included if adult participants had a diagnosis or trauma background indicative of complex trauma and had engaged in an evidenced-based professionally facilitated trauma therapy. Two overarching themes were reported: 1) Detached to survive, 2) Reconnecting through therapy. Themes reflect how therapy creates a dilemma for clients as it involves them letting go of established mechanisms for managing their trauma experience. Namely, clients have avoided and remained detached from their trauma, and therefore disclosure in therapy was extremely difficult. Essentially, the therapist provides containment for working through this, in part by establishing trust. This allows for reconnection with the trauma through processing experience, where clients developed new understandings about their trauma and associated symptoms. New connections were conceptualised as having benefits and drawbacks and form an on-going journey of 'recovery'. Theoretical frameworks such as Herman's (1992) model of trauma recovery, Perceptual Control Theory (Powers, 2005), and Personal Construct Theory (Kelly, 1955) inform the discussion in addition to limitations and suggestions for future research. Clinical implications include: suggestions of how to enhance the therapeutic alliance and build trust; advocate normalising avoidance to encourage dialogue about uncertainty; stress the importance of acknowledging client resilience and conceptualisation of 'recovery'.

Adult experiences of talking therapies following complex trauma: A meta-synthesis

Psychological distress resulting from trauma experience is typically conceptualised as a response to perceived or actual threat to self or others and can lead to “clinically significant distress” (American Psychiatric Association [APA], p.56). Post-traumatic stress disorder (PTSD) refers to a traumatic event that involves ‘actual or threatened death, serious injury or sexual violation’. Trauma can result from a single or repeated direct experience, such as abusive relational interactions and/or by witnessing such experience (APA, 2013, p.3). Although psychological or emotional trauma can be defined in various ways, international clinical guidance (e.g., Australian Centre for Posttraumatic Mental Health, 2010; National Institute of Health and Care Excellence [NICE], 2005) and diagnostic manuals (e.g., International Classification of Diseases version 10, World Health Organisation, 2010; The Diagnostic and Statistical Manual of Mental Disorders, APA, 2013) characterise the impact of trauma in relation to symptoms including re-experiencing (e.g., flashbacks or intrusive distressing images), hyperarousal (e.g., difficulty sleeping and concentrating) and emotional numbing (e.g., detachment from feelings, people and events).

In contrast to ‘single’ episodes of trauma, which are often unexpected (e.g., natural disaster), trauma can be conceptualised as ‘complex’ if it is experienced as more pervasive and multifaceted (Herman, 1992). Complex trauma, as considered in this review, is “a type of trauma that occurs repeatedly and cumulatively, usually over a period of time” (Courtois, 2008, p.86) and causes “overwhelming stress which is interpersonally generated, such as ongoing abuse, including within the context of intimate and familial relationships, and includes community violence, war and genocide” (Courtois & Ford, 2009, p.15). These traumatic experiences are seen to more seriously impact an individual’s emotional wellbeing, self-concept and relationships long-term (e.g., Beck, Grant, Clapp, & Paylo, 2009), as well as increasing the risk of an individual experiencing trauma in the future (Copeland, Keeler, Angold, & Costello, 2007). Given the devastating impact complex trauma can have (Herman 1992), it is essential to consider the effectiveness and meaningfulness of related therapeutic interventions.

Treatment for complex trauma requires a more intensive level of input compared to single trauma interventions (Benotsch et al., 2000). Beyond working with the trauma experience, such treatment must address the implications of trauma including relational dynamics (Ford & Kidd, 1998). Accordingly, a range of clinical guidance recommends a phased approach to treatment (e.g., Cloitre et al, 2012; Kezelman & Stavropoulos, 2012) where trauma-specific interventions (e.g., Trauma Focused Cognitive Behavioural Therapy, TFCBT) aim to improved emotional wellbeing (van der Hart, Nijenhuis, & Steele, 2006) while specifically considering relational need, both in the therapeutic space and in the clients' wider life.

Despite the unique features of different interventions (e.g., ways by which trauma experience is processed) trauma therapies share strong commonalities. Essential components include those detailed in Herman's (1992) model of trauma treatment, such as establishing safety through stabilisation work, exploring client experience, emotions and losses and within this developing new meaning and relational experiences (Rosen & Kuehlwein, 1996).

'Recovery' is deemed an important outcome of such clinical practice and mental health research (Davidson & Roe, 2007), although the measurement of this is contentious. Typically defined as a reduction or absence of 'symptoms', indicators of 'recovery' are often rated by a clinician (e.g., Van Minnen, Wessel, Dijkstra, & Roelofs, 2002) or by a service user on a predefined scale (e.g., Royal College of Psychiatrists, 2011). Subsequently, service users' subjective understandings of the effect of trauma experience and treatment on their own conceptualisation of 'recovery' has historically been neglected (Brown, Kallivayalil, Mendelsohn & Harvey, 2012).

Qualitative enquiry that considers the experience of trauma-informed therapies and associated wellbeing, is invaluable as clients hold an essential active role in their own healing process (Bohart & Tallman, 1999), and therefore arguably, ‘recovery’ should be determined by them. Clients’ conceptualisation of what is essential and important in therapy, and how this relates to their conceptualisation of ‘recovery’, is essential to understand, especially given the needs of this population.

Importantly, in recent years a growing body of qualitative research has offered insight into how individuals experience trauma therapies. In view of the importance of the service user perspective, and as these papers have yet to be reviewed, they have been identified by this meta-synthesis. Systemic reviews (e.g., meta-synthesis) allow for the useful drawing together of qualitative evidence to provide an integrated, interpretative and comprehensive summary (Dixon, Booth & Sutton, 2007) which is beyond the scope of an individual study (Thorne, Jensen, Noblit, & Sandelowski, 2004). In distinction to other reviews, such as a narrative review that summarises associated findings, a qualitative synthesis involves reinterpreting findings across papers to allow for a higher level of conceptual or theoretical development (Campbell et al., 2003).

In recognition of this, this meta-synthesis aims to review the qualitative evidence that reported how individuals, with complex trauma backgrounds, experience trauma therapies. Ultimately this can help inform clinical practice by highlighting factors which can contribute to change (Lebowitz, Harvey, & Herman, 1993), such as how individuals construct therapy in relation to their trauma experience, their sense of self and their personal ‘recovery’ journey (Connolly & Strupp, 1996). Key implications for therapy provision, including tailoring therapy to the unique needs of this client group, will be identified (Kallivayali, Levitan, Brown & Harvey, 2013). This review therefore seeks to synthesise qualitative studies that explore adult experience of talking therapy for those with complex trauma presentations.

Methodology

Search for primary articles

An online systematic literature search was completed between December 2013 and January 2014 across seven relevant databases: CINAHL (searchable years 1982-2013), MEDLINE (searchable years 1814-2013), PsycARTICLES (searchable years 1988-2013), PsycINFO (searchable years 1887-2013), Social Sciences Citation Index, Web of Science (searchable years 1956-2013), and PubMed (searchable years 1887-2013). Studies were initially searched by inputting the following terms: ‘trauma’ OR ‘traumatic’ OR ‘traumatised’ OR ‘PTSD’ AND ‘Post Traumatic Stress Disorder’ OR ‘Adverse life events’ OR ‘Abuse’ OR ‘Neglect’ OR ‘Complex’ OR ‘Severe’. Additional terms deemed to capture the experience of trauma focused therapy were then applied: ‘trauma therapy’ OR ‘intervention’ OR treatment’ OR ‘recovery’ OR ‘changes’ OR ‘adapting’ OR ‘differences’. The applied search terms were felt to encompass a range of psychological therapies for complex trauma therefore search terms relating to specific therapies were not included in the final search. Qualitative studies were later identified by using the keywords: ‘experience’ OR ‘expectations’ OR ‘client attitude’ OR’ client beliefs’ OR ‘qualitative research’ OR ‘semi-structured interview’. Adaption of terms, according to the individual database thesaurus and indexing systems, was applied to ensure the identification of an optimum numbers of relevant articles and to ensure terms used were relevant and justified.

Inclusion and exclusion criteria

Following the application of all search terms, an initial 1,582 studies were identified and assessed to check their ability to meet the review inclusion criteria. An additional key paper (Parker et al., 2008) was included following a review of references within the identified papers.

To address the research question, studies were included if they met the following criteria: (a) written in English; (b) peer reviewed; (c) qualitative in design (e.g., semi-structured interview, qualitative data analysis); (d) findings supported with quotes; (e) participants identified as having complex trauma history through diagnosis (e.g., PTSD, dissociative disorders) or reported trauma experience which was cumulative, repetitive and interpersonally generated (Courtois, 2008); (f) aimed to explore adult experience of trauma informed therapy; (g) therapy being defined as evidenced-based, promoted in guidance (e.g., TFCBT) and theoretically informed (i.e. driven by a accepted phased model where stabilisation work, processing trauma material and generating new meaning and relational patterns were salient components) and therapy was provided by a professional individually or in a group setting.

Papers were excluded if: (a) the nature of the trauma (e.g., single trauma episode) required a purposeful tailored intervention that would significantly differ from that offered for complex trauma; (b) reflections on therapy were provided by a child or therapists; (c) therapy was not trauma-specific (e.g., did not share essential elements of complex trauma treatment); (d) therapy used non-verbal techniques such as dance (e.g., so relational dynamics and processing of trauma were not explicit); (e) quantitative methodologies were solely used.’.

Insert Figure 1.

Insert Table 1.

Characteristics of the chosen studies

Nine qualitative articles (Table 1.) published between 2006 and 2013 were identified, with sample size ranging between 7-21 participants. Studies (see Table 1.) drew on samples from North America (two from Canada, two from America), Europe (two from the UK, two from Norway) and the Middle East (Israel).

Approaches to analysis were as follows: four papers used a phenomenological approach (Parker et al., 2008; Stige, Rosenvinge & Traeen, 2013; Stige, Binder, Rosenvinge & Traeen, 2013), one of which (Shamai & Levin-Megged, 2006) took a deductive approach by using a psychodynamic framework to generate their themes; two papers used interpretative phenomenological analysis (Shearing, Lee & Clohessy, 2011;Vincent, Jenkins, Larkin & Clohessy, 2013), two papers used grounded theory (Brown, Kallivayali, Mendelsohn & Harvey, 2012; Tummuala-Narra, Kallivayalil, Singer & Andreini, 2012) and one used thematic analysis (Gone, 2013). It was felt that synthesis of these articles was justifiable since all papers met the inclusion and exclusion criteria and as the only deductive analysis was strongly informed by the therapeutic principles informing the clinical intervention.

All but two of the included papers (Parker et al., 2008; Gone, 2013) stated participants had PTSD or other trauma related diagnoses (e.g., dissociative disorder). Moreover, all papers but one (Brown, Kallivayali, Mendelsohn & Harvey, 2012) provided examples of the type of trauma experience relevant to their participants, with one specifically referring to survivors of the Holocaust (Shamai & Levin-Megged, 2006).

All articles focused on service user experience of trauma-informed therapy which shared common aims and processes while offering a phased approach to treatment (e.g., Herman, 1992). All therapies involved establishing safety, processing and sharing trauma experiences and associated difficulties, while promoting new understandings and relational patterns. Therefore synthesis across these articles was felt to provide a justifiable and holistic view of service user experience of the shared and core features of trauma-informed therapy. Three articles described experiences of group interventions explicitly designed in line with Herman's (1992) model such as the Women Recovery from Abuse Programme (Parker et al., 2008), and an inclusive stabilisation group (Stige, Rosenvinge & Traeen, 2013; Stige, Binder, Rosenvinge & Traeen, 2013).

The remaining articles looked at TFCBT (Vincent, Jenkins, Larkin & Clohessy, 2013; Shearing, Lee & Clohessy, 2011) psychotherapy (Tummuala-Narra, Kallivayalil, Singer & Andreini, 2012; Shamai & Levin-Megged, 2006) and a therapeutic community (Gone 2013).

Although two articles referring to the stabilization group interviewed the same participants, both were included as they focused on different aspects of experience and reported separate themes. One article reported participant experience of their intervention and what helped engagement (Stige, Rosenvinge & Traeen, 2013), the other reported themes of change based on participant experience (Stige, Binder, Rosenvinge & Traeen, 2013).The risk of over-representing this group's experience was considered during the synthesis process so that themes were a fair reflection of the findings of all the papers. Finally, Gone (2013) reported staff and client experience, therefore only themes derived from client data and related to therapy were included.

Additionally, retrospective experiences of therapy were collected across six studies (Shamai & Levin-Megged, 2006; Shearing, Lee & Clohessy, 2011; Stige, Rosenvinge & Traeen, 2013; Stige, Binder, Rosenvinge & Traeen, 2013; Parker et al., 2008; Gone, 2013) where participants were interviewed a month to 36 months following the completion of their therapy. The remaining studies recruited participants who had engaged in a minimum of three months of therapy (Brown, Kallivayali, Mendelsohn & Harvey, 2012; Tummuala-Narra, Kallivayalil, Singer & Andreini, 2012; Vincent, Jenkins, Larkin & Clohessy, 2013).

Appraising the quality of the selected studies

Although considerably debated as a process (e.g., Barbour, 2001) a quality assessment tool was used. Assessing quality across qualitative research is complicated by the philosophy and epistemology that underpin such research, in addition to the implications of pragmatic decisions made when publishing work (Campbell et al., 2003). Therefore, in line with Miller and Dingwall's (1997) statement that checklists are "reflective rather than constitutive of good research", papers were not included or excluded based on quality. However, the Critical Appraisal Skills Programme (CASP, 2011) score given to each paper (see Table 2) was utilised during the synthesis to make sure themes were not purely based on papers of lower quality.

To determine a CASP score each article was individually assessed to check if they: stated aims appropriate to their research design; if the analysis of data and reported themes were clear, transparent and supported by quotations; reflected on limitations of their design; and proposed how findings might inform practice and future research. Articles were rated on a scale of zero to two on each criterion; zero was given if no information was provided to meet the criteria, a score of one was given if there was moderate information provided and a score of two if the articles were seen to fully address the quality criterion. With a possible total score range of 0-20 in total, all studies scored between14-19. Given all papers scored within a high range, the analysis and corresponding themes were developed giving equal attention to all papers.

Insert Table 2

Analysing and synthesising selected studies

Guidelines for a meta-ethnographic approach (Noblit & Hare, 1988) informed this meta-synthesis. Studies were read and re-read and key concepts or quotes relevant to the aims of the synthesis (e.g., client experience of therapy) were initially highlighted along with initial interpretations. This was later extracted from the original papers into a document (Appendix 1-B) where key concepts across all papers were listed in juxtaposition. Additionally, examples of difference or contradiction to key concepts were noted to be later reported within subthemes (for extract see Appendix 1-C).

Through an iterative process of re-reading papers and comparing their content, the author developed their interpretative account while critically engaging with each paper's findings (Jensen & Allen, 1996). This was achieved through considering the aims of each paper and assessing the supporting evidence reported as well as their overall quality. CASP scores were used to inform the weight given to claims made within the synthesis. If an interpretation was derived from an article with a comparably lower CASP score (i.e. 16 or below) the author would then review all articles to collect supporting evidence (e.g., quotes, contradictions). If no supporting evidence was found from papers of higher quality then the original interpretation was adapted in line with stronger evidenced claims or removed from the synthesis. Similarly, the synthesis subthemes were checked to ensure a minimum of five papers informed their content (over half of the synthesised papers). If a subtheme did not meet these requirements then it was removed or integrated within another sub-theme.

The final overarching themes (see Appendix 1-D) were developed through the synthesis to form an interpretive 'line of argument' that articulated the integrated findings, allowing for a summary of reciprocal themes across papers that was greater than within an individual study (Downe, 2008; Finfgeld, 2003), thereby providing a novel interpretation.

Findings

This meta-synthesis presents two overarching themes: 1) Detached to survive: engaging through despair 2) Reconnecting through therapy (Table 3). Both overarching themes include a number of subthemes. The synthesis aims to provide an interpretative overview of common experiences of adults who engage in talking therapies following a complex trauma experience, with quotations from the original studies used to illustrate themes.

Insert Table 3

Theme 1*:* Detached to survive: engaging through despair

A main theme across all papers was the recognition that therapy created a dilemma for participants. Substantial ambivalence surrounded what therapy might entail, with participants recognising they would have to let go of their established and active mechanisms for managing their experiences following their trauma experience. This protective process involved remaining detached from their experiences, conflicting with therapeutic aims of exploring trauma which asked them to embrace their vulnerability through openness. This theme is comprised of three subthemes; accepting change is needed; embracing vulnerability; and letting go and sharing: reducing avoidance.

Accepting change is needed

Despair and willingness for change were expressed as being highly related and important for engagement in therapy even when this felt threatening (Shearing, Lee & Clohessy, 2011; Brown, Kallivayali, Mendelsohn & Harvey, 2012). Continuing distress encouraged a readiness to immerse oneself in therapy and to experience change; "*I was really* *getting to the end of my rope. I was... I was tired of, sort of fighting to be alive….*" (Vincent, Jenkins, Larking & Clohessy, 2013, p.585). Moreover, this supported participants to consider therapy even when they felt it unlikely to result in meaningful change. "I *had no faith in it working. Umm, I couldn't believe, cos I'd spent so much time trying to forget it and to put it to the back of my mind" (*Shearing, Lee & Clohessy, 2011, p.463). In particular, this sense of desperateness appeared a necessary motive to support participants accessing therapy and engaging in a process that they did not think would be helpful.

> "*I'd got to a point that I was so desperate for something to work, or to feel better in some way, that, you know, they could have said well we'll try burning joss sticks and chanting for half an hour and I probably would have had a go' (*Shearing, Lee & Clohessy, 2011, p.461).

Additionally, a contrasting sense of 'timeliness' or being in a 'good position in life' informed decisions to engage in therapy. This was expressed across studies, where readiness for therapy came with realisation of the participant's active role, and need for strength and determination. *"[WRAP] was helpful because I was willing and I had a desire to involve myself* (Parker et al., 2008, p.71).

Beyond readiness, receptiveness to therapy related to the identification of problems and therefore consideration that a potential solution may exist (Stige, Rosenvinge & Traeen, 2013). For many, this was about seeking to understand their trauma experiences and how they may have contributed to what happened (Parker, et al. 2008). However, contrasting acceptance to engage, for some, therapy was experience as something to be cautious about fully engaging in (Shamai & Levin-Megged, 2006). One participant described how they avoided disclosing trauma experience in therapy: "*I'd been avoiding it for ages and ages…. I realised that I was scared of things, it was kind of instinctive reaction of like horror, not wanting to go there*'. (Shearing, Lee & Clohessy, 2011, p.462). During therapy participants often feared becoming overwhelmed by their distress and had managed this by remaining actively avoidant of their trauma experience.

Embracing vulnerability

Engaging in therapy was an emotionally ambivalent experience where initial uncertainty related to what therapy would entail (Gone, 2013; Brown, Kallivayali, Mendelsohn & Harvey, 2012). Therapy was conceptualised as a commitment of time and energy to a group or individual therapist (Stige, Rosenvinge & Traeen, 2013). For those in group therapy, in contradiction to concerns of being exposed or judged, sharing experiences with other members normalised and validated experience: "*you have realized: ''My God! I am not alone!'' Others too carry burdens and struggle. It is not just me*" (Stige, Rosenvinge & Traeen, 2013, p.424). Moreover group settings allowed for the opportunity to establish personal boundaries, "*…prior to the WRAP group…raging was something that was very normal….now I can actually go- 'no stop wait, think about this first'…* "' (Parker et al., 2008, p. 67).

Once engaged in the therapeutic process, participants reported experiencing fear associated with the risk of exposing oneself to trauma experience (Shearing, Lee & Clohessy, 2011). Crucially, through disclosing trauma and attending therapy, participants were making themselves vulnerable to the views and actions of others and were likely to experience an increase in symptoms.

> *"When you come, you have to really talk about it, and how you're feeling and that brings it like to the surface and it's really raw and that's really hard and sometimes, you know, you don't feel like doing that 'cause it's painful"* (Vincent, Jenkins, Larkin & Clohessy, 2013, p.586).

Re-experiencing emotions and body memories related to a trauma experience were often interpreted by the individual as an indication of "*lack of progress*" (Vincent, Jenkins, Larkin & Clohessy, 2013, p.584). This understanding of increased symptoms led to beliefs that therapy was not worth the distress it caused. Moreover, participants' beliefs about the helpfulness of therapy also informed their decisions about whether to continue. *"Up 'til now I don't know if it's helpful hundred percent or not because I do sometimes cancel the appointment with her [therapist]. I had a strong feeling to, to stop coming here….".* (Vincent, Jenkins, Larkin & Clohessy, 2013, p.586).

As therapy progressed doubt about the challenges of therapy appeared to lessen in intensity. Therefore therapy was recognised as a process of changing ones relationship to the trauma experience, although associated feelings of fear were still a huge concern. In contrast to negative interpretations of increased symptoms, participants conceptualised these changes as representing a greater connection with their emotions and body. "*I feel it in my body now, when I start to drift off…I have a new contact with this whole part of myself… I have more contact between my head and body and the world around me"* (Stige, Binder, Rosenvinge & Traeen, 2013, p.9). Although increased symptoms were a challenge, for those who had coped previously by remaining largely disconnected from such experiences, changes in symptoms became a marker of hope and the possibility for change.

Letting go and sharing: reducing avoidance

Participants experienced having to discussing their trauma experience as being opposite to strategies, such as avoidance, which had helped them feel in some control of their distress. Therefore when being asked to talk about trauma, participants felt resistant (Brown, Kallivayali, Mendelsohn & Harvey, 2012, p.107): *"… you are trying to forget them [abusers]…you are forced to remember, so you feel discouraged"* (Vincent, Jenkins, Larkin & Clohessy, 2013, p.584). Paradoxically, hope and despair motivated engagement in this process of disclosure and supported participants in overcoming difficult feelings because they ultimately felt something needed to be different for change to occur.

Importantly, given the content of trauma experience, concerns were held about being able to manage sharing and processing experience alongside increased symptoms. Vitally, participants avoided sharing their trauma experience, especially early on in therapy, a means by which they felt able to reduce the likelihood of losing control over their emotions. "*I'd been avoiding it [trauma experience] for ages and ages and ages, I'm just scared of it. That's why I've not faced it anyway, I'm just scared*". (Shearing, Lee & Clohessy, 2011, p.462).

Moreover, avoidance of disclosure related to the impact this may have on others, including the therapist (Shamai & Levin-Megged, 2006), where participants wondered if their 'horrible' trauma experience could be endured. Furthermore, reservations about sharing trauma material were sometimes maintained even when a safe relationship was established: "*I felt very safe in therapy…she [therapist] really cared…but there were things, like the event when I was raped that I didn't tell her"* (Shamai & Levin-Megged, 2006, p.705). Difficulties with trusting others and the strong motivation to continue protecting self by remaining detached led participants to 'regain power' and remain in control by limiting the information they shared (Gone, 2013).

In contrast, and vital to the facilitation of open disclosure and engagement, was the therapist who was seen to demonstrate qualities that gave participants confidence in them and the intervention *(*Shearing, Lee & Clohessy, 2011; Vincent, Jenkins, Larkin & Clohessy, 2013). Beyond expertise, therapists promoted engagement if they came across as genuine, empathic, honest and supportive (Shearing, Lee & Clohessy, 2011).

Over time, a number of participants reported that sharing their experience became easier and was cathartic (Vincent, Jenkins, Larkin & Clohessy, 2013). Through reflecting on processing trauma experiences and also their ability to manage associated feelings, openness and feelings of safety were slowly encouraged in therapy. Furthermore, the process of disclosing was experienced as "*the release of tension or the burden that you're carrying…"*

(Gone, 2013, p.756). Although feared, disclosing was experienced as liberating and played a large part in promoting the participants re-evaluation of their experience: *"I realised I picked the same type of men as my father, abusive….I just see it clearer and clearer"* (Tummuala-Narra, Kallivayali, Singer & Andreini, 2012, p. 645). Therefore, sharing and making sense of experiences offered an opportunity for new perspectives to be formed and the process of change to be continued.

Theme 2: Reconnecting through therapy

This theme captures participants conceptualising their 'recovery' as being about reconnection with their trauma experience, symptoms, others and, importantly, themselves. Reconnecting with another was often experienced initially with the therapist, where, due to ongoing relational difficulties, the therapeutic relationship was extremely valued. The therapeutic relationship was essential in supporting participants to disclose, explore and process their trauma experience. This change in connection was then often translated to relationships with others and self, and formed the on-going challenge that was the journey to 'recovery'. The theme comprises three subthemes: connecting within the therapeutic relationship; new relationship to self and others; and an ongoing journey of gains and losses.

Connecting within the therapeutic relationship

Beyond the immediacy of therapy, participants experienced feelings of isolation, relating either to participants not feeling able to share their trauma experience or due to difficulties in relationships. For holocaust survivors, relationships were often influenced by a strong belief that you can only trust yourself *(*Shamai & Levin-Megged, 2006). Therefore the therapeutic relationship, if experienced as safe and subsequently a context in which trust could be established, was vital. Similarly, for those who were asylum seekers, this simply provided "*somebody to talk to"* in a foreign, lonely and unpredictable place (Vincent, Jenkins, Larkin & Clohessy, 2013, p.587). "*She [therapist] was the point of return for me;*

whenever something happened…it is like I will be able to continue" (Shamai & Levin-Megged, 2006, pg. 706). For participants of group therapy, sharing one's story and hearing stories from other members offered an opportunity to develop and experience a healthy connection with another person.

> *"Being with other women in WRAP was really helpful. . . that makes me more connected to everybody because then you think everybody has a history. I tell myself probably she or he had a tough life too. Uh, and that helps me to be with people, to stay with them…."* (Parker et al., 2008, p. 68).

Although establishing a therapeutic relationship was essential, feelings of trust did not come naturally, particularly as participants held strong beliefs about the world being unsafe and people being untrustworthy following their trauma experiences: *"I feel extremely vulnerable and powerless in the world. I see people as vicious."* (Tummuala-Narra, Kallivayali, Singer & Andreini, 2012, p. 644). Trust within the therapeutic relationship could feel 'forced' (Vincent, Jenkins, Larkin & Clohessy, 2013, p.587). Nevertheless, it was through trust being developed over time, with the therapist or group, that participants were supported in taking the 'risk' of being open. Once trust had been genuinely established, the therapist could encourage reflection on the content of disclosure which led to the growth of new understandings.

A new relationship to self and others

Therapy was a vehicle that supported participants in accepting that horrible unpredictable things had, and could, happen (Brown, Kallivayali, Mendelsohn & Harvey, 2012), which came with associated feelings of powerlessness : "*I feel victimised and powerless…I feel scared a lot*" (Tummuala-Narra, Kallivayali, Singer & Andreini, 2012, p.645). Consequently, coming to terms with new understandings was difficult, particularly if this meant accepting that the world can be unsafe and that other people are not always well intentioned *(*Vincent, Jenkins, Larkin & Clohessy, 2013).

A key mechanism for change within therapy was the development of reflective skills that allowed for the growth of new understandings about trauma and relational experiences. "*It's a way for me to stop, take stock and figure out who I am….[Therapy] changes the whole way I structure my life*" (Brown, Kallivayali, Mendelsohn & Harvey, 2012, p.108). Within the safe therapeutic relationship participants started to feel a greater sense of connection with their identity: "*feeling more like myself as a being in the world instead of living this double identity*" (Tummuala-Narra, Kallivayali, Singer & Andreini, 2012, p.645). Additionally, the process of being *"confronted with yourself, what you were thinking and how you were doing" (*Stige, Rosenvinge & Traeen, 2013, p.424) encouraged new beliefs about self, including *"self-forgiveness"* (Tummuala-Narra, Kallivayali, Singer & Andreini, 2012, p.645) and the reduction in feelings of guilt *(*Parker et al, 2008).

> "*I feel less guilty than before. I learned that lots of things that happened in the past; it wasn't my fault. And I as a child didn't have the power to stop anything…so it wasn't my fault. That was the first thing that changed in my mind*" (Parker et al., 2008, p.66).

Furthermore, therapy offered new perspectives which validated and encouraged participants to acknowledge the role of others in their trauma or on-going unhealthy relational dynamics. This allowed participants to move away from internalising feelings of 'innate badness' toward feeling worthy of happiness (Parker et al, 2008; Stige, Rosenvinge & Traeen, 2013). "*I deserve to be happy. I didn't think that before. I didn't think that I deserved anything good. But now I feel that I deserve a good life, a happy life…*" (Parker et al. 2008, p.66).

With newly developing self-beliefs that were less critical and strengths focused, an increased sense of agency was experienced which allowed feelings of worthiness to grow (Tummuala-Narra, Kallivayali, Singer & Andreini, 2012). Resilience was demonstrated through participants becoming *"an advocate for myself, thinking in advance what is good for me*" (Stige, Rosenvinge & Traeen, 2013, p.10), or considering *"boundaries to protect myself"* *(*Parker et al., 2008, p.68*)*. In addition participants overcame feelings of vulnerability by tolerating being able to share their experience. This process helped participant's gain clarity about their needs and empowered them to get their needs met.

> "..[T]*hese problems… a dark cloud…that I could not touch, that I didn't manage to do anything about….now at the group, it is no longer a cloud…it is almost like building blocks…now I know the pieces that are still missing from my jigsaw. And it is such a wonderful feeling*!" (Stige, Binder, Rosenvinge & Traeen, 2013, p.8)

Importantly, practising communicating feelings and experience in the safe and trusted therapeutic relationship allowed participants to go on to connect with friends and family with the same openness *(*Stige, Rosenvinge & Traeen, 2013). "*I can be truthful with friends now. I feel that group helped a lot with being able to risk. That is a big thing as I never told anyone my true feelings*" (Tummuala-Narra, Kallivayali, Singer & Andreini, 2012, p.645).Therefore through trusting the therapist or group, participants began to generalise and share their experience and thereby were engaging in a process of change.

An ongoing journey of gains and losses

All papers in this meta-synthesis reported benefits of treatment, including participants considering their 'recovery' felt like they had *"a new life*" (Vincent, Jenkins, Larkin & Clohessy, 2013, p.588) or that they were "*a different person*" (Shearing, Lee & Clohessy, 2011, p. 446) as a consequence of their new understandings.

However several papers acknowledged continuing difficulties following therapy such as generalising what they had learnt in therapy to their broader life, as it was hard to sustain feelings of empowerment independently (Parker et al., 2008).

Importantly participants recognised that due to the nature of their trauma experience, this would always inform who they were: "*no one came out 'completely normal' from the holocaust*."(Brown, Kallivayali, Mendelsohn & Harvey, 2012, p. 705). Therefore moving forward during and following therapy was conceptualised as a journey which had gains and losses (Vincent, Jenkins, Larkin & Clohessy, 2013) including the painful acceptance of difficult experiences, increased symptoms and tolerating difficult emotions: "*Now I have to feel when I have pain*.", "*the reason why I am hurting now, I finally have been able to understand something that has been very difficult*" (Stige, Binder, Rosenvinge & Traeen, 2013, p.12).

Most noticeably, participants expressed that meaningful change or 'recovery' was not in the reduction of symptoms (Shearing, Lee & Clohessy, 2011) but instead in their changed relationship to their trauma experience and associated distress. Participants had moved away from conceptualising their responses as abnormal and grew in their confidence about being able to manage them (Stige, Rosenvinge & Traeen, 2013): "*I have the same load of symptoms still really, but it is a bit easier when they come, because I know…I can try to get out of it, not bundling up in it even more*" (Stige, Binder, Rosenvinge & Traeen, 2013, p.11).

Participants recognised that their new insights and emotions came with the challenge and choice to continue a process of change, *"I think with all of those problems and experiences you always have two ways, either to lose everything and to lose yourself or to improve and develop skills" (*Vincent, Jenkins, Larkin & Clohessy, 2013, p.584). Nevertheless, participants across studies felt better equipped to seek their own on-going healing or 'recovery' following therapy. As one participant reflected, therapy *"empowered* *me to go to the next level of understanding"* (Parker et al., p.*72).* Recovery was therefore conceptualised as an ongoing journey where participants felt more able and worthy of moving forward and accessing a meaningful and fulfilling life while managing the challenges of their reality.

Discussion

This review enabled the identification of the key experiences for adults who had engaged in a talking therapy following complex trauma while reflecting the breadth and paradoxical nature and meaning of the recovery process as conceptualised by clients (Tummuala-Narra, Kallivayali, Singer & Andreini, 2012). This review goes beyond the scope of a single paper by capturing how clients who experienced a trauma go on to manage through avoiding their trauma and associated experiences. Contrasting this, through engaging in therapy, the client overcomes fear to experience reconnection with their trauma through disclosure and exploration of its content and impact. Moreover, clients reconnect with their self and others through developing new meanings which are a significant part of their 'recovery'. Such vital findings highlight important clinical considerations and opportunities for further research.

Although the findings of this meta-synthesis may be hard to generalise, given reviewed papers included experiences of individual and group therapy and where clients were still engaged in or had completed therapy, trust and safety were strongly reported as being essential for the therapeutic alliance (Mendelsohn et al., 2011). The importance of the therapeutic relationship is well evidenced and is argued to improve engagement (Arnow et al., 2007) and outcomes of treatment (Martin, Garske, & Davis, 2000). However it appears even more essential for clients who have a limited network of relationships outside of therapy as a result of their trauma experience or interpersonal difficulties (Tummuala-Narra, Kallivayali, Singer & Andreini, 2012).

The importance of the therapeutic relationship is reflected in models of trauma recovery used within the synthesis papers. Herman's (1992) model for example, stresses the development of safety as an initial stage before moving on to later stages of processing and reconnecting. The current study could enhance Herman's model as the third stage of 'recovery' was more than reconnecting within interpersonal relationships but also the development of new connections to oneself. Additionally, although the stages of 'recovery' are illustrated in the findings of this meta-synthesis, it is unclear if clients experience these as discreet stages. It appears more likely that there is a non-linear progression between Herman's stages of establishing a therapeutic relationship and exploring their trauma. For example, feelings of trust did encourage disclosure within therapy; however associated feelings of fear and increased symptoms at these times may reduce confidence in the therapist and intervention.

Importantly, the findings of this meta-synthesis provide new insight into experiences of despair, hopelessness and engagement. Despair and hopelessness are conceptualised as highly related to each other and to emotional suffering (Flaming 1995).Interestingly, hopelessness has been argued to increase the risk of ending therapy prematurely and therefore is associated with poor therapeutic outcomes (Dahlsgaard, Beck & Brown 1998). Dahlsgaard et al. concluded higher levels of hopelessness were significantly associated with early termination of therapy. Specifically, they compared 17 clients who had committed suicide to a matched control group (e.g., on gender, diagnosis) of 17 outpatients who accessed treatment at the same time but had not committed suicide. Number of sessions attended, termination of therapy (e.g., against therapists' advice), hopelessness (Beck Hopelessness Scale, BHS, Beck & Steer, 1993) and suicidal ideation (The Scale for Suicide Ideation-Current; Beck, Kovacs, & Weissman, 1979) were compared. However, the research has clear limitations; being derived from a small sample, where historical attempts at suicide were not included in matching clients, and importantly where some clients reported going on to find other therapeutic support. Additionally the conclusions Dahlsgaard et al. made fail to account for the findings of this meta-synthesis. Specifically participants reported hopelessness and despair enabled engagement and continuation in a therapeutic process that was counter to the clients' established survival strategies of remaining detached and avoidant (e.g., Murphy & Rosen, 2006, Vincent, Jenkins, Larkin & Clohessy, 2013).

Furthermore, Kuyken (2004) explored hopelessness and outcome in cognitive therapy using a naturalistic study of 122 patients who had diagnoses of depression. A BHS (Beck & Steer, 1993) was completed at the beginning of each session, from which participants were identified as having 'responsive hopelessness' (e.g., if after four sessions BHS scores significantly reduced indicating hopelessness was reduced through therapy) or 'non-responsive hopelessness' (if BHS scores were not significantly reduced). This was analysed in relation to length of treatment and outcome (e.g., Endstate Functioning Index; Ogles, Lunnen, & Bonesteel, 2001). Kuyken concluded that clients who were identified as having 'responsive hopelessness' in early weeks of therapy had better outcomes from cognitive therapy than those with 'non-responsive hopelessness', regardless of depression severity or hopelessness at the beginning of therapy. Nevertheless, beyond the limitations of the study's design (e.g., effects of different therapists, measures of 'responsiveness'), 'responsive hopelessness' could instead be explained by other factors which influence treatment outcome as reported in this meta-synthesis. Hopelessness, for example, was found to be a complex process that supports initial engagement in therapy, but may change over time due to experiences within therapy where trust, safety and containment are developed and where feelings and experiences are normalised. Furthermore, developing trust encouraged clients to work through feelings of vulnerability that naturally arose when asked to share their difficult experience, accept new and painful understandings, experience increased symptoms and manage fear associated with a risk of losing control. These obstacles which were overcome in therapy were understandable given clients' experiences, their interpersonal struggles, feelings of shame and guilt, low self-worth, and negative beliefs (Brown, Kallivayali, Mendelsohn & Harvey, 2012; Lebowitz et al., 2003; Safran, Crocker, McMain, & Murray, 1990).

Furthermore, this meta-synthesis highlights that some clients did not feel it was necessary to disclose their experience, at least in its entirety, to achieve a positive outcome from therapy. Instead the therapeutic relationship and normalisation of experience that occurred in therapy were seen to be more powerful mechanisms for change. This finding is curious because it challenges the second stage of Herman's (1992) recovery model by suggesting clients do not feel disclosure and processing of trauma experience is central to encouraging change. Not wishing to disclose experience appeared to be motivated by a strategy of avoidance or detachment from the trauma which allowed clients to feel they could retain control over difficult experiences (e.g., symptoms). Avoidance fits with PTSD diagnostic criteria (e.g., APA, 2013) and is likely to reflect learning from historic difficult experiences (Shamai & Levin-Megged, 2006).

There are various ways avoidance of disclosing may be understood; firstly The Perceptual Control Theory (Powers, 2005) argues individuals evaluate and compare an ideal state with their current one and in doing so become motivated to reduce the difference between them. This could explain why participants in early stages of therapy who want to reduce their distress are motivated to act in ways to achieve this (e.g., avoid) in the short term (Vincent, Jenkins, Larkin & Clohessy, 2013). Alternatively, Personal Construct Theory (Kelly, 1955) would propose that clients experience 'threat' at times when evidence contradicts or invalidates their current constructs (Bannister & Fransella, 1987). Conversely, new constructs may evolve when clients experience, such as within therapy, provide new evidence that helps them successfully predict and therefore manage their experiences

(Winter, 1992). Cognitive models (e.g., Joseph & Linley, 2004) would similarly argue that evidence or new experiences encourage the accommodation or assimilation of appraisals. As the meta-synthesis demonstrates, clients in therapy recognise a crucial mechanism for change is through the processing of difficult experiences. Specifically, the development of more positive self beliefs encouraged feelings of empowerment (Shearing, Lee & Clohessy, 2011) and contrasted earlier despair.

Furthermore, change in therapy, and specifically ‘recovery’ from trauma was conceptualised as a challenging journey, with benefits and drawbacks. It is important to be aware of cultural influences that may have informed how ‘trauma’ and ‘recovery’ are conceptualised, given this meta-synthesis reviewed papers across cultures (e.g., Middle-Eastern, Native American and European). Nevertheless, conceiving ‘recovery’ as a challenge was similar across papers and supports ‘recovery’ being a conceptualised as something that cannot be rushed, but involves preparation, perseverance and action (Herman, 1992). However, clients did not conceptualise their ‘recovery’ as ending with only positive outcomes. Instead ‘recovery’ was seen to involve developing different and less distressing relationship to experience, one’s view of the world, others, self and on-going symptoms (Shearing, Lee & Clohessy, 2011).

Moreover, clients appeared to create something positive from their distress (Brown, Kallivayali, Mendelsohn & Harvey, 2012; Shearing, Lee & Clohessy’s, 2011) such as post-traumatic growth (PTG; Tedeschi & Calhoun, 2004) rather than reclaim their ‘former selves’ (Ehlers & Clark, 2000). PTG, a separate experience from recovery (Linley & Joseph, 2004), could demonstrate the positive changes and enhanced development clients reported as resulting from reflective meaning and recreated purpose following their adverse experience (Garbarino & Bedard, 1996). Although PTG is not limited to those engaged in therapy, it appeared to be reflected in the client experiences within this meta-synthesis.

Clinical implications

Current international and trauma guidelines (e.g., NICE, 2005; The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults, Cloitre et al, 2012) outline the essential components of interventions for complex trauma. These advocate for a phased approach which encourages stabilisation and skill-building and aim to reduce symptoms and improve overall functioning (e.g., self-regulation and strengthening resource; Courtois, Ford, & Cloitre, 2009). The aims of guidance appear to be reflected in the experiences captured in this meta-synthesis, specifically that clients reported that they developed feelings of safety and felt better able to manage their distress. Moreover the importance of the therapeutic alliance is also noted. For instance, UK NICE guidelines (p.18) state “professionals should consider devoting several sessions to establishing a trusting therapeutic relationship and emotional stabilization before addressing the traumatic event.”

Although the therapeutic relationship is highlighted as important, it is presented in guidance as a component of therapy that should be given most attention to early on in therapy rather than throughout. This does not fully capture the therapeutic relationship being a cornerstone of therapy or, moreover, that the therapeutic relationship develops in relation to changing experiences in therapy (Parker et al., 2008). In addition to trust and confidence being strengthened by clinicians offering consistent, transparent information about therapy and normalising likely feelings and symptoms that may come up during it (Dorahy et al., 2013), clinicians should make sure clients have obvious and multiple opportunities to air concerns throughout therapy.

Moreover, clinicians need to continue to hold in mind the reasons clients may struggle to feel able to re-tell their experience (e.g., fear of losing control). Clinician’s need to continue providing a safe, reliable, non-judgemental space that offers opportunities to share difficult experiences while normalising avoidance as a means of managing distress. This may help clients share their concerns around disclosing their trauma experience while providing an opportunity for trust to develop. Sharing trauma experience may also be encouraged through visual or creative therapeutic methods which may feel safe and less exposing. Clinicians also need to consider clients' wellbeing and risk following disclosure given the associated feelings of vulnerability.

Furthermore, clinicians should consider their expectations for change beyond symptoms and consider 'recovery' as reported by clients (Parker, 2008). Although 'recovery' can infer that at some point an individual may completely overcome their difficulties (e.g., be symptom free), clients appear to construct their 'recovery' as having no singular outcome and where remembrance of trauma experiences and associated difficulties continue. Therefore clinicians should privilege and be attuned to their clients' conceptualisation of their own recovery and use this as a motivator and measure of meaningful outcomes in therapy (Courtois, Ford, & Cloitre, 2009). This is essential given that clients are lead agents in their recovery journey (Asay & Lambert, 1999; Bohart & Tallman, 1999) and is imperative when establishing a trusting therapeutic relationship that empowers.

It is also important to consider client resilience. Brown et al., (2012) recognised that clinicians are challenged to find a balance between remaining focused on symptoms, which can reinforce hopelessness, and embracing resilience too strongly, which can collude with a client's avoidance of painful experiences. These mechanisms appear pivotal to how clients themselves struggle within therapy. Correspondingly, clinicians need to remain curious and attentive when listening for a client's strengths while also acknowledging their struggles. This may also be a powerful vehicle for engagement while providing evidence for the development of new beliefs, especially beliefs about self.

Future research

Research considering the experience of clients who engage in talking therapies following complex trauma is still limited and only recently a focus of exploration. Research could develop to investigate the aspects raised in this meta-synthesis. For example, exploring experiences of therapy at earlier stages may offer new and important insights into recovery and engagement (Shearing, Lee & Clohessy, 2011). Given the importance of trust in the therapeutic relationship, it may be a priority to investigate clients' experiences of what helps and hinders trust. It may be especially useful to sensitively investigate clients' feelings around disclosing, including those of vulnerability and need for control.

Future research may benefit from focused attention on the changing relationship clients report having with others and themselves over the course of treatment. This might provide useful information on how, and what, encourages clients to change or develop new beliefs, which is fundamental to 'recovery' and support clinicians in developing a more in-depth appreciation of trauma 'recovery' from a client perspective, (Parker et al., 2008). Further to this, exploration of the specific impact of trauma on self-concepts is essential; given the role self appraisals have in maintaining emotional difficulties following trauma and importantly have in encouraging positive change.

Additionally, as undertaken by Gone (2013), exploration of client and staff experiences of change and recovery would allow for a comparison of understanding during the same therapy process. This may encourage the consideration of change as being beyond the measures of symptom reduction towards recognition of the importance of an individual's view of change. It may also be valuable to consider the lasting effects of therapy on the changes identified in this review, a follow up interview would aid evidence being collected in support of 'recovery' from trauma being a journey.

Conclusion

Entering a trauma informed therapy understandably creates ambivalent feelings for clients who are being asked to move away from established mechanisms they use to manage their trauma experience. Contrastingly, clients feel exposed when disclosing their trauma experience as they fear losing control. Vitally, establishing a therapeutic relationship that engenders trust provides needed containment for working through this and should be an essential first step in therapy. Therapy was experienced as a vehicle to support clients in reconnecting with their trauma experience, which allows them to develop new relationships and understandings to their symptoms, others and, importantly, themselves. ‘Recovery’ was conceptualised as having benefits and drawbacks including developing new beliefs. Clinicians should therefore be attuned to how their clients conceptualise their own recovery and considering trauma and self within their therapeutic work.

References

*Denotes studies included in the synthesis

Alvesson, M., & Skoldberg, K. (2000). *Reflexive methodology: New vistas for qualitative research*. London: Sage.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).Washington, DC: American Psychological Association.

Arnow, B. A., Blasey, C., Manber, R., Constantino, M. J., Markowitz, J. C., Klein, D. N., & Rush, A. J. (2007). Dropouts versus completers among chronically depressed patients. *Journal of Affective Disorders,* 97, 197–202. Retrieved from: http://www.jad-journal.com/article/S0165-0327(07)00075-4/pdf

Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan & S. D. Miller (Eds.), *The heart and soul of change: what works in therapy* (pp. 23–55). Washington, DC: American Psychological Association.

Australian Centre for Posttraumatic Mental Health, (2010). *Australian guidelines for the treatment of acute stress disorder & posttraumatic stress disorder*. Australian government: National Health and Medical Research Council. Retrieved from: http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0CEIQFjAC&url=http%3A%2F%2Fwww.acpmh.unimelb.edu.au%2Fsite_resources%2Fguidelines%2FACPMH_Full_ASD_PTSD_Guidelines.pdf&ei=6yhhU7qTMYHMOfr9gegM&usg=AFQjCNH72Gq2KxRp2rd3sQh25C-BFM779g&sig2=igVwBI4VjPMsLlyGoEJN6w

Bannister, D., & Fransella, F. (1989). *Inquiring man: The psychology of personal constructs* (3rd ed). London: Routledge.

Barbour, R. S. (2001). Checklists for improving rigour in qualitative research: A case of the tail wagging the dog? *British Medical Journal*, 322, 1115-1117. http.dx.doi.org/10.1136 /bmj.322.7294.1115

Beck, J. G., DeMond, M. G., Clapp, J. D., & Palyo, S. A. (2009). Understanding the interpersonal impact of trauma: contributions of PTSD and depression. *Journal of Anxiety Disorders,* 23, 443–450. http.dx.doi.org/10.1016/j.janxdis.2008.09.00

Beck, A. T., Kovacs, M., & Weissman, A. (1979). Suicide ideation. *Journal of Consulting and Clinical Psychology*, 47, 343-352. http.dx.doi.org/ 10.1037/0022-006X.47.2.343

Beck, A. T., & Steer, R. A. (1993). *Manual for the Beck Hopelessness Scale*. San Antonio, TX: The Psychological Corporation.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *The Beck Depression Inventory*. (2nd ed.). San Antonio, TX: The Psychological Corporation.

Bohart, A.C., & Tallman, K. (1999). *How clients make therapy work: The process of active self-healing*. Washington, DC: American Psychological Association.

*Brown, N.R., Kallivayali, D., Mendelsohn, M., & Harvey, M.R. (2012). Working the double edge: Unbraiding pathology and resiliency in the narratives of early-recovery trauma survivors. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4, 102-111. http://dx.doi.org/10.1037/a0024969

Campbell, R., Pound, P., Pope, C., Britten, N., Pill, R., Morgan, M., & Donovan, J. (2003). Evaluating meta-ethnography: A synthesis of qualitative research on lay experiences of diabetes and diabetes care. *Social Science and Medicine*, 56, 671-684. http://dx.doi.org/10.1016/S0277-9536(02)00064-3

Carlson, E.B., & Dalenberg, C.J. (2000). A conceptual framework for the impact of traumatic experiences. *Trauma Violence Abuse*, 1, 4-28. http://dx.doi.org/10.1177/1524838000001001002

Cloitre, M., Courtois, C. A., Ford, J.D., Green, B.L., Alexander, P., Briere, J., Herman, J.L., Lanius, R., Stolbach, B.C., Spinazzola, J., Van der Kolk, B.A., Van der Hart, O. (2012). *The ISTSS expert consensus treatment guidelines for complex PTSD in adults.* Retrieved from: http://www.istss.org/AM/Template.cfm?Section=ISTSS_Complex_PTSD_Treatment_Guidelines&Template=%2FCM%2FContentDisplay.cfm&ContentID=5185

Connolly, M., & Strupp, H. (1996). Cluster analysis of patient reported psychotherapy outcomes. *Psychotherapy Research*, 6, 30-42. http://dx.doi.org/10.1080/10503309612331331558.

Courtois, C.A. (2008). Complex trauma, complex reactions: assessment and treatment. *Psychological Trauma: Theory, Research, Practice, and Policy,* 8, 86-100. http://dx.doi.org/10.1037/0033-3204.41.4.412

Courtois, C., & Ford, J. (2009). *Treating complex traumatic stress disorders: An evidence-based guide*. New York, NY: Guilford.

Courtois, C., Ford, J., & Cloitre, M. (2009). Best practices in psychotherapy for adults. In C. Courtois & J. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp. 82-103). New York: Guilford.

Copeland, W., Keeler, G., Angold, A., & Costello, E. (2007). Traumatic events and posttraumatic stress in childhood. *Archives of General Psychiatry*, 64, 577–584. http://dx.doi.org/10.1001/archpsyc.64.5.577

Critical Appraisal Skills Programme (2011). Critical appraisal skills programme: Making sense of evidence about clinical effectiveness. Oxford: Public Health Resource unit. Retrieved from: http://www.casp-uk.net/wpcontent/uploads/ 2011/11/ CASP_ Qualitative_Appraisal_Checklist_14oct10.pdf

Dahlsgaard, K. K., Beck, A. T., & Brown, G. K. (1998). Inadequate response to therapy as a predictor to suicide. *Suicide and Life-Threatening Behaviour*, 28, 197–204. Retrieved from: http://www.med.upenn.edu/suicide/publications.html

Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, 16, 459–470. http://dx.doi.org/10.1080/09638230701482394

Dixon, M., Sutton, A. J., & Booth, A. (2007) Synthesizing qualitative research: A review of published reports. *Qualitative Research*, 7, 375-421. http://dx.doi.org/10.1177/1468794107078517

Downe, S. (2008). Metasynthesis: A guide to knitting smoke. *Evidence Based Midwifery*, 6, 4-8. Retrieved from: http://www.doctoralmidwiferysociety.org/Portals/c8d3e3f8-9c01-4bf5-abd9-3fd6b4c510ae/Downe_S.pdf

Dorahy, M. J., Corry, M., Shannon, M., Webb, K., McDermott, B., Ryan, M. & Dyer, K.F.W. (2013). Complex trauma and intimate relationships: The impact of shame, guilt and dissociation. *Journal of Affective Disorders*, 147, 72-79. http://dx.doi.org/10.1016/j.jad.2012.10.010

Ehlers, A., & Clark, D. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, 38, 319–345. http://dx.doi.org/10.1016/S0005-7967(99)00123-0

Ehlers, A., Clark, D., Hackman, A., McManus, F., & Fennell, M. (2005). Cognitive therapy for posttraumatic stress disorder: Development and evaluation. *Behaviour Research and Therapy*, 43, 413–431. http://dx.doi.org/10.1016/j.brat.2004.03.006

Finfgeld, D. L. (2003). Metasynthesis: The State of the Art-So Far. *Qualitative Health Research*, 13, 893-904. http://dx.doi.org/10.1177/1049732303253462

Flaming, G. D. (1995) Patient suffering: a taxonomy from the nurse's perspective. *Journal of Advanced Nursing*, 22, 1120-1127. http://dx.doi.org/10.1111/j.1365-2648.1995.tb03113.x

Ford, J. D., & Kidd, P. (1998). Early childhood trauma and disorders of extreme stress as predictors of treatment outcome with chronic PTSD. *Journal of Traumatic Stress*, 11, 743–761. http://dx.doi.org/ 10.1023/A:1024497400891

Garbarino, J., & Bedard, C. (1996). Spiritual challenges to children facing violent trauma. *Childhood*, 3, 467-478. http://dx.doi.org/10.1177/0907568296003004004

*Gone, J. P. (2009). A community-based treatment for Native American historical trauma: prospects for evidenced-based practice. *Journal of counselling and clinical psychology*, 77, 751-762. http://dx.doi.org/10.1037/a0015390

Herman, J. L. (1992). *Trauma and recovery*. New York: Basic Books.

Holoway, K.A., & Paivio, S.C. (2011). Characteristics of client-identified helpful events in emotion-focused therapy for child abuse trauma. *Psychotherapy Research*, 22, 56-66. http://dx.doi.org/10.1080/10503307.2011.622727

Jensen, L. A., & Allen, M. N. (1996). Meta-synthesis of qualitative findings. *Qualitative Health Research*, 6, 553-560. http://dx.doi.org/10.1177/104973239600600407

*Kallivayalil, D., Levitan, J., Brown, N., & Harvey, M.R. (2013). Preliminary findings from a qualitative study of trauma survivors in treatment: Changes in personal narratives. *Journal of Aggression, Maltreatment and Trauma*, 22, 262-281. http://dx.doi.org/10.1080/10926771.2013.743942

Kelly, G. A. (1955). *The psychology of personal constructs*. New York: Newton.

Kezelman C. A., & Stavropoulos P. A. (2012). *Practice guidelines for treatment of complex trauma and trauma informed care and service delivery.* Adults Surviving Child Abuse. Retrieved from:

http://www.recoveryonpurpose.com/upload/ASCA_Practice%20Guidelines%20for%20the%20Treatment%20of%20Complex%20Trauma.pdf

Kuyken, W. (2004). Cognitive therapy outcome: The effects of hopelessness in a naturalistic outcome study. *Behaviour Research and Therapy,* 42, 631–646. http://dx.doi.org/10.1016/S0005-7967(03)00189-X

Lebowitz, L., Harvey, M. R., & Herman, J. L. (1993). A stage-by dimension model of recovery from sexual trauma. *Journal of Interpersonal Violence, 3,* 378–391. http://dx.doi.org/10.1177/088626093008003006

Lebowitz, B., Vitiello, B., & Norquist, G. (2003). Approaches to multisite clinical trials: The national institute of mental health perspective. *Schizophrenia Bulletin*, 29, 7–13. http://dx.doi.org/10.1093/oxfordjournals.schbul.a006992

Leseho, J., & Maxwell, L.R. (2009). Coming alive: creative movement as a personal coping strategy on the path to healing and growth. *British Journal of Guidance & Counselling*, 38, 17-30. http://dx/doi.org/10.1080/03069880903411301

Linley, P.A., & Joseph, S. (2004). Positive change processes following trauma and adversity: A review of the empirical literature. *Journal of Traumatic Stress*, 17, 11–22. http://dx.doi.org/10.1023/B:JOTS.0000014671.27856.7e

Martin, D. J., Garske, J. P., & Davis, K. M. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 68, 438- 450. Retrieved from: http://psycnet.apa.org/index.cfm?fa=buy.optionToBuy&uid=2000-15699-009

Mendelsohn, M., Herman, J., Shatzow, E., Coco, M., Kallivayalil, D., & Levitan, J. (2011). *The trauma recovery group: A treatment guide*. New York, NY: Guilford.

Miller, G., & Dingwall R., (1997). (eds.) *Context and method in qualitative research*. London: Sage.

Mirdal, G. M., Ryding, E., & Sondej, M.E. (2012). Traumatized refugees, their therapists, and their interpreters: Three perspectives on psychological treatment. *Psychology and Psychotherapy: Theory, Research and Practice*, 85, 436–455. http://dx.doi.org/10.1111/j.2044-8341.2011.02036.x

Mott, J. M., Sutherland, J. R., Williams, W., Lanier, S. H., Ready, D. J., & Teng, E. J. (2013). Patient perspectives on the effectiveness and tolerability of group-based exposure therapy for posttraumatic stress disorder: Preliminary self-report findings from 20 veterans. *Psychological Trauma: Theory, Research, Practice & Policy*, 5, 453-461. http://dx.doi.org/10.1037/a0029386

Murphy, R. T., & Rosen, C. S. (2006). Addressing readiness to change PTSD with a brief intervention: A description of the PTSD motivation enhancement group. In J. Garrick & M. B. Williams (Eds.), *Trauma treatment techniques: Innovative trends,* 7–29. New York: Haworth Press.

National Institute of Health and Care Excellence. (2005). Quick reference guide: Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care. London: National Institute of Clinical Excellence. Retrieved from: http://www.nice.org.uk/nicemedia/pdf/CG026quickrefguide.pdf

Noblit, G.W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing qualitative studies*. Newbury Park, CA: Sage.

Ogles, B. M., Lunnen, K. M., & Bonesteel, K. (2001). Clinical significance: History, application and current practice. *Clinical Psychology Review*, 21, 421–446. http://dx/doi.org/10.1016/S0272-7358(99)00058-6.

*Parker, A., Fourt, A., Langmuir, J., Dalton, E., & Classen, C. (2007). The experience of trauma recovery: A qualitative study of participants in the women recovering from abuse program (WRAP). *Journal of Child Sexual Abuse*, 16, 55-77. http://dx.doi.org/10.1300/J070v16n02_04.

Powers, W. T. (2005). *Behaviour: The control of perception*, (2nd ed). New Canaan, CT, USA: Benchmark Publications.

Rennie, D. (2000). Aspects of the client's conscious control of the psychotherapeutic process. *Journal of Psychotherapy Integration*, 10, 151-167. http://dx.doi.org/10.1023/A:1009496116174.

Rosen, H., & Kuehlwein, K. T. (1996). *Constructing realities: Meaning-making perspectives for psychotherapists*. San Francisco, CA: Jossey-Bass.

Royal College of Psychiatrists. (2011). *Outcome measures recommended for use in adult psychiatry*. Royal College of Psychiatrists: London. Retrieved from: http://www.rcpsych.ac.uk/files/pdfversion/op78x.pdf

Safran, J. D., Crocker, P., McMain, S., & Murray, P. (1990). Therapeutic alliance rupture as a therapy event for empirical investigation. *Psychotherapy Theory, Research, Practice, Training*, 27, 154–165. http://dx.doi.org/10.1037/0033-3204.27.2.154

Sayin, A., Candansaya, S., & Welkin, L. (2013). Group psychotherapy in women with a history of sexual abuse: what did they find helpful? *Journal of Clinical Nursing*, 22, 3249–3258. http://dx.doi.org/ 10.1111/jocn.12168

Sermpezis, C., & Winter, D.A. (2009). Is trauma the product of over- or under-elaboration? A critique of the personal construct model of posttraumatic stress disorder, *Journal of Constructivist Psychology*, 22, 306 -327. http://dx.doi.org/10.1080/10720530903113862

*Shamai, M., & Levin-Megged, O. (2006). The myth of creating an integrative story: The therapeutic experience of holocaust survivors. *Qualitative Health Research*, 16, 692-712. http://dx.doi.org/10.1177/1049732306286699

*Shearing, V., Lee, D., & Clohessy, S. (2011). How do clients experience reliving as part of trauma-focused cognitive behavioural therapy for posttraumatic stress disorder? *Psychology and Psychotherapy; Theory, Research and Practice*, 84, 458-472, http://dx.doi.org/10.1111/j.2044-8341.2010.02012.

*Stige, H.S., Binder, P., Rosenvinge, J.H., & Traeen, B. (2013). Stories from the road of recovery: How adult, female survivor of childhood trauma experiences ways to positive change. *Nordic Psychology*, 65, 3-8. http://dx.doi.org/10.1080/19012276.2013.796083

*Stige, H.S., Rosenvigne, J.H., & Traeen, B. (2013). A meaningful struggle: trauma clients' experiences with an inclusive stabilization group approach. *Psychotherapy Research*, 23, 419-429. http://dx.doi.org/10.1080/10503307.2013.778437

Tedeschi, R.G., & Calhoun, L.G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry,* 15, 1-18. http://dx.doi.org/10.1207/s15327965pli1501_01

Thorne, S., Jensen, L., Kearney, M.H., Noblit, G., & Sandelowski, M.(2004) Qualitative metasynthesis: Reflections on methodological orientation and ideological agenda. *Qualitative Health Research* 14, 1342-1365. http://dx.doi.org/10.1177/1049732304269888

*Tummala-Narra, P., Kallivayalil, D., Singer, R., & Andreini, R. (2012). Relational experiences of complex trauma survivors in treatment: Preliminary findings from a naturalistic study. *Psychological Trauma: Theory, Research, Practice, and Policy*, *4*, 640–648. http://dx.doi.org/10.1037/a0024929

van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2006). *The haunted self: Structural dissociation and the treatment of chronic traumatization*. London: W.W. Norton & Company.

van Minnen, A.,Wessel, I., Dijkstra, T., & Roelofs, K. (2002). Changes in PTSD patients' narratives during prolonged exposure therapy: A replication and extension. *Journal of Traumatic Stress*, 15, 255-258. http://dx.doi.org/10.1023/A:1015263513654

*Vincent, H., Jenkins, H., Larkin, M. & Clohessy, S. (2013). Asylum-seekers' experiences of trauma-focused cognitive behaviour therapy for post-traumatic stress disorder: A qualitative study. *Behavioural and Cognitive Psychotherapy*, 41, 579-593. http://dx.doi.org/10.1017/S1352465812000550

Wilson, D. R. (2009). Stress management for adult survivors of childhood sexual abuse: A holistic inquiry. *Western Journal of Nursing Research*, 32, 103-127. http://dx.doi.org/10.1177/0193945909343703

Wilson, N., d'Ardenne, P., Scott, C., Fine., H., & Priebe, S. (2012). Survivors of the London bombings with PTSD: A qualitative study of their accounts during CBT treatment**.** *Traumatology*, 18, 75–84. http://dx.doi.org/10.1177/1534765611426793

Winter, D. (1992). *Personal construct psychology in clinical practice: Theory, research and applications*. London: Routledge.

World Health Organisation. (2010). *International statistical classification of diseases and related health problems* (10th ed). Geneva: Author.

.

Tables and Figures. Table 1. Characteristics of studies

Study/ Journal No.	Aim of study	Sample; Diagnosis & Trauma *Country research conducted in*	Therapy	Data collection	Analysis	Themes defined
J1 Shamai & Levin-Megged (2006)	To explore how Holocaust survivors experience therapy	11 Holocaust survivors considered posttraumatic in presentation, even if they do not exhibit all of the characteristics of PTSD. Trauma: living in concentration camps, loss/ parental separation *Israel*	Had applied and received 1-2 years of individual psychodynamic therapy in their 60's	Semi-structured interview	Phenomenological (Creswell, 1998; Spinelli, 1989)	1. Knowing and not knowing the story of the trauma 2. Therapy as a reproduction of the trauma and its aftermath, 3. The fight to keep the therapist as a split object 4. The perception of therapy as interminable, 5. Creating alternative narratives
J2 Parker, Fourt, Langmuir, Dalton & Classen (2008)	To understand how women with a history of child maltreatment experienced (WRAP)	7 women who self-reported a history of child maltreatment (e.g., including one or more of sexual, physical,& emotional abuse and/ or neglect) America	6 months post completion of Women Recovery from Abuse Program treatment: 8 weeks x4 days	Semi-structured interview	Phenomenological Analysis (Portney & Watkins, 2000)	1. Breaking trauma-based patterns 2. Doing therapy 3. The healing journey as a continuous process.
J3 Shearing, Lee & Clohessy (2011)	To explore participants' experiences of undergoing reliving as part of CBT for PTSD to further clinicians' understanding	7 participants (6 female, 1 male) All participants had experienced a 'type 1' trauma, defined as a single-event trauma, and had a diagnosis of PTSD. Types of trauma included physical and sexual assault *UK*	Completed reliving component of trauma focused CBT in the previous month.	Semi-structured interview	IPA (Smith & Osborn, 2003)	1. Overcoming ambivalence 2. Painful but achievable 3. Positive change

J4 Brown, Kallivayali, Mendelsohn & Harvey (2012)	To document characteristics and dilemmas of early recovery from complex trauma and to identify sources of resilience	20 participants (2 men, 18 women) Majority PTSD diagnosis or comorbid diagnoses of Major Depressive Disorder, Bipolar Disorder, and Dissociative Identity Disorder *Canada*	Engaged in 3 months+ of treatment at adult outpatient clinic that specialised in complex trauma	Semi-structured interview	Grounded theory (Strauss & Corbin, 1990)	1. Preludes to vulnerability 2. Corruption of self-experience and identity development 3. Paradoxical extremes of functioning 4. Signs and sources of resiliency and well-being theme included
J5 Tummuala-Narra, Kallivayalil, Singer & Andreini (2012)	To increase understanding of how survivors of complex trauma engaged in treatment experience	21 participants (18 female and 3 male), most diagnosed with PTSD. Trauma included: child sexual and physical abuse, adult sexual assault, domestic violence, and neglect *Canada*	Actively engaged in individual or group psychotherapy 8 months into treatment	Semi-structured interview	Grounded theory (Strauss & Corbin, 1990)	1. Issues of safety 2. Forming new ways of relating 3. Changing sense of self
J6 Gone (2013)	To illuminate challenges of bridging evidence based therapies with culturally sensitive therapy by exploring narratives of healing	Explore healing from the perspective of 19 staff and native American's who had "historic trauma" Only including themes related to 11 clients. Trauma defined as anomie, bereavement, relational problems, sexual abuse *America*	8 graduates from the 10 week therapeutic programme (Models and Metaphors of Healing Project)	Semi-structured interview	Thematic content analysis	1. Emotional burdens 2. Cathartic disclosure 3. Self-as-project reflexivity 4. Impact of colonization

J7 Stige, Rosenvinge & Traeen (2013)	To explores how trauma clients experience participation in an inclusive psycho-educational stabilization group.	13 women Multiple traumas Including ;incest, sexual abuse, physical abuse, rape, partner abuse, and/or psychological abuse *Norway*	3 months following the completion of a 17 week stabilization group (informed by Herman's Trauma model)	Semi-structured interview	Hermeneutical–phenomenological approach (Alvesson & Skoldberg, 2000)	1. Dreading and hoping 2. Preparing for participation 3. Tuning in and staying put 4. Meeting other trauma survivors 5. Acquiring a stabilizing ballast 6. Being receptive to change
J8 Stige, Binder, Rosenvinge & Traeen (2013)	To explore how female survivors of childhood trauma who have sought treatment experience ways to positive change	13 women Multiple traumas Including ;incest, sexual abuse, physical abuse, rape, partner abuse, and/or psychological abuse *Norway*	3 months following the completion of a 17 week stabilization group	Semi-structured interview	Hermeneutical–phenomenological approach (Alvesson & Skoldberg, 2000)	1. Finding new ways to understand one's emotions and actions Moving from numbness toward vital contact 2. Becoming an advocate of one's own needs 3. Experiencing increased sense of agency 4. Staying with difficult feelings and choices
J9 Vincent, Jenkins, Larkin & Clohessy (2013)	Considers the acceptability of TFCBT for asylum-seekers with PTSD by exploring their experiences of treatment.	7 asylum-seekers (3 female, 4 male) PTSD diagnosis. Trauma: physical assault, sexual assault, witnessed others (including family) being killed or seriously harmed, gang rape, torture, war, imprisonment *UK*	Actively engaged in month+ of CBT involving a TFCBT component of individual treatment	Semi-structured interview	IPA (Smith & Osborn, 2003).	1. Staying where you are versus engaging in therapy 2. Experiences encouraging engagement in therapy 3. Experiences impeding engagement in therapy 4. Importance of the therapeutic relationship 5. Losing oneself 6. Regaining life

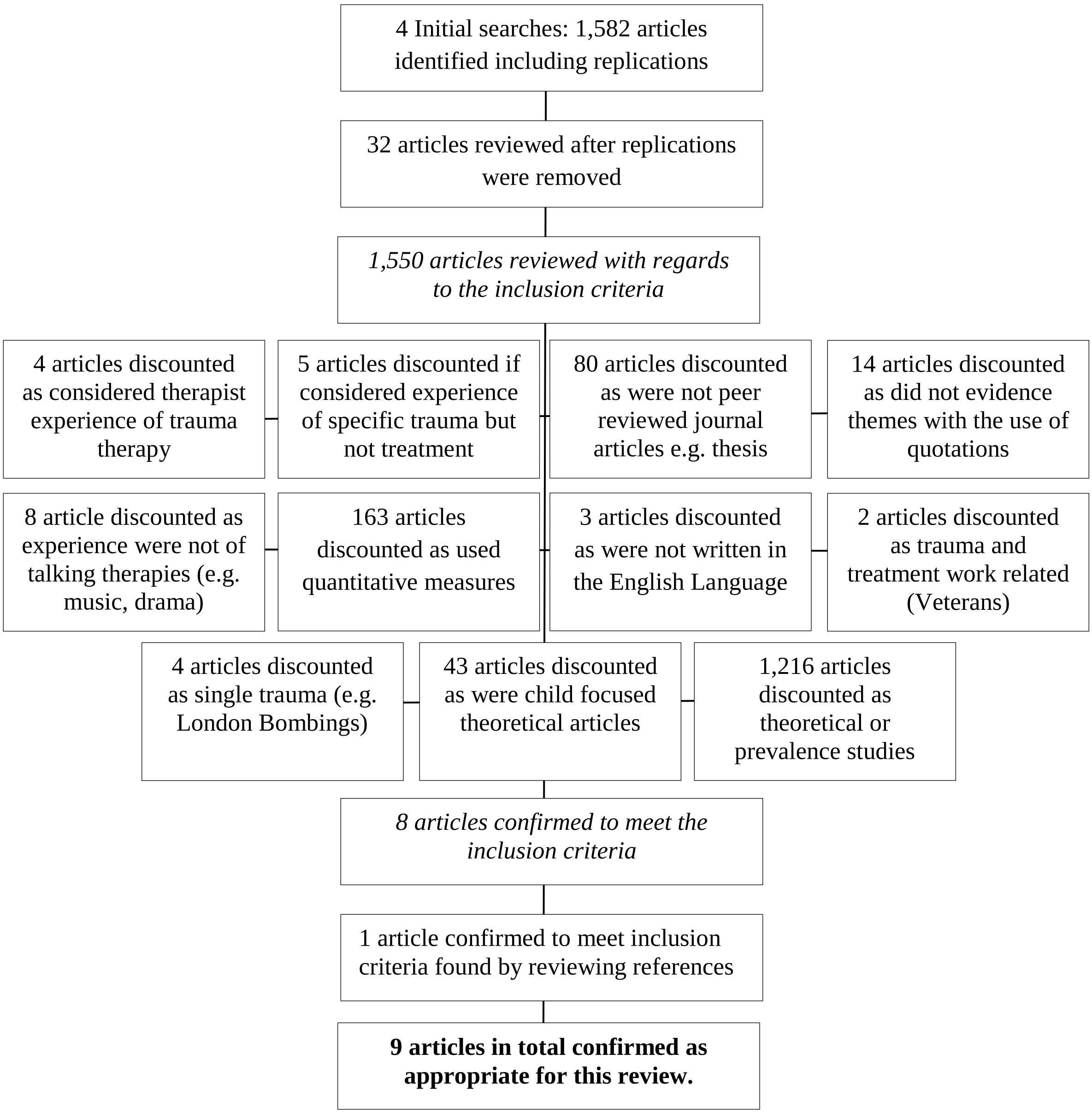
Table 2. summary of CASP assessment of quality of articles

CRITICAL APPRAISAL SKILLS PROGRAMME (2011) Criteria	Articles included in Meta-Synthesis								
	J1	J2	J3	J4	J5	J6	J7	J8	J9
1. Clear aims of the research?	2	2	2	2	2	2	2	2	2
2. Is a qualitative methodology appropriate?	2	2	2	2	2	2	2	2	2
3. Was the research design appropriate to address the aims of the research?	2	1	2	1	2	2	2	1	1
4. Was the recruitment strategy appropriate to the aims of the research?	1	1	2	1	2	2	2	2	2
5. Were the data collected in a way that addressed the research issue?	2	2	2	2	2	2	2	2	2
6. Has relationship between researcher and participants been adequately considered?	0	2	0	0	0	2	2	2	0
7. Have ethical issues been taken into consideration?	1	2	2	2	2	0	1	0	0
8. Was the data analysis sufficiently rigorous?	2	2	2	1	2	2	2	2	2
9. Is there a clear statement of findings?	2	2	2	1	2	1	2	2	1
10. How valuable is the research?	2	2	2	2	2	2	2	2	2
Total	16	17	18	14	18	17	19	19	14

Table 3. Summary of themes from this meta-synthesis

Main theme	Sub-theme	Studies supporting theme
Theme 1 Detached to survive: engaging through despair	Accepting change is needed	1, 2, 3, 4, 5, 6, 7, 9
	Embracing vulnerability	2, 3, 4, 6, 7, 8, 9
	Letting go and sharing: reducing avoidance	1, 3, 4, 5, 6, 7, 9
Theme 2 Therapy as incongruent to instincts	Connecting through the therapeutic relationship	1, 2, 5, 7, 8, 9
	A new relationship to self and others	2, 3, 4, 5, 7, 9
	An ongoing journey of gains and losses	2, 3, 4, 5, 8, 9

Process of identifying articles for meta-synthesis



Appendices:

Appendix 1-C: Author guidance for journal

Psychological Trauma: Theory, Research, Practice, and Policy

http://www.apa.org/pubs/authors/manuscript-check.aspx

Manuscripts for ***Psychological Trauma: Theory, Research, Practice, and Policy*** can vary in length, but may not exceed 25 double-spaced manuscript pages (including title page, abstract, manuscript body, references, and tables/figures.) Manuscripts that exceed this length may be returned without review. Authors do have the option of electronically archiving supplemental material, such as tables and figures, in order to assist them in keeping their articles to the required length. (See below.)

While ***Psychological Trauma*** primarily publishes original empirical studies, we are also open to reviewing high quality literature reviews and clinical, qualitative, theoretical and policy articles.

Manuscript Preparation

Prepare manuscripts according to the ***Publication Manual of the American Psychological Association*** (6th edition). Manuscripts may be copyedited for bias-free language (see Chapter 3 of the ***Publication Manual***).

Review APA's Checklist for Manuscript Submission before submitting your article.

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the ***Manual***.

If your manuscript was mask reviewed, please ensure that the final version for production includes a byline and full author note for typesetting.

Below are additional instructions regarding the preparation of tables.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Submitting Supplemental Materials

APA can place supplemental materials online, available via the published article in the PsycARTICLES® database. Please see Supplementing Your Article With Online Material for more details.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 260 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

- **Journal Article:**
  Hughes, G., Desantis, A., & Waszak, F. (2013). Mechanisms of intentional binding and sensory attenuation: The role of temporal prediction, temporal control, identity prediction, and motor prediction. ***Psychological Bulletin, 139,*** 133–151. http://dx.doi.org/10.1037/a0028566

- **Authored Book:**
  Rogers, T. T., & McClelland, J. L. (2004). ***Semantic cognition: A parallel distributed processing approach.*** Cambridge, MA: MIT Press.
- **Chapter in an Edited Book:**
  Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), ***Destructive organizational communication: Processes, consequences, and constructive ways of organizing*** (pp. 53–73). New York, NY: Taylor & Francis.

Figures

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.

The minimum line weight for line art is 0.5 point for optimal printing.

For more information about acceptable resolutions, fonts, sizing, and other figure issues, please see the general guidelines.

When possible, please place symbol legends below the figure instead of to the side.

APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.

For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

- $900 for one figure
- An additional $600 for the second figure
- An additional $450 for each subsequent figure

Permissions

Authors of accepted papers must obtain and provide to the editor on final acceptance all necessary permissions to reproduce in print and electronic form any copyrighted work, including test materials (or portions thereof), photographs, and other graphic images (including those used as stimuli in experiments).

On advice of counsel, APA may decline to publish any image whose copyright status is unknown.

- Download Permissions Alert Form (PDF, 13KB)

Publication Policies

APA policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications.

See also APA Journals® Internet Posting Guidelines.

APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

- Download Disclosure of Interests Form (PDF, 38KB)

Authors of accepted manuscripts are required to transfer the copyright to APA.

- For manuscripts **not** funded by the Wellcome Trust or the Research Councils UK
  Publication Rights (Copyright Transfer) Form (PDF, 83KB)
- For manuscripts funded by the Wellcome Trust or the Research Councils UK
  Wellcome Trust or Research Councils UK Publication Rights Form (PDF, 34KB)

Ethical Principles

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

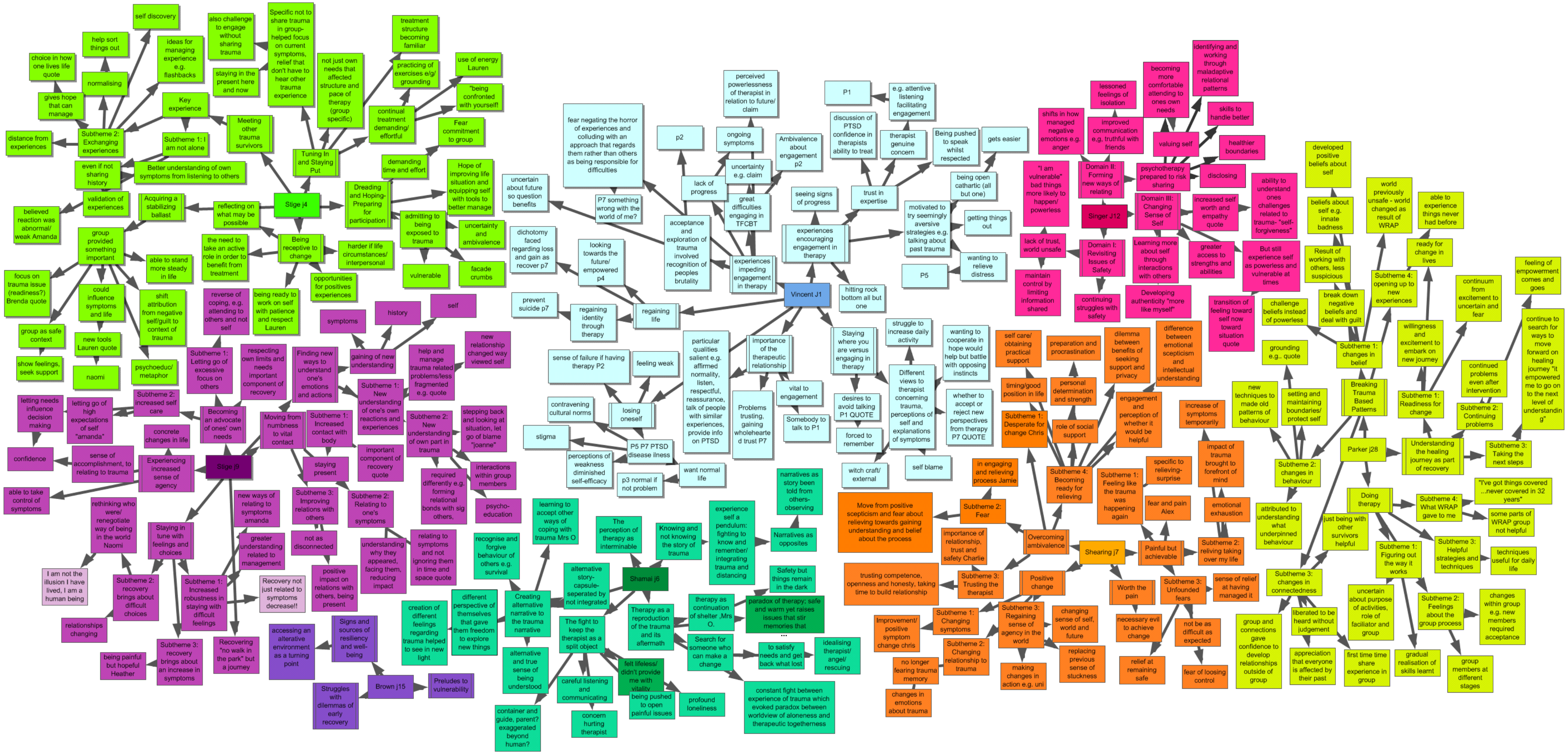
APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.

Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

- Download Certification of Compliance With APA Ethical Principles Form (PDF, 26KB)

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on its website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, ***American Psychologist***, Vol. 47, pp. 1597–1611.

Appendix 1-B: Extract from beginning stage of synthesis



Appendix 1-C : Extract of working up early theme about therapeutic relationship including supporting quotes and aspects of contradiction

Theme considering role of therapeutic relationships **(Colour indicates paper of origin)**

Therapist's as an expert

Participants understood their therapists to be trained and experienced, and this facilitated "trust in the therapist's professional expertise", which appeared to aid engagement.
P5: He [therapist] deals with these people who have problems so he tells you like that. He can't just tell you from nowhere to do things, so it must have a result. [. . .] I used to force myself to do it just because I feel that it's going to help me.
P1, P4, P5 and P7 reported that their therapist discussed a PTSD diagnosis with them. Some described that this increased their confidence in the therapists' abilities to identify and treat their difficulties:
P7: With this diagnosis they can lead me to the way I can deal with this illness.

Wholehearted trust

All participants spoke about the importance of their relationship with their therapist, describing how experiencing trust, and safety within this relationship encouraged their engagement in reliving.
Charlie: 'I think having the support from [therapist] was a big help, cos I trusted her. And I believed if she told me that it was gonna help, cos there was a small part of me that thought this was never gonna help, but then I did, I trusted her so that was a massive thing for me'.
Participants spoke about trusting the therapist's competence, openness and honesty, and the importance of taking time to build a relationship prior to completing reliving

Several participants described problems trusting people following their traumas and initially distrusted their clinician. Over time, participants described gaining whole-hearted trust in their therapist, despite their original suspicions:
P7: He forced me to trust him, whereas I am a person who doesn't trust people and I was telling him everything. I was myself shocked because I thought, you know, he is a doctor, he might tell anybody about my experience. Trust in the therapist appeared vital to participants and their engagement.

BUT……Concerns about safety also led one participant to try to regain power by limiting the amount of information revealed to others, and by refraining from maintaining friendships altogether. Several participants (*n* _ 10), however, described continuing struggles with their perception of safety, primarily through a continuing lack of trust in others or a general feeling that the world is an unsafe place. As one participant noted, *"I feel extremely vulnerable and powerless in the world. I see people as vicious."*

Genuine empathy and validation

In addition to trusting the therapist's professional expertise, the participants also spoke about perceiving their therapists to be genuinely concerned for them, over and above their job. This was demonstrated through practical help, attentive listening, and signs of empathy, and it was perceived to facilitate the participants' engagement in therapy:

Many participants recalled feeling abnormal and ashamed due to their problems and valued having their normality reaffirmed by their therapists. Participants recounted how therapists affirmed their normality by listening with respectful understanding, providing reassurance, telling them about other people who had similar experiences, and by providing information about PTSD

P1: So as the time goes she, you know, I could say anything to her without getting, you know, without even minding about it, but if she had, if she has not won my love, some of the things, it's not easy to talk about it, you know. So that's the way, you know, she made me feel that surely she's a good, she's a good person, she's a friend, she's concerned with my life.

BUT…..Mrs. R. illustrates this duality:….something beyond being heard,,,,
I did not like to come to the therapeutic sessions, though I liked Mrs. H. [the therapist] very much. She was a clever woman, she listened to me, she accepted me, but I needed something else. I felt that I needed to be loaded, I felt lifeless. I needed to be loaded with some vitality and she didn't provide it . . . however, I respected her very much and liked to talk with her, but I didn't feel a real closeness. I loved the way she dressed up.

Exchanging experiences with the other group members was reported as being particularly significant by these participants. It resulted in a normalization of their experiences, a feeling of being competent, and the validation of their own experiences.

For many participants, WRAP represented the first time they had a chance to share their experiences with others. Participants reported that talking, working, and just being with other survivors in WRAP was helpful. Participants stressed how liberating it was to have their story heard without being judged. As one woman put it: *Um . . . I guess the fact that you're not alone in your struggle. WRAP taught me that. How other people have been through traumatic experiences and everyone has to deal with them differently but* ***I felt part of the group because no one was judging me, no one was condemning me or looking at you like you were dirty or shameful****. It just made me feel connected to the other women.*

Appendix 1-D. Table example of grouping and working up overarching themes

Overarching theme	Supporting theme(s) from original papers	Quote from original paper	Original paper's author
Accepting change is needed: ambivalence	• Overcoming ambivalence	'I'd got to a point that I was so desperate for something to work, or to feel better in some way, that, you know, they could have said well we'll try burning joss sticks and chanting for half an hour and I probably would have had a go'.	Shearing, Lee & Clohessy (2011)
	• Breaking Trauma Based Patterns • Doing therapy	At first I thought [leisure] was ridiculous, as I did the art part of it. But I could see the reasons why. Because it was a release, it was a distraction. It's okay to laugh; it's okay to have fun. You know, not always being accomplishing something.'	Parker, Fourt, Langmuir, Dalton & Classen (2008)
	• Staying where you are versus engaging in therapy • Experiences impeding engagement in therapy	Up 'til now I don't know if it's helpful hundred percent or not because I do sometime cancel the appointment with her [therapist]. Just I had a strongly feeling to, to stop come here and sometime I feel like and sometime I ring her and say "can I make appointment with you?". So it's like levels of feeling and I don't know for how long I will see her.	Vincent, Jenkins, Larkin & Clohessy (2013)
	• Dreading and Hoping- Preparing for participation	Initially, I dreaded the group, because I know I am not a verbal person, really. (. . .) Maybe because I am so anxious and a bit scared of talking; it takes some time for me to formulate everything the way I want, so I don't see it as my strength. So I dreaded beginning to speak in front of a group.	Stige, Rosenvinge & Traeen (2013)
	• Therapy as a reproduction of the trauma and its aftermath • The fight to keep the therapist as a split object	I felt very safe in therapy; she [referring to the therapist] was there with me. She really cared . . . but there were things, like this event when I was raped that I didn't tell her. Maybe if I had talked about it during the years it would be easier . . . so, the therapy eased my discomfort feelings and that was enough. I did not touch the depths of my soul, and I don't think that it was necessary to do so.	Shamai & Levin-Megged (2006)
Readiness and despair	• Understanding the healing journey as part of recovery	I sat down one day and went, OK, um . . . I'm in, I'm the reason that this abuse is happening, I'm part of the program, I'm part of the equation, I can't keep saying it's the people that I'm picking, it's the people that are in my life. No, I'm picking these people for a reason, but I don't know what that reason is.	Parker, Fourt, Langmuir, Dalton & Classen (2008)
	• Becoming ready for relieving	I think if I hadn't been in such a good position in my life in generally, I don't think I would've had the effort or the determination or the energy to kind of do it, or the support'.	Shearing, Lee & Clohessy (2011)
	• Experiences encouraging engagement in therapy	P2: I was really getting at the end of my rope. I was, I was tired of, sort of, like fighting to be alive [. . .] I was really, really close to just ending everything	Vincent, Jenkins, Larkin & Clohessy (2013)
	• Dreading and Hoping- Preparing for participation	Now I was receptive! I had identified myself with having problems. I had understood that it is not the German measles. It doesn't help to eat painkillers. I was receptive to getting help. Earlier, when I lived like a machine, I wasn't receptive at all. That is the difference	Stige, Rosenvinge & Traeen (2013)

Section Two: Research Paper

Exploration of how children and young people self-construe following a traumatic experience

Word Count: 7,973

Amy D'Sa

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:
Amy D'Sa
Doctorate in Clinical Psychology
Furness College
Lancaster University
Lancaster
LA1 4YT
a.dsa@lancaster.ac.uk

Prepared for Journal Child & Adolescent Trauma

---

[1] See Appendix 1-A for 'Notes to Contributors'

Abstract

Given associations between self-esteem, emotional difficulties, relational issues and trauma, this study explored how children and young people think about themselves following traumatic experience. Personal construct methodology, namely, a pictorial self characterisation was used to encourage creative and developmentally appropriate exploration of how seven children and young people (9-15 years) construe self. Individual constructs were identified through the use of self-characterisation analysis guidance, where reviewed transcripts later informed a thematic analysis. Four overarching themes were generated: The Inferior, The Misfortunate, The Protective and The Enhanced selves. Findings were considered in relation to relevant research and theory. Clinical implications include consideration of importance of exploring different parts of self from a child or young person's perspective.

Exploration of How Children and Young People Self-construe Following a Traumatic Experience Understanding Trauma

Trauma experience has important consequences for informing a child or young person's "cognitive and emotional orientation to the world" (Finkelhor & Browne, 1985, p.531) such as difficulties identifying, expressing and regulating emotions and struggles to sustain attention which can contribute to weaknesses in cognitive abilities (Cook, et al. 2005). Trauma can impact on an individual's ability to build and maintain relationships (e.g., Hill & Safran, 1994). Moreover, a child's world view and sense of self is affected, where feelings of shame, guilt and low self-worth are common and where the world is experienced as being unsafe (Herman, 1992).

Various definitions of trauma have been proposed (e.g. Greeson et al., 2011). This research adopts a broad definition which is widely used in the trauma literature (e.g. Silberg, 2012) and is in line with evidence that emphasises the importance of subjective experience (e.g. Agar, Kennedy, & King, 2006). Trauma is defined as a "unique experience of an event or enduring conditions in which the individual's ability to integrate his/her (emotional) experience is overwhelmed and the individual experiences (either objectively or subjectively) a threat to his/her life, overall integrity or that of a caregiver or family member" (Pearlman & Saakvitne (1995, p.60).

Trauma can result from a range of disparate 'traumatic' experiences including one-off events such as car accidents and violent crimes and include multiple stressors such as chronic poverty, war, abuse, the loss of a loved one or a natural disaster (Janoff-Bulman, 1992). Trauma may also be understood to relate to experiences of bullying, family breakdown, witnessing others under the influence of drugs or alcohol and through implications of illness (e.g. separation from attachment figures; van der Kolk, 1988).

Historically conceptualisations of trauma have been derived from adult experiences and cannot be meaningfully generalised to children and young people (Alisic, Jongmans, Wesel, & Kleber, 2010). A child’s limited life experience, developmental abilities and resources to independently cope with difficult experiences are reflected in how they present differently to adults following trauma. Children often express distress following trauma through disorganised behaviour or re-enacting trauma through play and are unable to detach themselves from distress as an adult might (Ronen, 1996). Correspondingly, the new Diagnostic Statistical Manual (DSM-5) introduced a trauma category specific to children under six to reflect key differences described above (APA, 2013).

Self-Construing

Importantly, how a child or young person responds to a trauma experience in relation to their self-image (how they think about themselves) or self-esteem (how they evaluate and feel about themselves; Butler & Green, 1998) is strongly related to development (e.g. Evans, Brody, & Noam, 2001). Through continuous experience the way a child self-construes changes and typically gains in complexity (Salmon & Bryant, 2002). Given the changing nature of construing, it is not surprising that research has focused on developmental differences, such as exploring the role of language acquisition between adolescents, who are found to use more abstract constructs of self, in comparison to younger children who are more concrete (Evans, Brody, & Noam, 2001).

Self-construing is vital in a child or young person’s social and emotional growth (Kagen, Moore, & Bredekamp, 1995) as low self-worth is indicative of depression, adult mental health difficulties and relational issues (Evans, 1994). Conversely, construing self positively is related to resilience and could support an individual in managing difficult situations (Elmer, 2001). Showers (1992) asserted that holding positive self-concepts is associated with wellbeing when he found students who reported active positive self-concepts scored higher on self-esteem measures and lower of depression scales.

Nevertheless, child trauma models have neglected subjective experience, and instead have prioritised explanations for factors associated with post-traumatic reactions generated from quantitative investigation (e.g. La Greca, Silverman, Vernberg, & Prinstein, 1996). Few studies have explored self-construing in traumatised children. Goins, Winter, Sundin, Patient, & Aslan (2012), for example, explored self-constructs in child soldiers who had being forcibly conscripted. Using quantitative analysis they found, compared to children who had not entered combat, child soldiers construed themselves in more positive ways (e.g., I am good). Goins et al. explained this within a context of specific social and cultural processes while also reporting that children renounced responsibility for their crimes given they did not participate of their free will. Additionally, Ijaz and Mahmood (2012) reported a case of an adolescent runaway who had been rejected by his parents. Through quantitative analysis they found this young person construed himself positively, as being distant from others, and as being independent. The specific nature and cultural context of both papers makes it hard to translate the findings to children in the UK although it indicates that children may construe self in unexpected ways.

Furthermore, research looking at self-construing in adults has focused on victims of childhood sexual abuse. Participants within such research have been found to construe themselves as being different from others, while holding limited constructs relating to emotional experience (Bhandari, Winter, Messer, & Metcalfe, 2011; Harter, Erbes, & Hart, 2004). This limited empirical evidence means models explaining the relationship between trauma experience and self remains restricted largely to empirical evidence from adult populations (e.g. Ehlers & Clark, 2000) or those specific to children are often generated based on clinical experience (e.g. Herman, 1992).

Theory of Personal Construct Psychology

This research draws on the theory of Personal Construct Psychology (PCP). PCP provides a theoretical framework which describes how an individual constructs personal meaning from their experience (Gergen, 2011) which includes self-constructs. Kelly argued constructs are dichotomous. Supporting research has compared methods of eliciting constructs and found consistently that constructs hold contrasting or negatively correlated pole ends (Epting, Suchman & Nickeson, 1971; Walker & Winter, 2007).

The dichotomy of constructs is argued to allow for personal meaning (Adams-Webber, 1979). Through lived experience a child continues to evaluate and modify their construct (e.g. ‘good—bad’). Indeed, appraising experience is central in other theories (e.g. cognitive) and supported by empirical evidence (e.g. Agar, Kennedy, & King, 2006). Evans, Ehlers, Mezey and Clark (2007) found youth offenders were more likely to have significant PTSD symptomology if they held negative appraisals about the likelihood of danger when compared to high measures of objective threat.

Constructs are argued to be organised within a complex hierarchical structure (Harter, 1999) according to how accessible they are (e.g., ability to bring it to mind or express it). The less available (superordinate) constructs tend to be core, more resistant to change and stable over time, whereas the more accessible (subordinate) constructs are more adaptive (Butler, 2006). Neimeyer, Anderson and Stockton (2010) provided support for a hierarchical construal system by investigating students’ constructs. Laddering (Hickle, 1965) questions were used to explore meaning and are assumed to tap into superordinate constructs. Through interviewing 103 students, Neimeyer et al. analysed the structure and content of interviews. They reported students elicited superordinate constructs as constructs that reflected purpose and core meaning which was distinct from other elicited constructs that were more adaptive (subordinate).

More specifically, there are adult PCP models relating to trauma and self. Sewell (2005; 2003) believed that traumatic events fail to be anticipated under a person's current construct system. When a trauma occurs this invalidates or conflicts their view of the world. Given the person does not have an alternative way of making sense of their experience this creates feelings of 'threat' (Janoff-Bulman, 1992). Trauma related constructs are therefore simplistic, negative, 'under-elaborated' (lack richness) and remain detached from established constructs an individual may draw upon in other contexts or relationships (Sewell, 1996). In contrast Sermpezis and Winter (2009) proposed that adults who experience trauma construe in ways that are instead rich meaning trauma related constructs are superordinate and form a reference point within a person's autobiography which has a wide reaching impact on the way someone sees themselves (e.g., I am worthless), others (e.g., are untrustworthy) and the world (e.g., is unsafe).

Therefore, in recognition of the limited research on self construing and trauma in children and young people, and in consideration of the potential impact of a traumatic experience, this qualitative study recognises the value of exploring self from a child or young person's perspective. This can provide valuable insight which may illustrate differences between how children construe self compared to adults who also have experienced trauma (e.g. Goins et al, 2012). Moreover, such understanding could help develop practice to meet the specific needs of children and young people. Therefore the current study aimed to explore how children and young people think about themselves (self-construe) following a traumatic experience.

Methodology

Design

A qualitative research design was adopted where children and young people (8-16 years) were invited to an interview where they would complete and then discuss a pictorial self-characterisation sketch (Bell & Bell, 2008).

Recruitment

Participants of 8-16 years were recruited; the age range reflected a minimum and maximum age that was necessary to complete aspects of inclusion criteria (e.g. Trauma Symptoms Checklist- Alternate, TSSC-A) while also assuring all participants were able to engage in a creative interview process which included verbally and non-verbally elaborating on content.

Participants were recruited from clinical sites within NHS services in the north of England: four teams within a Child and Adolescent Mental Health Service (CAMHS) and two teams in a Children's Psychological Service. These services were identified as Tier 3 services that support children and young people who have experienced a trauma, as recommended by UK national guidance (NICE, 2005). Ethical approval was granted from the North West REC and two NHS Trusts Research and Development departments (see ethics section).

Participants were initially identified by clinicians in accordance with guidance set out in clinician information packs (ethics section). In order to identify children who had experienced trauma but had not necessarily been diagnosed with PTSD, clinicians were asked to apply a broad definition of trauma (Pearlman & Saakvitne, 1995). Additionally the entire TSCC-A was administered to screen for a trauma presentation according to objective criteria.

TSCC-A

The TSCC-A (Briere, 1996) is a self-report measure of posttraumatic stress and related psychological difficulties for children ages 8-16 years. It has five clinical subscales (anxiety, depression, post-traumatic stress, dissociation and anger; Feindler, Rathus, & Silver, 2003). The TSCC-A is commonly used in services and research for a range of traumatic experiences where normative scores, good internal consistency and validity have been reported using diverse clinical and non-clinical samples (e.g. Elliot & Briere, 1994; Lanktree & Briere, 1995).

The TSCC-A involves rating 44 items on a four point Likert scale from 0 (never), to 3 (almost all the time) which results in a total raw score for each subscale. The post-traumatic stress (PTS) subscale raw score ranges from 0-30, where a higher scores indicates greater posttraumatic distress. T scores can only be derived for each subscale, where a T score of 60 or above indicates a ‘sub-clinically trauma presentation’ and scores of 65 or above indicate a ‘clinically significant symptomology’ (Briere, 1996). Given the PTS subscale is the only subscale that reflects criteria specific to a posttraumatic presentation (e.g. scary ideas pop into my head) rather than related distress (e.g. worrying about things) the researcher was interested in the PTS subscale T score.

Inclusion and Exclusion Criteria

The TSCC-A allowed the researcher and clinicians a way of identifying trauma, using a common language. Moreover, it distinguished children and young people with moderate levels of distress from those reporting highly symptomatic presentations. Given this study was a new venture, the TSCC-A was used as an added precaution, so participants were only invited to take part if they obtained a PTS subscale T score of 80 or below. A lower limit PTS score was not applied as an exclusion criterion as individuals can appear stable and not symptomatic at one time then may present with extreme levels of distress following a triggering experience (Briere, 1996). Therefore children and young people who had a known traumatic history (identified by clinicians and latterly by parents/participants) were invited to take part even if they were not symptomatic at the time of completing the TSSC-A.

Additionally, participants had to have attended three or more clinical appointments suggesting established engagement with a clinician beyond a standard assessment. This allowed for a named clinician to be identified on the expression of interest form (see ethics section) so that there was a clear path for managing risk issues. Moreover, this supported clinicians making a professional judgment to ensure participants were safe to take part.

Potential participants were excluded if they did not speak English, given the need for verbal elaboration. Participants not in a ‘stable environment’ i.e. as defined as being ‘cared for’, not in a long term placement, not attending mainstream school, or for whom safeguarding issues were active, were also excluded. These parameters were used to minimise the potential risk to those taking part.

Procedure

Following inclusion criteria being met, the clinician provided a recruitment pack (see ethics section). This pack included a letter to the parent/guardian(s), a parent information sheet (PISa), a child/young person information sheet (PISb), an expression of interest form (EIS) and a stamped addressed envelope. On behalf of their child, parent/guardian(s) were asked to return the fully completed EIS (including contact details, a named clinician and PTS T score).

Once in receipt of an EIS, the researcher contacted the parent/guardian(s) on behalf of the child to answer questions and arrange an interview. Consent from both the child and parent(s) were recorded separately (see ethics section) before the interview. Confidentiality was stated on information sheets and before the interview. The interview was digitally audio-recorded to allow the researcher to fully attend to the child’s needs.

Participants

An EIS was completed and returned by 10 participants, however only seven remained eligible to take part and were interviewed (see Table 1). Participant pseudonyms, age and trauma related information shared during taking part is provided in Table 2 which notes six participants were female aged 14-15. Six participants had ‘clinically significant presentations’ according to their TSCC-A PTS subscale score, scores ranged from 47-78. The seventh child was included in line with inclusion criteria.

Insert Table 1.

Insert Table 2.

Interview Procedure

A 60 minute interview involved the young person being invited to draw a pictorial self-characterisation (Bell & Bell, 2008). This adapted developmentally appropriate PCP technique is designed to support an individual articulating self-constructs (Marsh et al., 2002) while using both verbal and visual methods (Fantuzzo et al., 1996). Visual methods supported those accessing the interview, given delays in developmental milestones, including expressive and receptive language, are associated with trauma (Blaustein et al., 2007). Moreover, this creative way of exploring self is found to encourage spontaneous undirected expression while supporting the safe exploration of difficult emotive constructs which may be in a ‘lower level of awareness’ (Ravenette, 1977).

The primary instructions were:

“We are here to see how you think about yourself. Although one of the reasons you have been asked is because something scary or worrying may have happened, I will not be asking you to tell me about this. Instead I am going to start by asking you to draw me a picture(s). Just think about yourself and draw a picture. When you are done we can spend some time talking about what you drew”.

Following the completion of the drawing the researcher asked the young person “could you tell me about your drawing?” In relation to the response, constructs or phrases verbalised by the young person would be noted down and key aspects were repeated back (e.g., I am different). Then the young person would be asked which constructs they wanted to talk about first. The researcher encouraged the sharing and elaboration of constructs by using laddering questions (Hickle, 1965) which explore core meanings (e.g., is ‘being different important?’) and pyramiding questions (Landfield, 1971) which explore descriptions of self or actions (e.g., ‘how do you know someone is ‘being different?). Also to elicit both pole ends of a construct, young people were asked additional questions (e.g., “if you weren’t different what would you be?).

It is important to note one young person chose not to complete a pictorial self-characterisation. However, this interview was still conducted. The participant, although encouraged to engage in the entire process, way keen to engage in the verbal elaboration of constructs in keeping with the methodology used with other young people.

At the end of the interview the young person was asked how they had found the process and if they wanted to share any information with their parent(s) or clinician. As a means of supporting emotional regulation before leaving the interview a fun activity (e.g., board game) was offered.

Data analysis

For the purpose of this research, the following operational definition of construct was applied; “a means whereby a child verbally makes discriminations about the world in relation to self and others” (Robinson, 2012, p.45), such as I am “worthless” but others are “perfect”.

Self characterisation guidance

Having transcribed interviews the researcher individually analysed each transcript with reference to self characterisation guidelines (Bell & Bell, 2008; Kelly, 1955). This guidance is used to identify constructs, record process and identify important context. A table was created for each participant (Tables 3-9) to capture; (a) observations of what was drawn, (b) constructs first elaborated, (c) sequence and transitions between constructs, (d) ‘core’ and repeated constructs and (e) details of the context of construing (f) details shared about trauma experience. The researcher then went through a process of identifying similarities and differences across the 6 areas of self characterisation analysis and summarized this in a table (see Appendix 2-J). This processes allowed the researcher to become familiar with the data while identifying areas of importance and commonality.

Identifying individual constructs

The researcher then went back to each transcript to identify emergent constructs (constructs mentioned first e.g. secretive) and contrasting constructs (elicited as opposite to the emergent construct e.g. open). Where possible a preferred position (P) within the construct was noted (e.g. secretive-----open (P)). This information was collated into individual tables (see Appendix 2B-2H).

Insert Table’s 3-9.

Generating themes

Thematic analysis (Braun & Clarke, 2006) was identified as the most appropriate method of analysis given its flexibility which allowed for a rich account of how young people think about themselves while complementing the PCP methodology and constructivist position that individuals “create rather than discover constructions of reality” (Ruskin, 2002, p.2).

Through reading and re-reading transcripts, codes (relating to individual constructs) were noted on individuals transcripts which started a process of identifying aspects of interest (for example, Appendix 2-I). Following this, initial constructs and associated codes from individual transcripts where grouped in tables in juxtaposition. To ensure that the individual context was not lost in this process, the participants’ names were also included. Through a process of organizing these constructs and codes the researcher began to identify aspects of commonality which later formed subthemes and overarching themes (also see Appendices 2K-2N).

Evidence to support emerging themes was gathered including the researcher reviewing the self characterisation analysis summary table (Appendix, 2-J). This assured themes reflected all identified areas of importance to the research question. Furthermore a process of checking and reviewing themes within individual transcripts and then across transcripts took place. Following a continual process of naming and renaming themes, clear, comprehensive and representative names were given to each theme, where subthemes demonstrate diversity and complexity within themes.

Reflexive Position

Keeping a reflective diary promoted the researcher to consider their own biases (e.g., clinical experiences) which informed how the study was developed, conducted and reported. Through sharing reflections during regular discussions with their supervisors, the researcher increased transparency in the analysis including comparing independently formed initial codes made across transcripts (see example, Appendix 2-0).

Discussing potential interpretations supported the development of a richer understanding of the data's meaning (Tracy, 2010). Consequently, the researcher adapted an earlier theme 'not wanting to be a bad person'. Following discussions with supervisors, about the commonality of this interpretation across participants, the researcher developed themes to reflect the entire data set. At these times, the researcher shared the analysis process (e.g., Appendices 2K-2N) which lead to discussions, for example, that participants described demonstrating 'not wanting to be seen as being bad' which could also be interpreted as being about how participants established positive ways of relating. This was later conceptualised within the subtheme 'seeking caring roles'. Through this dynamic process of discussing themes, there was final agreement that the themes reported reflected the data.

Findings

Although findings report commonalities across participants, it is important to hold in mind "the traumatic syndrome, despite its many constant features, is not the same for everyone" (Herman, 1992, p.58). Four overarching themes were derived from the data: The Inferior Self, The Misfortunate Self, The Protective Self and The Enhanced Self. Figure 1 diagrammatically represents how the 4 overarching themes, 10 subthemes and individual constructs were organised. Overarching themes reflect similarities across participants constructs. Quotations are used to provide individual context and evidence for themes.

Insert Figure 1.

Theme 1: The Inferior Self

Predominantly, young people construed themselves as different from others. Although PCP methodology lends itself to these explicit comparison, it appeared an established way by which the young people conceptualised themselves, while struggling to do so in a positive light. This construing of difference was often context specific and involved comparison of physical attributes, abilities, social acceptance, and confidence. Most importantly, having experienced a traumatic event, the young people construed themselves as less worthy and unable to connect with peers.

Difference in worth: “never been special”

While comparing self to others who were conceptualised as ‘normal’ and ‘happy’, all young people expressed (emergent) negative self-constructs and a strong sense of worthlessness. Izzy illustrated how social comparison informed her construal system when describing her self-characterisation:

> *“…my character is sort of different in a way…and like, the eye is to represent how I see myself compared to people and…like people being smarter than me and you know, people being closer and not feeling like I am as good as everyone else.”*

Vitally, all but Alice, conceptualised these differences as reflecting their inferiority to others; Izzy conceptualised herself as “*not good enough*”, Tom construed himself as having “*never been special*” and as being “*just a piece of junk*”. Emily reflected her low self-worth in relation to her self-characterisation, where she felt it was not important to try and capture her likeness. Additionally, Yazmin wondered whether her experience of being abused demonstrated her worthlessness when she construed herself as “*worth being used*”. Vitally, construing such interactions with others formed and maintained feelings of worthlessness.

Interestingly, for Izzy, her low self-worth meant that when someone was “nice” she experienced this as “*they are lying to me… they know it is false, they are just laughing at* *me*". Additionally, Yazmin construed "*I would not say I am nice*" and Emily reported "*I don't see myself as someone who is, people would be like 'oh look at her, isn't she amazing*". Conceptualising self positively was unrepresented in the constructs of the young people.

Unconfident: "scared what people will say"

The young people were influenced by significant worry that their feelings of inferiority would be reflected in the judgements of others, and were therefore "*scared about what people will say*" (Maggie). Beyond feeling unaccepted by peers, the protective strategy of remaining distant from others was construed, Alice spoke of "*staying under the radar*" at school and Emily kept herself "*invisible*".

Interestingly, Emily, Alice, Izzy and Scarlett, construed "*popular*" peers and 'ideal self' as having the "*confidence*" to "*not care what others thought*" (Izzy). This contrasted their current self which was construed as "*self-conscious*" (Izzy), "*isn't very confident*" (Scarlett), "*not strong enough*" (Yazmin) and "*don't have enough confidence*" (Emily). Understandably, "*confidence*" and "*no longer caring what others thought*" were preferred given this was associated with freedom from worry.

For some young people, confidence was experienced in situations with close supportive friends (e.g., Maggie, Scarlett) or family (Emily). As demonstrated through her description of her self-characterisation sketch, Alice was the only young person who construed in relation to a positive social context. This enabled her to feel able to *"escape reality*" and be with others who "*shared the same passion*" and vitally be with those who were open about their similar difficulties. Alice's diverse experiences between the context of "*stressful school*" and Scouts meant that the pole ends of her constructs were often specific to one or other context. Furthermore, Alice felt at Scouts she was "*not being judged*" and therefore was able to be the "*most social person in the world*" and importantly her ideal 'true self'.

Unable to connect: "don't fit in"

Interestingly even when trauma experience had occurred within other contexts or relationships, all the young people construed self with considerably reference to ongoing difficulties within school (e.g., bullying), indicating the importance of this context. Tom, for example, recalled an experience when "*everyone laughed at me …and they all…and I had to storm out….I didn't like it, it was horrible*". Similarly, the young people conceptualised themselves as socially isolated and disconnected from peers, or as Tom construed as "*having no friends*".

Interestingly not being able to connect with peers, was at times conceptualised as being prescriptive and imposed; "*you are basically categorised into these groups*" (Alice). Emily, Izzy, Maggie and Alice all felt "*I don't fit in*" within "*popular*" groups at school. Importantly, "*popular*" was conceptualised as being powerful, having lots of friends and, specifically for Emily, as a way of protecting oneself from rejection and hurt. Furthermore, when Izzy was asked to elaborate the opposite of "*it's hard to get close to someone*" she said "*I think there are other ways of being close to someone. I just don't know some of the ways*". This illustrated that all the young people struggled to elaborate ways they might develop relationships.

Vitally, the young people conceptualised forming relationships as being significantly strengthened by having things in common with others. For all but Tom, feeling different was construed in relation to having experiencing a trauma. Additionally, these experiences and associated emotional and relational difficulties meant the young people felt it would be hard to get close and form meaningful relationships. For Izzy, Scarlett and Emily this caused frustration, as others were construed to have had a "*good childhood"* or were "*naïve"* and therefore unable to comprehend their experiences. The majority of the young people spoke of peers' seemingly trivial problems: *"I feel like saying, grow up! It is not like a life experience,* *well it is life experience but it is not life trauma…" (Emily).* While construing others as not having had difficult life experiences, Izzy and Emily expressed jealousy, which maintained a barrier to connecting with "*spoilt*" others. Inversely, having friends who had "*been through the same as me*" (Alice) was one of the few ways that a few young people felt able to connect and develop relationships.

Theme 2: The Misfortunate Self

The way the young people construed was highly suggestive of them feeling unable to influence change, especially at school. Whether a reflection of experiencing adverse life events, on-going psychological distress or a sense of isolation, all the young people construed themselves as "unlucky" and worse off than others. Furthermore, the young people demonstrated a bias to construe in negative and elaborated ways, while struggling to elaborate on ideal or contrasting constructs.

Lacking agency: "you can't even trust life"

The young people construed in ways that reflected their perception of having a limited ability to influence change. In Izzy's case, she construed herself as "*born unlucky"* and others as being "*born with luck*". 'Luck' was externally located as Izzy believed "*fate always goes the wrong way for me*" and Yazmin construed that "*life may be written as not happy".* Constructing luck externally meant that 'lucky' others appeared to have "*things go their way*" without clear rationale. Without a mechanism to explain this, the young people construed this as further evidence that they were "*not good enough*" (Izzy) or that the world was unsafe.

Significantly, Izzy and Yazmin construed themselves, others and the world in relation to luck while making explicit links to their adverse life experiences. Yazmin expressed that "*you can't even trust life and where that's going to take you".* Furthermore, Yazmin was the only young person who spoke of her faith, and construed her adverse life experiences as being "*punishments*" or "*tests*" from God. Although Yazmin conceptualised herself as "*just* *not lucky*", her faith was a mechanism for her to *"give myself hope*" and Yazmin believed prayer and blessings could influence positive change.

Significant distress: "like a storm is pulling you down"

One way the young people construed themselves as worse off than others was in relation to having to access mental health services. Scarlett, for example, conceptualised a friend as "*just really sad*" and made a distinction with her construing of self as "*depressed*" due to having "*a trauma"* and *"a diagnosis, tablets and counselling*". Constructs also illustrated how young people understood their emotional distress, such as "*it's like I have been torn open*" (Scarlett) and "*It's horrible, like a storm is pulling you down*" (Tom). Maggie, Scarlett, Emily and Alice all referred to themselves as "*depressed*" alongside other constructs (e.g., "*sadness*", "*stressed*", "*guilt*" and "*worried*") that represented their strong, enduring and at times overwhelming negative feelings. Moreover, Maggie construed herself at times as "*bored of being alive*" and Yazmin as "*wish[ing] I wasn't alive*".

Importantly, the young people reported substantially more negative rather than positive emergent constructs, which was most evident when they spoke of their distress. Conversely, all young people expressed a limited range of contrasting constructs (e.g. "*happy"*, "*feeling good"*) even when these were predominately described as 'ideal self' or others. Izzy, for example, construed "*happy*" as being contrasting to "*feeling alone*", "*feeling like you have nothing in common*" and "*nobody needs you*". Yet when asked to elaborate said "*I don't know erm… erm…I don't know how to explain happy, like…I can't think of a context to put it in. I guess it is the opposite of sad".* Similarly Tom referred to the character Rudolph the red nosed reindeer as "*happy"*" but when asked how he might know he replied *"I don't know what makes him happy*". All young people struggled to elaborate positive constructs. Scarlett became noticeably restless when asked to describe the opposite to "*depressed*" and conceptualised this as "*a pinch to the heart*" or "*having no feelings*" but struggled to elaborate further.

Theme 3: The Protective Self

All the young people, other than Tom, elaborated on conscious means of protecting oneself in particular settings (e.g., school) and when with untrustworthy others. In response to construing others and the world as unreliable the young people conceptualised a need to be self-sufficient while also deciding when to share their 'true self' as opposed to "*pretending*" or "*wearing a mask*".

Initiate independence: "no one is going to help you; you have to do things for yourself"

The young people made explicit links between their adverse life experience while construing the world as unpredictable and others as untrustworthy. When elaborating constructs of "*isolation*" (Emily), "*feeling alone*" (Izzy) and "*everyone forgets you*" (Scarlett) the young people expressed a need to be self-sufficient in managing their difficulties. Maggie, Izzy and Yazmin had similar explicit constructs about not being able to rely on others and concerns about abandonment. Izzy conceptualised that it is "*hard to rely on somebody because you think they will leave you*" which she recognised affected her ability to relate and connect to others. Maggie stated that "*keeping things in*" related to "*fear of being let down, disappointments and heartache*". Similarly, Yazmin construed herself as someone who "*learnt from life*" to be "*independent*" and this was a core part of how she conceptualised herself, so much so that "*even if you are not strong you have to pretend that you are*".

In addition to seeking "*independence*", Yazmin and Maggie construed a need to protect their loved ones from their distress. Having construed herself as a protector, Yazmin did not feel she could burden her mother with her concerns. "*The mum I wanted or need is* *weak herself. I don't think she could help me out with this business. It is just me trying to be strong"* (Yazmin). Similarly, when elaborating on how she would "*keep things in*" Maggie spoke of doing this "*for everyone else's benefit".*

Pretend happiness: "wearing a mask"

For Maggie, Alice, Emily and Yazmin, construing themselves as someone who "pretends" was highly elaborated in the interview. Alice expressed that in a "*stressful*" school environment she would be "*acting happy*" but was an "*empty shell, a robot*". This contrasted with the way she construed herself in Scout's, where she felt accepted and could be "*completely myself*".

Interestingly, when elaborating constructs such as "*put a brave face on*" (Emily), the young people conceptualised that when they were "*pretending*" others would see them as their 'ideal self, "*happy*". Maggie construed "*you are putting on a front; you have to pretend you are happy, when really you just…you want to sit there and be miserable*". Contrasting "*pretending*", most of the young people's 'ideal self' was conceptualised as being "*open*" (Maggie), "*completely myself*" (Alice), "*able to share your true self*" (Izzy) and "*speak my mind*" (Emily). This 'ideal self,' as Yazmin stated would be "*known inside and out*", and would be able to express difficult feelings and share experiences. Openness about true feelings was construed to lead to "*feeling better*" (Alice), "*takes the stress off*" (Izzy), and a "*weight off your shoulders*" (Maggie, Alice).

Managing risk of rejection: "careful who you speak to; it could back fire"

Although construing openness as 'ideal', the young people continued to "*pretend*" due to its key function of being a means of protecting self. The young people did not have confidence that their true self would be accepted. "*I would like to be completely myself, but it is whether, whether people sort of like the true me…I am not really sure, but it could back fire…it has happened before so it puts me off doing it again*" (Izzy).

Furthermore, the young people made clear links to their trauma experiences and when trust was, as Alice and Yazmin referred to it, "*betrayed*". This meant trusting others with "true self" was risky. For Tom this was reflected in the interview when he stated "*I don't know if you might believe me*". All the young people appeared to have generalised their struggle to trust across contexts and people; as Emily illustrates "*she uses it against me. That is what a lot of people tend to do*". Furthermore, Yazmin construed that to share her trauma experience and then the person goes "*home and forgets*" would be too painful, and that she would prefer no one cared at all.

Theme 4: The Enhanced Self

In reflecting on their trauma experiences, young people construed themselves as changed and, for some, a "better" person. Most significantly, additional to challenging stereotypes of how they should be, the young people reported developing empathy while seeking caring roles or purpose. This allowed them to feel needed and to demonstrate through their actions a reason to be worthy of love.

Post traumatic growth: "maybe there is a reason all of this happened"

Emily and Alice both made explicit connections between their "*traumatic*" (Emily) and "*damaging*" (Alice) experiences and being 'better people'. Emily construed that her "*hard life lessons*" made her "*mature*" and "*a* [emotionally] *bigger better person*". The following quote summarises Alice's similar conceptualisation:

> "*I am half glad that some of what happened happened to me… at the time it was horrible and the flashbacks are horrible but it has made me a better person. I don't think I would be anywhere near the person I am now if that didn't happen".*

Specific to her "*damaging*" experiences and "*daddy issues*", Alice conceptualised that these experiences left her likely to become someone she did not want to be (e.g., promiscuous). Therefore Alice spoke with passion about being “*determined to succeed*” and driven to “*prove them wrong*”.

Further to considering their strength, the majority of young people conceptualised themselves as being emotionally sensitive as a direct result of their trauma experience. Emily made these connections and how this “*makes you stronger which makes you understand and empathize more*”. Yazmin also construed her ‘*empathy’* as resulting from “*seeing someone in pain*” and wanting to “*help that person*”. Similarly, Maggie commented “*I wouldn’t want someone else to feel the way I felt so I think it is important to help them to make sure they don’t*”. Moreover, Alice construed *“it’s like I am not completely worthless, maybe there is a reason all of this happened*” when describing helping an upset friend by sharing what she had learnt from CAMHS.

Seeking caring roles: “give me a purpose”

Notably, many of the young people understood themselves as being “*caring*”. Crucially, the young people constructed “*helping others*” as a means of making others “*happy*” and therefore themselves “*happy*”. Correspondingly, Alice, Maggie and Yazmin all referred to their ‘future selves’ as working in caring professions (e.g., mental health nurse, counsellor).

In contrast, only Izzy expressed that “*making other people happy can kind of make you feel worse*”. Izzy construed herself as someone “*nobody particularly needs*”. When elaborating on this construct Izzy made connections with her ‘ideal self’ who has a “*reason for being here*” which feels “*like you are good at something and that person cares about you*”. A commonality between Izzy’s ideal self “*as having a purpose*” and other caring roles were that they were conceptualised as giving a “*boost in mood*”. Furthermore, purpose, as Izzy conceptualised, was about connecting and being worthy of love.

Discussion

Summary of findings

Through participating in an interview that included a pictorial self characterisation, young people who had experienced a trauma shared and elaborated their constructs. A novel finding being that the young people held a strong bias to construe in negative over-elaborated ways and struggled to elaborate contrasting constructs. Moreover, in reflection of their self-identified needs (e.g., to protect self) young people reported that they had multiple versions of self which they could become in different contexts and relationships (e.g., ‘pretending self’). Specifically, conceptualising self as ‘inferior’ and ‘different’ reflected how young people construed forming relationships with others as near to impossible or fraught with risks of rejection, betrayal or further hurt. Nevertheless, young people were highly motivated, understandably so, to reduce the likelihood of being hurt in light of difficult past experiences (Ronen, 1996). In reflection of their past experience and their belief that they could not influence change, young people described two active means they had of protecting self through distancing themselves from others (Schimmenti, 2012). Firstly, the young people actively sought independence and secondly young people would “pretend to be happy” so as not to alert others to their distress.

In contrast to these protective mechanisms, the young people expressed a desire to adopt a ‘true self’ across contexts but struggled to achieve this. Moreover, they conceptualised ways they related to others, specifically, “caring” was construed as a means of making others “happy” and therefore oneself “happy”. Exceptionally, the construct of “caring” was an important part of self that transcended “pretend” and “true self”, while also being the only way the young people could elaborate on their ‘ideal self’. Encouragingly, young people’s constructs also indicated post-traumatic growth (Tedeschi & Calhoun, 2004) as construing self as a “better person” was seen to directly result from learning from trauma experience.

Implications for theory

The different parts of self shared by the young people support Mair’s (1977) proposal that we all actively become and can move between different ‘selves’ and consequently that a person can experience “different ways of being” (Mair, 1977, p.141). Additionally, the young people construed with strong reference to “otherness” (Mair, 1977) which is essential as through interactions with others we form possible selves (Kelly, 1955). Developmentally children and young people are seen to rely on similarities when forming relationships (Adams-Webber, 1979) and context appears essential to consider (Procter, 2005) when constructs about self are relationally driven.

The current research illustrates that young people define their difference beyond a typical developmental process as they made strong reference to their adverse or traumatic life experience(s), associated emotional difficulties and their perceived inability to influence change. This differs from constructs generated from non-clinical populations, such as Robinson (2012) who grouped types of constructs generated from children, 4-6 years old, within a school setting, and reported these as being “characteristics of the person” (i.e. tall), “behaviour” (i.e. kind), “emotions” (i.e. cross), “academic” (i.e. clever), and “interactions with others” (i.e. bullies). In divergence, the young people in the current study construed themselves in detailed and negative ways where constructs of worthlessness and inferiority (Harter, 1999) could be explained by the internalisation of “innate badness” following trauma (Herman, 1992). This is supported by similar findings in adult populations when victims of childhood sexual abuse similarly construe self as different (Harter, Erbes, & Hart, 2004).

The protective strategies of seeking independence could be explained by Pearlman’s conclusion (1997, p.10) that trauma experience “interferes with the internalization of loving others"; moreover, young people may seek independence as a means of establishing control (Bromberg, 2001). However this contrasted with Herman's (1992, p.107) proposal that following trauma a "child continues to seek desperately and indiscriminately, for someone to depend upon" by instead suggesting that independence is important for young people because they want to be self-reliant.

Moreover, "pretending to be happy" is supported by Ronen (1996) who proposed "children are [seen to be] trained, whether unintentionally or deliberately, to hide what they feel**" (**p.149). Enhancing Herman's argument, that children present a false self to avoid rejection, young people in the current study described, with a great level of insight, the relational and historical reasons for this conscious, powerful and protective process of "pretending to be happy".

Similarly, constructs of "caring" reflected relational need, as the young people wanted to lessen the distress of others. This supports literature on 'altruism born of suffering' (Staub, 2005) as the young people expressed feelings of sympathy and evidence of perspective taking (Eisenberg, 2000). However such findings need to be considered in relation to the development of a young person's forming identity, which suggest 'caring', may hold a particular function that may differ from that of adults. Specifically, that following trauma, young people may learn that caring is socially promoted and can get their needs met.

Importantly, the young people articulated a desire to adopt a 'true self' across contexts but felt unable to achieve this. This could suggest they hold extremely narrow or limited perspectives of self (Mair, 1977). Accordingly, if an individual's constructs are too 'tight' or rigid (e.g., others cannot be trusted), this can lead to difficulties (e.g., depression) as this limits their ability to act or construe in varied ways and therefore reduces experience (e.g., meaningful interactions) that encourage change.

While holding in mind the influence of on-going development, the current study reflects similarities with adult research, as reduced agency (Streeck & van der Kolk, 2000) and difficulties considering future self (Sewell & Williams, 2002) were seen to follow trauma experiences (Mikulincer et al.,1989). Although the young people appeared to locate control for their experiences externally (Rotter, 1966) an alternative explanation may reflect the fact that it feels safer for young people to assume something bad will happen that is out of their control rather than to try to influence change and fail. In relation to Kelly's (1955) 'range of convenience', construing self as "unlucky" could reflect experiences (e.g., trauma) which were outside the child or young person's previous understanding and therefore were not anticipated.

Findings related to the young people construing in negative over-elaborated ways supports adult trauma models (Sermpezis & Winters, 2009). However, the current study's findings contradict the notion that trauma experience is invalidating of the young people's constructs by instead illustrating that it fundamentally informs how they conceptualised themselves. Young people construed self as inferior following trauma rather than experiencing trauma as invalidating of their high self-worth.

Furthermore, when the young people had an experience that opposed their negatively held constructs, this was experienced as threatening (Pearlman, 1997). Kelly (1970) would explain this in relation to the 'experience cycle', where experiences that illustrate they need to change their construal system can create feelings of threat, anxiety or guilt. Current theories of trauma assume trauma experiences are rare, and therefore will be 'invalidating' of an individuals established way of construing. However for children and young people who have limited life and relational experience (Salmon & Bryant, 2002) and who experience repeated trauma, it is arguable that this will have a vast impact on their internal world.

Clinical implications

The use of ‘protective self’ has important implications for clinical practice as children and young people may not share their “true self” easily or at all. Modelling openness, demonstrating confidentiality is maintained and using creative methods are essential when engaging in discussions about difficult experiences (Ronen, 1993). It is vital for therapists to seek to understand from a child or young person’s perspective, such as what ‘protective self’ means and what this communicates about their need for safety. Moreover, if and when a child or young person is able to share their ‘true self’ this should not be rushed or underplayed but instead validated.

Trauma interventions often consider the integration of ‘fragments of self’ as essential (Neimeyer, Herrero & Botella, 2006) given inconsistencies between different selves can cause distress (Sewell & Williams, 2002). An alternative approach to this could be to support children and young people in using creative methods to help children and young people share, loosen and develop their understanding about the functions of different parts of self (Ryle and Kerr, 2002; Mair, 1977). This important individual formulation (e.g., ‘caring for others means I feel worthy’) could aid the introduction of strategies for achieving the underlying need. This can also help children and young people develop core, healthier ‘ideal’ constructs of self across contexts which would build self-esteem, reduce discrepancy between different ‘selves’, and offer opportunities for change. Moreover exploring personal meanings can support clinicians in maintaining a curious stance rather than formulating based on their assumptions (Ballat & Campling, 2011).

Limitations and future research

Although young people make links between their trauma experience and self, it is hard to draw distinct conclusions about the influence trauma experience had on the way participants construed. Young people were recruited who accessed therapeutic support which may have informed the constant and active process of construing (Kelly, 1955). Moreover, constructs of independence may reflect the age of participants (e.g., mostly14-15) and type of trauma (e.g., neglect).

Future research would benefit from further explorations of how children and young people construe following trauma, to allow for clearer distinctions to be made between their experiences and those of adults. Moreover research would benefit from exploring factors such as development, gender, culture, faith and the role of therapeutic work and self-construing following trauma. For example, exploring the influence of different stages of intervention on self-construing following trauma could be achieved while comparing this with the construing of children and young people not accessing services.

Conclusion

This study's findings suggest a child or young person's experience of traumatic event(s) fundamentally informs their construal system rather than invalidates it. This challenges adult models and highlights the need for further research and the development of a child trauma model. Moreover, working therapeutically to explore different selves (Mair, 1977) offers powerful opportunities to understand these different selves, reduce vast differences between them and to develop healthier 'ideal' constructs. Crucially, understanding motives behind constructs and protective strategies can aid the validation of experiences and provide opportunities for needs to be met. Future specialist trauma interventions should emphasise the importance of ensuring safety, promoting trust and exploring self rather than solely focusing on reducing symptoms (e.g., NICE, 2005).

References

Adams-Webber, J. (1979). Construing persons in social contexts. In *Constructs of sociality and individuality,* ed. P. Stringer and D. Bannister, 195-220. New York: Academic Press.

Agar, E., Kennedy, P., & King, N.S. (2006). The role of negative cognitive appraisals in PTSD symptoms following spinal cord injuries. *Behavioural and Cognitive Psychotherapy,* 34, 437-452. http://dx.doi.org/10.1017/S1352465806002943

Alisic, E., Jongmans, M. J., Wesel, F. & Kleber, R. J. (2010). Building child trauma theory from longitudinal studies: A meta-analysis. *Clinical Psychology Review,* 31, 736-747. http://dx.doi.org/10.1016/j.cpr.2011.03.001

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.).Washington, DC: Author.

Ballat, J. & Campling, J. (2011). *Intelligent Kindness: Reforming the Culture of Healthcare*. LondonLRCPsych Publications

Bell, S. J., & Bell, R.C. (2008). An illustration of self-characterisation in a child's drawing: the importance of the process. *Personal Construct Theory*. London: Wiley-Blackwell

Bhandari, S., Winter, D., Messer, D., & Metcalfe, C. (2011). Family characteristics and long-term effects of childhood sexual abuse. *British Journal of Clinical Psychology*, 50, 435–451. http://dx.doi.org/ 10.1111/j.2044-8260.2010.02006.x

Blaustein, M., Cloitre, M., Cook, A., DeRosa, R., Ford, J., Hubbard, R., et al. (2007). *Complex trauma in children and adolescents*. Boston: Child Trauma Center. Retrieved from http://www.nctnet.org/nctsn_assests/pdf/edu_materials/Complex

Trauma_All.pdf

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77–101. http://dx.doi.org/10.1191/1478088706qp063oa

Briere, J. (2006). Dissociative symptoms and trauma exposure: Specificity, affect dysregulation, and posttraumatic stress. *Journal of Nervous and Mental Disease,* 194, 78-82. http://dx.doi.org/10.1097/01.nmd.0000198139.47371.54

Briere, J. (1996). *Trauma Symptom Checklist for Children (TSCC) professional manual.* Odessa, FL: Psychological Assessment Resources.

Bromberg, P. M. (2001). Treating patients with symptoms, and symptoms with patience: Reflections on shame, dissociation, and eating disorders. *Psychoanalytic Dialogues,* 11, 891–912. http://dx.doi.org/10.1080/10481881109348650

Butler, R. J. & Green, D. (1998). *A child within*. Oxford: Butterworth-Heninemann.

Butler, R. J. (2006). Investigating the content of core constructs. *Personal Construct Theory & Practice*, 3, 27-33. Retrieved from: http://www.pcp-net.org/journal/pctp06/butler06.pdf

Cason, D. R., Resick, P. A., & Weaver, T.L. (2002). Schematic Integration of Traumatic Events. *Clinical Psychology Review*, 22, 131-153. http://dx.doi.org/10.1016/S0272-7358(01)00085-X

Cohen, E. (1999). Contemporary application of Ferenczi: Co-constructing past traumatic experiences through dream analysis. *The American Journal of Psychoanalysis*, 59, 367-384. http://dx.doi.org/10.1023/A:1023452025636

Cohen, J. A., Mannarino A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children & adolescents.* New York: Guilford Press.

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Liautaud, J., Mallah, K., Olafson, E., & van der Kolk, B. (2005). Complex Trauma in Children and Adolescents. *Psychiatric Annual*, 35, 390-398. Retrieved from: http://www.traumacenter.org/products/pdf_files/Complex_Child_Trauma.pdf

Ehlers, A. & Clarke, D.M. (2000). A Cognitive Model of Posttraumatic Stress Disorder. *Behaviour Research and Therapy*, 38, 319-345. http://dx.doi.org/10.1016/S0005-7967(99)00123-0

Elmer, N. (2001). *Self-esteem: The costs and causes of low self-worth*. York: Joseph Rowntree Foundation, York Publishing Service Ltd.

Eisenberg, N. (2000). Emotion, regulation, and moral development. *Annual Review of Psychology*, 51, 665–697. http://dx.doi.org/10.1146/annurev.psych.51.1.665

Evans, D.W., Brody, L., & Noam, G.G. (2001). Ego development, self-perception, and self-complexity in adolescence: A study of female psychiatric inpatients. *American Journal of Orthopsychiatry*, 71, 79-86. http://dx.doi.org/10.1037//0002-9432.71.1.79

Evans, C., Ehlers, A., Mezey, G., & Clark, D. M. (2007). Intrusive memories in perpetrators of violent crime: emotions and cognitions. *Journal of Consultant Clinical Psychology*, 75, 134-144. http://dx.doi.org/10.1037/0022-006X.75.1.134

Evans, D.W. (1994). Self-complexity and its relation to development, symptomatology and self-perception during adolescence. *Child Psychiatry Human Development*, 24, 173-182. http://dx.doi.org/10.1007/BF02353194

Fantuzzo, J.W., McDermott, P.A., Holliday-Manz, P., Hampton, V. R., & Burdick, N. A. (1996). The pictorial scale of perception competence and social acceptance: Does it work for low-income urban children? *Child Development*, 67, 1071-1084. http://dx.doi.org/10.1111/j.1467-8624.1996.tb01783.x

Feindler, E.L, Rathus, J.H., & Silver, L.B. (2003). *Assessment of Family Violence: A Handbook for Researchers and Practioners.* Washington, DC: American Psychological Association.

Finkelhor, D. & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualisation. *America Journal of Orthopsychiatry,* 66, 530-541. Retrieved from: http://lilt.ilstu.edu/mjreese/psy331/CSA%20articles/Finkelhor%20and%20 Browne%201985.pdf

Gergen, K. (2011) The delight of continuing the conversation. *Journal of Constructivist Psychology*, 24, 340-344. http://dx.doi.org/10.1080/10720537.2011.593476

Greeson, J. K. P., Ake, G. S., Howard, M. L., Briggs, E. C., Ko, S. J., Pynoos. R. S., Kisiel, C. L., Gerrity, E.T., Fairback, J. A., Layne, C. M., & Steinberg, A. M. (2011). Complex Trauma and Mental Health in Children and Adolescents Placed in Foster Care: Findings from the National Child Traumatic Stress Network. *Child Welfare*, 90, 91-108. Retrieved from: http://web.b.ebscohost.com.ezproxy.lancs.ac.uk/ehost/detail? vid=4&sid=489b4985-5ab2-48d9-9cea 0ea59722d257%40sessionmgr198&hid=127 &bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#db=a9h&AN=74247647

Goins, S., Winter, D., Sundin, J., Patient, S., & Esther, A. (2012). Self-construing in former child soldiers. *Journal of Construct Psychology*, 25, 275-301. http://dx.doi.org/10.1080/10720537.2012.703568

Harter, S. (1999). *The construction of the self: A developmental perspective.* New York: Guilford Press.

Harter, S. L., Erbes, C. R., & Hart, C. C. (2004). Content analysis of the personal constructs of female sexual abuse survivors elicited through repertory grid technique. *Journal of Constructivist Psychology,* 17, 27–43. http://dx.doi.org/10.1080/10720530490250679

Herman, J. L. (1992). *Trauma and recovery*. Basic Books: New York.

Hickle, D. (1965). The change of personal construct from the viewpoint of a theory of construct implications, unpublished PhD thesis, Ohio State University.

Hill, C. R., & Safran, J. D. (1994). Assessing interpersonal schemas: Anticipated responses of significant others. *Journal of Social and Clinical Psychology,* 13, 366–632. http://dx.doi.org/10.1521/jscp.1994.13.4.366

Ijaz, T. & Mahmood, Z. (2012). Personal construct system of a runaway adolescent: An illustrative case study. *Journal of Constructivist Psychology,* 25, 325-345. http://dx.doi.org/10.1080/10720537.2012.703576

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. Free Press: New York.

Jonkman, C. S., Verlinden, E., Bolle, E. A., Boer, F, & Lindauer, R. J. L. (2013). Trauma stress symptomatology after child maltreatment and single traumatic events: Different profiles. *Journal of Traumatic Stress,* 26, 225-232. http://dx.doi.org/10.1002/jts.21792

Joseph, S., & Linley, P. A. (2005). Understanding Posttraumatic Stress: Theory, Reflections, Context and Future. *Behavioual and Cognitive Psychotherapy,* 33, 423-441. http://dx.doi.org/ 10.1017/S1352465805002328

Kagen, S. L., Moore, E., & Bredekamp, S. (1995). *Considering children's early development and learning: Toward common views and vocabulary* (Report No. 95-03). Washington, DC: National Education Goals Panel.

Kelly, G. A. (1970). A brief introduction to personal construct theory. In D.Bannister (ed.), *Perspectives in Personal Construct theory*, London: Academic Press.

Kelly, G. A. (1955). *The psychology of personal constructs*. New York: Norton.

La Greca, A., Silverman, W. K., Vernberg, E. M., & Prinstein, M. J. (1996). Symptoms of posttraumatic stress in children after hurricane andrew: A prospective study. *Journal of Consulting and Clinical Psychology*, 64, 712−723. http://dx.doi.org/10.1037//0022-006X.64.4.712

Landfield, A.W. (1971). *Personal Construct Systems in Psychotherapy*. Lincoln: Nebraska Press.

Lanktree, C. B., & Briere, J. (1995) Early data on the new sexual concerns and dissociation subscales of the TSCC. Unpublished manuscript, Dept. of Psychiatry, University of Southern California School of Medicine. Cited in Briere, J. (1996) *Trauma Symptom Checklist for Children: Professional Manual.* Florida: Psychological Assessment Resources Inc.

Leydesdorff, S., Dawson, G., Burchardt, N., & Ashplant, T. G. (2004). Introduction: Trauma and life stories. In K. L. Rogers, S. Leydesdorff & Dawson, G. (Eds), *Trauma: Life stories of survivors* (pp. 1-26). New Jersey: Transaction Publishers.

Mair, J. M. M. (1977) The community of self. In D. Bannister. (Ed.) *New Perspective in Personal Construct Theory*. London: Academic Press.

NICE (2005). Quick reference guide: Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care. London. Retrieved from: http://www.nice.org.uk/nicemedia/pdf/CG026quickrefguide.pdf

Neimeyer, R., Herrero, O., & Botella, L. (2006). Chaos to coherence: Psychotherapeutic integration of traumatic loss. *Journal of Constructivist Psychology,* 19, 127-145. http://dx.doi.org/10.1080/10720530500508738

Pearlman, L. A. (1997) Trauma and the self, *Journal of Emotional Abuse*, 1, 7-25. http://dx.doi.org/10.1300/J135v01n01_02

Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: W.W. Norton.

Procter, H. G. (2005). Family therapy In Fay Fransella (ed)*The Essential Practitioner's Handbook of Personal Construct Psychology* Chichester: John Wiley & Sons

Procter, H. G. and Dallos, R. (2006) Making me angry: the constructions of anger. In Cummins, P. (Ed.) *Working with anger: a constructivist approach.* pp 131 – 148. Chichester: Wiley.

Procter, H. G. & Procter, J. (2008). The use of qualitative grids to examine the development of the construct good and evil in byron's play "Cain: A Mystery". *Journal of Constructivist Psychology*, 21, 343-354. http://dx.doi.org/10.1080/10720530802255301

Raskin, J. D. (2002). Constructivism in psychology: personal construct psychology, radical constructivism and social constructionism. In J.D. Raskin & S.K. Bridges (Eds.), *Studies in meaning: Exploring constructivist psychology* (pp. 1-25). New York: Pace Univeristy Press.

Ravenette, A.T. (2003). Constructivist intervention when children are presented as problems. In Fransella, F. (Ed.) *International handbook of personal construct psychology*. Chichester: Wiley.

Ravenette, A.T. (1997). *Selected papers. Personal construct psychology and the practice of an educational psychologist.* Great Britain: ECPA Publications.

Ravenette, A.T. (1977). Personal construct theory: an approach to the psychological investigation of children and young people. *New Perspectives in Personal Construct Theory*. D. Bannister (ed.) London: Academic Press

Reyes, C.J. (2008). Exploring the relations among the nature of the abuse, perceived parental support, and child's self-concept and trauma symptoms among sexually abused children, *Journal of Child Sexual Abuse,* 17, 51-70. http://dx.doi.org/10.1080/10538710701884482

Ryle, A. & Kerr, I. (2002). *Introducing Cognitive Analytic Therapy.* Chichester: Wiley.

Robinson, J. (2012). Understanding how young children view themselves: A personal construct approach. Cited in: Giliberto, M., Dell’Aversano, C.,Velicogna, F. (2012*)*. *PCP and Constructivism: ways of working, learning and living.* Proceedings of the XVIIIth International Congress on personal construct psychology. Libri:Liberisrh.

Ronen, T. (1996). Constructivist therapy with traumatized children. *Journal of Constructivist Psychology*, 9, 139-156. http://dx.doi.org/10.1080/10720539608404660

Ronen, T. (1993). Decision making about children’s therapy. *Child Psychiatry and Human Development,* 23, 259-272. http://dx.doi.org/10.1007/BF00707679

Salmon, K., & Bryant, R. A. (2002). Posttraumatic stress disorder in children. The influence of developmental factors. *Clinical Psychology Review*, 22, 163−188. http://dx.doi.org/10.1016/S0272-7358(01)00086-1

Schimmenti, A. (2012). Unveiling the hidden self: Developmental trauma and pathological shame. *Psychodynamic Practice: Individuals, Groups and Organisations,* 18, 195-211. http://dx.doi.org/10.1080/14753634.2012.664873

Sermpezis, C. & Winter, D. A. (2009). Is trauma the product of over- or under-elaboration? A critique of the personal construct model of posttraumatic stress disorder, *Journal of Constructivist Psychology,* 22, 306-327. http://dx.doi.org/10.1080/10720530903113862

Sewell, K. W. (1996). Constructional risk factors for a post-traumatic stress response after a mass murder. *Journal of Constructivist Psychology*, 9, 97-107. http://dx.doi.org/10.1080/10720539608404657

Sewell, K. W. (2003). An approach to post-traumatic stress. In F. Fransella (Ed.), *Personal Construct Psychology*. Chichester: John Wiley and Son Ltd.

Sewell, K. W. (2005). Constructivist trauma psychotherapy: A framework for healing. In D.A. Winter and L.L. Viney (Ed.), *Personal Construct Psychotherapy. Advances in Theory, Practice and Research*. London: Whurr Publishers.

Sewell, K..W., Cromwell, R. L., Farrell-Higgins, J., Palmer, R., Ohlde, C., & Patterson, T. W. (1996). Hierarchical elaboration in the conceptual structure of Vietnam veterans. *Journal of Constructivist Psychology,* 9, 79-96. http://dx.doi.org/10.1080/10720539608404656

Sewell, K. W., & Williams, A. M. (2002). Broken Narratives: Trauma, Metaconstructive Gaps, and the Audience of Psychotherapy. *Journal of Constructivist Psychology*, 15, 205-218. http://dx.doi.org/10.1080/10720530290100442

Showers, C. (1992). Compartmentalization of positive and negative self-knowledge: Keeping bad apples out of the bunch. *Journal of Personality and Social Psychology.* 62, 1036-1049. http://dx.doi.org/10.1037//0022-3514.62.6.1036

Silberg, J. L. (2012). *The child survivor: Healing developmental trauma and dissociation*. New York: Routledge.

Staub, E. (2005). The roots of goodness: The fulfilment of basic human needs and the development of caring, helping and nonaggression, including caring, moral courage, active bystandership, and altruism born of suffering. In G. Carlo & C. Edwards (Eds.). *Nebraska Symposium on Motivation: Vol 51. Moral motivation through the life span: Theory, research, applications*. Lincoln: Nebraska Press.

Streeck-Fischer, A., & van der Kolk, B. (2000). Down will come baby, cradle and all: Diagnostic and therapeutic implications of chronic trauma on child development. *Australian and New Zealand Journal of Psychiatry*. 34, 903-918. http://dx.doi.org/10.1046/j.1440-1614.2000.00827.x

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry*, 15, 1-18. http://dx.doi.org/10.1207/s15327965pli1501_01

Tracy, S. J. (2010). Qualitative quality: Eight “big-tent” criteria for excellent qualitative research. *Qualitative Inquiry*, 16, 837-851. http://dx.doi.org/10.1177/1077800410383121 van der Kolk, B. A. (1988). “The trauma spectrum: The interaction of biological and social events in the genesis of the trauma response.” *Journal of Traumatic Stress,* 1, 273-290. http://dx.doi.org/10.1177/107682309894901

Walker, B. M. & Winter, D. A. (2007). The elaboration of personal construct psychology. *Annual Review of Psychology*, 58, 453-477. http://dx.doi.org/10.1146/annurev.psych.58.110405.085535

Tables and Figures.

Table 1. Participant recruitment numbers

No of participants who took part	No of participants following expressing interest no longer met the inclusion criteria so did not take part	No of participants following expressing interest no longer wanted to take part	No of reported participants who met inclusion criteria but declined taking part
7	3 *due to risk/safeguarding	2	14

Table 2. Demographics of participants

Name (pseudonym)	**Age**	**Gender**	**1) Trauma experience(s)** **2) Presenting difficulties** N:B Participants independently shared this information Items* if participants made explicit links between 1+2
Scarlett	14	Female	1) A trauma(s) mentioned in general terms 2) Low mood* contributing to overdose and self-harm
Tom	9	Male	1) Family breakdown, absence of dad 2) Problems sleeping
Maggie	15	Female	1) A trauma(s) mentioned in general terms (5 years ago) *2)* Starting to keep things to herself, problems sleeping*
Emily	15	Female	1) Death of parent, bullying at school 2) Self-harm, feelings of worthlessness*
Izzy	15	Female	1) A trauma(s) mentioned in general terms 2) Problems sleeping/nightmares
Yazmin	14	Female	1) Abduction of family member, sexual abuse 2) Flashbacks*
Alice	14	Female	1) Neglect, emotional and physical abuse from parent, death of sibling (still birth), bullying at school 2) Flashbacks*, depression*, self-harm*, intrusive negative self-beliefs* e.g., worthlessness, self-blame

Table 3. Summary of Scarlett's Self Characterisation Sketch

SCARLETT			
Reflections on Scarlett's interview (based on guidelines proposed by Bell & Bell, 2008; Kelly, 1955)	Observations while Scarlett drew	Drawing	How Scarlett responded to the question 'Can you tell me what you have drawn?'
Scarlett drew a character called Dude. Scarlett's constructs were often interchangeably external (in relation to 'Dude' who she had drawn) and at other times reported in the first person (I and me). Although Scarlett did not speak about her difficult experiences in detail, she did refer to these experiences as impacting her. Scarlett spoke of her difficulties at school and also her difficulties with 'depression' and feeling 'worthless'. At times it became difficult for Scarlett to talk about herself (often when discussing negative aspects of self) or as the length of the interview grew, this was observed at times when Scarlett was observed appearing restless, e.g., looking around the room, or even standing up to stretch. Scarlett began the interview discussing how hard it was to think about herself and ended with her talking about her construct of calm.	Scarlett started by drawing her character 'dude's' face which appears angry. She reported having drawn this image before. Scarlett only took a minute to complete her drawing.	Picture of 'Dude'	**"**yep he (Dude) is confused and not sure…" "there are loads of waves…..he doesn't know which way to go…..yeah or what to do or think erm…." **"**he isn't very confident……with some stuff like subjects or erm……with relationships, friends……it's hard for dude"

Table 4. Summary of Tom's Self Characterisation Sketch

TOM			
Reflections on Tom's interview (based on guidelines proposed by Bell & Bell, 2008; Kelly, 1955)	Observations while Tom drew	Drawing	How Tom responded to the question 'Can you tell me what you have drawn?'
Tom explicitly stated at the beginning of the interview that he was keen to demonstrate his 'artistic' nature through drawing multiple pictures. Tom referred to himself using I and externalised some of his thinking when discussing Rudolph the red nose reindeer. Tom engaged in the interview process with a strong motivation to show his skill and that he could do things well. Tom referred to difficulties at home leading to his father's absence multiple times in the interview suggesting these important events had an impact on him. Moreover, Tom expressed constructs around being isolated and friendless at school. During the interview Tom moved from wonder if he would be believed to talking about Rudolph and not being sure what makes him happy.	Tom drew Henry the 8th first to demonstrate his artist skill as this had been something he had won a prize for at school. He then went on to draw his other pictures. Tom struggled to elaborate constructs about self which may reflect his age as well as a general difficulty in thinking about himself. At these times Tom became animated, drawing with more force (e.g., harder and larger brush strokes) or when he would change topic being discussed	Henry the 8th Candle flame Bonfire Picture	**"**trying to do my best "This is what I did….what I did to King Henry the eighth…trying to do a portrait of someone is art and ….and I won doing this"

Table 5. Summary of Maggie's Self Characterisation Sketch

MAGGIE			
Reflections on Maggie's interview (based on guidelines proposed by Bell & Bell, 2008; Kelly, 1955)	Observations while Maggie drew	Drawing	How Maggie responded to the question 'Can you tell me what you might have drawn?'
Maggie did not complete a self characterisation. However it was evident from Maggie's constructs that she found being at school difficult and this was the first things she discussed. Although Maggie did not speak about her difficult experiences in detail, she did refer to 'trauma' in the interview and made a link to how these experiences impacting her (referring to self using I, me and you). Maggie's spoke a lot about the importance of being caring towards others. Maggie particularly spoke of admired others (friends, professionals) and how she tried to be similar to these 'ideal'. This was conveyed at times when Maggie spoke of protected others from her feelings (e.g., through putting 'on a front'). Maggie ended the interview discussing the importance of helping people.	Once Maggie had settled into the interview, Maggie's constructs of 'putting face up' appeared to reflect how she appeared when sharing difficult emotion and engaged in interview e.g., smiling laughing, sharing examples of nice things.	No self-characterisation sketch/drawing completed	"I don't know….I am not very good at drawing….I think I would rather just talk…" "Yep…erm my favourite band is a day to remember, I've got the t-shirt----and I don't know erm…..I love every animals, they are all just great…I have such as soft spot, I just get really emotional about them 'cause they are so cute"

Table 6. Summary of Izzy’s Self Characterisation Sketch

IZZY			
Reflections on Izzy’s interview (based on guidelines proposed by Bell & Bell, 2008; Kelly, 1955)	Observations while Izzy drew	Drawing Appendix No.	How Izzy responded to the question ‘Can you tell me what you have drawn?’
Izzy engaged well in the interview and was extremely articulate about how she sees herself, using I, my and me when referring to self. Izzy particularly expressed her feelings of difference in relation to others and feeling inferior, both a school and home. Purpose was also a meaningful construct for Izzy as she felt she lacked this but that having purpose was fundamental to being loved. Izzy did not refer to any specific examples of difficult experiences during the interview. The content remained largely focused on here and now. Izzy began the interview talking about being different and ended discussing how she felt no one needed her.	Izzy quickly got involved in drawing her picture in silence and with deep concentration. Initially drawing a small figure with a sad face (later identified as her). Went on to draw eye in middle of the page and then people with smiley faces on the other side of the eye to her. There is a difference in colours used for these characters as Izzy gave herself blue hair while using typical colours for the ‘normal’ people (e.g., brown hair).	Picture of ‘different’ self, and eyes and ‘normal others’	**“**I have drawn a person and it sort of represents me, and then like everyone else sort of like, I have drawn everyone sort of normal looking….and my character is sort of different in a way…and like the eye is to represent how I see myself compared to people and….the way like they have got a university cap on (points to ‘normal’ people) is like people being smarter than me and you know, people being closer and not feeling like I am as good as everyone else….”

Table 7. Summary of Yazmin's Self Characterisation Sketch

YAZMIN			
Reflections on Yazmin's interview (based on guidelines proposed by Bell & Bell, 2008; Kelly, 1955)	Observations while Yazmin drew	Drawing Appendix No.	How Yazmin responded to the question 'Can you tell me what you have drawn?'
Yazmin engaged well in the interview although she did become upset at appropriate points when sharing her trauma experiences. Yazmin talking about the 'abduction' of a family member, being 'abused' as a child, and moving to a new country. Yazmin was able to connect these experiences to how she sees herself. When offered the chance to stop or at least break, Yazmin demonstrated resilience and asked to continue. Yazmin's culture and faith could be understood to inform her constructs which were often community focused. When talking about self, Yazmin used I and me. She began the interview talking about wanting to not have to see her pain and ended the interview talking about others feeling better if someone cared for them.	Yazmin requested a pencil as she does not "draw in colour". In pen Yazmin drew in silence a small eye, taking time to define it and shade. The eye was drawn in the corner of the page leaving most of the page blank.	The Eye	"It is an eye; you can see from it, you can see the world. And then, those eyes can see everyone else. It's like if you are not having your eyes then you wouldn't be able to see the pain…and the happiness of course as well. It's like, all of these things that I do, sometimes I wish I was blind so I could not see all that pain from my own eyes, like so I didn't have to regret the bits that I did do and for the bits that…."

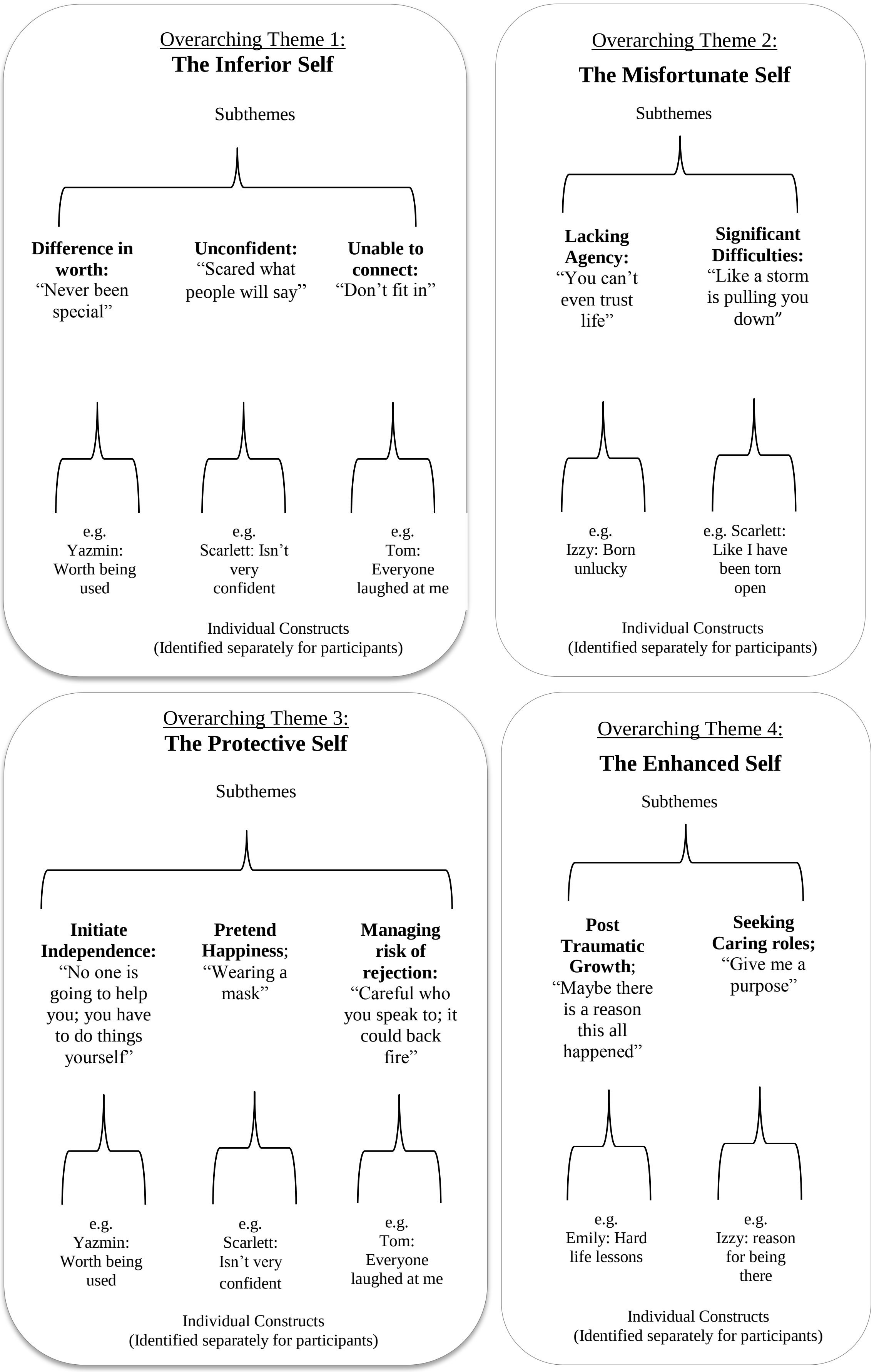
Table 8. Summary of Emily's Self Characterisation Sketch

EMILY			
Reflections on Emily's interview (based on guidelines proposed by Bell & Bell, 2008; Kelly, 1955)	Observations while Emily drew	Drawing	How Emily responded to the question 'Can you tell me what you have drawn?'
Emily appeared a little nervous about taking part, and although extremely articulate reported struggling at times to share some of her thinking about herself. Emily referred at multiple times to the death of a parent and made explicit links to how this difficult experience informed who she was. Emily reported difficulties at school, where she felt an outsider. Emily spoke about feeling mature due to her difficult experiences and losses and how this was different to how she perceived her peers. Emily also demonstrated constructs indicating post traumatic growth Emily referred to self using I and began the interview talking about being overweight. Emily's final comment was about how she uses baking as a distraction.	Emily started by drawing a girl in the centre of the page. She asked if she could add writing about important things e.g., interests around the person. The first was "Overweight person".	The person and the important things	I have got baking, because I like baking, being overweight, I'm not popular…er a lot of people at school see me as invisible, sorta clever…er….I have put not a lot of people like me, but that is having not a lot of friends, er, things I like are yoga and swimming and er…I like watching TV and I have put I like dogs and I like monkeys, because I am a little weird.

Table 9. Summary of Alice's Self Characterisation Sketch

ALICE			
Reflections on Alice's interview (based on guidelines proposed by Bell & Bell, 2008; Kelly, 1955)	Observations while Alice drew	Drawing Appendix No.	How Alice responded to the question 'Can you tell me what you have drawn?'
Alice made a comment during the interview that her being so talkative was reflective of how she is in her preferred context (Scouts) when she is able to be herself and how this compared to school where she pretended to be happy. Alice referred to self using I, me and myself. Alice spoke about being different people in different contexts. Alice made explicit links between her trauma (neglect, physical and verbal abuse from parent and partner), self, and core drive to prove people wrong (e.g., stereotypes of what she should be) and succeed. Interestingly, Alice also spoke of the constructs she felt others applied to her e.g., nerd, teacher's pet. At the beginning of the interview Alice spoke of Scouts being a place to escape reality and ended the interview talking about how making others happy was a means to make herself happy.	Alice started by drawing a tent, spending time giving this some detail. Alice then went on to draw to stick people with smiley faces next to the tent.	Scouts; two people and a tent	I just drew a tent and two people with their neckers on… it is the scouts. Scouts is really good because, it is kind of escaping reality. Over here (raises left with hand) you have all the stress and school work or people judging you and saying things, and then over here (right hand) in camp all the girls, it's brilliant, you can talk to them and they will not go and gossip about…and twist things…. I didn't want to draw one person, because you have always got someone there for you. You are never left on your own or isolated.

Figure 1. Diagrammatic representation of the development of themes, subthemes from individual constructs



Appendices

Appendix 2-A: Notes for contributors for Journal Child & Adolescent Trauma

Please note that ***Journal of Child & Adolescent Trauma*** uses CrossCheck™ software to screen papers for unoriginal material. By submitting your paper to ***Journal of Child & Adolescent Trauma*** you are agreeing to any necessary originality checks your paper may have to undergo during the peer review and production processes.

Journal of Child & Adolescent Trauma receives all manuscript submissions electronically via their ScholarOne Manuscripts website located at: http://mc.manuscriptcentral.com/WCAT . ScholarOne Manuscripts allows for rapid submission of original and revised manuscripts, as well as facilitating the review process and internal communication between authors, editors and reviewers via a web-based platform. For ScholarOne Manuscripts technical support, you may contact them by e-mail or phone support via http://scholarone.com/services/support/ . If you have any other requests please contact the journal at journals@alliant.edu .

Each manuscript must be accompanied by a statement that it has not been published elsewhere and that it has not been submitted simultaneously for publication elsewhere. Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. As an author you are required to secure permission if you want to reproduce any figure, table or extract text from any other source. This applies to direct reproduction as well as "derivative reproduction" (where you have created a new figure or table which derives substantially from a copyrighted source). All accepted manuscripts, artwork, and photographs become the property of the publisher.

All parts of the manuscript should be typewritten, double-spaced, with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Each article should be summarized in an abstract of not more than 120 words. Avoid abbreviations, diagrams, and reference to the text in the abstract. Please consult our guidance on keywords here .

References. References, citations, and general style of manuscripts should be prepared in accordance with the most recent APA Publication Manual. Cite in the text by author and date (Smith, 1983) and include an alphabetical list at the end of the article.

Examples:

Journal : Anderson, A.K. (2005). Affective influences on the attentional dynamics supporting awareness. *Journal of Experimental Psychology General* , *154* , 258-281. doi: 10.1037/0096-3445.134.2.258

Book: Weschsler, D. (1997). *Technical manual for the Wechsler Adult Intelligence and Memory Scale - III* . New York, NY: Psychological Corporation.

Chapter in a Book : Chow, T.W., & Cummings, J.L. (2000). The amygdale and Alzheimer's disease. In J.P. Aggleton (Ed.), *The amygdale: A functional analysis* (pp. 656-680). Oxford, England: Oxford University Press.

Illustrations. Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

- 300 dpi or higher
- Sized to fit on journal page
- EPS, TIFF, or PSD format only
- Submitted as separate files, not embedded in text files

Color Reproduction: Color art will be reproduced in the online production at no additional cost to the author. Color illustrations will also be considered for the print publication; however, the author will bear the full cost involved in color art reproduction. Please note that color reprints can only be ordered if the print reproduction costs are paid. Art not supplied at a minimum of 300 dpi will not be considered for print. Print Rates: $900 for the first page of color; $450 for the next 3 pages of color. A custom quote will be provided for authors with more than 4 pages of color. Please ensure that color figures and images submitted for publication will render clearly in black and white conversion for print.

Tables and Figures. Tables and figures (illustrations) should not be embedded in the text, but should be included as separate sheets or files. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet.

Proofs. Page proofs are sent to the designated author using Taylor & Francis' Central Article Tracking System (CATS). They must be carefully checked and returned within 48 hours of receipt.

Reprints and Issues. Authors from whom we receive a valid email address will be given an opportunity to purchase reprints of individual articles, or copies of the complete print issue. These authors will also be given complimentary access to their final article on *Taylor & Francis Online* .

Open Access. Taylor & Francis Open Select provides authors or their research sponsors and funders with the option of paying a publishing fee and thereby making an article fully and permanently available for free online access – *open access* – immediately on publication to anyone, anywhere, at any time. This option is made available once an article has been accepted in peer review. Full details of our Open Access program .

Taylor & Francis
Author Services

Visit our Author Services website for further resources and guides to the complete publication process and beyond.

Appendix 2-B: Summary Table of Scarlett's Constructs

Scarlett (Self Characterisation Sketch, Appendix No,2-B)			
Emergent Constructs *Emergent Constructs are the constructs initially shared by the individual in their own words*	Contrasting Constructs *Contrasting constructs are the individual's response when being asked what is opposite to an emergent construct.* *(e.g., If you were X what would you be?)*	Current position if identified	Preferred Position if identified
It is really difficult to think about myself			
Confused and not sure			
Hard with relationships and confidence			
Doesn't know which way to go			
What to do or think			
Isn't very confident	Confident; show off		
Shy			
Worried			
shut yourself away			
Ok with people they know			
I do worry what people think of me			
Terror			
Scared			
People might be looking down on him			
Get angry at yourself			
Then you get depressed			
Feels safer to stay inside			
Worry	feeling better inside, it's like being loved	I feel like this [worry] a lot,	
Like being loved; people are there for you		Sometimes[feel loved]	
Want to hurt yourself	Feeling better is like being calm		
Angry	Feel nothing, like numb, there are no feelings	Angry, Smallest things	I hate it [being angry]
Having no feelings			
Depressed	It feels like a pinch to the heart		
Being alone; everyone forgets you			
Think about hurting yourself			
Feel like you are not worth anything			
Like being torn open			
You have to have a trauma			
There are nightmares			
Just not the same as being really sad			

Appendix 2-C: Summary Table of Tom's Constructs

TOM (Self Characterisation Sketch, Appendix No 2-C)			
Emergent Constructs *Emergent Constructs are the constructs initially shared by the individual in their own words* **Constructs struggled to elaborate*	Contrasting Constructs *Contrasting constructs are the individual's response when being asked what is opposite to an emergent construct.(e.g., If you were X what would you be?)*	Current position if identified	Preferred Position if identified
I don't know if you might believe me			
Trying to do my best			
I won doing this			
Everyone laughed at me			
I had to storm out			Didn't like it
I can't control my own strength			Doesn't hurt people
I don't hurt anyone			
Heartbroken		Still brokenheart	
Just feels sad	Happy!*		
Sometimes when I fall wrong			
Artist		I am good at drawing	
Special	Never been special	I've never been special before	Special
I think I'm just a piece of junk			
I have no friends		I have no friends	
People loved me when		When they actually liked me	
It's really good*			
Nice	Horrible, selfish, spoilt, nasty	I'm sometimes nasty	Doesn't hurt people
Brokenheart still			
Have a smile on their face			
Just a nice mannered			
Playful guy			
Sometimes they take the micky out of me			
Kind*			
Really really sad			
It's horrible, like a storm is pulling you down			
Scared		I get a bit scared sometimes	
Different			
Full of joy			
Sometime he is a big of a sad			
I don't know what makes him happy*			

Appendix 2-D: Summary Table of Maggie's Constructs

MAGGIE			
Emergent Constructs *Emergent Constructs are the constructs initially shared by the individual in their own words* **Constructs struggled to elaborate*	Contrasting Constructs *Contrasting constructs are the individual's response when being asked what is opposite to an emergent construct.* *(e.g., If you were X what would you be?)*	Current position if identified	Preferred Position if identified
Friends because of our taste in music		Different things in common	
Soft people	Dress dark and stuff	Do try and make people happy	
They make other people happy			
She has problems she will just deal with them	people might let it out a different way**	I keep things in a lot	
Keeps her sadness to herself			
Keep things in	On your own and you can let it all out	I don't tell a lot of things	keep things to myself
For everyone else's sake, try and be happy		Feel like you have to for everyone else	
I was about to burst	Ask for help, share things	I didn't used to ask for help	Let things out
If you're not feel like quite shy	Not shy to talk about it		
You think people might judge you			
Good front, this good front			
Kind of hide it from everyone		No-one can know about it	
Have to pretend you are happy			
I am quite secretive	Open, weight of your shoulders, feel freer	Secretive; do it because of past experiences	Open, no worries,
Distant from people	People can come to you if they need help*	You distance yourself because you are hurt	
Bad mood	Happy, enjoy things, feel good*	Usually always in bad mood	It's better to be happy
Bored of being alive		Bored of being alive	
Depressed		Constantly upset	
Hate self			
Confident, share things ask for help, open	Not confident, scared what people will say	With my friends I am fine quite confident	Feel ok. Shouldn't worry
I get really self-conscious			
Trust		I wouldn't tell anyone secret	Trusted
Can rely on them to be there if you need them			
Wouldn't want someone else to feel the way I felt			
Helps people		I just feel better about if I have helped	Helping, MH nursing
Nice; smiling or asking how they are			
Caring; more emotion, more attachments	Quite distant, keep themselves to themselves,		
Fear being let down, disappointments & heartache		Avoid making attachment with people	
Tend to always think about the bad side like	A quite optimistic person	I try to look at the bright side but it is hard.	

Appendix 2-E: Summary Table of Izzy's Constructs

IZZY (Self Characterisation Sketch, Appendix No, 2-D)			
Emergent Constructs *Emergent Constructs are the constructs initially shared by the individual in their own words *Constructs struggled to elaborate*	Contrasting Constructs *Contrasting constructs are the individual's response when being asked what is opposite to an emergent construct. (e.g., If you were X what would you be?)*	Current position if identified	Preferred Position if identified
Different; the way they	Normal	Closer to different, only one	
Don't fit in a category		I don't really fit in	
Nothing in common	Lots of friends, Happier, People want them around		
Last choice			
No one really cares			
I am not as good as everyone else		Not as good as everybody	
Judge myself against other people			
It is hard to get closer to people	Other ways of being close to someone	Never feel close to others, or truly liked	
Like wearing a mask	Able to share their true self	I feel like people don't like that kinda me	Be completely myself
Just hiding it [self]			
Pretending	Don't have to pretend		
Popular			
Not caring what people think	Caring what people think	I care way to much	
Self-conscious	Confident in themselves	I see myself as unconfident.	More confidence
Always worrying about themselves			
Nobody needs you	Needed, got a reason or task, happy*	Never feel like I have a purpose.	Cat needed ME, a purpose.
You are just kind of there		I am kind of here for no reason	
They don't really mind you being there		No one wants me here anyway	
They are never going to rely on you	Relied on, love and appreciate you	Never needed, they are supposed to love me	To be need, feel good
Lost; there is sort of nothing there			
Unsure, you don't even want to look			
Scared of what the reality might be			
No-one really out there to take care of you	You feel like people care about you	Want to rely on somebody but find it hard because you think they will leave you	
Feeling alone	Happy; I don't know how to explain happy like*		
Unlucky person	Born with luck, things go their way, life perfect	I am normally unlucky	
Somehow things will go wrong			
Fate always goes the wrong way for me			
Perfect	I would never feel perfect	I really don't like the real me	

Appendix 2-F: Summary Table of Yazmin's Constructs

YAZMIN (Self Characterisation Sketch, Appendix No, 2-E)			
Emergent Constructs *Emergent Constructs are the constructs initially shared by the individual in their own words* ***Constructs struggled to elaborate*	Contrasting Constructs *Contrasting constructs are the individual's response when being asked what is opposite to an emergent construct.* *(e.g., If you were X what would you be?)*	Current position if identified	Preferred Position if identified
Not having eyes you wouldn't see the pain	Some people are thankful for their eyes		I wish I couldn't see pain, didn't regret
Had a lot of pain since they were a kid			
Trust	Doesn't trust at all	You can't even trust life	
I just don't expect anything from them		I have trusted a lot of people	
Trusting someone with all your heart	Every trust ended up betrayed	Learning not to [trust].	
Hoping is when you are hoping for something		I hope my future is ok	Every single day praying and hoping
Independence: doing stuff by yourself really		I am more independent	It is better to do things for myself really
What I have learnt from life			
No one is going to help you out			
Don't know how long they would be there			
Help out	Selfish, only care about own feelings		You should learn to help, no matter how bad
It is a choice really			
I wouldn't say I am nice			
Regret; something you did or wanted to do	Going the wrong way, don't regret		
A mistake, you spend your whole life regretting			
I wish I wasn't alive	Some people might love their life*		
Better to not live at all then to live with pain			
Not strong enough	Confident	Pretend to be strong	Pretend to make others happy
More about confidence	Confident		
Happy*	Happiness if not made for them	Wish to be happy	Happy makes them feel better
Sadness			
Crying eyes out			
I will never talk about it			
Don't think they understand so don't bother telling them			
People who know you inside and out			

Appendix 2-G: Appendix 2-J: Summary Table of Emily's Constructs

EMILY (Self Characterisation Sketch, Appendix No,2-F)			
Emergent Constructs *Emergent Constructs are the constructs initially shared by the individual in their own word*	Contrasting Constructs *Contrasting constructs are the individual's response when being asked what is opposite to an emergent construct. (e.g., If you were X what would you be?)*	Current position if identified	Preferred Position if identified
Overweight	Skinny	Overweight	*used to be skinny
Lack motivation to have better life	Motivated to have a good life		
Sort of not give up			
Otherwise they will be judged			
I'm not popular	Popular (really, quiet popular	Not popular	Not popular I will turn out better
Invisible	Popular	Invisible; easier than risk	
I am a little weird			
Ugly		Ugly	
No one really cares			
I will just embarrass myself			
A downer		A downer	
Sad			
Depressed			
Not a lot of people tend to like me			
Don't have enough confidence	Confidence; you can go quite far		
I speak my mind			
Want to be heard			
Hiding in the shadows			
Don't think they would tell the truth			
I have gone through a lot	People are in a dream land		
Nice person	Not a nice person	Can't be nice at school	Nice person
Not a lot of people tend to like me			
Been through a lot (trauma)			
Understand			
Empathise	Wouldn't care what others feel		As older need to empathise
Mature	Immature, spoilt brat, never had to think of others, naive	Mostly mature	Mature
Tend to help others			
I have not coped as well			
Had to grow up straight away			
Can't rely			

Have responsibility			
Tough times	Good childhood		make you a bigger better person
Put a brave face on to the world			
Appear weak			
Never tell every person	Tell everyone for attention	Tell specialists, family	Tell specialists, family
Get hurt	Risk is low that you are going to get hurt		
Used against me			
Don’t have trust	Trust		
Understand life experience			
Careful who you speak to			
Grown up knowing I can’t be a kid forever			
Bottle it up and not tell anyone			
Recognise others upset			
Turn around and say me to	Don’t compare, just listen		
Learning hard lessons			

Appendix 2-H: Summary Table of Alice Constructs

ALICE (Self Characterisation Sketch, Appendix No, 2-G)			
Emergent Constructs *Emergent Constructs are the constructs initially shared by the individual in their own words* ***Constructs struggled to elaborate*	Contrasting Constructs *Contrasting constructs are the individual's response when being asked what is opposite to emergent construct.* *(e.g., If you were X what would you be?)*	Current position if identified	Preferred Position if identified
Escaping reality			Escaping reality
Categorised as different	No specific groups		
People judging you	You don't get judged at all		You don't get judged
Always have someone to talk to			
Don't fit in	Share the same passion, Fit in	I never feel like I fit in	Share the same passion
Forced into confined space	Choose to go		
Completely different		Completely different	
Stay under the radar	Voice opinion	Stay under the radar	
Weak		it was all my fault	Here has helped a lot
Emotionally unstable			
Crazy			
Insane			
Popular groups are accepted	Groups that are not accepted	Not accepted	
No one is like me			
I always feel alone		I feel alone a lot	
I don't feel I can trust them			
I don't think they would understand			
Not really similar	We are similar, mental health problems,		
Don't connect	Connect on a different level		Connect
Not on the same wavelength			
Not things in common	Been through the same thing as me		Easier if things in common
Isolated			
Want to push feelings down	It's letting things out		It's letting things out; is good
Focus on the happy stuff		I try and bottle things up at school	
Bottle things up			
Betrayal	Trust	I find it really really hard to trust	Scouts, only place I trust
I haven't trusted my family in a long time	Trust	Really hard to trust people	Scouts, only place I trust
Confidentiality is not existent			
Put this act on	Being completely myself and completely relaxed.	Split personality	Being completely myself

Bouncing all over the place			
Entire drama performance			
Acting happy			
I have lots of practice pretending to be happy			
I am this empty shell, a robot			
People think I am really anti-social	At scouts, I am one most social people in the world		
I am determined to succeed		Determined;	Determined
I will do anything to prove them wrong			I am going to break the stereotype
Pushed myself too far		Push self; I do a lot	
Daddy issues		Daddy issues	
Gone the opposite way	Committed relationship		Committed relationship;
Depression			
A lot of issues		Constantly negative thoughts	good problems are as big as mine
Hate myself			
I blamed myself completely			
Scarred me for life! Damaged me			
people come to me with problems			
I am half glad that some of what happened		Made me a better person,	
I can connect		Connect	
Empathise		Empathise	
Make others happy, it makes me happy*			I am going to do psychology

Appendix 2-I: Extract from Yazmin's	Initial Codes	Second Codes	Subtheme	Overarching
Y: I don't want, at the moment I am still waiting for it…still waiting for an answer. I didn't tell the police, I should have done earlier so that he went to prison earlier really. Obviously nowadays I hope this wouldn't happen to other people, so if she was abused she could just tell someone as soon as possible so she has no regret, what will they say, the court the judge. Half of me is waiting thinking they will say no. I don't want another person to feel like..., I am sure I wouldn't be able to do it. I wouldn't want them to feel they can't get him punished. I don't want it to be a main; I would be scared if there was a bad point bigger than me that I wouldn't be able to help them out. If I didn't help them out I would feel guilty inside. If I am working with marriage and divorce I could work around that, but I wouldn't do that only because I wouldn't be able to do it. I am not strong enough.	Still waiting Answer Should have Hope this wouldn't happen Abused/Could just tell She has no regret Court Waiting/thinking I don't want another person to feel Wouldn't want them to feel Scared/Bad point Wouldn't be able to help Guilty inside Work with marriage Wouldn't do that/Not strong enough	External/lack of agency Protecting others/self Negative/distress External/lack of agency Negative/distress External/lack of agency Lack confident and ideal	Lacking agency Seeking caring roles Unable to connect Unable to connect Lacking agency	The Misfortunate Self The Enhanced Self The Misfortunate Self The Misfortunate Self
R: Ok, so helping someone to get justice would be important so that you can help them not feel the way you did?				
Y: Yeah				
R: Can you to tell me about strong?				
Y: It is more about confidence for me really. Cause being strong is not really a good…even if you are not strong you have to pretend that you are, to make someone else feel better, to make them feel ok, to tell them that….to be honest, sometimes I give up, I just cry my head off or scream out really, I don't really have anyone to speak to really. If I spoke to my mum it would be really like, awkward I would not want her to feel bad about herself, that I regret letting that happen to her. Or making her feel sad. It is like when I feel sad and stuff, I just need to scream and like crying and do it myself. But, when it comes to someone else, I don't feel like telling them at all, cause they wouldn't know how I feel inside out and the mum I wanted or need is weak herself. I don't think she could help me out with this business. It is just me trying to be strong.	Confidence Strong is not really good If not strong pretend you are Make someone else feel ok I give up/cry head off Scream out I don't really have anyone to speak to Awkward/Bad about herself/Regret Make her feel sad Feel sad and stuff scream/cry, do it myself I don't feel like telling them Wouldn't know how I feel Mum is weak she couldn't help Just trying to be strong	Lack confidence Lack confidence Not visible/sharing feelings Protecting other Negative/distress Protecting others Protecting others Negative/distress Distress/not sharing Not visible/sharing Others unable to handle my distress Others unable to handle me	Unconfident Unconfident Pretend Happiness Initiate independence Protecting others Pretend Happiness Initiate independence	The Inferior Self The Protective Self The Misfortunate Self The Protective Self
R: So you have told me about trying to be strong for others, and that people may….				

Appendix 2-J: Comparison of pictorial self characterisation sketch (PSCS) analysis across young people

Self Characterisation guidelines proposed by Bell & Bell, 2008)	**Similarities**	**Differences/Less common**	**Examples of how this analysis informed/was used to check findings important to research question were reported**
1) Observations of how and what was drawn	• 'Human' characters within PSCS (Izzy, Emily, Alice, Tom, Scarlett) • In initially describing PSCS Izzy and Emily reflected their negative self constructs and feeling inferior to others • Yazmin, Izzy and Scarlett's description of their PSCS involved emotive constructs (e.g., pain) • PSCS included explicit representation of self (Izzy, Emily, Alice)	• Expressions on face of characters drawn (Sad and Happy, Izzy; Angry, Scarlett; Happy, Alice) • PSCS abstract in nature (Yazmin, Tom) • Tom used the PSCS as an opportunity to nonverbally express his construct of being artist • Izzy used colours on her PSCS to depict difference • Yazmin requested to draw in pencil • Emily wrote words on her PSCS • Alice drew her PSCS in reference to a positive social context	• Referenced examples where self has been reflected as inferior or flawed • Reported Alice's PSCS as an exception (positive context)
2) Construct first elaborated	• Scarlett and Emily both construed struggling to think about themselves • Maggie and Alice both spoke about positive relationships (Maggie in reference to admired friend, Alice in relation to Scouts)	• Tom wondered if he would be believed • Izzy spoke about feeling different • Emily spoke about being overweight • Alice reference Scouts as a positive social context • Yazmin spoke of wanting to not have to see her pain • Maggie spoke of wanting to be like admired friends	• Reported constructs of difference or inferiority being emergent from the PSCS • Reported evidence of struggles to elaborate positive constructs of self • Reported Alice's PSCS as an exception (positive context)
3) Sequence and transitions between constructs	• Most young people moved from sharing emotive topics to ending the interview with a positive or neutral construct (e.g., Scarlett started talking about not be able to think about herself and ended construing calm; Tom did not feel he would be believed and ended by construing what makes Rudolph happy). • When discussing content that involved elaborating contrasting constructs the young people demonstrated this non-verbally (e.g., Scarlett became restless, Tom more animated while continuously drawing, Yazmin became visibly upset)	• Izzy ended the interview construing how she lacked purpose and would feel better if someone cared about her • Emily ended the interview construing baking as a distraction	• Reported evidence of young people struggling to elaborate positive contrasting constructs • Reported the core similarity in content in relation to protective self • Referenced the construct of caring to make self and others happy • Reported how Izzy's construct of purpose was different to constructs

3) Sequence and transitions between constructs	• Most young people transition from construing feeling inferior or different to construing their protective strategies of pretending (Emily, Maggie, Alice, Izzy) • Some young people may have presented a “pretend happy self” in the interview (e.g., Maggie, Izzy, Alice and Yazmin all laughed at times when talking about their distress) • Most young people ended the interview construed caring (e.g., Yazmin, Alice, Maggie) as a means of making themselves and others happy.		of caring
4) Core or repeated constructs	• Constructs relating to difference or worthlessness were common (e.g., Scarlett feeling worthless; Tom feeling like piece of junk, Izzy not good enough) • Most young people construed in relation to feeling unable to connect with peers and being isolated (Tom, Izzy, Maggie, Alice) • Maggie and Yazmin construed protecting others from feelings • Young people construed “pretending” as a protective mechanism (Yazmin, Alice, Izzy, Maggie, Emily, Scarlett). • Alice, Yazmin, and Maggie construed in relation to self at home but mostly like the other young people, at school • Most young people ended the interview construed caring (e.g., Yazmin, Alice, Maggie) as a means of making themselves and others happy.	• Yazmin construed in relation to her faith and culture (e.g., as a means of understanding trauma, influencing change and construing luck) • Alice and Emily both construed in with direct reference to their trauma experience as having developed and being better people. • Alice construed wanting to prove people wrong in relation to future self and relationships	• Reported how Yazmin construed in relation to faith and culture • Reported pretend self as an important protective strategy • Reported Alice and Emily as growing through trauma • Reported Alice as seeking to be ideal self, against the odds • Reported caring as an important construct
5) Details of a constructs context evident through elaboration.	• All the young people construed in relation to school and their difficulties in relating to peers • Young people felt their trauma set them apart from peers (Emily, Izzy, Maggie, Alice).	• Alice was the only young person who construed in relation to a positive context (Scouts)	• Reported all young people construe in relation to school • Reported Alice as exception, Scouts as a positive context
Additional Details relating to trauma experience	• All young people alluded to a difficult or adverse experience • All but Tom made a link between their difficult experience and the way their self construed • All young people (other than Yazmin) referred to their on-going difficulties as school • Scarlett, Izzy, Maggie and Tom did not share great detail about their trauma experiences • Alice, Yazmin and Emily disclosed their trauma experience in some detail. • Maggie, Yazmin, Scarlett and Alice used the term Trauma.	• Izzy construed largely in the ‘here and now’ with little reference to the past	• Trauma experience shared to give context • Reported that the young people make connections between experiences and way they construed self

Appendix 2-K: Table. Summary of Theme 1: The Inferior Self

Overarching Theme 1: The Inferior Self			
Main Constructs identified as relating to each subtheme (*indicates if participants expressed a position within construct) Reported as: Emergent Construct-------Contrasting Construct	Participant	Initial Codes Used to group constructs into subthemes	Subthemes Grouped into overarching theme
People might be looking down on him [dude]	Scarlett	Feeling worthless	Difference in Worth: “never been special”
Feel like you are not worth anything*		Feeling worthless	
A time when they liked me	Tom	Historically liked	
I think I’m just a piece of junk*		Feeling worthless/negative	
Special--- Never been special*		Feeling worthless/negative	
Different*		Feeling different	
Different things in common*	Maggie	Feeling different	
Dress dark and stuff*----- Soft people		Feeling Different; physical	
Hate self*		Feeling different	
Just happy		Others being different/positive	
Different*------Normal	Izzy	Feeling worthless/negative	
Not as good at academics*----Academic		Feeling different; abilities	
Perfect- I would never feel perfect*		Feeling worthless/negative	
Individuality		Others being different/positive	
Worth being used for	Yazmin	Feeling worthless/negative	
I wouldn’t say I am nice		Feeling worthless/negative	
Overweight*-----Skinny	Emily	Different; physically/negative	
I am a little weird*		Feeling different	
Ugly*		Different; physically/negative	
No one is like me*	Alice	Feeling different	
Hate myself		Feeling worthless/negative	
People might be looking down on him [dude]	Scarlett	Feeling worthless	Unable to connect: “don’t fit in”
I do worry what people think of me		Different; judgement	
Have to have a trauma*----not the same as being really sad		Different/difficult life event	
I have no friends*	Tom	Feeling different; unworthy	
Everyone laughed at me		Treated differently; unworthy	
Sometimes they take the micky out of me		Treated differently; unworthy	
A time when they liked me		Treated differently; worthy	
Secretive and distant*----people come to you	Maggie	Different; protecting self	
Different things in common*		Relating; things in common	
Dress dark and stuff*----- Soft people		Relating; things in common	
Because of past experiences		Different/difficult life events	
Don’t fit in*-----Lots of friends	Izzy	Feeling unworthy, things in common	

Nothing in common*		Relating; things in common	Unable to connect: "don't fit in"
Lost*		Different/difficult life events	
Unsure*		Different/difficult life events	
Had a lot of pain since they were a kid*	Yazmin	Different/difficult life events	
What I have learnt from life*		Different/difficult life events	
A mistake, you spend your whole life regretting		Different/difficult life events	
Invisible*-----Popular	Emily	Feeling different; unworthy	
I am a little weird*		Feeling different; unworthy	
Not a lot of people tend to like me*		Treated differently; unworthy	
I have gone through a lot*-----people live in a dream land		Feeling different; unworthy	
Been through a lot		Different/difficult life events	
Spoilt brat		Different/difficult life events	
Never had to think of others		Different/difficult life events	
Naïve		Different/difficult life events	
It's not life trauma		Different/difficult life events	
Had to grow up straight away		Different/difficult life events	
Tough times*----Good childhood		Different/difficult life events	
Learning hard lessons		Different/difficult life events	
Categorised as different-----No specific groups	Alice	Different/difficult life events	
Don't fit in*		Feeling different; unworthy	
Popular groups are accepted------groups that are not accepted*		Feeling different; unworthy	
Being able to escape reality		Feeling different; unworthy	
Forced to fit in------share the same passion		Relating; things in common	
Not really similar-----we are similar		Relating; things in common	
Not on the same wavelength------connect on a different level		Relating; things in common	
Not things in common*		Relating; things in common	
Been through the same as me*		Relating; things in common	
People think I am really anti-social---At scouts, I am most social person in the world		Relating; things in common Context and connection	
Daddy issues		Impact of life event	
A lot of issues		Impact of life event	
Scarred me for life! Damaged me		Impact of life event	
It is good that not everyone's problems are as big as mine		Different/difficult life event	
I do worry what people think of me	Scarlett	Different; judgement	Unconfident: "scared what people will say"
Isn't very confident*----Confident		Lack confident and ideal	
Scared what people say*- shouldn't have to worry	Maggie	Different; judgement	
You think people might judge you		Different; judgement	
Confident-----Not confident		Lack confident and ideal	

Self-conscious*----Confident in themselves	Izzy	Lack confident and ideal	
Don’t get picked on		Lack confident and ideal	
Not caring what people think		Others being different/Positive	
Not strong enough*-----Confidence	Yazmin	Different; judgement	
Invisible*-----Popular	Emily	Different; judgement	Unconfident: “scared what people will say”
Not a lot of people tend to like me*		Lack confident and ideal	
Don’t have enough confidence*----Confidence		Lack confident and ideal	
Just not being judged	Alice	Different; judgement	
Popular groups are accepted------groups that are not accepted*		Different; judgement	
I am really anti-social---At scouts, I am most social		Context; social	
		Context; social	

Appendix 2-L: Table. Summary of Theme 2: The Misfortunate Self

Overarching Theme 2: The Misfortunate Self			
Main Constructs identified as relating to each subtheme (*indicates if participants expressed a position within construct) Reported as: Emergent Construct-------Contrasting Construct	Participant	Initial Codes *Used to group constructs into subthemes*	Subthemes *Grouped into overarching theme*
Have to have a trauma*----not the same as being really sad	Scarlett	Different/difficult life event	Adverse Experiences “You have to have a trauma*”*
Because of past experiences	Maggie	Different/difficult life event	
Fear of being let down again and disappointments & heartache*		Different/difficult life event	
Lost*	Izzy	Uncertainty/life event	
Unsure*		Uncertainty/life event	
Had a lot of pain since they were a kid*	Yazmin	Impact of life event	
What I have learnt from life*		Different/difficult life event	
A mistake, you spend your whole life regretting		Different/difficult life event	
I have gone through a lot*-----people live in a dream land	Emily	Different/difficult life event	
Been through a lot		Different/difficult life event	
Spoilt brat		Others do not understand	
Never had to think of others		Others do not understand	
Naïve		Others do not understand	
It’s not life trauma		Different/difficult life event	
Had to grow up straight away		Impact of life event	
Tough times*----Good childhood		Different/difficult life event	
Learning hard lessons		Different/difficult life event	
Not on the same wavelength------connect on a different level	Alice	Different/difficult life event	
Been through the same as me*		Same difficult life event	
Daddy issues		Impact of life event	
A lot of issues		Impact of life event	
Scarred me for life! Damaged me		Impact of life event	
It is good that not everyone’s problems are as big as mine		Different/difficult life event	
Tend to always think about the bad side like—Quite optimistic	Maggie	Bad side/lack agency	Lacking Agency; “You can’t even trust life”
Unlucky person*----Born with luck	Izzy	External/lack of agency	
Things go their way		External/others lucky	
I am normally unlucky		External/lack of agency	
Somehow things will go wrong*		External/lack of agency	
Fate always goes the wrong way for me		External/lack of agency	

Since my past is bad, I hope my future is ok*	Yazmin	Hope	Lacking Agency; “You can’t even trust life”
Every trust ended up betrayed		Trust/difficult life event	
You can’t even trust life and where that’s going to take you		External/lack of agency	
Every single day you are praying*		Hope	
Hoping something goes good*		Hope	
Some people might feel like, I love my life		External/others lucky	
God gives you punishments,		External/lack of agency	
God gives you tests		External/lack of agency	
Some people are just not lucky*		External/lack of agency	
Their life may be written as not happy, not meant to be happy		External/lack of agency	
Like been torn open*	Scarlett	Negative/distress	Significant Difficulties; “Like a storm is pulling you down”
Depressed*		Negative/distress Negative/distress	
Just really sad		Negative/distress Negative/distress	
Want to hurt yourself		Negative/distress Negative/distress	
It feels like a pinch to the heart*		Positive/under-elaborated	
Having no feelings		Positive/under-elaborated	
Feeling nothing, like numb		Positive/under-elaborated	
Brokenheart still*	Tom	Negative/distress Negative/distress	
It’s horrible, like a storm is pulling you down*		Negative/distress	
Happy		Positive/under-elaborated	
Full of joy		Positive/under-elaborated	
I don’t know what makes him happy**		Positive/under-elaborated	
Kind		Positive/under-elaborated	
Really Good		Positive/under-elaborated	
Constantly upset	Maggie	Negative/distress/hopeless	
I was about to burst		Negative/distress	
Tired		Negative/distress/hopeless	
Stressful		Negative/distress Negative/distress	
Bad mood		Negative/distress/uncertain	
Bored of being alive		Negative/distress/uncertain	
Depressed		Negative/distress/uncertain	
Constantly upset		Negative/distress/uncertain	
Guilt and being bad		Negative/distress/hopeless	
Other people might let it out a different way		Positive/under-elaborated	
People can come to you if they need help**Opposite to being distant		Positive/under-elaborated	
Feel good		Positive/under-elaborated	
Lost*	Izzy	Negative/distress	
Unsure*		Negative/distress	

Worried*		Negative/distress	
Scared of what reality might be*		Negative/distress	
I think there are other ways of being close to someone. I don’t know some of the		Positive/under-elaborated	
ways.		Positive/under-elaborated	
Happy; I don’t know how to explain happy like *		Positive/under-elaborated	
Sometimes I wish I was blind so I could not see all that pain	Yazmin	Negative/distress	
Had a lot of pain since they were a kid		Negative/distress/hopeless	Significant Difficulties; “Like a storm is pulling you down”
Sadness		Negative/distress/hopeless	
Crying eyes out		Negative/distress	
Regret		Negative/distress	
Naturally happy---- think happiness if not made for them*		Negative/distress	
I wish I wasn’t alive*---some people might feel I love life		Negative/distress	
It is better to not live at all then to live with the pain of life		Positive/under-elaborated	
I wish I wasn’t alive---some people might feel I love life		Positive/under-elaborated	
Happy		Negative/distress	
Sad	Emily	Negative/distress	
Depressed		Negative/distress	
A downer*		Negative/distress	
Get hurt		Negative/distress	
Emotionally Unstable	Alice	Negative/distress	
Crazy		Negative/distress	
Insane		Negative/distress	
Hate self		Negative/distress	
Depression		Negative/distress	
It makes me happy*		Positive/under-elaborated	

Appendix 2-M: Table. Summary of Theme 3: The Protective Self

Overarching Theme 3: The Protective Self			
Main Constructs identified as relating to each subtheme (*indicates if participants expressed a position within construct) Reported as: Emergent Construct-------Contrasting Construct	Participant	Initial Codes *Used to group constructs into subthemes*	Subthemes *Grouped into overarching theme*
Shut yourself away*	Scarlett	Not visible/sharing self	Pretend Happiness; “Wearing a mask”
Its stressful and its feels safer to stay inside		Safer to hide self	
Keep things in*	Maggie	Not visible/sharing feelings	
For everyone else’s sake, try and be happy		Protecting others/happy	
You don’t want to talk about stuff		Not visible/sharing feelings	
Good front, this good front*		Not visible/sharing feelings	
Kind of hide it from everyone*		Not visible/sharing feelings	
You just wait until you are on your own and you can let it all out		Not visible/sharing feelings	
Have to pretend you are happy		Not visible/happy	
I am quite secretive*----Open		Not visible/sharing feelings	
Weight of your shoulders		Sharing feelings	
Like wearing a mask*----Able to share true self	Izzy	Not visible/sharing self	
Just hiding it [self]		Not visible/sharing self	
Pretending”----Don’t have to pretend		Not visible/sharing feelings	
Takes the stress off		Share feelings	
People who know you inside and out	Yazmin	Not visible/sharing true self	
I will never talk about it		Not visible/sharing feelings	
I don’t think they understand so I don’t bother telling them		Not visible/sharing feelings	
Even if you are not strong you have to pretend that you are*		Not visible/sharing feelings	
Known you inside and out		Not visible/sharing true self	
Hiding in the shadows	Emily	Not visible/sharing true self	
Put a brave face on to the world*		Not visible/sharing true self	
Careful who you speak to		Not visible/risk of true self	
Want to push feelings down*---letting them out	Alice	Not visible/sharing true self	
Put this act on----completely myself		Not visible/sharing true self	
Entire drama performance*		Not visible/sharing true self	
Acting happy*		Not visible/happy	
I have lots of practice pretending to be happy*		Not visible/happy	
I am this empty shell, a robot*		Not visible/sharing true self	
Feel better		Sharing true self	
Being alone*	Scarlett	No one to rely on	Initiate Independence; “No one is going to help you; you have to do things
Everyone forgets you		No one to rely on	
You can rely on them to be there if you need them	Maggie	No one to rely on	

Distant from people		No one to rely on	Initiate Independence; “No one is going to help you; you have to do things for yourself”
Fear of being let down and disappointments & heartache		No one to rely on/fear	
Avoid making attachment with people		No one to rely on/avoidance	
For everyone else’s benefit		No one to rely on/fear	
No-one really out there to take care of you*---people care	Izzy	No one to rely on/fear	
Feeling alone*---Happy		No one to rely on	
You think they will leave you		No one to rely on/left	
Independence: is where you are doing stuff by yourself really	Yazmin	Self sufficient	
What I have learnt from life		Self sufficient	
I just don’t expect anything from them		Self sufficient	
No one is going to help you, you have to do things for yourself		Self sufficient	
Even if you are not strong you have to pretend that you are*		Self-sufficient/pretend	
The mum I wanted or need is weak herself		Self sufficient	
I am determined to succeed	Alice	Self sufficient	
I will do anything to prove them wrong		Self sufficient	
Pushed myself too far		No one to rely on	
Isolated		Self-sufficient/pretend	
Had to grow up straight away	Emily	No one to rely on	
Shut yourself away	Scarlett	Not visible/sharing self	Managing risk of rejection; “Careful who you speak to; it could back fire”
It feels safer to stay inside		Safer to hide self	
I don’t know if you might believe me	Tom	Believe/rejected	
I keep things in a lot	Maggie	Protecting others/self	
You distance yourself because you are really hurt		Protecting others/self Protecting	
Secretive because of past experiences		others/self Protecting others/self	
Fear of being let down and disappointments & heartache		Protecting others/self Protecting	
Avoid making attachment with people		others/self Protecting others/self	
Takes the stress off	Izzy	Ideal self/true self	
Don’t like the real you		Rejected self	
You might get picked on		Rejected/risk	
I have trusted a lot of people in my life but it turned out not good	Yazmin	Rejected/risk	
I am kinda of learning not to [trust]		Not to trust	
Every trust ended up betrayed		Trust/Betrayal	
Betrayed*----Trust	Alice	Others unable to handle me	
I haven’t trusted my family in a long time		Trust/Betrayal	
Confidentiality is not existent		Trust/Betrayal	
The fear of rejection	Emily	Rejected/risk/Used	
Don’t have trust*----Trust		Trust/Betrayal	
Careful who you speak to		Trust/Betrayal	

Appendix 2-N: Table. Summary of Theme 4: The Enhanced Self

Overarching Theme 4: The Enhanced self			
Main Constructs identified as relating to each subtheme (*indicates if participants expressed a position within construct) Reported as: Emergent Construct-------Contrasting Construct	Participant	Initial Codes *Used to group constructs into subthemes*	Subthemes *Grouped into overarching theme*
I don’t want people to have to hold them in ‘cause I know	Maggie	Empathy/experience driven	Post traumatic growth; “Maybe there is a reason all of this happened”
It was later that I realised it wasn’t my fault	Yazmin	New learning/not fault	
I would tell them the experiences I had so that they did not do the same things I did		Empathy/experience driven	
Forget about yours and help that person		Empathy/experience driven	
Someone in pain I will just be there		Empathy/experience driven	
I don’t want another person to feel like me		Empathy/experience driven	
Like telling a person, someone is there for you		Empathy/experience driven	
You understand and empathize	Emily	Empathy/experience driven	
Mature*---Immature		Mature/experience driven	
The things that have happened make you a bigger and better person		Post traumatic growth	
Recognise others upset		Caring/empathy	
As you get older need to empathise		Empathy	
I am determined to succeed	Alice	Post traumatic growth	
Gone the opposite way		PTG/Determined	
I will do anything to prove them wrong		PTG/Determined	
Going to be myself, and how I was born to be		PTG/Determined	
Pushed myself too far		PTG/Determined	
I am not completely worthless		PTG/Determined	
Maybe there is a reason all of this happened		Post traumatic growth	
Psychology a-level		Post traumatic growth	
Empathise		Empathy	
Helps people	Maggie	Caring	Seeking caring roles; “Give me a purpose”
I do try and make people happy		Caring/Happy	
I just feel better about myself if I have helped somebody		Happy self/Help	
Nice		Caring	
Smiling or asking how they are		Caring	
Caring		Caring	
I want to be a nurse		Caring role	
Nobody needs you----Needed	Izzy	Needed	
Got a reason or a task		Reason/Purpose	
Notice own strengths		Strengths and reason	
You are just kind of there		Reason/Purpose	
Never feel like I have a purpose		Reason/Purpose Reason/Purpose	

Cat needed ME it gave me a purpose		Reason/Purpose Reason/Purpose	
They are never going to rely on you*-----Relied on		Reason/Purpose/Love	
Without that person, you wouldn’t be able to live		Reason/Purpose/Love	
They love and appreciate you		Reason/Purpose/Love	
No one wants me here anyway		Reason/Purpose/Love	
It feels like they are just supposed to love me		Caring	
I would like someone to need me to give me a purpose		Others not caring	
Help out----They would be quite selfish	Yazmin	Others not caring	
Only cared about their own feelings		Caring/Love	
Didn’t think about anyone else		Caring role	Seeking caring roles; “Give me a purpose”
Blessings			
Help those people who have difficulties get justice			
Mature	Emily	Caring/experience	
Never that to think of others		Caring	
Tend to help others		Caring	
Help others before themselves		Caring	
Understand life experience- Emily		Caring/experience	
People come to me with problems	Alice	Caring	
Can connect		Caring/Connecting	
I make my other friends happy, it makes me happy		Happy self/Help	
A counsellor one day		Caring role	
When I can help them		Caring	

Appendix 2-0. Comparison of Initial Themes Across Alice's Transcript

Main Researcher		Academic Supervisor	
Theme Description	Supporting Quote	Theme Descriptions	Supporting Quote
'Different places different self' Alice construed herself as being different in different contexts. This seemed to relate directly to the relational and historical experiences that she associated with each social context. School was a place of stress whereas Scouts allowed her to escape reality where she could be a preferred 'self' without judgment.	A: Erm, well it is, school work is really stressful and the bullying on top of that and erm, it's it's a bit like I have a split personality. I am one person at home, one person at school and another person at scouts and erm, it is so easy to be myself at scouts but then at home I am not quite there, I go and do my homework, and don't have time for a lot of anything else and then school, I don't say much, and here I am talking like mad now, which is what I do at scouts.	School vs Scouts Being judged/not being judged (personality vs appearance)	Line 11: Scouts is really good because, it is kind of escaping reality. Over here (raises left with hand) you have all the stress and school work or people judging you and saying things, and then over here (right hand) in camp all the girls, it's brilliant, you can talk to them and they will not go and gossip about…and twist things, no one wears makeup, I don't like wearing makeup, makeup up at all. You don't get judged at all, you can wear what you want, massive baggy hoodies and, and you walk around like a complete mess and no one really cares, they kinda look for your personality more than your appearance
'Others can't be trusted' Alice made links between her past experiences and that she struggles to trust others. This was a theme that transcended contexts and relationships. For example it related to her traumatic experience with her father but also her experience of teachers at school. Consequently Alice believed that she could not trust people with her experience	A: Erm….yeah it is really important. I haven't trusted my family in a long time. Ever since my…my parents broke up when I was in year 6, I was about 10 and it is kinda like, there is a lot of lying. A: Then it is like Chinese whispers, and then its exaggerated and people over hear, they have heard something while outside the staff room or school office, you kind of learn, I just don't trust teachers any more.	Trust vs betrayal ('confide' at scouts vs other – 'fake friends' line 139)	Line 100: I always feel alone. I have friends who say if you ever need me I am here to talk to but I don't feel like I can trust them, because I am a little paranoid about what other people have said and I don't think they would understand because they are not on the same wavelength. It is different with people at scouts because I can talk to them openly about it 'cause, some of them have not been through the same things as me, but we connect on a different level so I feel safe talking to them.

'Putting on a performance' An extension of being different people in different contexts. Alice specifically spoke of pretending to be happy and this appeared to have a protective function, especially in school which was an environment she associated with judgement. Once again this contrasted to her experience at Scouts where she felt she would be safe from judgement	A: Yeah I got an A* in drama maybe because I have lots of practice pretending to be happy A: At school I am like in this shell, this empty shell. But when I go to scouts I am kinda like, I can kinda like be myself and not really care what people think of me, because they don't judge anyone	Protecting self (against judgment and ridicule)	152: It is like going to scouts, and you can say anything that you want. If you are going through a tough time, they can tell, like at school I put on this act that I am completely happy and completely fine, I will be bouncing all over the place kind of convincing people…school has been an entire drama performance at the end of the day, acting happy and acting you are ok, even if you are really not and you have all these thoughts in your head.
'I will prove them wrong' Alice spoke of perceiving her trauma experience; in particular her "daddy issues" could lead her down a path she did not wish to go. Alice reported a strong drive to break this stereotype and to instead be the person she would like to be.	A: I tend to do a lot to prove myself to other people erm, like a lot of people, people put it that I prove myself because I have "daddy issues". A:.. a girl in my class who dad disowned her when she was 7 and she has major daddy issues like similar to me but she has gone the opposite way about it, she is pregnant at 14 and I definitely do not want to turn out like her	Stronger Self	301: I used to view it as a weakness. Here has helped a lot, thinking is it your fault? Like when my dad used to pin things on me, erm, I used to think it was all my fault and that I was weak. Now I have half come to, erm, like getting better within how I view myself. 310: I am half glad that some of what happened, happened to me, because I now have a completely new outlook on life, it is like at the time it was horrible and the flashbacks are horrible but it has made me a better person at the end of the day. I don't think I would be anywhere near the person I am now if that didn't happen.

Section Three:

Critical Appraisal of the Paper 'Exploration of how children and young people self-construe following a traumatic experience'

Word Count: 3,999

Amy D'Sa

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:
Amy D'Sa
Doctorate in Clinical Psychology
Furness College
Lancaster University
Lancaster
LA1 4YT
a.dsa@lancaster.ac.uk

This critical appraisal provides a companion piece to the research to allow for a more in-depth consideration of particular issues that were not fully reported in the research paper due to practical constraints. This paper is written in the first person to allow for reflection on decisions made while including participant accounts and consulting research where relevant. Additionally, recommendations for future research and clinical practice will be made.

Within the critical appraisal I consider five key areas. Firstly, I acknowledge the complexity of the research question by considering the assumptions I made, particularly about exploring the relationship between self-construing and trauma. Secondly, I detail considerations I made about defining trauma for the research including using the Trauma Symptoms Checklist for Children – Alternate as a means of identifying a trauma presentation (TSCC-A; Briere, 1996). Thirdly, I reflect on the applied recruitment strategy and how this may reflect some biases but also essential factors relating to encouraging participation. Fourthly, I go on to discuss the strengths and limitations of using a personal construct methodology, including the appropriateness of the pictorial self characterisation sketch. Finally, I reflect on how I managed completing this emotive piece of research while not being therapeutically involved with participants.

Acknowledging underlying assumptions

The research paper took a novel exploratory approach in considering how children and young people think about themselves following a traumatic experience. One limitation of this research, which was kept in mind throughout, was the assumption I made about being able to capture and untangle the relationship between self-construing and the trauma experience. Although, as the research paper notes, adult literature and child theory (e.g., Sewell, 1996; Herman, 1992) acknowledge that trauma experience has a fundamental impact on a person’s wellbeing, including the way they think and feel about themselves, there are also multiple factors that may inform this process. These include age, development, previous traumatic experiences, having consistent support networks, family and culture (McFarlane & Yehuda, 1996). This complexity was illustrated explicitly at times in the study, for example when Yazmin spoke about how her faith and culture were important for her, and therefore informed how she thought and felt about herself following her trauma .

Furthermore, Kelly (1955) argued that construing is an ongoing, active process which reflects new experiences (Kelly's fundamental postulate). Therefore it is highly likely that a child or young person's ongoing experience following a traumatic event, such as therapeutic input, will play a meaningful role in how they construe. Such experience could explain constructs of post traumatic growth demonstrated in the research paper (e.g., Emily construing "I am a bigger better person").

In light of this dilemma, I decided that the title of the research needed to reflect that a relationship between trauma experience and self-construing was assumed and was going to be explored in the interview. However, while acknowledging other factors I did not want the paper to infer that trauma experience alone would inform how a child construed. Hence the title "Exploration of how children and young people self-construe *following* a traumatic experience" was developed. Furthermore, I considered the ways I might best maximise the likelihood that trauma was a meaningful contributor to how children and young people think about themselves. Such deliberations, discussed within this critical appraisal, include how I came to define trauma, the ways children and young people were identified as potential participants with a trauma background (e.g., as accessing mental health settings, screening for trauma using the TSCC-A), and the role that clinicians were asked to take within the recruitment process.

Defining trauma

While reading the trauma research, I considered my own beliefs about defining trauma which were informed by my lived experience and clinical practice. As a trainee clinical psychologist I often approach formulating another’s distress by being largely informed by how the individual defines their own experience. Therefore, I was interested in the debate in the literature around prioritising objective experience (e.g., which forms the basis for diagnosis frameworks such as the DSM-5 definition of Post-Traumatic Stress Disorder) or subjective experience (e.g., Allen, 1995).

Examining the literature helped me develop my thinking and inform my position when defining trauma in my research. I decided to apply a definition that acknowledged both objective and subjective elements (Sar & Ozturk, 2006). However, in line with Allen’s (1995, p.14) position that “it is the subjective experience of the objective events that constitutes the trauma”, how the child or young person made sense of this experience, remained at the heart of how I understood trauma and the basis from which I asked clinicians to identify potential participants. The following applied definition was considered in in keeping with the research as it described trauma as a “unique experience of an event or enduring conditions in which the individual’s ability to integrate his/her emotional experience is overwhelmed and the individual experiences (either objectively or subjectively) a threat to his/her life, overall integrity or that of a caregiver or family member” (Pearlman & Saakvitne, 1995, p.60).

Having identified a definition, I decided to recruit through child mental health services, which I believed would allow me safe and monitored access to a population of young people, some of whom may have experienced something traumatic. I recognised that within such settings, diverse understandings of trauma would be held, even if the wider service encouraged a medical perspective (e.g., symptom focused). Therefore to strengthen the research beyond applying a definition of trauma, a standardised validated measure of trauma symptomology (TSCC-A) was used as an inclusion criterion for identifying potential participants. This is a familiar tool for most clinicians, furthermore it allowed for some consensus in identifying a group of young people who had experienced and were affected by traumatic experiences.

While reflecting on the process of defining trauma, I am aware that I had not fully anticipated how the term would be received by the children, young people and their families. Through the interviews it became clear that the term 'trauma' was understood differently (e.g., as applying only to extreme experiences of abuse). Furthermore that the children and young people may conceptualise their 'traumatic' experiences differently and therefore would not identify with the term trauma (e.g., I am bullied). However, some participants did apply the term 'trauma' alongside other clinical terms, such as depression, within their interview. This made me wonder about how contact with services and increased awareness of mental health issues in society may encourage children and young people to adopt clinical terms in relation to their own experiences. In a therapeutic setting this could result from a clinician's attempt to identify and normalise distress or them using this term as short hand for describing something that is often complex.

In my reflective diary, I wondered about how using the term 'trauma' reflected my intentions, as a researcher, to capture a complex web of experiences in a single term. Moreover, as I completed this thesis, I have recognised using this language and making assumptions about applying such terms sat uncomfortably with me. Therefore when reporting the findings of the research I chose to use the term 'difficult or adverse life events' when reflecting on experiences that were not labelled as being a 'trauma' by the young people, even if feelings of threat were acknowledged. Completing this research has reminded me to question and be sensitive to the language I apply in research and my clinical work, and whenever possible privilege client language.

A further illustration of trauma being conceptualised differently from my chosen definition was when parents challenged me about using this to term to reflect their child's experience. One such parent stressed "*my child has not experienced a trauma*". In response I tried gently and sensitively to explain my position on what I meant by 'trauma', particularly that it was not just about extreme cases of abuse but included any experience that caused a child or young person significant distress (e.g., bullying). In all cases, parents appeared to accept this and agree that their child's experience would be captured within such a definition. Interestingly, this response to the term is likely also to depict the emotiveness of the word, and what this captures for each of us. For parents a 'traumatic event' may represent something not only difficult to acknowledge, but something that reflects their parental abilities (e.g., ability to protect their child) or their perceptions of how others may judge them or their child. Future research would benefit from exploring parent's understandings and response to such terms used in relation to their child's experience.

The use of the term 'trauma' may have alienated those being asked to be involved in the project. This may reflect why less potential participants expressed interest in taking part. Moreover, if 'trauma' was not a term used in therapeutic work, it may have created a barrier for clinicians to offer an invitation for children and young people to take part. With this in mind, future research would benefit from exploring how children, young people, families and clinicians construe trauma experiences, especially the language they use, to allow for the development of alternative terms to be used when referring to such experiences.

Reflections on recruiting participants

Vitally, the research was designed to reduce any potential risk of distressing participants, given its emotive topic, novel nature and vulnerable population. A consequence of this was that I applied vigorous exclusion criteria. Unfortunately, this meant important groups of children and young people were not asked to take part, namely looked after children. Further research would benefit from including such populations to enrich the understanding of how children and young people think about themselves while holding in mind the influence of different and ongoing traumatic experiences. Furthermore, a cut off score was identified for the TSCC-A Post Trauma Subscale as a safeguard against asking children or young people who rated highly on associated trauma symptoms and therefore could be considered more vulnerable to distress if taking part. This criterion did not end up being applied as no participants scored above 80, so this appeared an irrelevant precaution, especially as clinicians appropriately identified young people who were able to manage taking part. Within my reflective diary I had wondered if my use of such strict criteria was in pre-empting anxiety and resistance from services and the ethics committee, but also my own uncertainty about how children and young people may engage in these types of discussions about self outside of a therapeutic setting.

Drawing across a common theme from the meta-synthesis and research paper, trust was also essential for the success of and containment within the research. Primarily, clinicians had to trust in me, the researcher, that I would conduct the interview with the best intentions and skill, with respect to the young person's experience and the clinical work that was underway. Interestingly, all clinicians who supported recruitment had met with me in person, and often knew of me from a previous clinical placement. Additionally, trust and confidence in the clinician was fundamentally important for encouraging participation. This was demonstrated by all parents and young people referring to their clinician with respect and positive regard. I have since wondered if recruitment would have been successful if clinicians had not been so actively involved. Further research in this area, particularly if the researcher is unknown to the service, would benefit from including clinicians in early stages of research development and recruitment. Such transparency and personal investment could encourage a safe and successful piece of research.

Having clinicians recruit on my behalf, did however create the potential for biased recruitment, given clinicians held their own concerns and interests. This could offer one explanation for why the majority of participants were bright, articulate young people who demonstrated resilience, and at times evidence of post-traumatic growth. I wondered if, understandably, clinicians were more likely to ask young people they believed could more effectively manage talking about their experiences or with whom they had a good relationship. This limitation of recruitment, which to some extent was implicit in the inclusion criteria (e.g., clinicians asked to use their clinical judgement), meant children and young people who are not fully engaged in a positive therapeutic relationship may have been less likely to be asked to take part. Additionally, I did not put in place a robust method of asking clinicians to feedback their decisions around who was approached, and why people declined to take part. Future research could benefit from collecting this detailed information to reduce unhelpful biases affecting recruitment (e.g., girls are more inclined to talk about their experiences; Goldshmidt & Weller, 2000) while reflecting necessary limitations (e.g., stable environment).

Reflections on the methodology

As detailed in the research paper, I felt Personal Construct Psychology (PCP) provided an appropriate framework to explore the research question. Having used PCP to inform my clinical work with children and young people I felt confident that I could utilise this methodology. While holding in mind that it was a research interview rather than a therapeutic piece of work, I engaged in three mock interviews with trainee clinical psychologists as participants. This helped me to practise and refine this methodology and develop my own confidence while receiving constructive feedback.

A pictorial self characterisation sketch (PSCS) was chosen from other PCP informed methods (e.g repertory grids and written self-characterisation sketches; Kelly, 1955) as an adapted developmentally appropriate means of exploring self given the research aimed to interview across children and young people between the ages of 8-16. This reflects proposals by Fantuzzo, McDermott, Holiday-Manz, Hamptom & Burdick (1996) and more recently, Robinson's (2012, p.47) that "both verbal and visual elicitation methods may be needed to ensure a comprehensive account of a child's view of self that will best meet the needs of the child". Applying such a creative method could allow the child or young person an opportunity to voice their own experience in their own words without my imposing my beliefs about how trauma affects construing of self, even if it was derived from theory. Moreover, interviewing children about such an emotive and personal subject needed to have an appropriate and containing structure (e.g., PSCS). Vitally, as trauma impacts a child or young person's cognitive abilities (Finkelhor & Browne, 1985), including verbal language (Graham-Bermann, Howell, Miller, Kwek, & Lilly, 2010), the PSCS allowed children to assess the interview even if they might struggle to verbalise their experience in rich descriptive ways.

Throughout the research process, I kept reflective notes on how this method appeared to be received and whether it supported young people in accessing the interview and elaborating their constructs. In the main, I was surprised by how naturally the young people engaged in doing a PSCS. Some young people took the instruction 'think of yourself and draw a picture' very literally (e.g., Izzy and Emily drew a representation of self) while others took the instruction less so (e.g., Tom drew a picture that he felt he could do well, Yazmin drew an eye). Nevertheless, the appropriateness of the PSCS methodology within this study was considered retrospectively as the majority of participants were adolescents. If this had been by design then other methodology, such as a written self-characterisation sketch may have been as, if not more, appropriate for this age group.

Furthermore, one young person (Maggie) chose not to complete a PSCS but was able to engage verbally in the interview. This difficultly in engaging in the PSCS appeared to reflect Maggie's anxiety and also her preference in the way she wanted to take part in the interview. I decided that it was important to make Maggie feel comfortable and so engaged her in a brief discussion about any ideas that came to mind when thinking about herself. I had hoped this would offer her time to settle into the interview, but even after a while Maggie declined to complete a PSCS. Consequently the constructs Maggie shared may have been different from those of other participants since, as Ravenette (1996) argued, drawing allows a child or young person to access different experiences from those elicited from questions. However as the same types of questioning (e.g., laddering and pyramiding) were used with all participants, this may have allowed Maggie to tap into a similar network of constructs.

Interestingly, the interviews did show that, for the majority, the PSCS appeared a useful and engaging way of eliciting constructs. Using a mixed methodology of verbal and non-verbal components supported individuals differently in engaging in the interview. For those young people who disclosed trauma experience (e.g., Alice, Yazmin, Emily), the PSCS appeared to provide a safe means to discuss this vital but emotive material. As intended, the PSCS supported the young people in expressing constructs at a lower level of awareness (Ravenette, 1996). The extract from Yazmin's transcript below illustrates this, and her surprise at what the PSCS had facilitated.

> *Yazmin: ....Wow these are coming out really well, they have come out like, hope and trust and I didn't think....*
> *Researcher: Are you surprised?*
> *Yazmin: I am actually surprised....it's weird I draw eyes all the time and flowers but... So whenever I don't feel good I go to draw. Then this eye comes out (points at drawing) or a flower comes out. I don't talk about it, so it is a bit unusual, all these words that are coming out!*

Furthermore, as I often had to end the interview due to practical reasons (e.g., room bookings, parents waiting), I wonder if offering a second interview would have allowed for further reflection on the PSCS and therefore more exploration of how the young people construed themselves and their experiences. It could also have provided an integral mechanism for validating the constructs that were most meaningful for each young people and therefore should be considered in further research.

Reflections on managing the emotive topic of the research

In developing this research I had hoped it would be "clinically meaningful in order to reduce the gap that exists between clinical research and actual practice" (Avdi, 2005, p.494). However this meant that it was important to acknowledge and manage the associated tension between my role as a clinician and as a researcher (Yanos & Ziedonis, 2006). As the research paper and ethics section detail, the interview had been designed in respect to clinical guidance (e.g., National Institute of Health and Care Excellence, 2005), so that I, the researcher, would not directly ask the children or young people about their trauma experience. Nevertheless, during the interview the majority of young people naturally alluded to, if not named their trauma experience, demonstrating I had wrongly presumed they could talk about themselves without reflecting on the significant events that informed this.

In my reflective diary, I wondered how the children or young people experienced this boundary I had placed around the research. I had hoped this felt protective and non-intrusive given we had no established relationship, but instead this may have felt invalidating or silencing. The later may be reflected by Scarlett who said while alluding to her trauma, "*I know I can't talk about that*". In distinction, most young people shared trauma material in the interview without expressing concern that this would not be ok. Future research could benefit from thinking through the implications of such boundaries while offering clarity on these decisions for participants. Furthermore, within clinical practice, and as reflected in the meta-synthesis, it is essential to communicate that when a child is ready to disclosure a traumatic experience this can be tolerated by the therapist.

All the young people expressed extremely negative and emotive constructs about themselves during the interview, during which, I was struck by how differently I experienced hearing this as a researcher. Managing such discussions within a stand-alone interview, felt at odds with what I might do in a therapeutic context. Although, as within my clinician work, I aimed to develop a collaborative understanding of how a child or young person construed, I noted that within a therapeutic paradigm this would be an evolving process underpinned by a growing therapeutic relationship. Furthermore, such shared understanding may lead to interventions where beliefs about self, others and the world might be worked with (e.g., Trauma Focused Cognitive Behavioural Therapy; Ehlers, Clark, Hackman, McManus, & Fennell, 2005). Instead, within the interview, I was conscious of validating what the young people shared but in a manner that I hoped was not experienced as agreement or collusion. Mainly, I tried to reflect content back sensitively, in a way that clearly noted I was using their words (e.g., “You have told me about how you see yourself as being a piece of junk…that sounds really difficult).

When setting up the research I had realised that I would be hearing distressing material. Yet retrospectively, I recognised that I had not expected or prepared myself to have been so moved by the content of what I heard. Even when transcribing interviews I recognised the content was difficult to hear. Moreover, I noticed I felt great compassion for the young people and anger at what had happened to them. This meant debriefing with my supervisor was vital, to notice and understand such feelings and the role of transference (Anderson & Baum, 1994) while also considering my understanding of the child or young person’s construing process (social corollary; Kelly, 1955). Moreover I accessed peer supervision to manage and reflect on general processes and tensions relating to the thesis.

Both supervisory processes helped me to develop my skills and ensure that I was able to conduct the research in a sensitive, safe and ethical way.

While transcribing I recognised my confidence in asking about negative constructs grew as the interviews went on. Additionally, I appeared to reach a balance in elaborating meaningful and often negative constructs while being conscious of not creating distress. I noticed in earlier interviews I sometimes showed a bias toward asking young people to elaborate more neutral constructs (e.g., confidence) rather than emotive negative ones (e.g., “It feels like being torn open”). I wondered if this reflected an unconscious process of seeking positives or being motivated to introduce positives into the interview (e.g., Scheel, Davis, & Henderson, 2013). An important implication of this is that clinicians and researchers who may be drawn into similar dynamics, need to take time to notice these patterns of responding and reflect on why this might be the case. In focusing on positive aspects of experience, it is also possible that a child or young person is not given the opportunity to share distressing material and that they may struggle to consider positives. Supervision again offers a crucial opportunity to consider such dynamics, and how these may be necessary at times to establish safety.

One final clinical implication, generated from the findings, is that young people construed a ‘protective self’ and therefore may have censored themselves or presented their experience in a more positive light in the interview. This also related to the meta-synthesis finding that adults also seek to avoid sharing trauma related experience. Therefore clinicians need to be mindful of these protective processes and through normalising this could open up discussions about underlying reasons or concerns, which can then be addressed through the developing therapeutic relationship.

Conclusion

Completing this piece of research has involved learning and developing as a researcher and clinician. I have developed my knowledge around trauma and felt privileged to listen to how children and young people think about themselves following such experiences. This provided me with an opportunity to consider the issues that are raised when trying to design and carry out a piece of emotive and sensitive research within an area of complex human experience. Nevertheless, I hope this illustrates that even with challenges, conducting such research is necessary and possible to develop a better understanding of how children and young people who experience trauma go on to think and feel about themselves. It has also allowed me the opportunity to acknowledge the challenges that face clinicians who are trying to model a relationship and safe space from which trauma experience can be shared, explored and processed.

References

Allen, J. G. (1995). *Coping with trauma: A guide to self-understanding*. Washington, DC: American Psychiatric Press.

Andersen, S. M., & Baum, A. (1994). Transference in interpersonal relations: Inferences and affect based on significant-other representations. *Journal of Personality*, 62, 459–497. http://dx.doi.org/10.1111/j.1467-6494.1994.tb00306.x

Avdi, E. (2005). Negotiating a pathological identity in the clinical dialogue: Discourse analysis of a family therapy. *Psychology and Psychotherapy: Theory, Reseach and Practice*, 78, 493-511. http://dx.doi.org/10.1348/147608305X52586

Briere, J. (1996). *Trauma symptom checklist for children (TSCC) professional manual.* Odessa, FL: Psychological Assessment Resources.

Ehlers, A., Clark, D., Hackman, A., McManus, F., & Fennell, M. (2005). Cognitive therapy for posttraumatic stress disorder: Development and evaluation. *Behaviour Research and Therapy*, 43, 413–431. http://dx.doi.org/10.1016/j.brat.2004.03.006

Fantuzzo, J. W., McDermott, P. A., Holliday-Manz, P., Hampton, V. R., & Burdick, N. A. (1996). The pictorial scale of perception competence and social acceptance: Does it work for low-income urban children? *Child Development*, 67, 1071-1084. http://dx.doi.org/10.1111/j.1467-8624.1996.tb01783.x

Herman J. L. (1992).*Trauma and recovery*. Basic Books: New York.

Goldshmidt, O. T. & Weller, L. (2000). “Talking emotions”: Gender differences in a variety of conversational contexts. *Symbolic Interaction*, 23, 117-134. http://dx.doi.org/ 10.1525/si.2000.23.2.117

Graham-Bermann, S., Howell, K., Miller, L., Kwek, J., & Lilly, M. (2010). Traumatic events and maternal education as predictors of verbal ability for preschool children exposed to intimate partner violence (IPV). *Journal of Family Violence*, 25, 383-392. http://dx.doi.org/10.1007/s10896-009-9299-3

Kelly, G. A. (1955). *The psychology of personal constructs*. New York: Norton

McFarlane, A. C., & de Girolamo, G. (1996). The nature of traumatic stressors and the epidemiology of posttraumatic reactions. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The overwhelming experience on mind, body, and society* (pp. 129-154). New York: Guilford.

National Institute of Clinical Excellence. (2005). *Quick reference guide: Post-traumatic stress disorder* (PTSD): The management of PTSD in adults and children in primary and secondary care. London. Retrieved from: http://www.nice.org.uk/nicemedia/pdf/CG026quickrefguide.pdf

Ravenette, T. (1996). An exploration of personal meaning through the use of drawings: A brief introduction to an experimental workshop. In B.M. Walker, J. Costigan, L.L., Viney & Warren, B. (Eds). *Personal Construct theory: A psychology for future beings*. Sydney: Australian Psychology Society Ltd.

Robinson, J. (2012). Understanding how young children view themselves: A personal construct approach. Cited in: Giliberto, M., Dell'Aversano, C.,Velicogna, F. (2012*).* *PCP and constructivism: ways of working, learning and living.* Proceedings of the XVIIIth International Congress on personal construct psychology. Libri:Liberisrh.

Pearlman, Laurie A., & Saakvitne, Karen W. (1995). *Trauma and the therapist: countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: W.W. Norton.

Scheel, M.J., Davis, C. K., & Henderson, J.D. (2012). Therapist use of client strengths: A qualitative study of positive processes. *The Counselling Psychologist*, 41, 392-427. http://dx.doi.org/10.1177/0011000012439427

Vedat Sar, M.D., & Ozturk, E. (2006). What is trauma and dissociation? *Journal of Trauma Practice*, 4, 7-20. http://dx.doi.org/10.1300/J189v04n01_02

Yanos, P.T., & Ziedonis, D. M. (2006). The patient-oriented clinician-researcher: Advantages and challenges of being a double agent. *Psychiatry Services*, 57, 249-253. http://dx.doi.org/10.1176/appi.ps.57.2.249

Section Four: Ethics Documents

Exploration of how children and young people self-construe following a traumatic experience

Word Count: 5,989

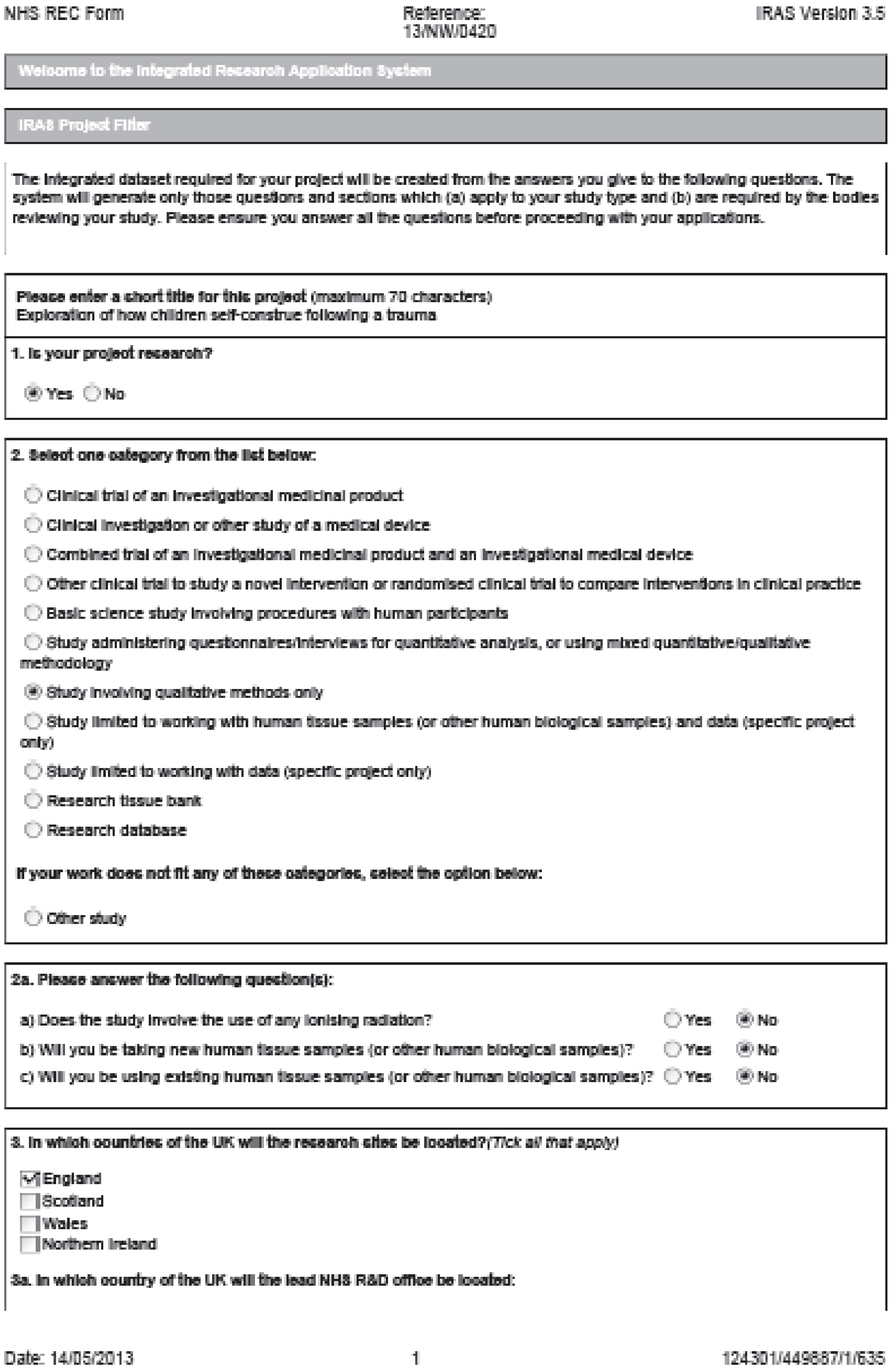
Amy D’Sa

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:
Amy D’Sa
Doctorate in Clinical Psychology
Furness College
Lancaster University
Lancaster
LA1 4YT
a.dsa@lancaster.ac.uk

NHS Research Ethics Committee (REC) Application Form



NHS REC Form
Reference:
13/NW/0420
IRAS Version 3.5

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
Exploration of how children self-construe following a trauma

1. Is your project research?

● Yes ○ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product
○ Clinical investigation or other study of a medical device
○ Combined trial of an investigational medicinal product and an investigational medical device
○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
○ Basic science study involving procedures with human participants
○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
● Study involving qualitative methods only
○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
○ Study limited to working with data (specific project only)
○ Research tissue bank
○ Research database

If your work does not fit any of these categories, select the option below:

○ Other study

2a. Please answer the following question(s):

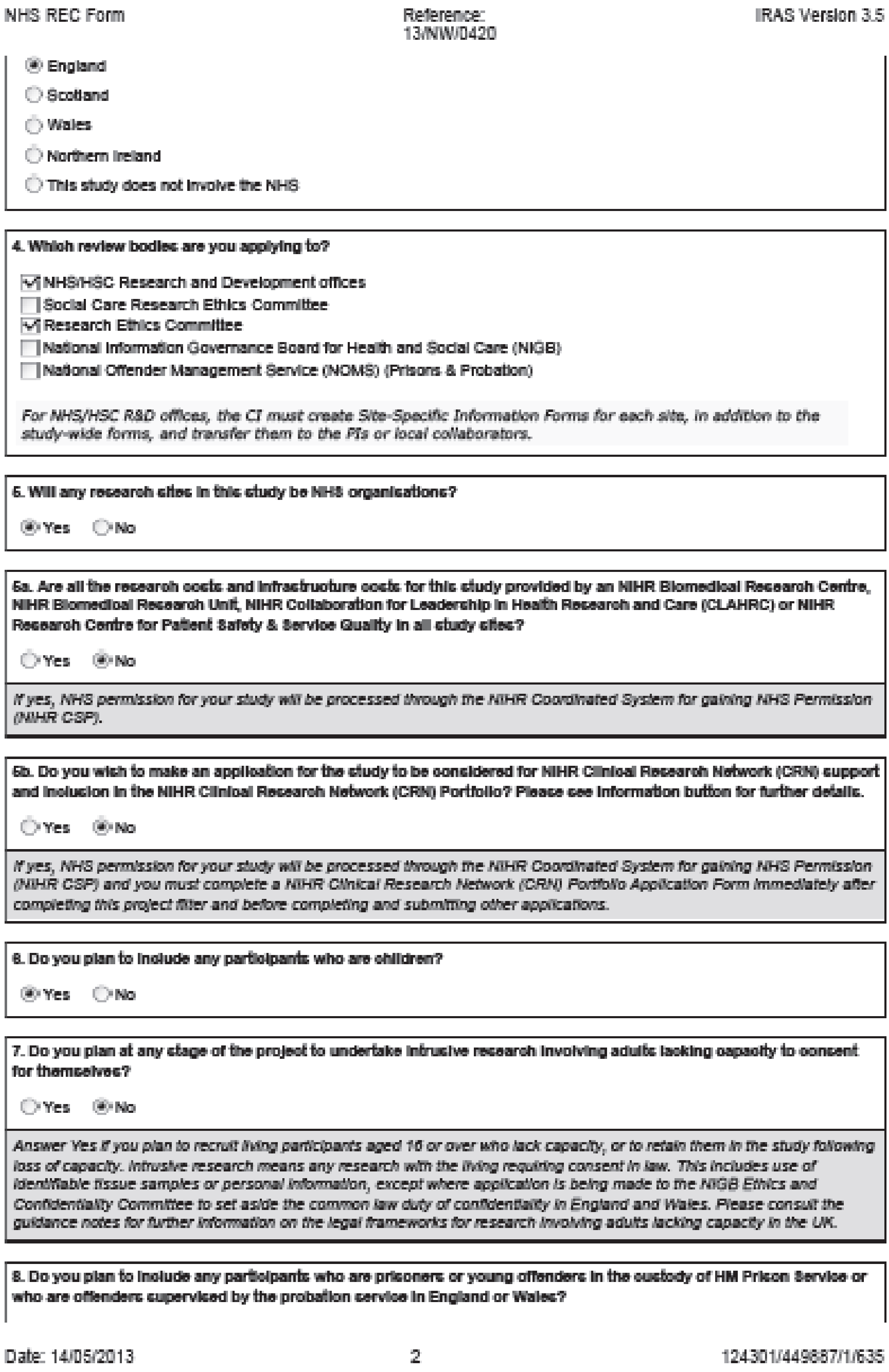
a) Does the study involve the use of any ionising radiation?	○ Yes	● No
b) Will you be taking new human tissue samples (or other human biological samples)?	○ Yes	● No
c) Will you be using existing human tissue samples (or other human biological samples)?	○ Yes	● No

3. In which countries of the UK will the research sites be located?*(Tick all that apply)*

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

Date: 14/05/2013 1 124301/449687/1/635



● England
○ Scotland
○ Wales
○ Northern Ireland
○ This study does not involve the NHS

4. Which review bodies are you applying to?

☑ NHS/HSC Research and Development offices
☐ Social Care Research Ethics Committee
☑ Research Ethics Committee
☐ National Information Governance Board for Health and Social Care (NIGB)
☐ National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D offices, the CI must create Site-Specific Information Forms for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.

5. Will any research sites in this study be NHS organisations?

● Yes ○ No

5a. Are all the research costs and infrastructure costs for this study provided by an NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC) or NIHR Research Centre for Patient Safety & Service Quality in all study sites?

○ Yes ● No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP).

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) support and inclusion in the NIHR Clinical Research Network (CRN) Portfolio? Please see information button for further details.

○ Yes ● No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP) and you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form immediately after completing this project filter and before completing and submitting other applications.

6. Do you plan to include any participants who are children?

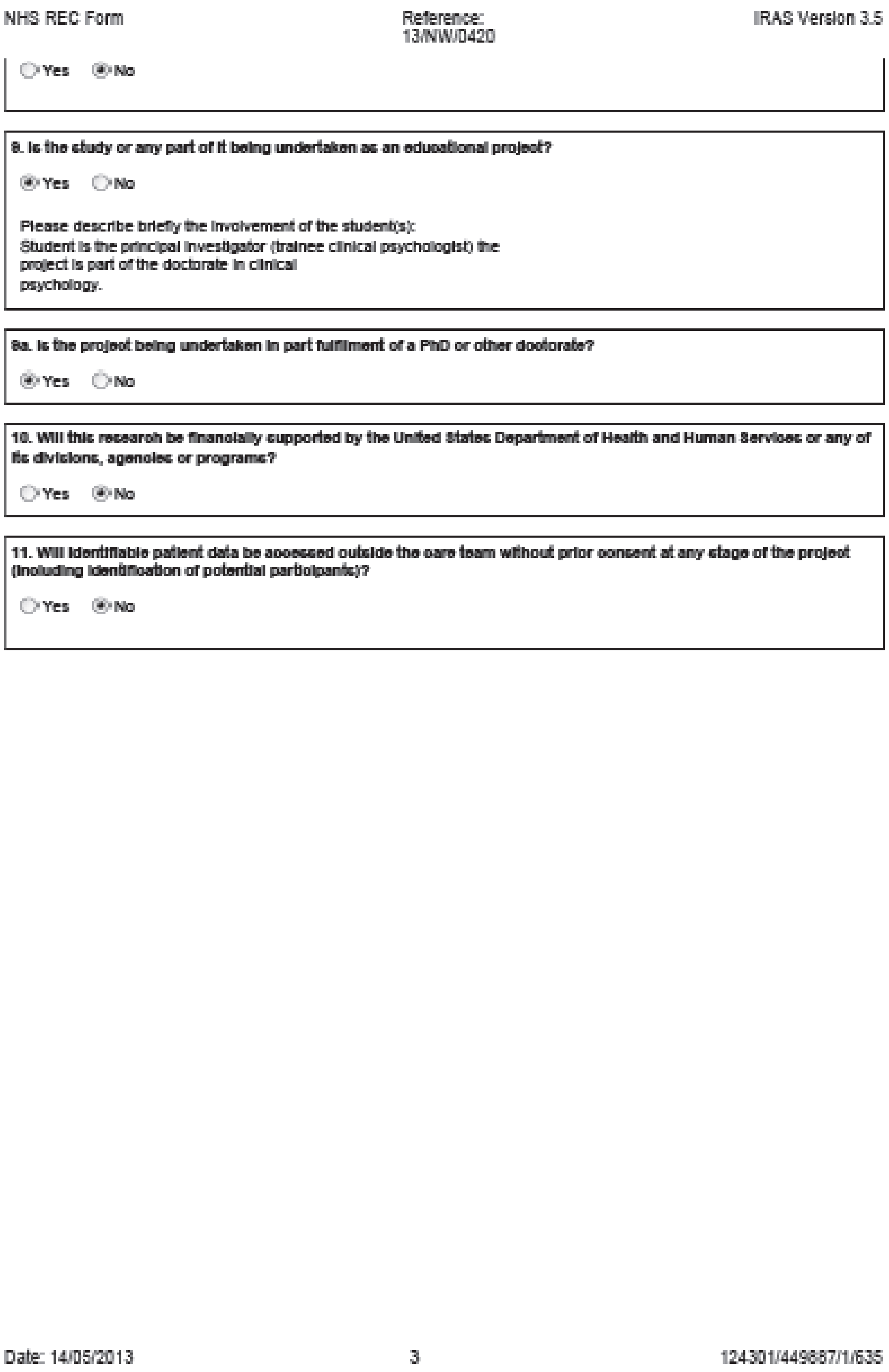
● Yes ○ No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ● No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the NIGB Ethics and Confidentiality Committee to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?



○ Yes ● No

9. Is the study or any part of it being undertaken as an educational project?

● Yes ○ No

Please describe briefly the involvement of the student(s):
Student is the principal investigator (trainee clinical psychologist) the
project is part of the doctorate in clinical
psychology.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

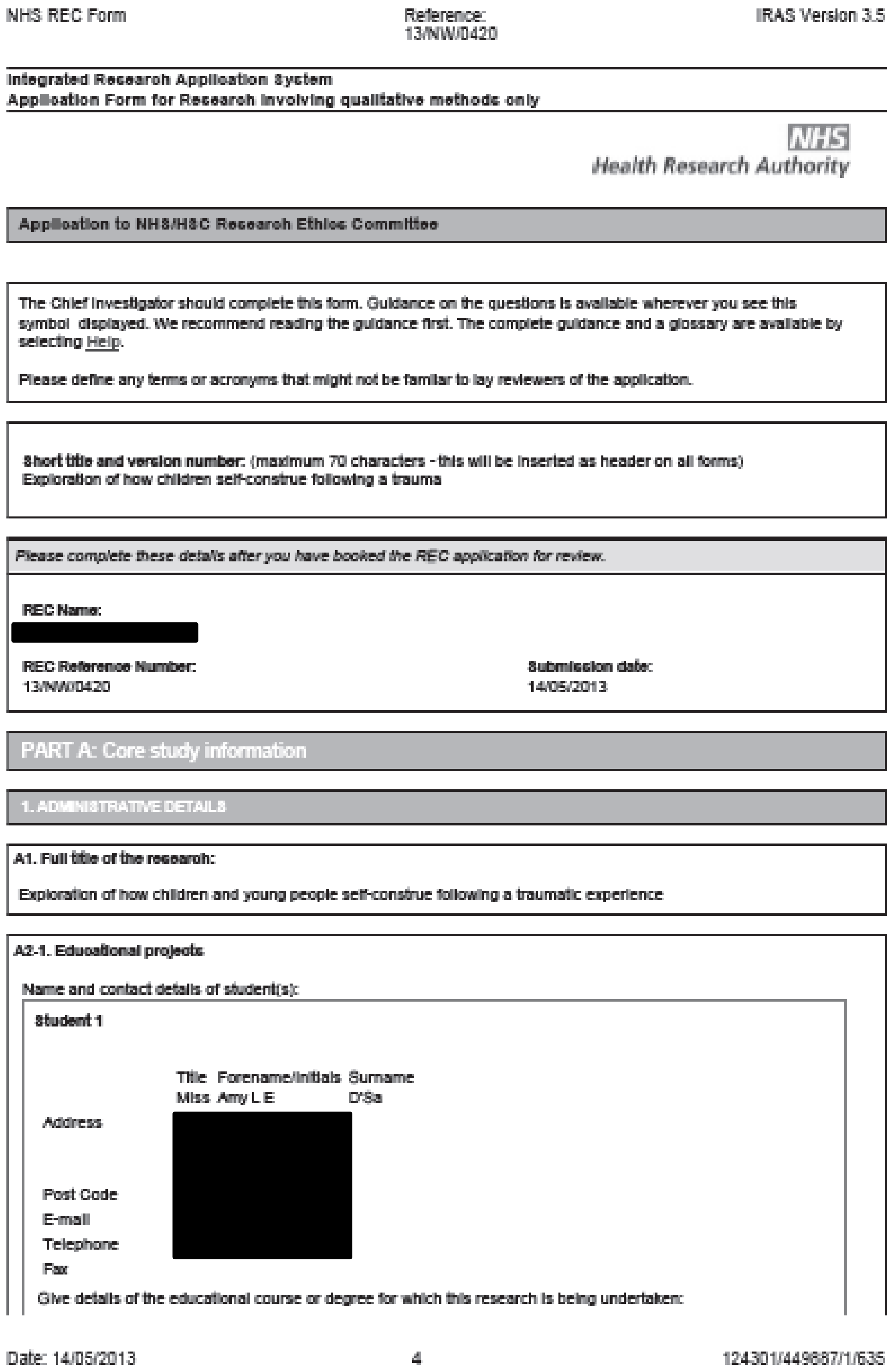
● Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ● No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ● No



NHS REC Form

Reference:
13/NW/0420

IRAS Version 3.5

Integrated Research Application System
Application Form for Research involving qualitative methods only

Health Research Authority

Application to NHS/HSC Research Ethics Committee

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Exploration of how children self-construe following a trauma

Please complete these details after you have booked the REC application for review.

REC Name:
[redacted]

REC Reference Number:
13/NW/0420

Submission date:
14/05/2013

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Exploration of how children and young people self-construe following a traumatic experience

A2-1. Educational projects

Name and contact details of student(s):

Student 1

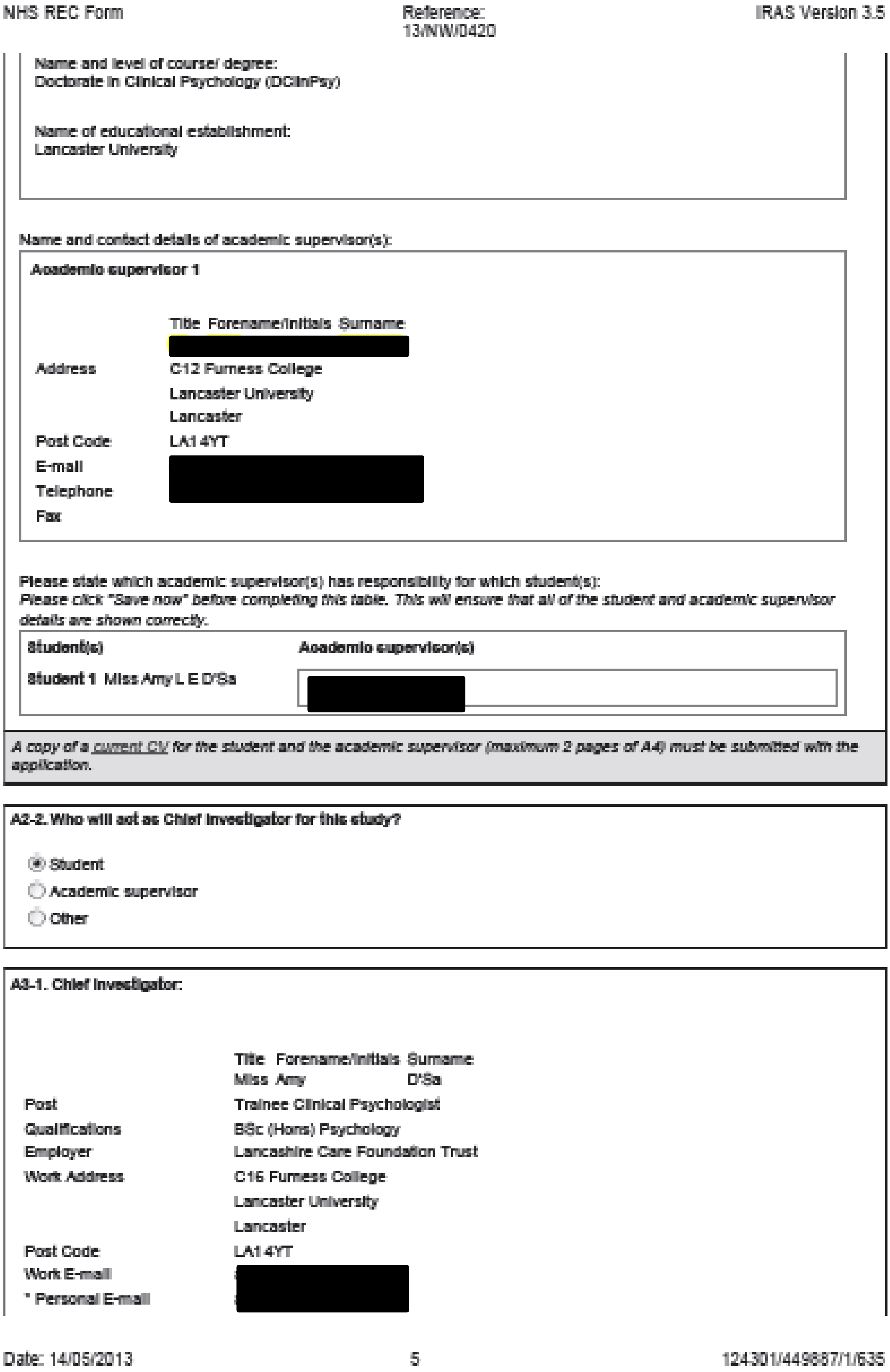
	Title	Forename/Initials	Surname
	Miss	Amy L E	D'Sa
Address	[redacted]		
Post Code			
E-mail			
Telephone			
Fax			

Give details of the educational course or degree for which this research is being undertaken:

Date: 14/05/2013

4

124301/449887/1/635



Name and level of course/ degree:
Doctorate in Clinical Psychology (DClinPsy)

Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

	Title Forename/Initials Surname
	[redacted]
Address	C12 Furness College Lancaster University Lancaster
Post Code	LA1 4YT
E-mail	[redacted]
Telephone	
Fax	

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	Academic supervisor(s)
Student 1 Miss Amy L E D'Sa	[redacted]

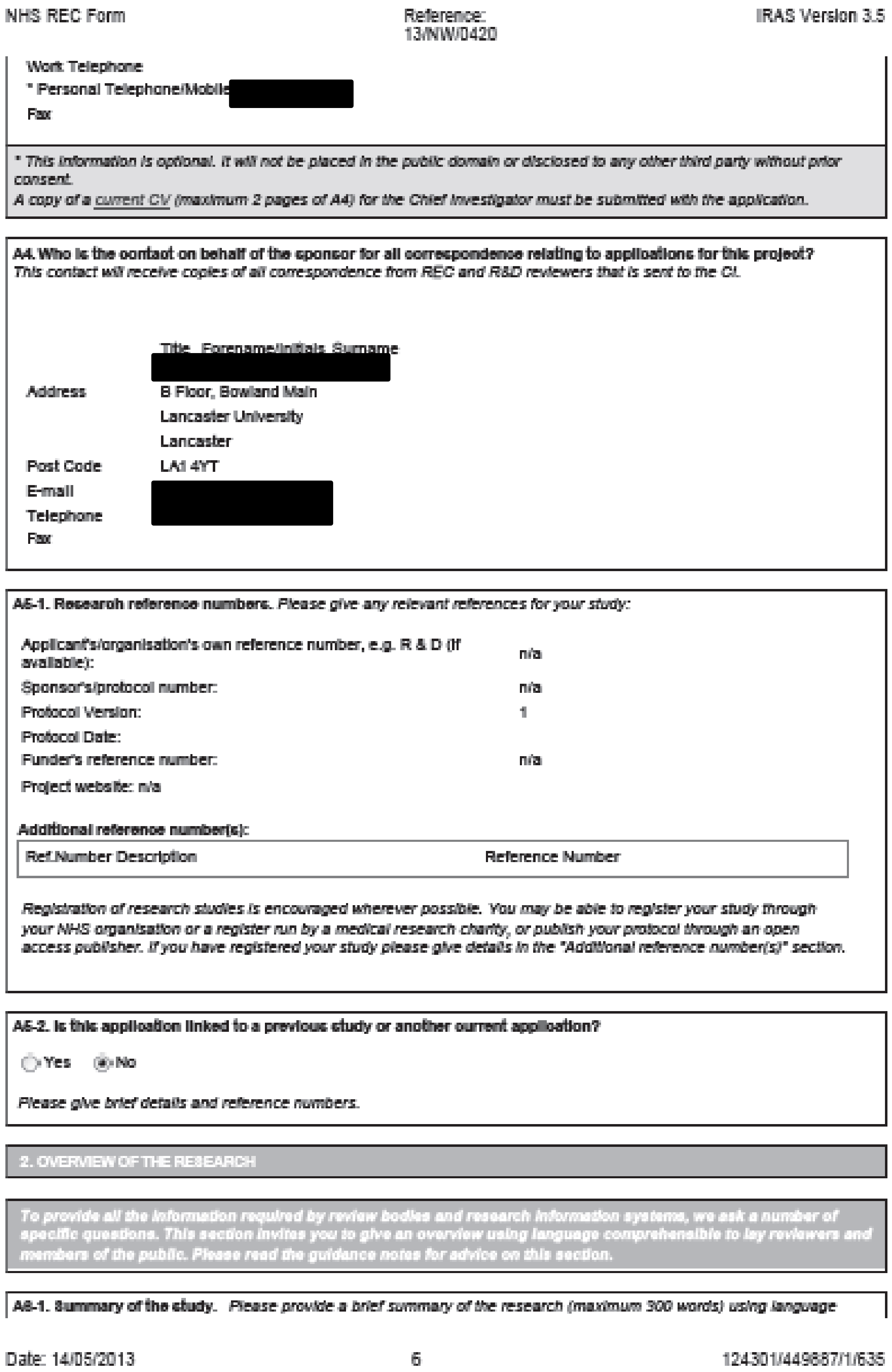
A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

● Student
○ Academic supervisor
○ Other

A3-1. Chief Investigator:

	Title Forename/Initials Surname
	Miss Amy D'Sa
Post	Trainee Clinical Psychologist
Qualifications	BSc (Hons) Psychology
Employer	Lancashire Care Foundation Trust
Work Address	C16 Furness College Lancaster University Lancaster
Post Code	LA1 4YT
Work E-mail	[redacted]
* Personal E-mail	



Work Telephone
* Personal Telephone/Mobile [redacted]
Fax

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and R&D reviewers that is sent to the CI.

Title Forename/Initials Surname
[redacted]

Address	B Floor, Bowland Main Lancaster University Lancaster
Post Code	LA1 4YT
E-mail Telephone	[redacted]
Fax	

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	n/a
Sponsor's/protocol number:	n/a
Protocol Version:	1
Protocol Date:	
Funder's reference number:	n/a

Project website: n/a

Additional reference number(s):

Ref.Number Description	Reference Number

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

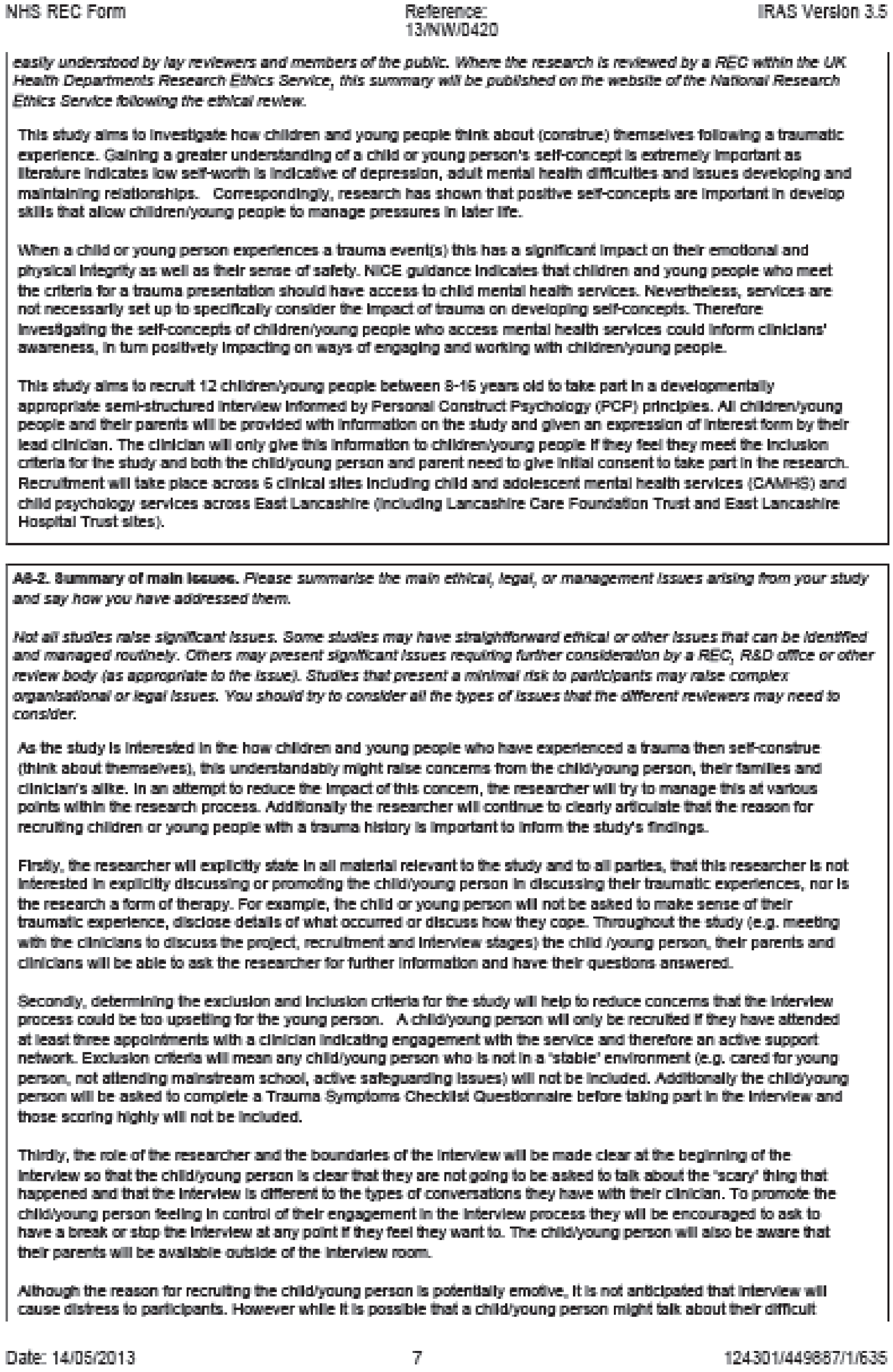
○ Yes ● No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language*



easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, this summary will be published on the website of the National Research Ethics Service following the ethical review.

This study aims to investigate how children and young people think about (construe) themselves following a traumatic experience. Gaining a greater understanding of a child or young person's self-concept is extremely important as literature indicates low self-worth is indicative of depression, adult mental health difficulties and issues developing and maintaining relationships. Correspondingly, research has shown that positive self-concepts are important in develop skills that allow children/young people to manage pressures in later life.

When a child or young person experiences a trauma event(s) this has a significant impact on their emotional and physical integrity as well as their sense of safety. NICE guidance indicates that children and young people who meet the criteria for a trauma presentation should have access to child mental health services. Nevertheless, services are not necessarily set up to specifically consider the impact of trauma on developing self-concepts. Therefore investigating the self-concepts of children/young people who access mental health services could inform clinicians' awareness, in turn positively impacting on ways of engaging and working with children/young people.

This study aims to recruit 12 children/young people between 8-16 years old to take part in a developmentally appropriate semi-structured interview informed by Personal Construct Psychology (PCP) principles. All children/young people and their parents will be provided with information on the study and given an expression of interest form by their lead clinician. The clinician will only give this information to children/young people if they feel they meet the inclusion criteria for the study and both the child/young person and parent need to give initial consent to take part in the research. Recruitment will take place across 6 clinical sites including child and adolescent mental health services (CAMHS) and child psychology services across East Lancashire (including Lancashire Care Foundation Trust and East Lancashire Hospital Trust sites).

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, R&D office or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

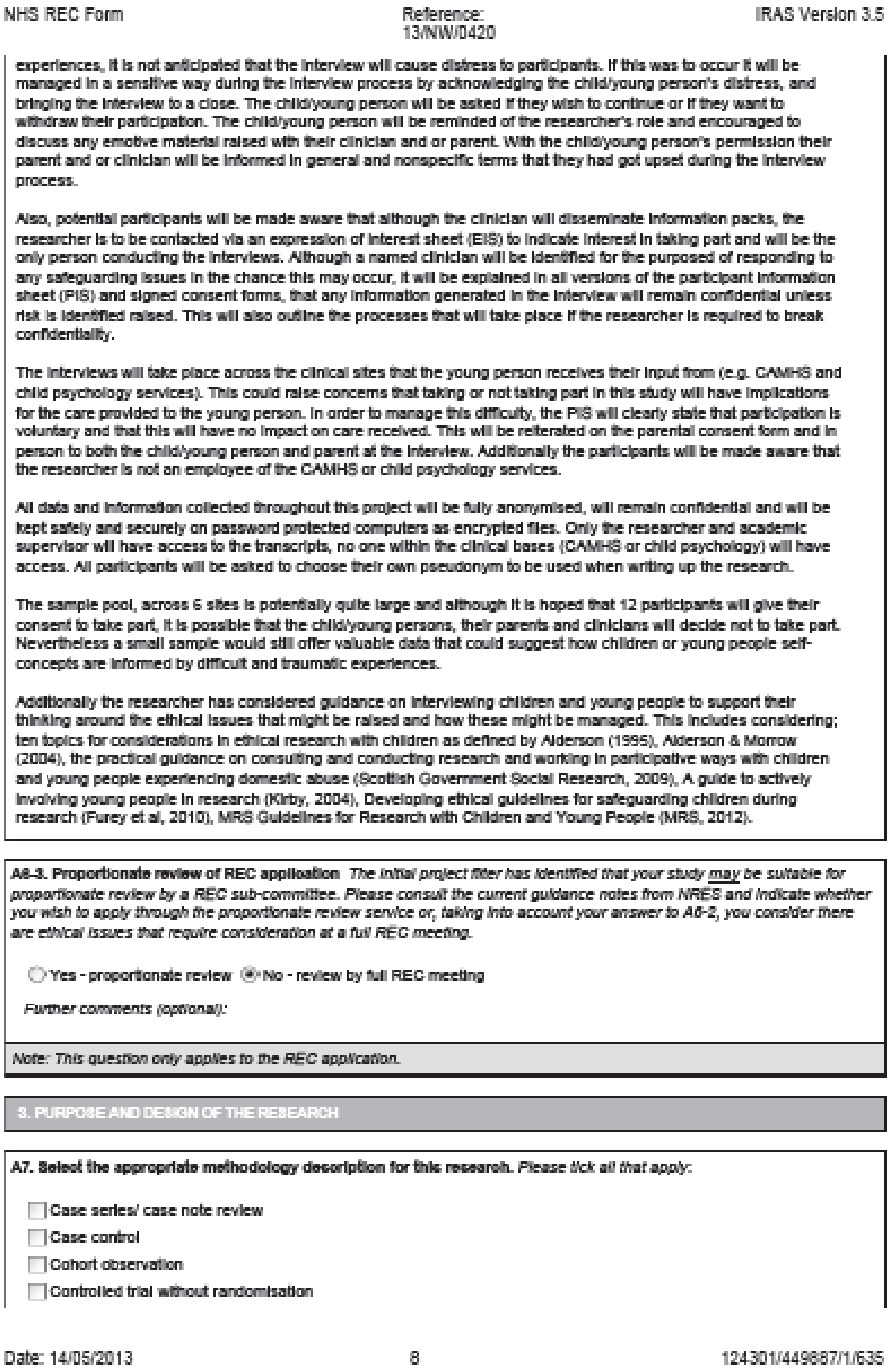
As the study is interested in the how children and young people who have experienced a trauma then self-construe (think about themselves), this understandably might raise concerns from the child/young person, their families and clinician's alike. In an attempt to reduce the impact of this concern, the researcher will try to manage this at various points within the research process. Additionally the researcher will continue to clearly articulate that the reason for recruiting children or young people with a trauma history is important to inform the study's findings.

Firstly, the researcher will explicitly state in all material relevant to the study and to all parties, that this researcher is not interested in explicitly discussing or promoting the child/young person in discussing their traumatic experiences, nor is the research a form of therapy. For example, the child or young person will not be asked to make sense of their traumatic experience, disclose details of what occurred or discuss how they cope. Throughout the study (e.g. meeting with the clinicians to discuss the project, recruitment and interview stages) the child /young person, their parents and clinicians will be able to ask the researcher for further information and have their questions answered.

Secondly, determining the exclusion and inclusion criteria for the study will help to reduce concerns that the interview process could be too upsetting for the young person. A child/young person will only be recruited if they have attended at least three appointments with a clinician indicating engagement with the service and therefore an active support network. Exclusion criteria will mean any child/young person who is not in a "stable" environment (e.g. cared for young person, not attending mainstream school, active safeguarding issues) will not be included. Additionally the child/young person will be asked to complete a Trauma Symptoms Checklist Questionnaire before taking part in the interview and those scoring highly will not be included.

Thirdly, the role of the researcher and the boundaries of the interview will be made clear at the beginning of the interview so that the child/young person is clear that they are not going to be asked to talk about the "scary" thing that happened and that the interview is different to the types of conversations they have with their clinician. To promote the child/young person feeling in control of their engagement in the interview process they will be encouraged to ask to have a break or stop the interview at any point if they feel they want to. The child/young person will also be aware that their parents will be available outside of the interview room.

Although the reason for recruiting the child/young person is potentially emotive, it is not anticipated that interview will cause distress to participants. However while it is possible that a child/young person might talk about their difficult



experiences, it is not anticipated that the interview will cause distress to participants. If this was to occur it will be managed in a sensitive way during the interview process by acknowledging the child/young person's distress, and bringing the interview to a close. The child/young person will be asked if they wish to continue or if they want to withdraw their participation. The child/young person will be reminded of the researcher's role and encouraged to discuss any emotive material raised with their clinician and or parent. With the child/young person's permission their parent and or clinician will be informed in general and nonspecific terms that they had got upset during the interview process.

Also, potential participants will be made aware that although the clinician will disseminate information packs, the researcher is to be contacted via an expression of interest sheet (EIS) to indicate interest in taking part and will be the only person conducting the interviews. Although a named clinician will be identified for the purposed of responding to any safeguarding issues in the chance this may occur, it will be explained in all versions of the participant information sheet (PIS) and signed consent forms, that any information generated in the interview will remain confidential unless risk is identified raised. This will also outline the processes that will take place if the researcher is required to break confidentiality.

The interviews will take place across the clinical sites that the young person receives their input from (e.g. CAMHS and child psychology services). This could raise concerns that taking or not taking part in this study will have implications for the care provided to the young person. In order to manage this difficulty, the PIS will clearly state that participation is voluntary and that this will have no impact on care received. This will be reiterated on the parental consent form and in person to both the child/young person and parent at the interview. Additionally the participants will be made aware that the researcher is not an employee of the CAMHS or child psychology services.

All data and information collected throughout this project will be fully anonymised, will remain confidential and will be kept safely and securely on password protected computers as encrypted files. Only the researcher and academic supervisor will have access to the transcripts, no one within the clinical bases (CAMHS or child psychology) will have access. All participants will be asked to choose their own pseudonym to be used when writing up the research.

The sample pool, across 6 sites is potentially quite large and although it is hoped that 12 participants will give their consent to take part, it is possible that the child/young persons, their parents and clinicians will decide not to take part. Nevertheless a small sample would still offer valuable data that could suggest how children or young people self-concepts are informed by difficult and traumatic experiences.

Additionally the researcher has considered guidance on interviewing children and young people to support their thinking around the ethical issues that might be raised and how these might be managed. This includes considering; ten topics for considerations in ethical research with children as defined by Alderson (1995), Alderson & Morrow (2004), the practical guidance on consulting and conducting research and working in participative ways with children and young people experiencing domestic abuse (Scottish Government Social Research, 2009), A guide to actively involving young people in research (Kirby, 2004), Developing ethical guidelines for safeguarding children during research (Furey et al, 2010), MRS Guidelines for Research with Children and Young People (MRS, 2012).

A6-3. Proportionate review of REC application *The initial project filter has identified that your study may be suitable for proportionate review by a REC sub-committee. Please consult the current guidance notes from NRES and indicate whether you wish to apply through the proportionate review service or, taking into account your answer to A6-2, you consider there are ethical issues that require consideration at a full REC meeting.*

○ Yes - proportionate review ● No - review by full REC meeting

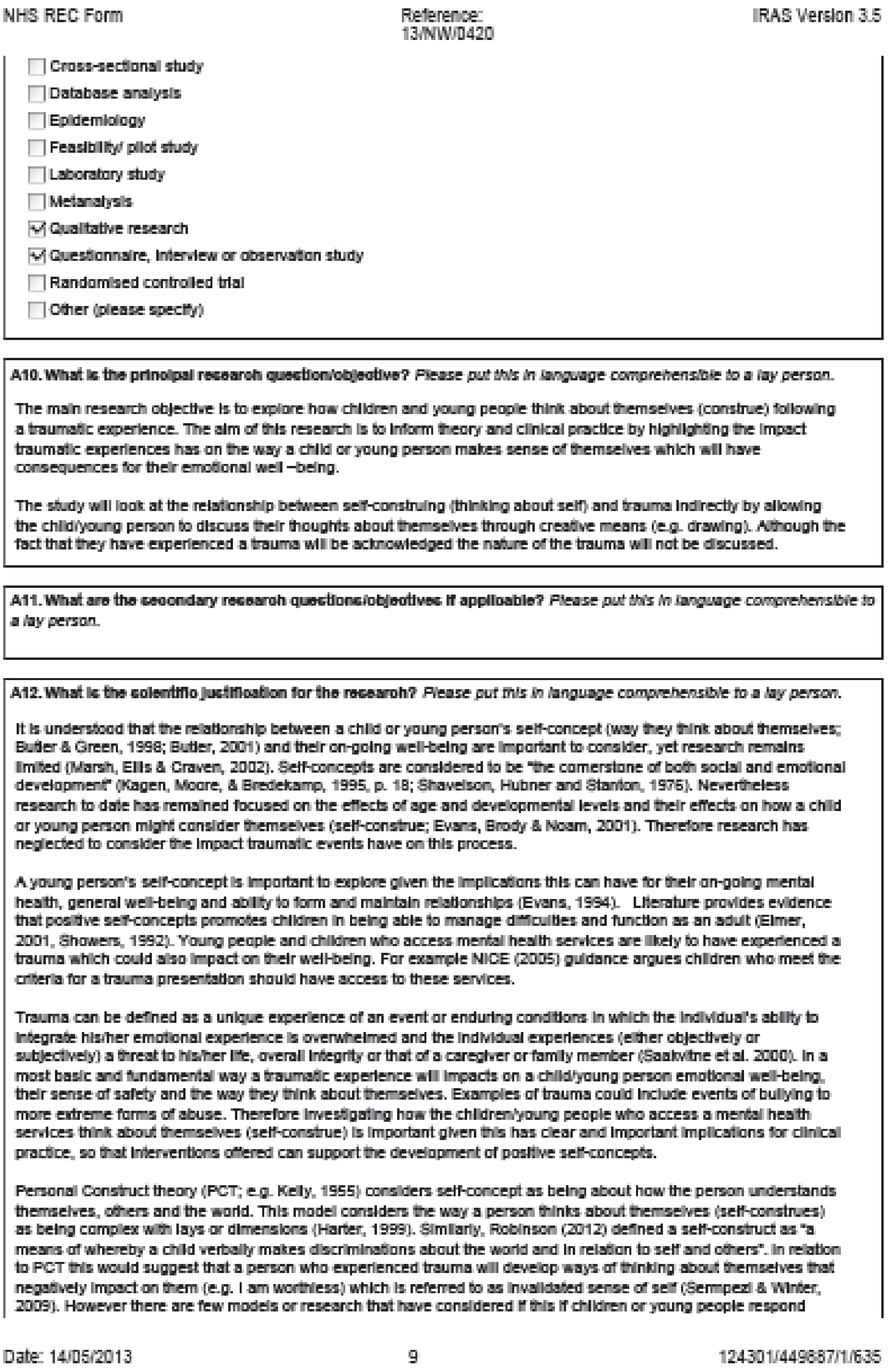
Further comments (optional):

Note: This question only applies to the REC application.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply:*

☐ Case series/ case note review
☐ Case control
☐ Cohort observation
☐ Controlled trial without randomisation



- ☐ Cross-sectional study
- ☐ Database analysis
- ☐ Epidemiology
- ☐ Feasibility/ pilot study
- ☐ Laboratory study
- ☐ Metanalysis
- ☑ Qualitative research
- ☑ Questionnaire, interview or observation study
- ☐ Randomised controlled trial
- ☐ Other (please specify)

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

The main research objective is to explore how children and young people think about themselves (construe) following a traumatic experience. The aim of this research is to inform theory and clinical practice by highlighting the impact traumatic experiences has on the way a child or young person makes sense of themselves which will have consequences for their emotional well –being.

The study will look at the relationship between self-construing (thinking about self) and trauma indirectly by allowing the child/young person to discuss their thoughts about themselves through creative means (e.g. drawing). Although the fact that they have experienced a trauma will be acknowledged the nature of the trauma will not be discussed.

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

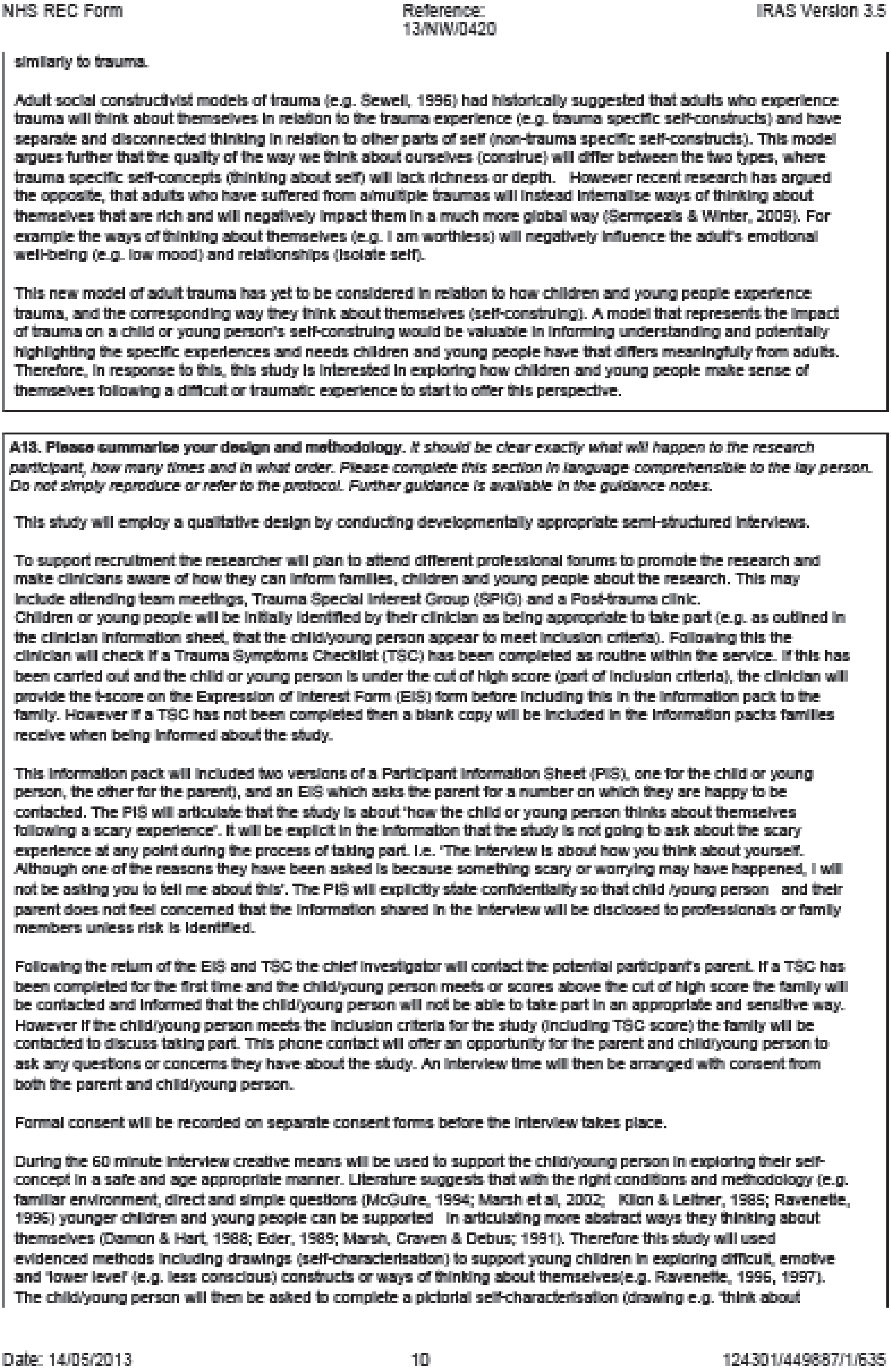
A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

It is understood that the relationship between a child or young person's self-concept (way they think about themselves; Butler & Green, 1998; Butler, 2001) and their on-going well-being are important to consider, yet research remains limited (Marsh, Ellis & Craven, 2002). Self-concepts are considered to be "the cornerstone of both social and emotional development" (Kagen, Moore, & Bredekamp, 1995, p. 18; Shavelson, Hubner and Stanton, 1976). Nevertheless research to date has remained focused on the effects of age and developmental levels and their effects on how a child or young person might consider themselves (self-construe; Evans, Brody & Noam, 2001). Therefore research has neglected to consider the impact traumatic events have on this process.

A young person's self-concept is important to explore given the implications this can have for their on-going mental health, general well-being and ability to form and maintain relationships (Evans, 1994). Literature provides evidence that positive self-concepts promotes children in being able to manage difficulties and function as an adult (Elmer, 2001, Showers, 1992). Young people and children who access mental health services are likely to have experienced a trauma which could also impact on their well-being. For example NICE (2005) guidance argues children who meet the criteria for a trauma presentation should have access to these services.

Trauma can be defined as a unique experience of an event or enduring conditions in which the individual's ability to integrate his/her emotional experience is overwhelmed and the individual experiences (either objectively or subjectively) a threat to his/her life, overall integrity or that of a caregiver or family member (Saakvitne et al. 2000). In a most basic and fundamental way a traumatic experience will impacts on a child/young person emotional well-being, their sense of safety and the way they think about themselves. Examples of trauma could include events of bullying to more extreme forms of abuse. Therefore investigating how the children/young people who access a mental health services think about themselves (self-construe) is important given this has clear and important implications for clinical practice, so that interventions offered can support the development of positive self-concepts.

Personal Construct theory (PCT; e.g. Kelly, 1955) considers self-concept as being about how the person understands themselves, others and the world. This model considers the way a person thinks about themselves (self-construes) as being complex with lays or dimensions (Harter, 1999). Similarly, Robinson (2012) defined a self-construct as "a means of whereby a child verbally makes discriminations about the world and in relation to self and others". In relation to PCT this would suggest that a person who experienced trauma will develop ways of thinking about themselves that negatively impact on them (e.g. I am worthless) which is referred to as invalidated sense of self (Sermpezi & Winter, 2009). However there are few models or research that have considered if this if children or young people respond



similarly to trauma.

Adult social constructivist models of trauma (e.g. Sewell, 1996) had historically suggested that adults who experience trauma will think about themselves in relation to the trauma experience (e.g. trauma specific self-constructs) and have separate and disconnected thinking in relation to other parts of self (non-trauma specific self-constructs). This model argues further that the quality of the way we think about ourselves (construe) will differ between the two types, where trauma specific self-concepts (thinking about self) will lack richness or depth. However recent research has argued the opposite, that adults who have suffered from a/multiple traumas will instead internalise ways of thinking about themselves that are rich and will negatively impact them in a much more global way (Sermpezis & Winter, 2009). For example the ways of thinking about themselves (e.g. I am worthless) will negatively influence the adult's emotional well-being (e.g. low mood) and relationships (isolate self).

This new model of adult trauma has yet to be considered in relation to how children and young people experience trauma, and the corresponding way they think about themselves (self-construing). A model that represents the impact of trauma on a child or young person's self-construing would be valuable in informing understanding and potentially highlighting the specific experiences and needs children and young people have that differs meaningfully from adults. Therefore, in response to this, this study is interested in exploring how children and young people make sense of themselves following a difficult or traumatic experience to start to offer this perspective.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

This study will employ a qualitative design by conducting developmentally appropriate semi-structured interviews.

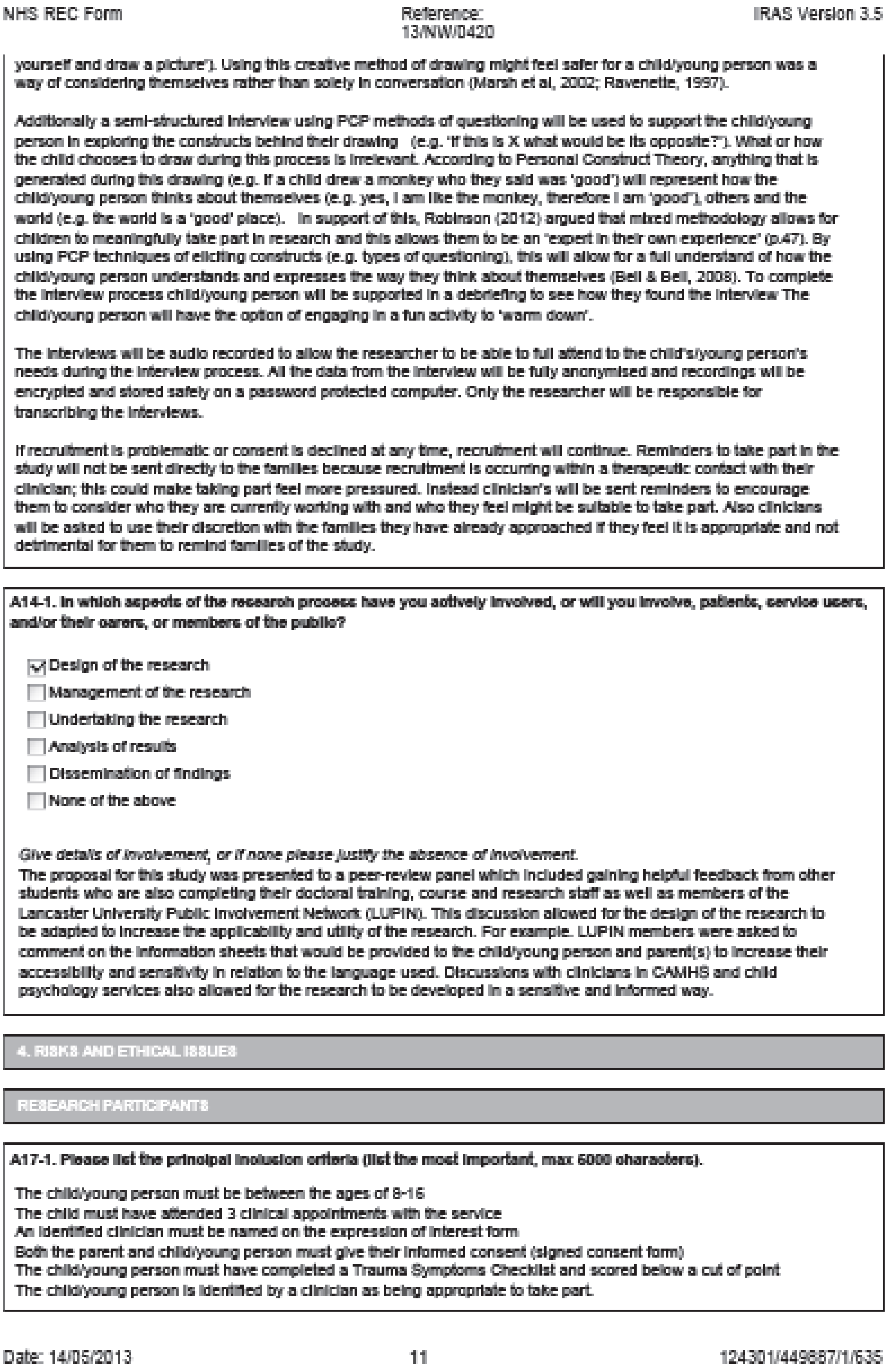
To support recruitment the researcher will plan to attend different professional forums to promote the research and make clinicians aware of how they can inform families, children and young people about the research. This may include attending team meetings, Trauma Special Interest Group (SPIG) and a Post-trauma clinic.
Children or young people will be initially identified by their clinician as being appropriate to take part (e.g. as outlined in the clinician information sheet, that the child/young person appear to meet inclusion criteria). Following this the clinician will check if a Trauma Symptoms Checklist (TSC) has been completed as routine within the service. If this has been carried out and the child or young person is under the cut of high score (part of inclusion criteria), the clinician will provide the t-score on the Expression of Interest Form (EIS) form before including this in the information pack to the family. However if a TSC has not been completed then a blank copy will be included in the information packs families receive when being informed about the study.

This information pack will included two versions of a Participant Information Sheet (PIS), one for the child or young person, the other for the parent), and an EIS which asks the parent for a number on which they are happy to be contacted. The PIS will articulate that the study is about 'how the child or young person thinks about themselves following a scary experience'. It will be explicit in the information that the study is not going to ask about the scary experience at any point during the process of taking part. I.e. 'The interview is about how you think about yourself. Although one of the reasons they have been asked is because something scary or worrying may have happened, I will not be asking you to tell me about this'. The PIS will explicitly state confidentiality so that child /young person and their parent does not feel concerned that the information shared in the interview will be disclosed to professionals or family members unless risk is identified.

Following the return of the EIS and TSC the chief investigator will contact the potential participant's parent. If a TSC has been completed for the first time and the child/young person meets or scores above the cut of high score the family will be contacted and informed that the child/young person will not be able to take part in an appropriate and sensitive way. However if the child/young person meets the inclusion criteria for the study (including TSC score) the family will be contacted to discuss taking part. This phone contact will offer an opportunity for the parent and child/young person to ask any questions or concerns they have about the study. An interview time will then be arranged with consent from both the parent and child/young person.

Formal consent will be recorded on separate consent forms before the interview takes place.

During the 60 minute interview creative means will be used to support the child/young person in exploring their self-concept in a safe and age appropriate manner. Literature suggests that with the right conditions and methodology (e.g. familiar environment, direct and simple questions (McGuire, 1994; Marsh et al, 2002; Kilon & Leitner, 1985; Ravenette, 1996) younger children and young people can be supported in articulating more abstract ways they thinking about themselves (Damon & Hart, 1988; Eder, 1989; Marsh, Craven & Debus; 1991). Therefore this study will used evidenced methods including drawings (self-characterisation) to support young children in exploring difficult, emotive and 'lower level' (e.g. less conscious) constructs or ways of thinking about themselves(e.g. Ravenette, 1996, 1997). The child/young person will then be asked to complete a pictorial self-characterisation (drawing e.g. 'think about



yourself and draw a picture"). Using this creative method of drawing might feel safer for a child/young person was a way of considering themselves rather than solely in conversation (Marsh et al, 2002; Ravenette, 1997).

Additionally a semi-structured interview using PCP methods of questioning will be used to support the child/young person in exploring the constructs behind their drawing (e.g. 'If this is X what would be its opposite?"). What or how the child chooses to draw during this process is irrelevant. According to Personal Construct Theory, anything that is generated during this drawing (e.g. if a child drew a monkey who they said was 'good') will represent how the child/young person thinks about themselves (e.g. yes, I am like the monkey, therefore I am 'good"), others and the world (e.g. the world is a 'good' place). In support of this, Robinson (2012) argued that mixed methodology allows for children to meaningfully take part in research and this allows them to be an "expert in their own experience' (p.47). By using PCP techniques of eliciting constructs (e.g. types of questioning), this will allow for a full understand of how the child/young person understands and expresses the way they think about themselves (Bell & Bell, 2008). To complete the interview process child/young person will be supported in a debriefing to see how they found the interview The child/young person will have the option of engaging in a fun activity to 'warm down'.

The interviews will be audio recorded to allow the researcher to be able to full attend to the child's/young person's needs during the interview process. All the data from the interview will be fully anonymised and recordings will be encrypted and stored safely on a password protected computer. Only the researcher will be responsible for transcribing the interviews.

If recruitment is problematic or consent is declined at any time, recruitment will continue. Reminders to take part in the study will not be sent directly to the families because recruitment is occurring within a therapeutic contact with their clinician; this could make taking part feel more pressured. Instead clinician's will be sent reminders to encourage them to consider who they are currently working with and who they feel might be suitable to take part. Also clinicians will be asked to use their discretion with the families they have already approached if they feel it is appropriate and not detrimental for them to remind families of the study.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

☑ Design of the research
☐ Management of the research
☐ Undertaking the research
☐ Analysis of results
☐ Dissemination of findings
☐ None of the above

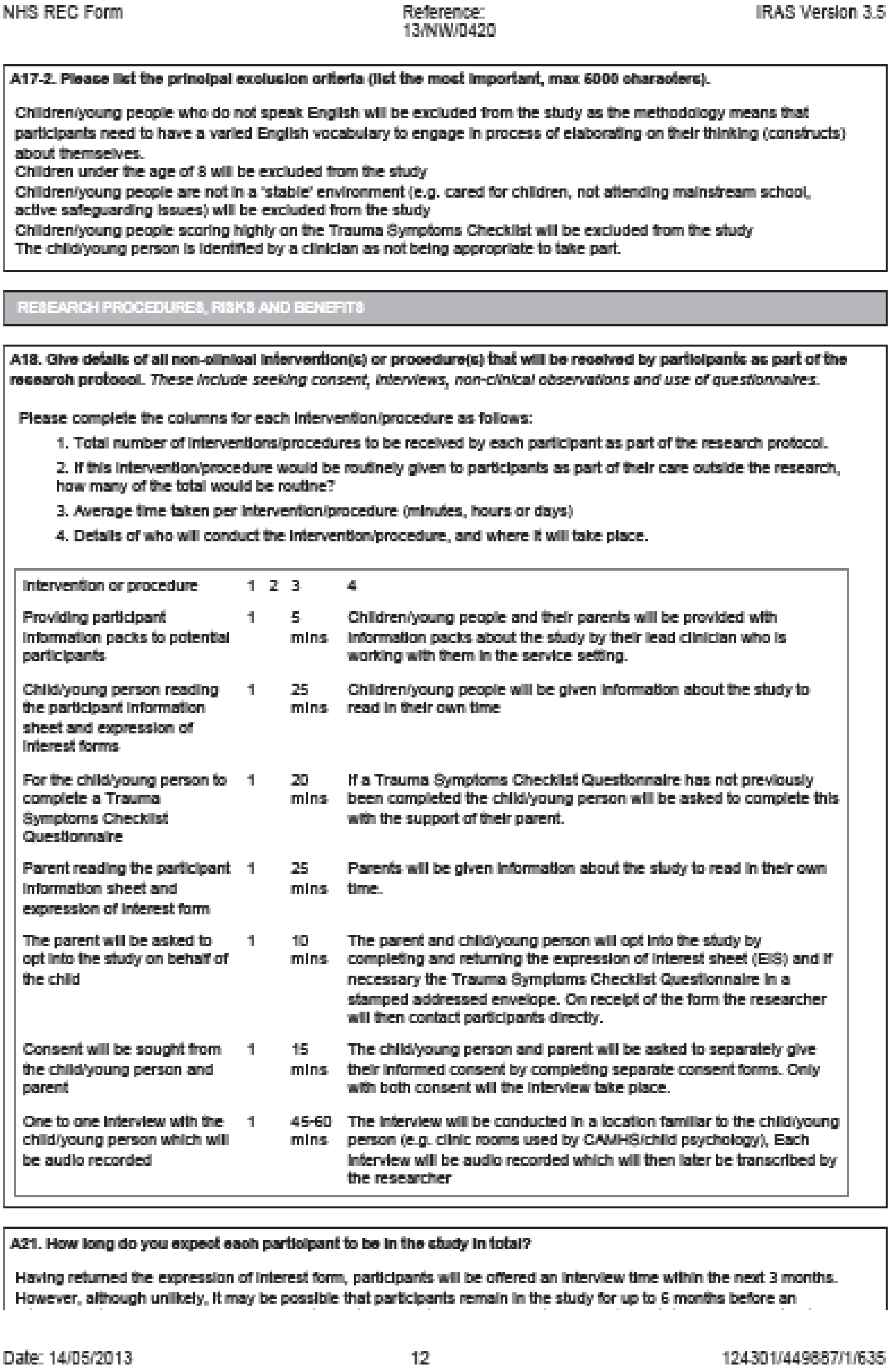
Give details of involvement, or if none please justify the absence of involvement.
The proposal for this study was presented to a peer-review panel which included gaining helpful feedback from other students who are also completing their doctoral training, course and research staff as well as members of the Lancaster University Public Involvement Network (LUPIN). This discussion allowed for the design of the research to be adapted to increase the applicability and utility of the research. For example. LUPIN members were asked to comment on the information sheets that would be provided to the child/young person and parent(s) to increase their accessibility and sensitivity in relation to the language used. Discussions with clinicians in CAMHS and child psychology services also allowed for the research to be developed in a sensitive and informed way.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

The child/young person must be between the ages of 8-16
The child must have attended 3 clinical appointments with the service
An identified clinician must be named on the expression of interest form
Both the parent and child/young person must give their informed consent (signed consent form)
The child/young person must have completed a Trauma Symptoms Checklist and scored below a cut of point
The child/young person is identified by a clinician as being appropriate to take part.



A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

Children/young people who do not speak English will be excluded from the study as the methodology means that participants need to have a varied English vocabulary to engage in process of elaborating on their thinking (constructs) about themselves.
Children under the age of 8 will be excluded from the study
Children/young people are not in a 'stable' environment (e.g. cared for children, not attending mainstream school, active safeguarding issues) will be excluded from the study
Children/young people scoring highly on the Trauma Symptoms Checklist will be excluded from the study
The child/young person is identified by a clinician as not being appropriate to take part.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

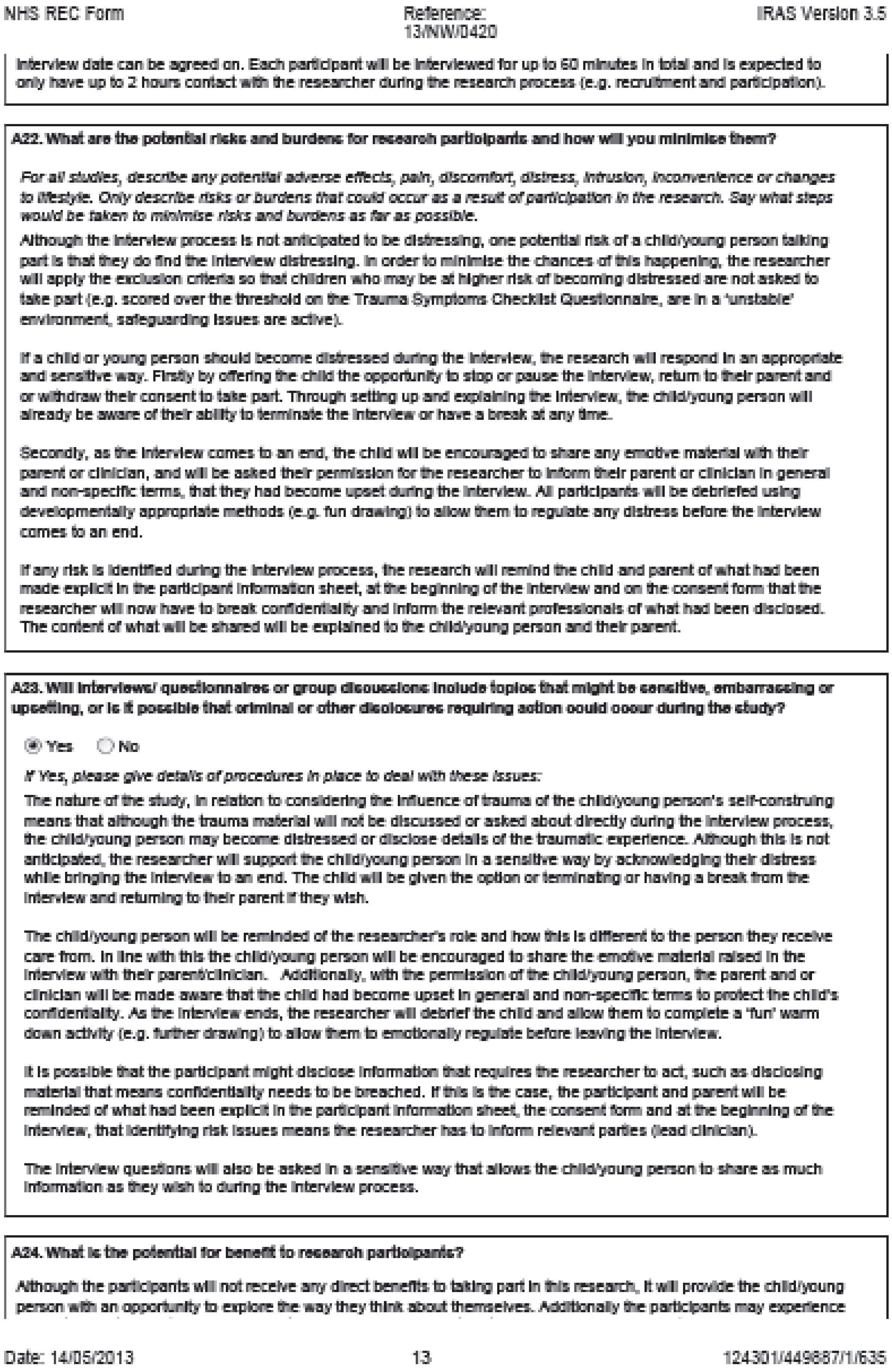
Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Providing participant information packs to potential participants	1		5 mins	Children/young people and their parents will be provided with information packs about the study by their lead clinician who is working with them in the service setting.
Child/young person reading the participant information sheet and expression of interest forms	1		25 mins	Children/young people will be given information about the study to read in their own time
For the child/young person to complete a Trauma Symptoms Checklist Questionnaire	1		20 mins	If a Trauma Symptoms Checklist Questionnaire has not previously been completed the child/young person will be asked to complete this with the support of their parent.
Parent reading the participant information sheet and expression of interest form	1		25 mins	Parents will be given information about the study to read in their own time.
The parent will be asked to opt into the study on behalf of the child	1		10 mins	The parent and child/young person will opt into the study by completing and returning the expression of interest sheet (EIS) and if necessary the Trauma Symptoms Checklist Questionnaire in a stamped addressed envelope. On receipt of the form the researcher will then contact participants directly.
Consent will be sought from the child/young person and parent	1		15 mins	The child/young person and parent will be asked to separately give their informed consent by completing separate consent forms. Only with both consent will the interview take place.
One to one interview with the child/young person which will be audio recorded	1		45-60 mins	The interview will be conducted in a location familiar to the child/young person (e.g. clinic rooms used by CAMHS/child psychology). Each interview will be audio recorded which will then later be transcribed by the researcher

A21. How long do you expect each participant to be in the study in total?

Having returned the expression of interest form, participants will be offered an interview time within the next 3 months. However, although unlikely, it may be possible that participants remain in the study for up to 6 months before an



interview date can be agreed on. Each participant will be interviewed for up to 60 minutes in total and is expected to only have up to 2 hours contact with the researcher during the research process (e.g. recruitment and participation).

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

Although the interview process is not anticipated to be distressing, one potential risk of a child/young person talking part is that they do find the interview distressing. In order to minimise the chances of this happening, the researcher will apply the exclusion criteria so that children who may be at higher risk of becoming distressed are not asked to take part (e.g. scored over the threshold on the Trauma Symptoms Checklist Questionnaire, are in a 'unstable' environment, safeguarding issues are active).

If a child or young person should become distressed during the interview, the research will respond in an appropriate and sensitive way. Firstly by offering the child the opportunity to stop or pause the interview, return to their parent and or withdraw their consent to take part. Through setting up and explaining the interview, the child/young person will already be aware of their ability to terminate the interview or have a break at any time.

Secondly, as the interview comes to an end, the child will be encouraged to share any emotive material with their parent or clinician, and will be asked their permission for the researcher to inform their parent or clinician in general and non-specific terms, that they had become upset during the interview. All participants will be debriefed using developmentally appropriate methods (e.g. fun drawing) to allow them to regulate any distress before the interview comes to an end.

If any risk is identified during the interview process, the research will remind the child and parent of what had been made explicit in the participant information sheet, at the beginning of the interview and on the consent form that the researcher will now have to break confidentiality and inform the relevant professionals of what had been disclosed. The content of what will be shared will be explained to the child/young person and their parent.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

● Yes ○ No

If Yes, please give details of procedures in place to deal with these issues:

The nature of the study, in relation to considering the influence of trauma of the child/young person's self-construing means that although the trauma material will not be discussed or asked about directly during the interview process, the child/young person may become distressed or disclose details of the traumatic experience. Although this is not anticipated, the researcher will support the child/young person in a sensitive way by acknowledging their distress while bringing the interview to an end. The child will be given the option or terminating or having a break from the interview and returning to their parent if they wish.

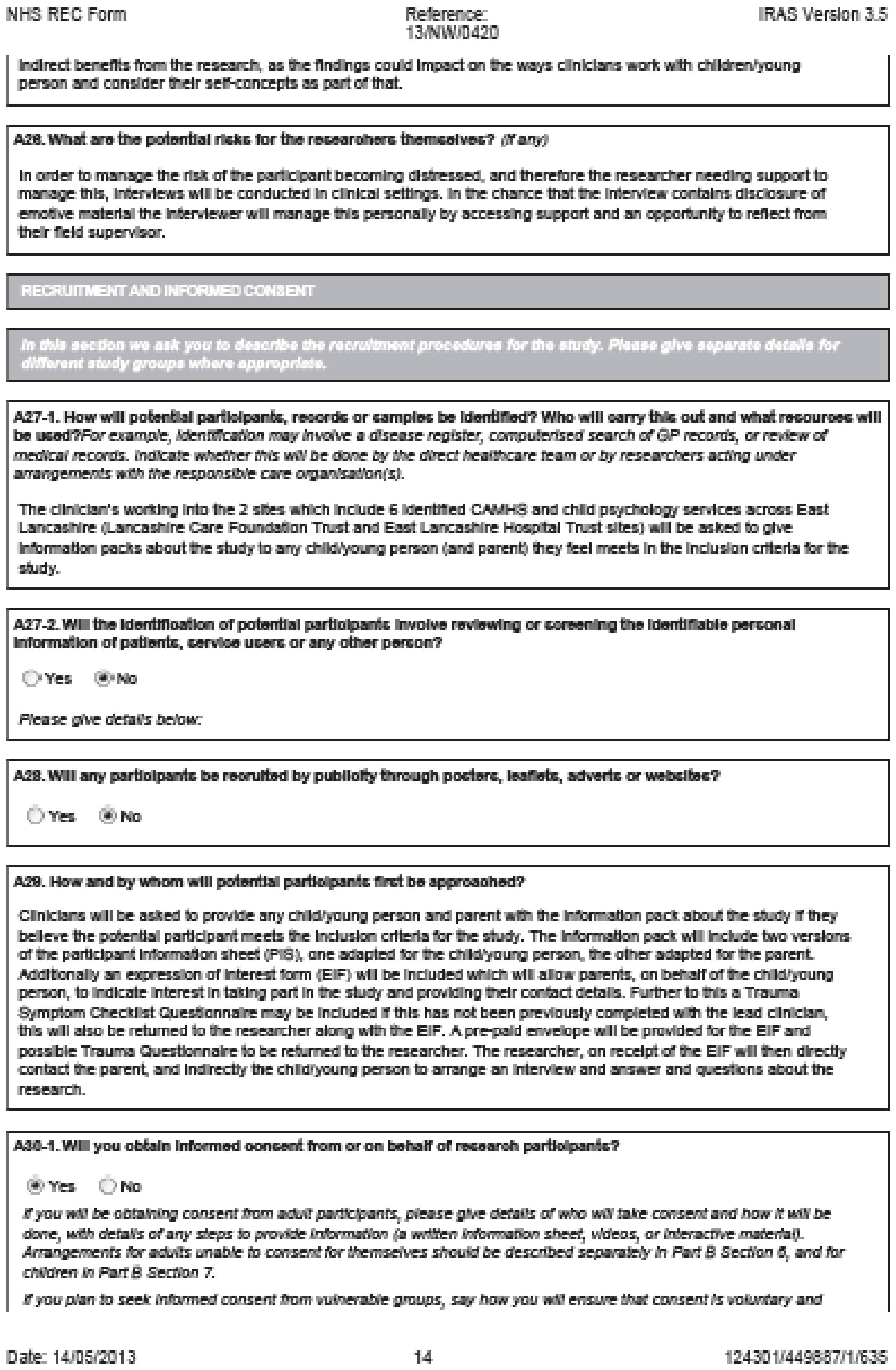
The child/young person will be reminded of the researcher's role and how this is different to the person they receive care from. In line with this the child/young person will be encouraged to share the emotive material raised in the interview with their parent/clinician. Additionally, with the permission of the child/young person, the parent and or clinician will be made aware that the child had become upset in general and non-specific terms to protect the child's confidentiality. As the interview ends, the researcher will debrief the child and allow them to complete a 'fun' warm down activity (e.g. further drawing) to allow them to emotionally regulate before leaving the interview.

It is possible that the participant might disclose information that requires the researcher to act, such as disclosing material that means confidentiality needs to be breached. If this is the case, the participant and parent will be reminded of what had been explicit in the participant information sheet, the consent form and at the beginning of the interview, that identifying risk issues means the researcher has to inform relevant parties (lead clinician).

The interview questions will also be asked in a sensitive way that allows the child/young person to share as much information as they wish to during the interview process.

A24. What is the potential for benefit to research participants?

Although the participants will not receive any direct benefits to taking part in this research, it will provide the child/young person with an opportunity to explore the way they think about themselves. Additionally the participants may experience



NHS REC Form | Reference: 13/NW/0420 | IRAS Version 3.5

indirect benefits from the research, as the findings could impact on the ways clinicians work with children/young person and consider their self-concepts as part of that.

A26. What are the potential risks for the researchers themselves? *(if any)*

In order to manage the risk of the participant becoming distressed, and therefore the researcher needing support to manage this, interviews will be conducted in clinical settings. In the chance that the interview contains disclosure of emotive material the interviewer will manage this personally by accessing support and an opportunity to reflect from their field supervisor.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?*For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

The clinician's working into the 2 sites which include 6 identified CAMHS and child psychology services across East Lancashire (Lancashire Care Foundation Trust and East Lancashire Hospital Trust sites) will be asked to give information packs about the study to any child/young person (and parent) they feel meets in the inclusion criteria for the study.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

○ Yes ● No

Please give details below:

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

○ Yes ● No

A29. How and by whom will potential participants first be approached?

Clinicians will be asked to provide any child/young person and parent with the information pack about the study if they believe the potential participant meets the inclusion criteria for the study. The information pack will include two versions of the participant information sheet (PIS), one adapted for the child/young person, the other adapted for the parent. Additionally an expression of interest form (EIF) will be included which will allow parents, on behalf of the child/young person, to indicate interest in taking part in the study and providing their contact details. Further to this a Trauma Symptom Checklist Questionnaire may be included if this has not been previously completed with the lead clinician, this will also be returned to the researcher along with the EIF. A pre-paid envelope will be provided for the EIF and possible Trauma Questionnaire to be returned to the researcher. The researcher, on receipt of the EIF will then directly contact the parent, and indirectly the child/young person to arrange an interview and answer and questions about the research.

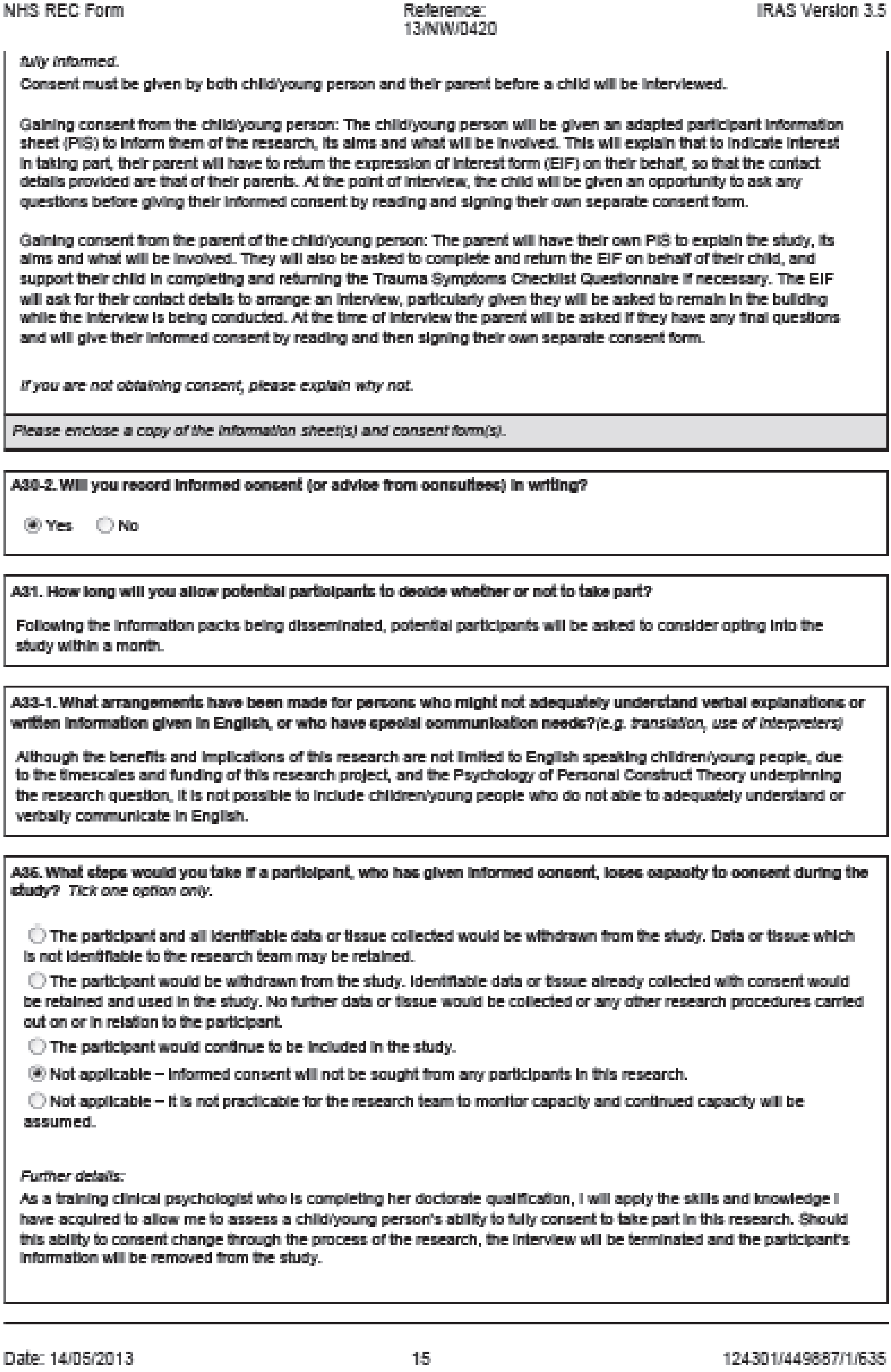
A30-1. Will you obtain informed consent from or on behalf of research participants?

● Yes ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and

Date: 14/05/2013 | 14 | 124301/449887/1/635



fully informed.

Consent must be given by both child/young person and their parent before a child will be interviewed.

Gaining consent from the child/young person: The child/young person will be given an adapted participant information sheet (PIS) to inform them of the research, its aims and what will be involved. This will explain that to indicate interest in taking part, their parent will have to return the expression of interest form (EIF) on their behalf, so that the contact details provided are that of their parents. At the point of interview, the child will be given an opportunity to ask any questions before giving their informed consent by reading and signing their own separate consent form.

Gaining consent from the parent of the child/young person: The parent will have their own PIS to explain the study, its aims and what will be involved. They will also be asked to complete and return the EIF on behalf of their child, and support their child in completing and returning the Trauma Symptoms Checklist Questionnaire if necessary. The EIF will ask for their contact details to arrange an interview, particularly given they will be asked to remain in the building while the interview is being conducted. At the time of interview the parent will be asked if they have any final questions and will give their informed consent by reading and then signing their own separate consent form.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

● Yes ○ No

A31. How long will you allow potential participants to decide whether or not to take part?

Following the information packs being disseminated, potential participants will be asked to consider opting into the study within a month.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?*(e.g. translation, use of interpreters)*

Although the benefits and implications of this research are not limited to English speaking children/young people, due to the timescales and funding of this research project, and the Psychology of Personal Construct Theory underpinning the research question, it is not possible to include children/young people who do not able to adequately understand or verbally communicate in English.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

○ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.

○ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

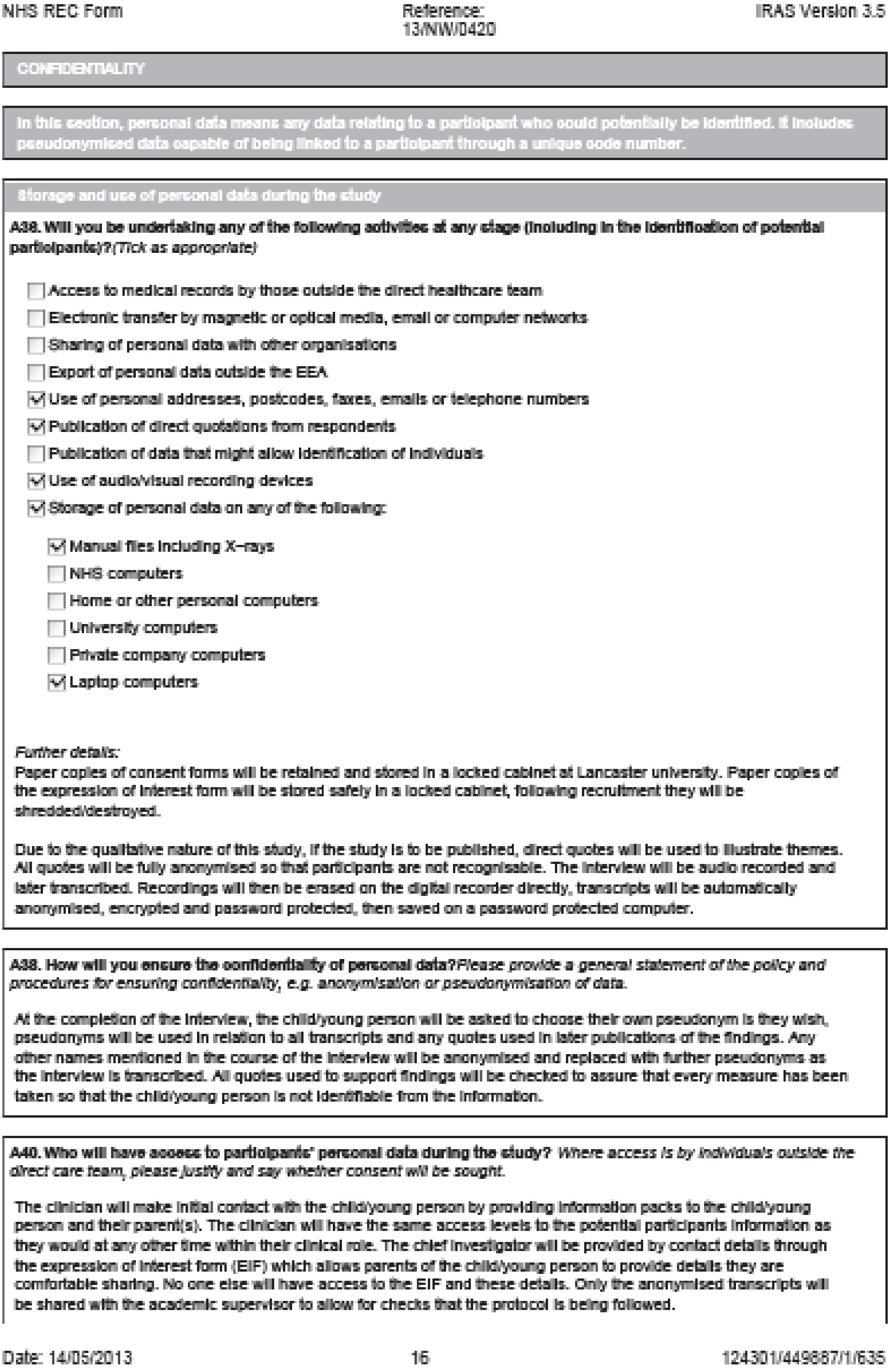
○ The participant would continue to be included in the study.

● Not applicable – informed consent will not be sought from any participants in this research.

○ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

As a training clinical psychologist who is completing her doctorate qualification, I will apply the skills and knowledge I have acquired to allow me to assess a child/young person's ability to fully consent to take part in this research. Should this ability to consent change through the process of the research, the interview will be terminated and the participant's information will be removed from the study.



NHS REC Form | Reference: 13/NW/0420 | IRAS Version 3.5

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)? *(Tick as appropriate)*

- ☐ Access to medical records by those outside the direct healthcare team
- ☐ Electronic transfer by magnetic or optical media, email or computer networks
- ☐ Sharing of personal data with other organisations
- ☐ Export of personal data outside the EEA
- ☑ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☑ Publication of direct quotations from respondents
- ☐ Publication of data that might allow identification of individuals
- ☑ Use of audio/visual recording devices
- ☑ Storage of personal data on any of the following:
  - ☑ Manual files including X–rays
  - ☐ NHS computers
  - ☐ Home or other personal computers
  - ☐ University computers
  - ☐ Private company computers
  - ☑ Laptop computers

Further details:
Paper copies of consent forms will be retained and stored in a locked cabinet at Lancaster university. Paper copies of the expression of interest form will be stored safely in a locked cabinet, following recruitment they will be shredded/destroyed.

Due to the qualitative nature of this study, if the study is to be published, direct quotes will be used to illustrate themes. All quotes will be fully anonymised so that participants are not recognisable. The interview will be audio recorded and later transcribed. Recordings will then be erased on the digital recorder directly, transcripts will be automatically anonymised, encrypted and password protected, then saved on a password protected computer.

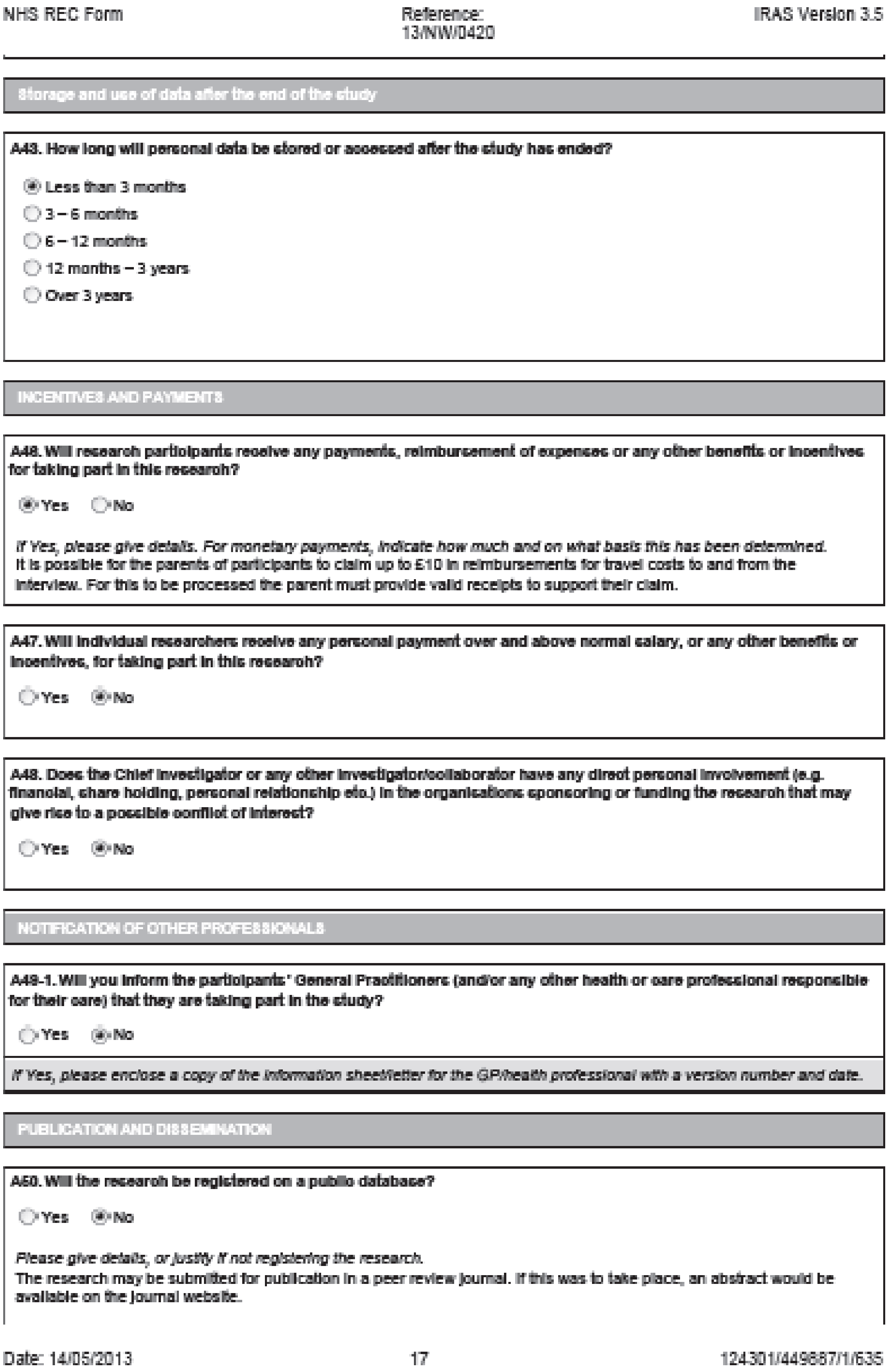
A38. How will you ensure the confidentiality of personal data? *Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

At the completion of the interview, the child/young person will be asked to choose their own pseudonym is they wish, pseudonyms will be used in relation to all transcripts and any quotes used in later publications of the findings. Any other names mentioned in the course of the interview will be anonymised and replaced with further pseudonyms as the interview is transcribed. All quotes used to support findings will be checked to assure that every measure has been taken so that the child/young person is not identifiable from the information.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

The clinician will make initial contact with the child/young person by providing information packs to the child/young person and their parent(s). The clinician will have the same access levels to the potential participants information as they would at any other time within their clinical role. The chief investigator will be provided by contact details through the expression of interest form (EIF) which allows parents of the child/young person to provide details they are comfortable sharing. No one else will have access to the EIF and these details. Only the anonymised transcripts will be shared with the academic supervisor to allow for checks that the protocol is being followed.

Date: 14/05/2013 | 16 | 124301/449887/1/635



Storage and use of data after the end of the study

A43. How long will personal data be stored or accessed after the study has ended?

● Less than 3 months
○ 3 – 6 months
○ 6 – 12 months
○ 12 months – 3 years
○ Over 3 years

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

● Yes ○ No

If Yes, please give details. For monetary payments, indicate how much and on what basis this has been determined.
It is possible for the parents of participants to claim up to £10 in reimbursements for travel costs to and from the interview. For this to be processed the parent must provide valid receipts to support their claim.

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

○ Yes ● No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ● No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

○ Yes ● No

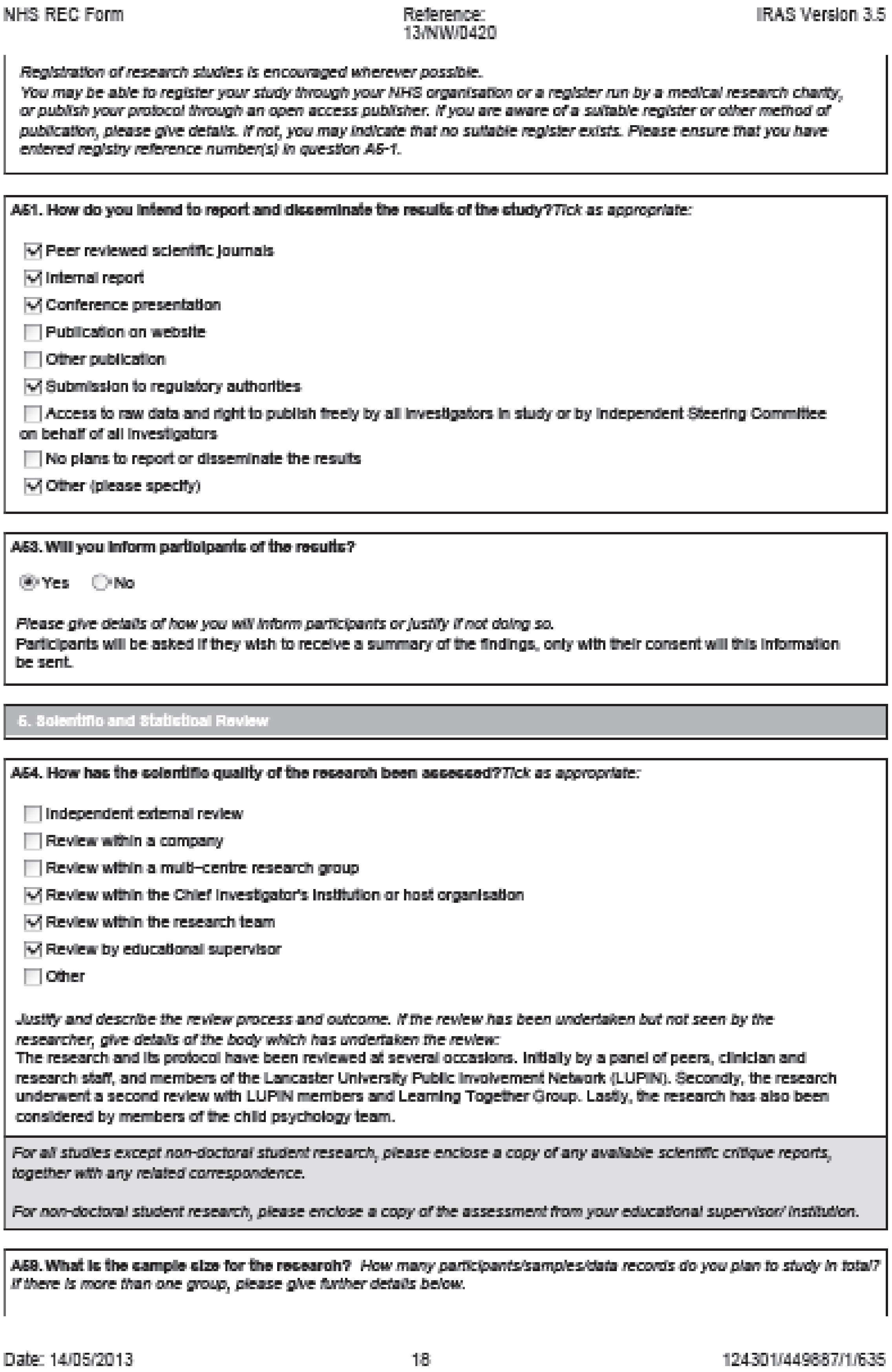
If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

○ Yes ● No

Please give details, or justify if not registering the research.
The research may be submitted for publication in a peer review journal. If this was to take place, an abstract would be available on the journal website.



Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

☑ Peer reviewed scientific journals
☑ Internal report
☑ Conference presentation
☐ Publication on website
☐ Other publication
☑ Submission to regulatory authorities
☐ Access to raw data and right to publish freely by all investigators in study or by independent Steering Committee on behalf of all investigators
☐ No plans to report or disseminate the results
☑ Other (please specify)

A53. Will you inform participants of the results?

● Yes ○ No

Please give details of how you will inform participants or justify if not doing so.
Participants will be asked if they wish to receive a summary of the findings, only with their consent will this information be sent.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? *Tick as appropriate:*

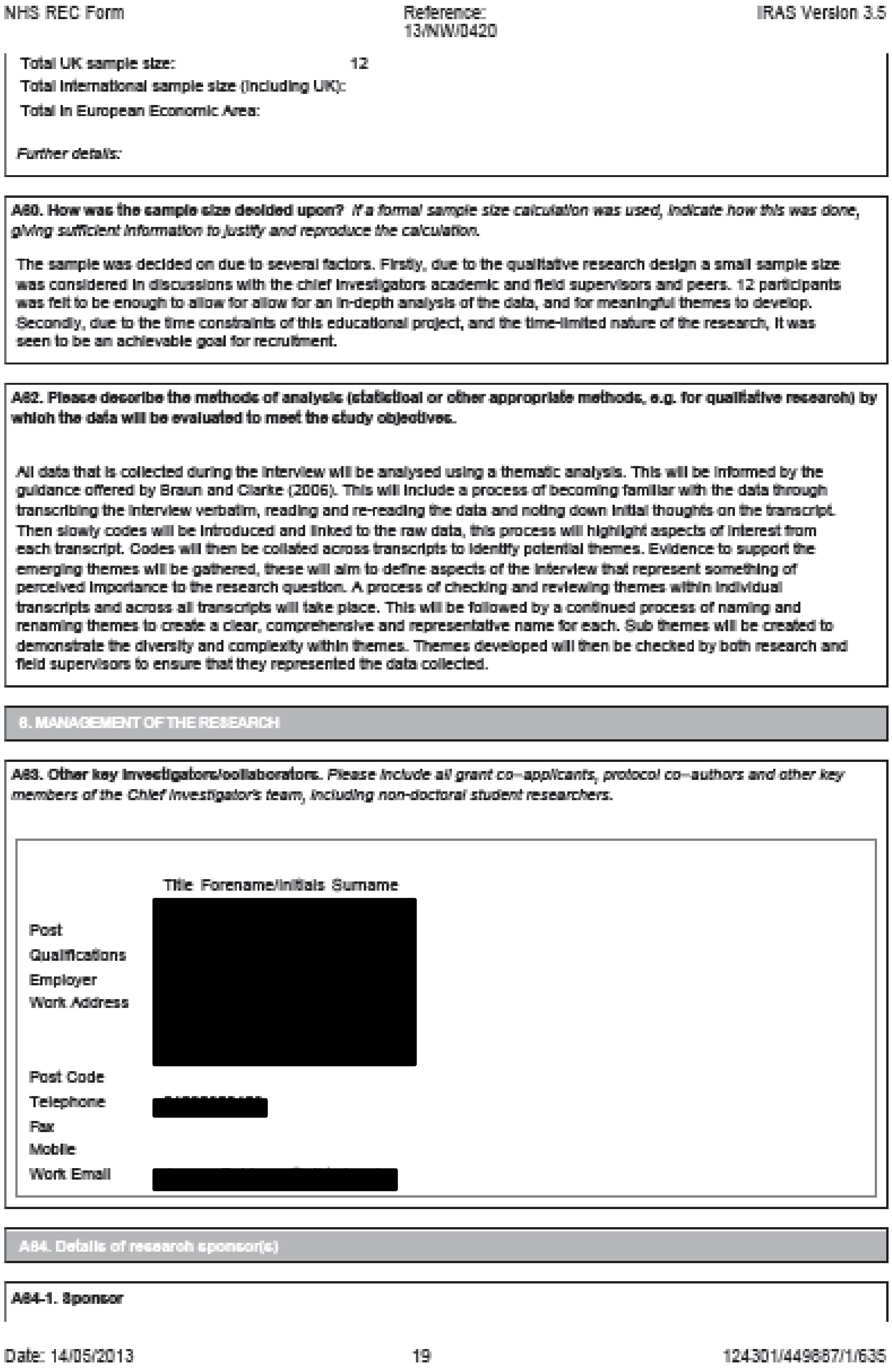
☐ Independent external review
☐ Review within a company
☐ Review within a multi–centre research group
☑ Review within the Chief Investigator's institution or host organisation
☑ Review within the research team
☑ Review by educational supervisor
☐ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
The research and its protocol have been reviewed at several occasions. Initially by a panel of peers, clinician and research staff, and members of the Lancaster University Public Involvement Network (LUPIN). Secondly, the research underwent a second review with LUPIN members and Learning Together Group. Lastly, the research has also been considered by members of the child psychology team.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*



NHS REC Form | Reference: 13/NW/0420 | IRAS Version 3.5

Total UK sample size: 12
Total International sample size (including UK):
Total in European Economic Area:

Further details:

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

The sample was decided on due to several factors. Firstly, due to the qualitative research design a small sample size was considered in discussions with the chief investigators academic and field supervisors and peers. 12 participants was felt to be enough to allow for allow for an in-depth analysis of the data, and for meaningful themes to develop. Secondly, due to the time constraints of this educational project, and the time-limited nature of the research, it was seen to be an achievable goal for recruitment.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

All data that is collected during the interview will be analysed using a thematic analysis. This will be informed by the guidance offered by Braun and Clarke (2006). This will include a process of becoming familiar with the data through transcribing the interview verbatim, reading and re-reading the data and noting down initial thoughts on the transcript. Then slowly codes will be introduced and linked to the raw data, this process will highlight aspects of interest from each transcript. Codes will then be collated across transcripts to identify potential themes. Evidence to support the emerging themes will be gathered, these will aim to define aspects of the interview that represent something of perceived importance to the research question. A process of checking and reviewing themes within individual transcripts and across all transcripts will take place. This will be followed by a continued process of naming and renaming themes to create a clear, comprehensive and representative name for each. Sub themes will be created to demonstrate the diversity and complexity within themes. Themes developed will then be checked by both research and field supervisors to ensure that they represented the data collected.

8. MANAGEMENT OF THE RESEARCH

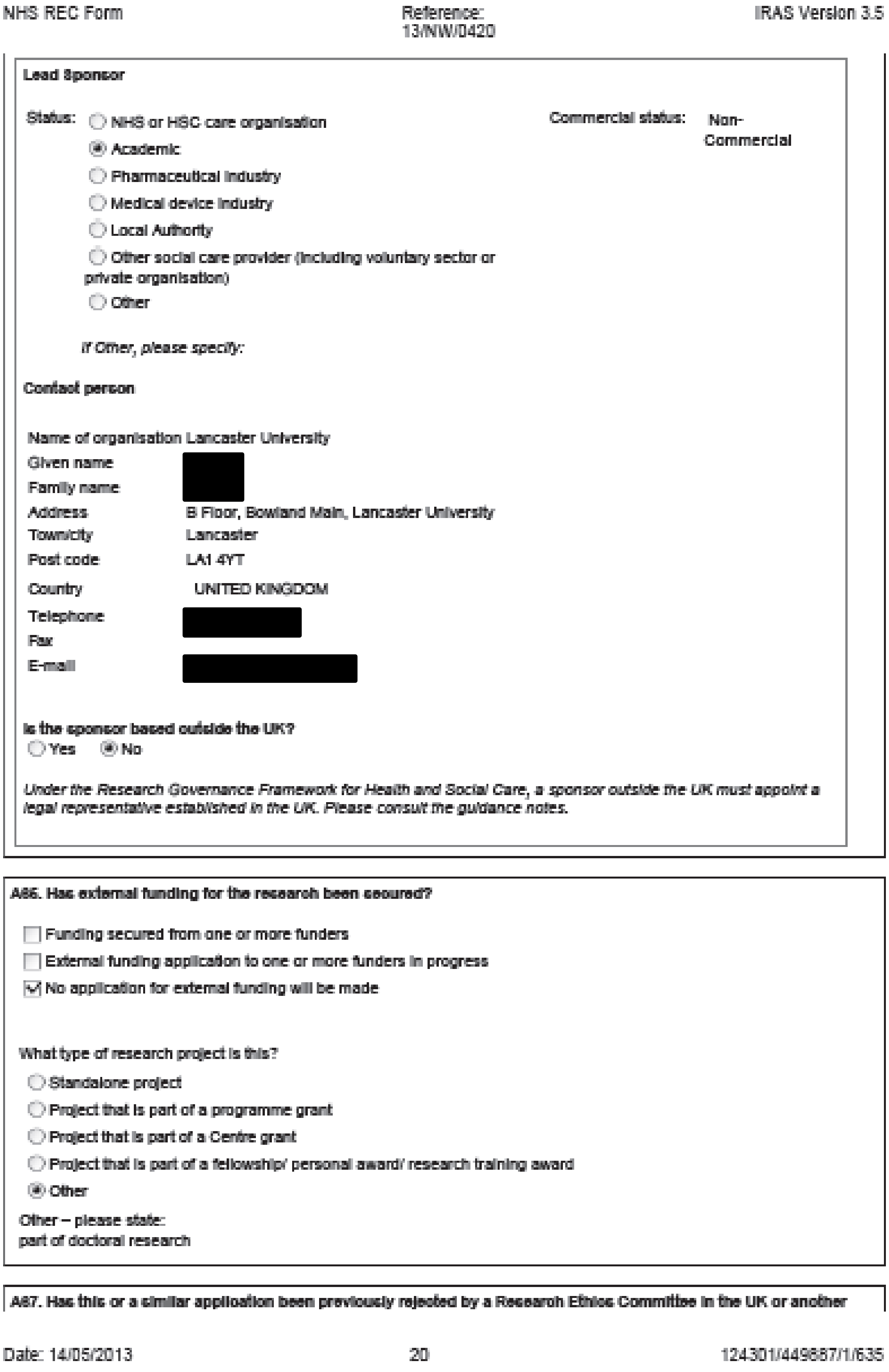
A63. Other key investigators/collaborators. *Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

	Title Forename/Initials Surname
Post	[redacted]
Qualifications	
Employer	
Work Address	
Post Code	
Telephone	[redacted]
Fax	
Mobile	
Work Email	[redacted]

A64. Details of research sponsor(s)

A64-1. Sponsor

Date: 14/05/2013 | 19 | 124301/449667/1/635



Lead Sponsor

Status:
○ NHS or HSC care organisation
● Academic
○ Pharmaceutical industry
○ Medical device industry
○ Local Authority
○ Other social care provider (including voluntary sector or private organisation)
○ Other

Commercial status: Non-Commercial

If Other, please specify:

Contact person

Name of organisation Lancaster University
Given name [redacted]
Family name
Address B Floor, Bowland Main, Lancaster University
Town/city Lancaster
Post code LA1 4YT
Country UNITED KINGDOM
Telephone [redacted]
Fax
E-mail [redacted]

Is the sponsor based outside the UK?
○ Yes ● No

Under the Research Governance Framework for Health and Social Care, a sponsor outside the UK must appoint a legal representative established in the UK. Please consult the guidance notes.

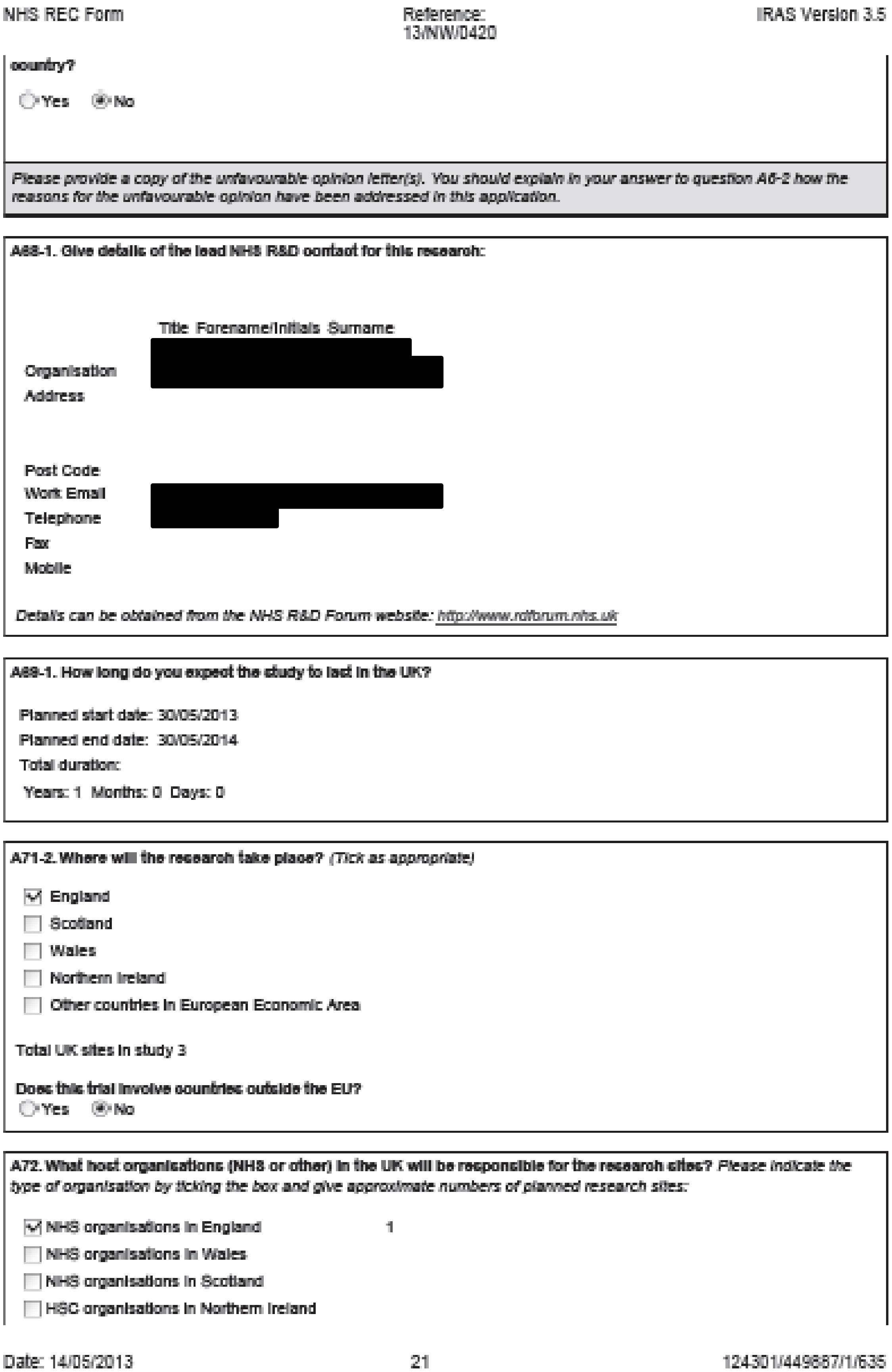
A66. Has external funding for the research been secured?

☐ Funding secured from one or more funders
☐ External funding application to one or more funders in progress
☑ No application for external funding will be made

What type of research project is this?
○ Standalone project
○ Project that is part of a programme grant
○ Project that is part of a Centre grant
○ Project that is part of a fellowship/ personal award/ research training award
● Other

Other – please state:
part of doctoral research

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another



country?

○ Yes ● No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

Title Forename/Initials Surname

[redacted]

Organisation

Address

Post Code

Work Email

[redacted]

Telephone

Fax

Mobile

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 30/05/2013

Planned end date: 30/05/2014

Total duration:

Years: 1 Months: 0 Days: 0

A71-2. Where will the research take place? *(Tick as appropriate)*

☑ England

☐ Scotland

☐ Wales

☐ Northern Ireland

☐ Other countries in European Economic Area

Total UK sites in study 3

Does this trial involve countries outside the EU?

○ Yes ● No

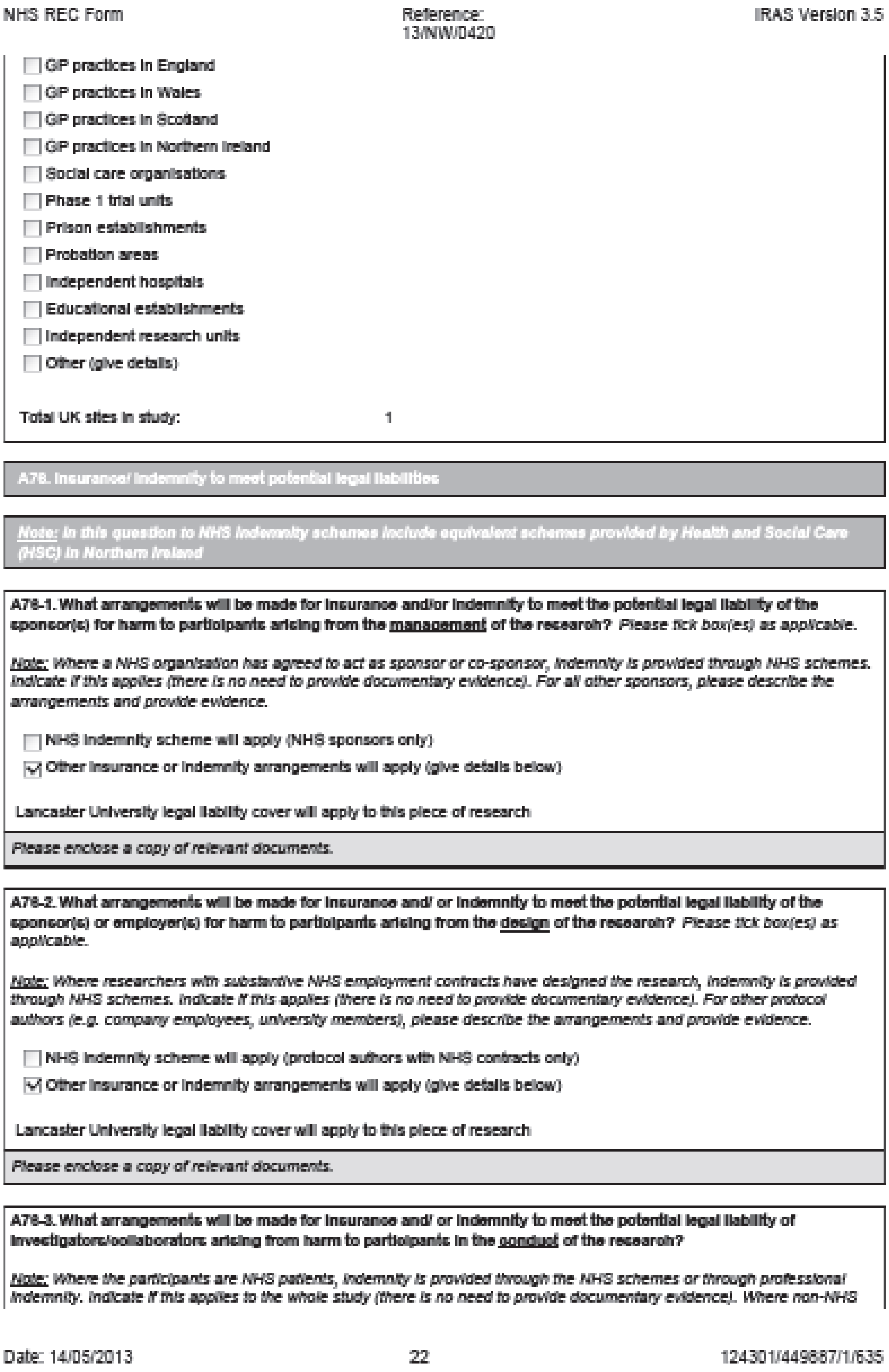
A72. What host organisations (NHS or other) in the UK will be responsible for the research sites? *Please indicate the type of organisation by ticking the box and give approximate numbers of planned research sites:*

☑ NHS organisations in England 1

☐ NHS organisations in Wales

☐ NHS organisations in Scotland

☐ HSC organisations in Northern Ireland



☐ GP practices in England
☐ GP practices in Wales
☐ GP practices in Scotland
☐ GP practices in Northern Ireland
☐ Social care organisations
☐ Phase 1 trial units
☐ Prison establishments
☐ Probation areas
☐ Independent hospitals
☐ Educational establishments
☐ Independent research units
☐ Other (give details)

Total UK sites in study: 1

A76. Insurance/ indemnity to meet potential legal liabilities

***Note:** In this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland*

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)
☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply to this piece of research

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

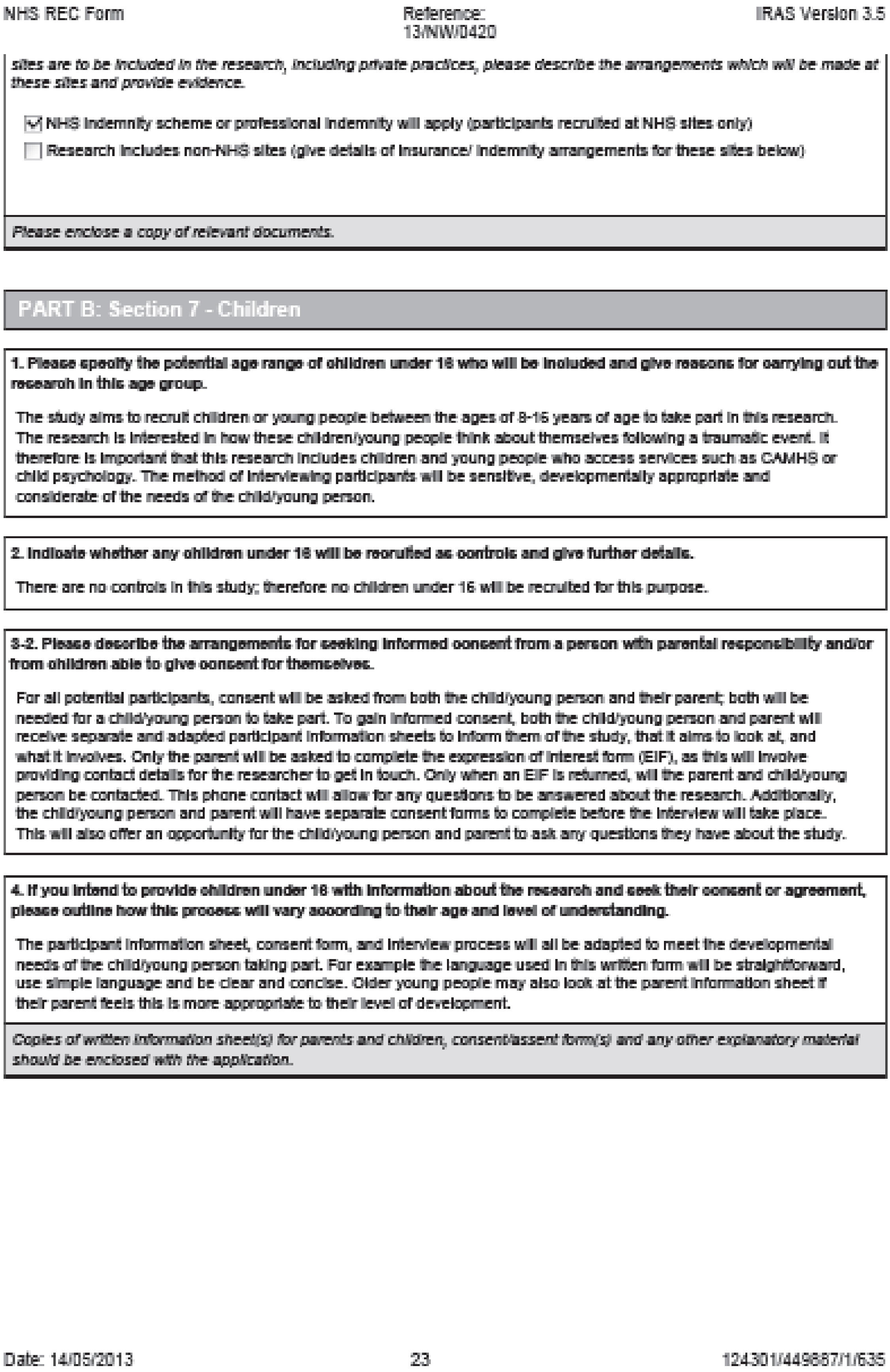
☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)
☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply to this piece of research

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS



sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

☑ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)

☐ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Please enclose a copy of relevant documents.

PART B: Section 7 - Children

1. Please specify the potential age range of children under 16 who will be included and give reasons for carrying out the research in this age group.

The study aims to recruit children or young people between the ages of 8-16 years of age to take part in this research. The research is interested in how these children/young people think about themselves following a traumatic event. It therefore is important that this research includes children and young people who access services such as CAMHS or child psychology. The method of interviewing participants will be sensitive, developmentally appropriate and considerate of the needs of the child/young person.

2. Indicate whether any children under 16 will be recruited as controls and give further details.

There are no controls in this study; therefore no children under 16 will be recruited for this purpose.

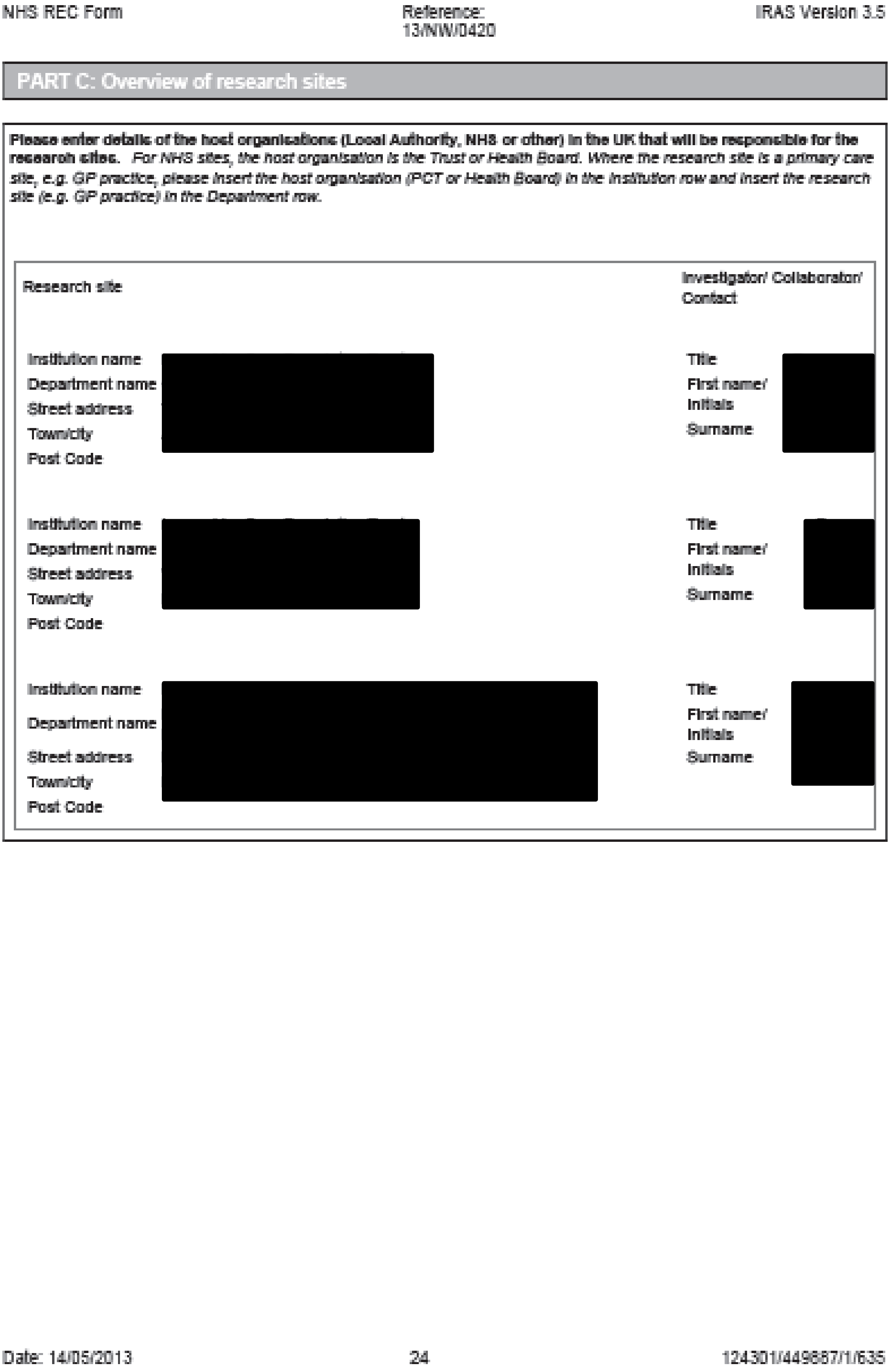
3-2. Please describe the arrangements for seeking informed consent from a person with parental responsibility and/or from children able to give consent for themselves.

For all potential participants, consent will be asked from both the child/young person and their parent; both will be needed for a child/young person to take part. To gain informed consent, both the child/young person and parent will receive separate and adapted participant information sheets to inform them of the study, that it aims to look at, and what it involves. Only the parent will be asked to complete the expression of interest form (EIF), as this will involve providing contact details for the researcher to get in touch. Only when an EIF is returned, will the parent and child/young person be contacted. This phone contact will allow for any questions to be answered about the research. Additionally, the child/young person and parent will have separate consent forms to complete before the interview will take place. This will also offer an opportunity for the child/young person and parent to ask any questions they have about the study.

4. If you intend to provide children under 16 with information about the research and seek their consent or agreement, please outline how this process will vary according to their age and level of understanding.

The participant information sheet, consent form, and interview process will all be adapted to meet the developmental needs of the child/young person taking part. For example the language used in this written form will be straightforward, use simple language and be clear and concise. Older young people may also look at the parent information sheet if their parent feels this is more appropriate to their level of development.

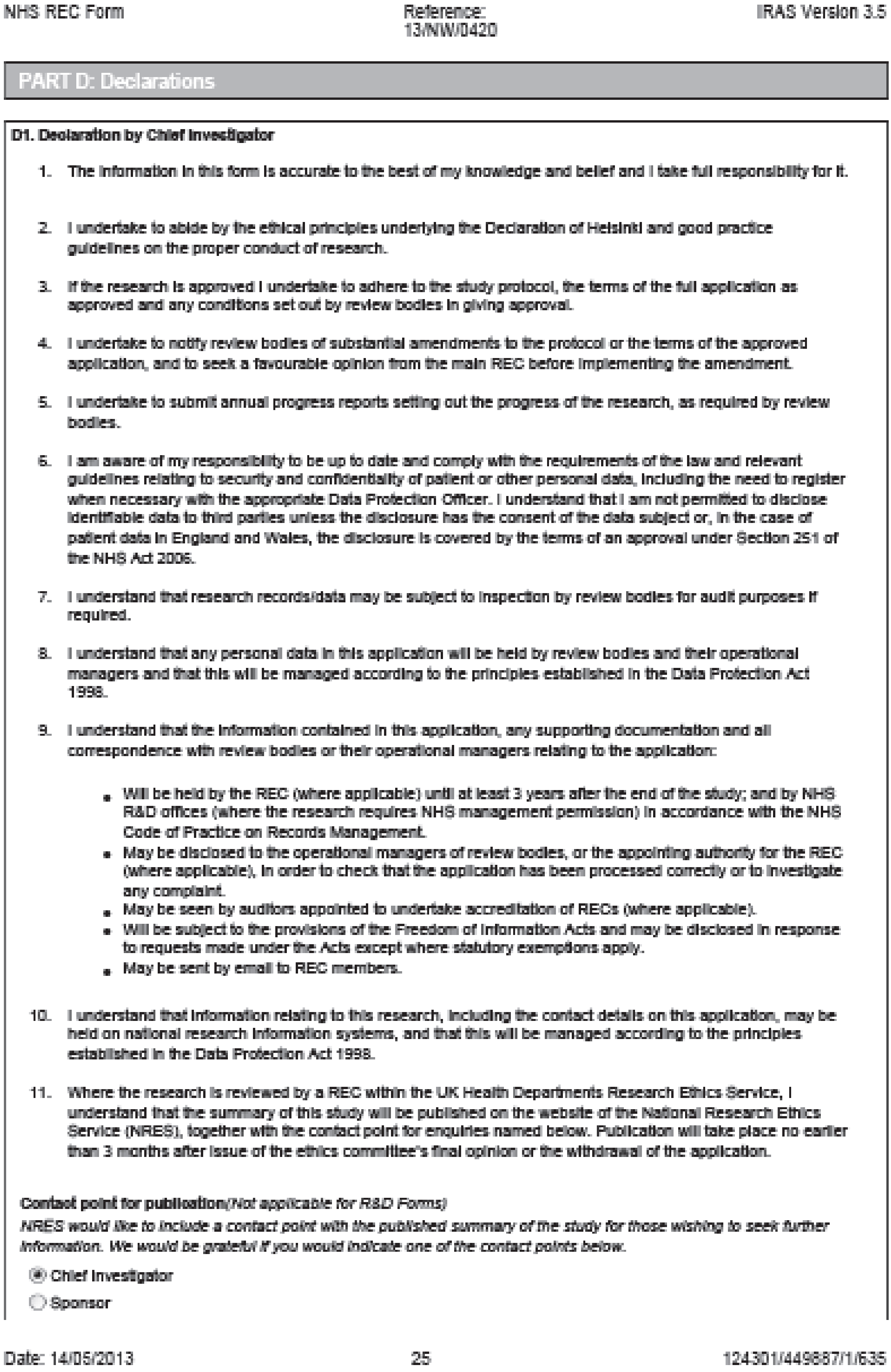
Copies of written information sheet(s) for parents and children, consent/assent form(s) and any other explanatory material should be enclosed with the application.



PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For NHS sites, the host organisation is the Trust or Health Board. Where the research site is a primary care site, e.g. GP practice, please insert the host organisation (PCT or Health Board) in the institution row and insert the research site (e.g. GP practice) in the Department row.*

Research site		Investigator/ Collaborator/ Contact	
Institution name Department name Street address Town/city Post Code	[redacted]	Title First name/ Initials Surname	[redacted]
Institution name Department name Street address Town/city Post Code	[redacted]	Title First name/ Initials Surname	[redacted]
Institution name Department name Street address Town/city Post Code	[redacted]	Title First name/ Initials Surname	[redacted]



NHS REC Form Reference: 13/NW/0420 IRAS Version 3.5

PART D: Declarations

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
3. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
4. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
5. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
6. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
7. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
8. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 1998.
9. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:
    - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
    - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
    - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
    - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
    - May be sent by email to REC members.
10. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.
11. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

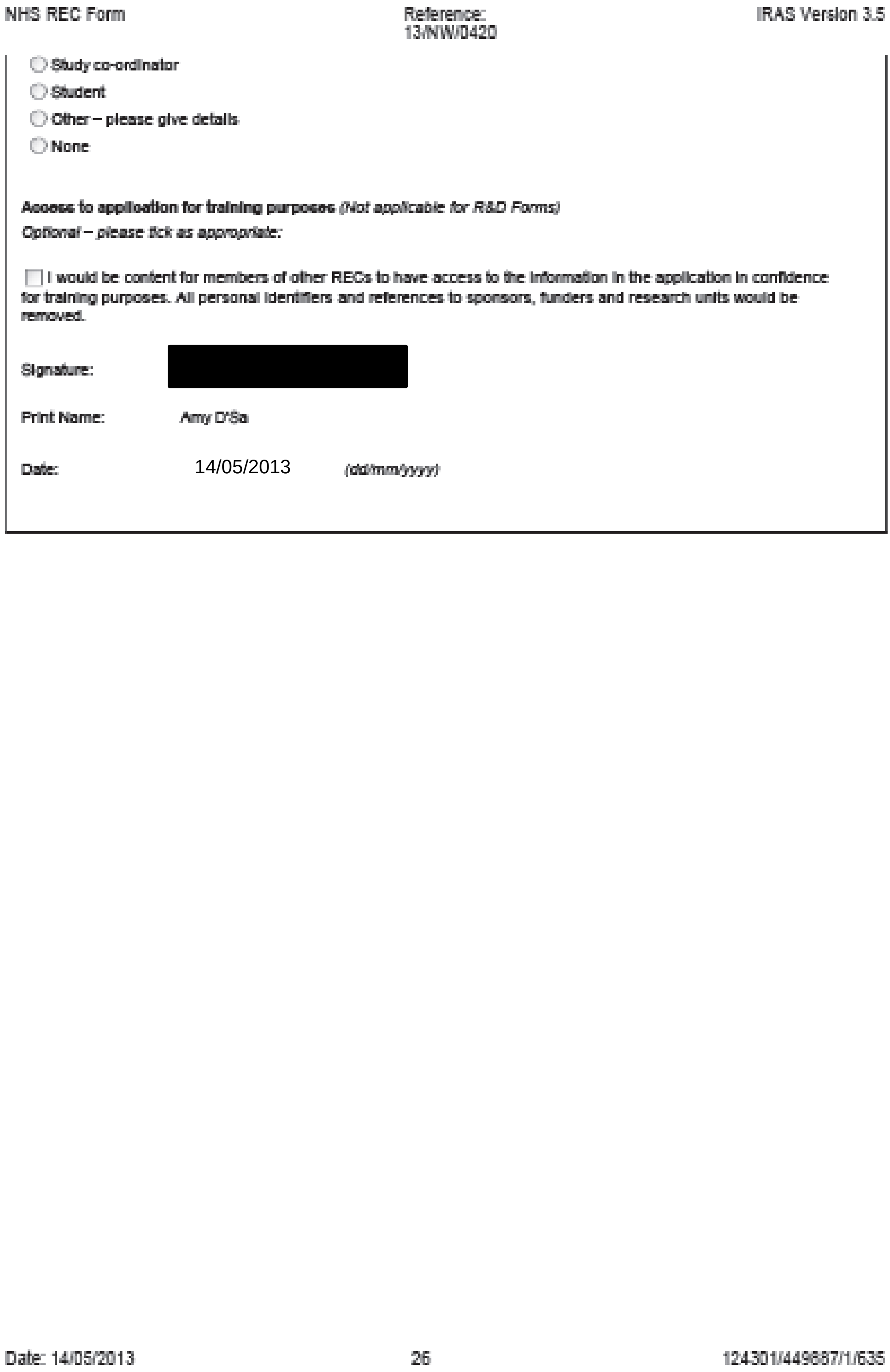
Contact point for publication*(Not applicable for R&D Forms)*

NRES would like to include a contact point with the published summary of the study for those wishing to seek further information. We would be grateful if you would indicate one of the contact points below.

● Chief Investigator

○ Sponsor

Date: 14/05/2013 25 124301/449887/1/635



NHS REC Form | Reference: 13/NW/0420 | IRAS Version 3.5

○ Study co-ordinator

○ Student

○ Other – please give details

○ None

Access to application for training purposes *(Not applicable for R&D Forms)*

Optional – please tick as appropriate:

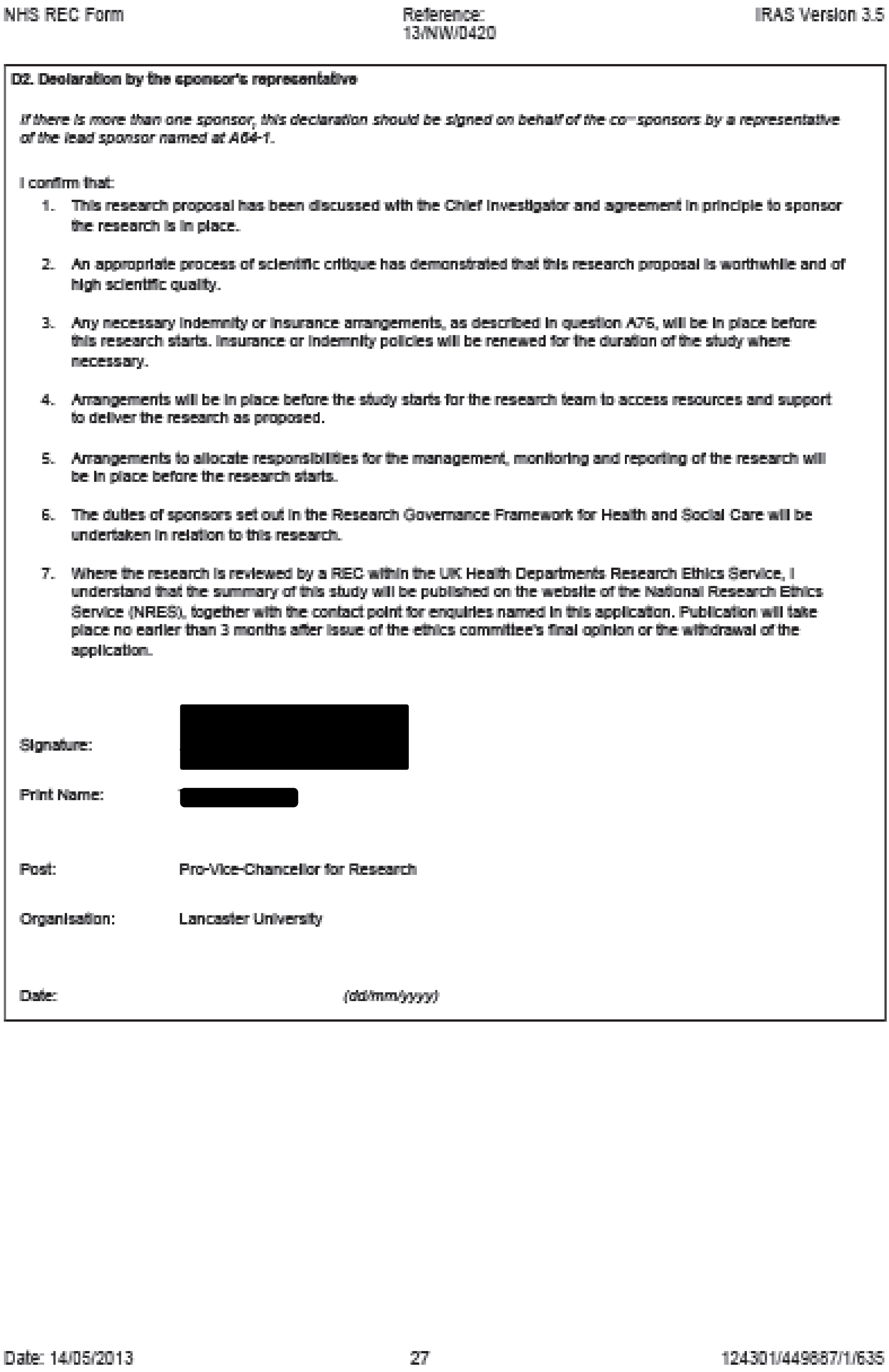
☐ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

Signature: [redacted]

Print Name: Amy D'Sa

Date: 14/05/2013 *(dd/mm/yyyy)*

Date: 14/05/2013 | 26 | 124301/449887/1/635



D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.

2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.

3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.

4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.

5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.

6. The duties of sponsors set out in the Research Governance Framework for Health and Social Care will be undertaken in relation to this research.

7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

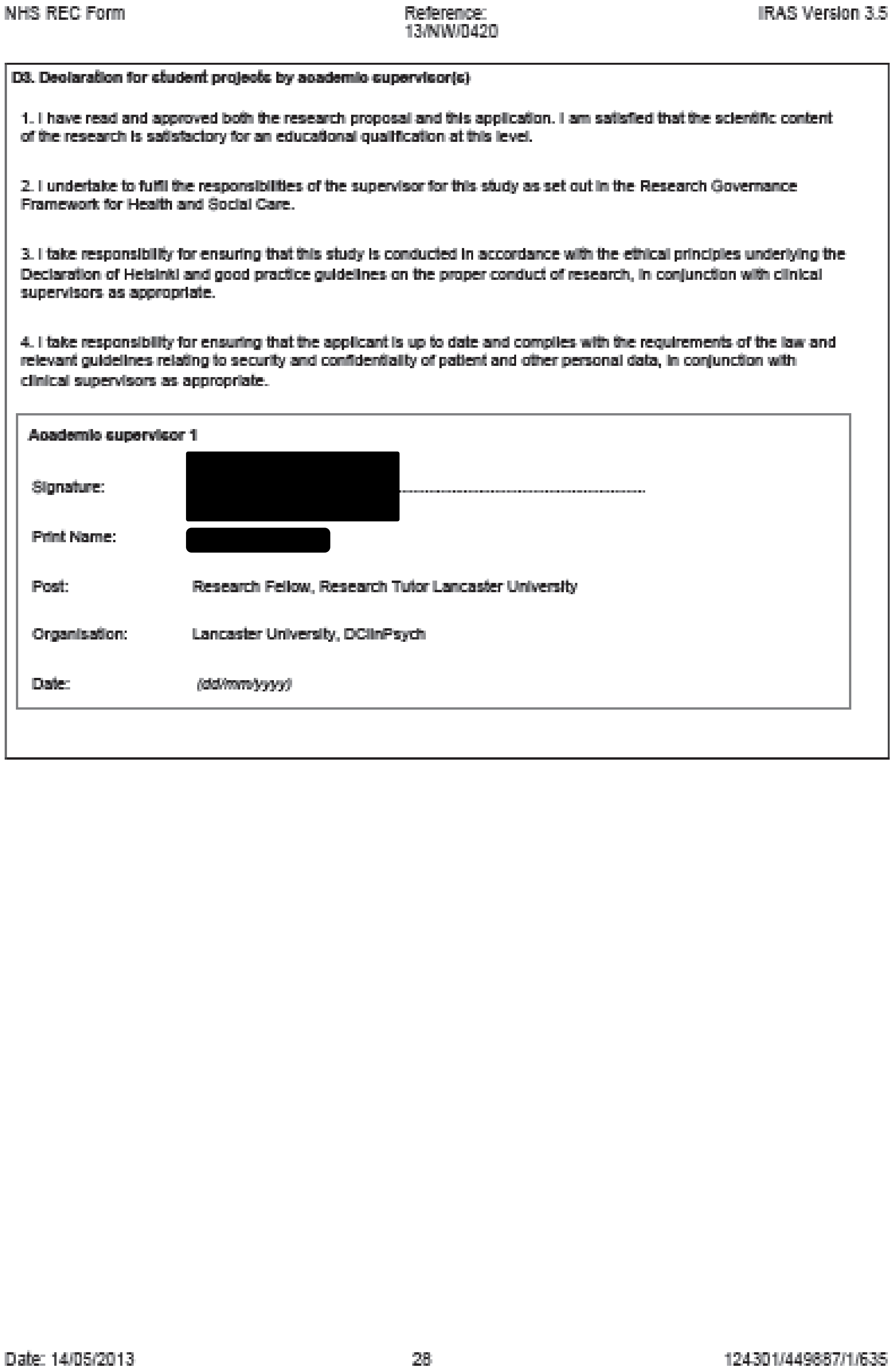
Signature: [redacted]

Print Name: [redacted]

Post: Pro-Vice-Chancellor for Research

Organisation: Lancaster University

Date: *(dd/mm/yyyy)*



D8. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the Research Governance Framework for Health and Social Care.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

Signature: [redacted] ....

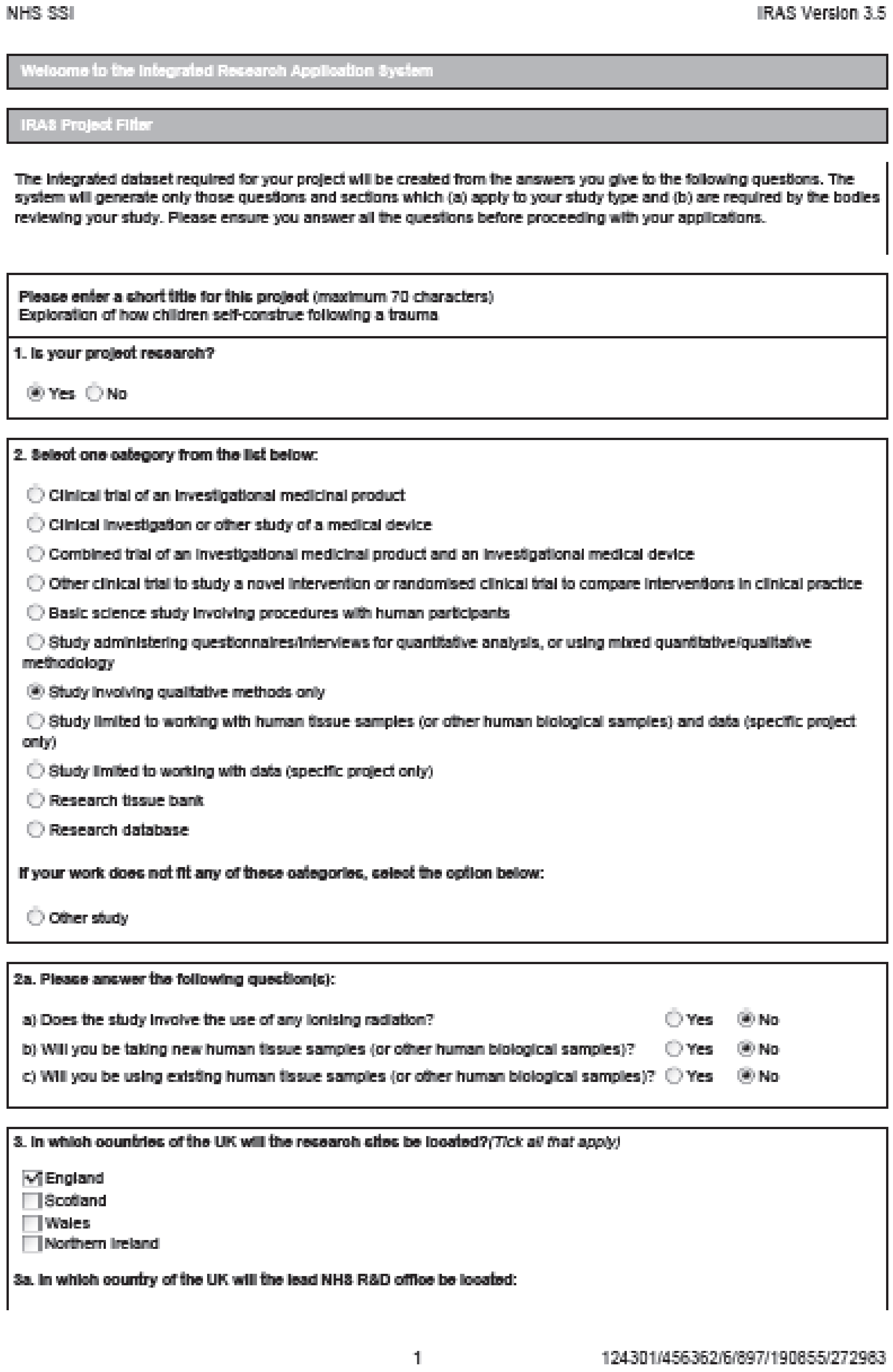
Print Name: [redacted]

Post: Research Fellow, Research Tutor Lancaster University

Organisation: Lancaster University, DClinPsych

Date: *(dd/mm/yyyy)*

NHS Site- Specific Information (SSI) Application Form (Trust 1)



NHS SSI IRAS Version 3.5

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
Exploration of how children self-construe following a trauma

1. Is your project research?

● Yes ○ No

2. Select one category from the list below:

- ○ Clinical trial of an investigational medicinal product
- ○ Clinical investigation or other study of a medical device
- ○ Combined trial of an investigational medicinal product and an investigational medical device
- ○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
- ○ Basic science study involving procedures with human participants
- ○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
- ● Study involving qualitative methods only
- ○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
- ○ Study limited to working with data (specific project only)
- ○ Research tissue bank
- ○ Research database

If your work does not fit any of these categories, select the option below:

○ Other study

2a. Please answer the following question(s):

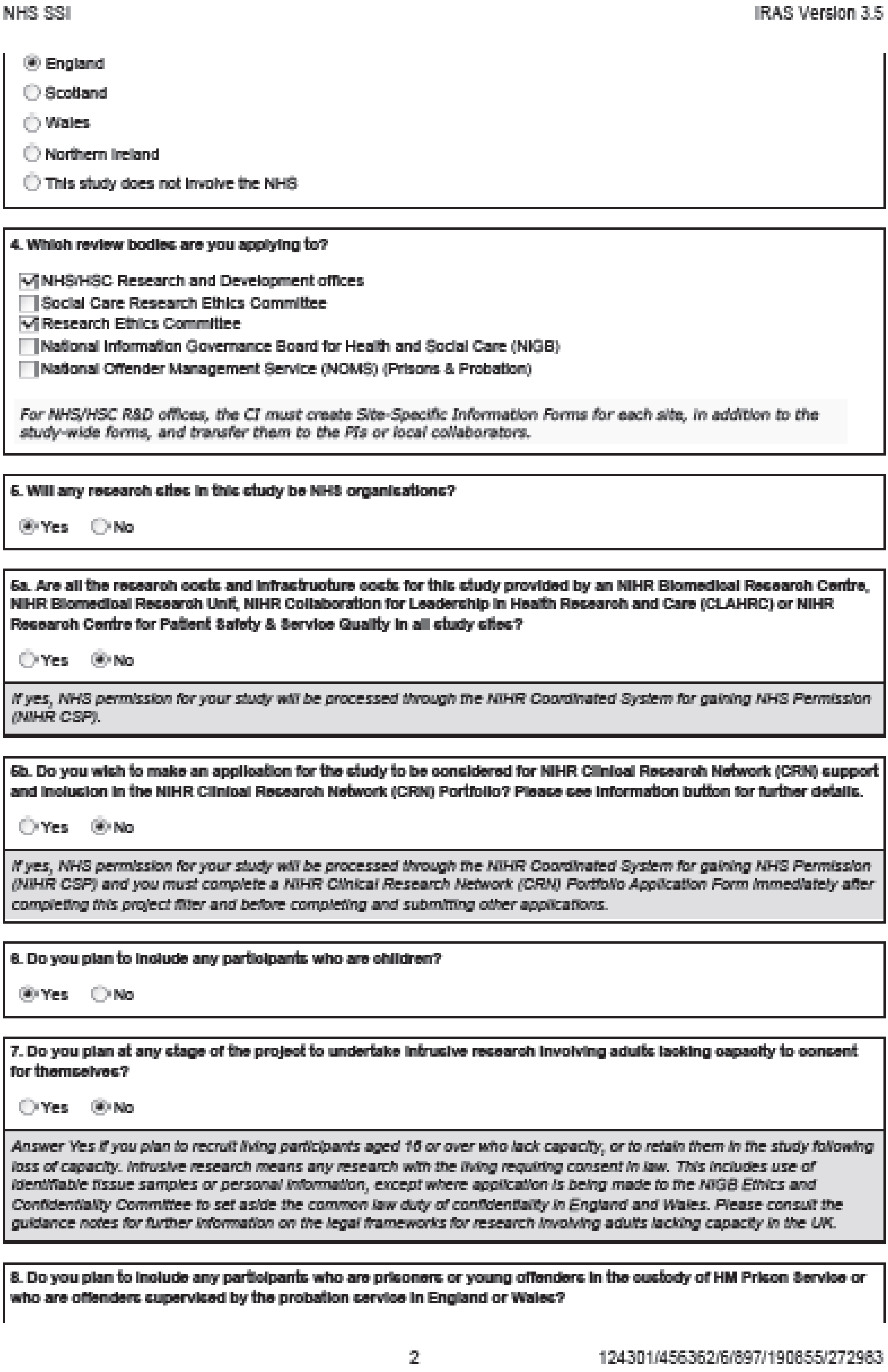
a) Does the study involve the use of any ionising radiation?	○ Yes	● No
b) Will you be taking new human tissue samples (or other human biological samples)?	○ Yes	● No
c) Will you be using existing human tissue samples (or other human biological samples)?	○ Yes	● No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

- ☑ England
- ☐ Scotland
- ☐ Wales
- ☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

1 124301/456362/6/897/190855/272983



NHS SSI IRAS Version 3.5

● England
○ Scotland
○ Wales
○ Northern Ireland
○ This study does not involve the NHS

4. Which review bodies are you applying to?

☑ NHS/HSC Research and Development offices
☐ Social Care Research Ethics Committee
☑ Research Ethics Committee
☐ National Information Governance Board for Health and Social Care (NIGB)
☐ National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D offices, the CI must create Site-Specific Information Forms for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.

5. Will any research sites in this study be NHS organisations?

● Yes ○ No

5a. Are all the research costs and infrastructure costs for this study provided by an NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC) or NIHR Research Centre for Patient Safety & Service Quality in all study sites?

○ Yes ● No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP).

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) support and inclusion in the NIHR Clinical Research Network (CRN) Portfolio? Please see information button for further details.

○ Yes ● No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP) and you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form immediately after completing this project filter and before completing and submitting other applications.

6. Do you plan to include any participants who are children?

● Yes ○ No

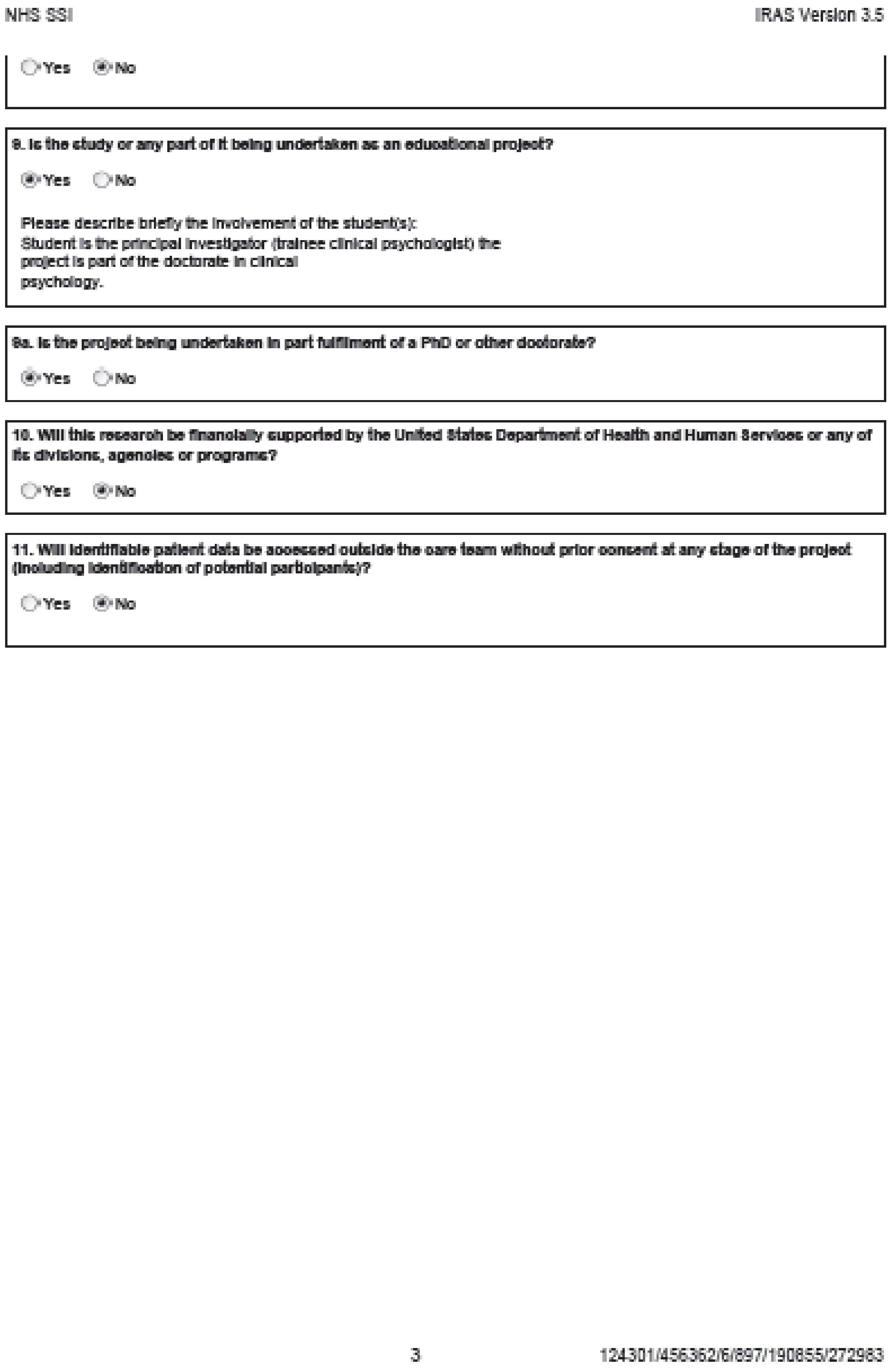
7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ● No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the NIGB Ethics and Confidentiality Committee to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

2 124301/456362/6/897/190855/272963



NHS SSI IRAS Version 3.5

○ Yes ● No

9. Is the study or any part of it being undertaken as an educational project?

● Yes ○ No

Please describe briefly the involvement of the student(s):
Student is the principal investigator (trainee clinical psychologist) the
project is part of the doctorate in clinical
psychology.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

● Yes ○ No

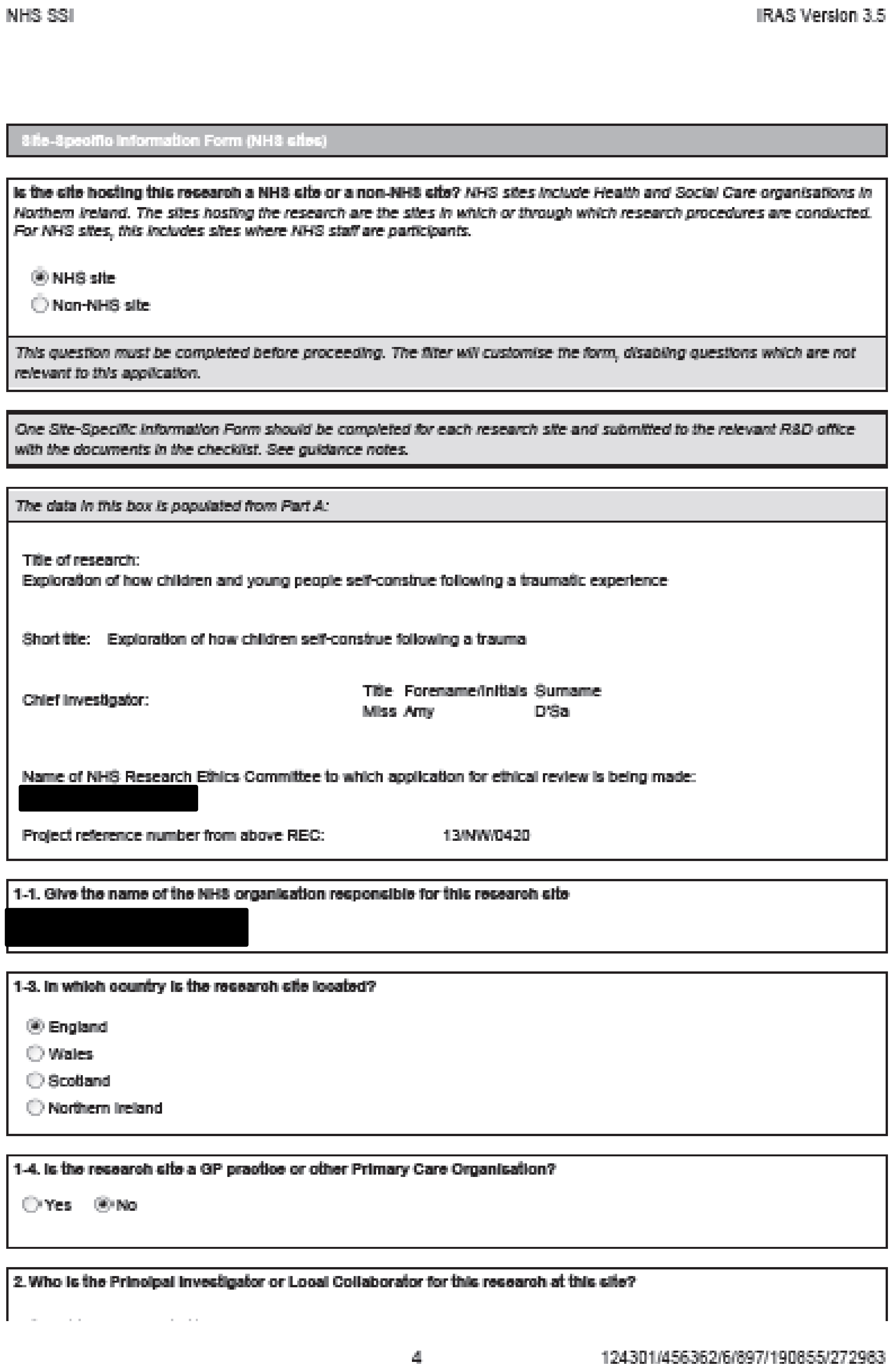
10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ● No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ● No

3 124301/456362/6/897/190855/272983



NHS SSI IRAS Version 3.5

Site-Specific Information Form (NHS sites)

Is the site hosting this research a NHS site or a non-NHS site? *NHS sites include Health and Social Care organisations in Northern Ireland. The sites hosting the research are the sites in which or through which research procedures are conducted. For NHS sites, this includes sites where NHS staff are participants.*

● NHS site
○ Non-NHS site

This question must be completed before proceeding. The filter will customise the form, disabling questions which are not relevant to this application.

One Site-Specific Information Form should be completed for each research site and submitted to the relevant R&D office with the documents in the checklist. See guidance notes.

The data in this box is populated from Part A:

Title of research:
Exploration of how children and young people self-construe following a traumatic experience

Short title: Exploration of how children self-construe following a trauma

	Title	Forename/Initials	Surname
Chief Investigator:	Miss	Amy	D'Sa

Name of NHS Research Ethics Committee to which application for ethical review is being made:
[redacted]

Project reference number from above REC: 13/NW/0420

1-1. Give the name of the NHS organisation responsible for this research site

[redacted]

1-3. In which country is the research site located?

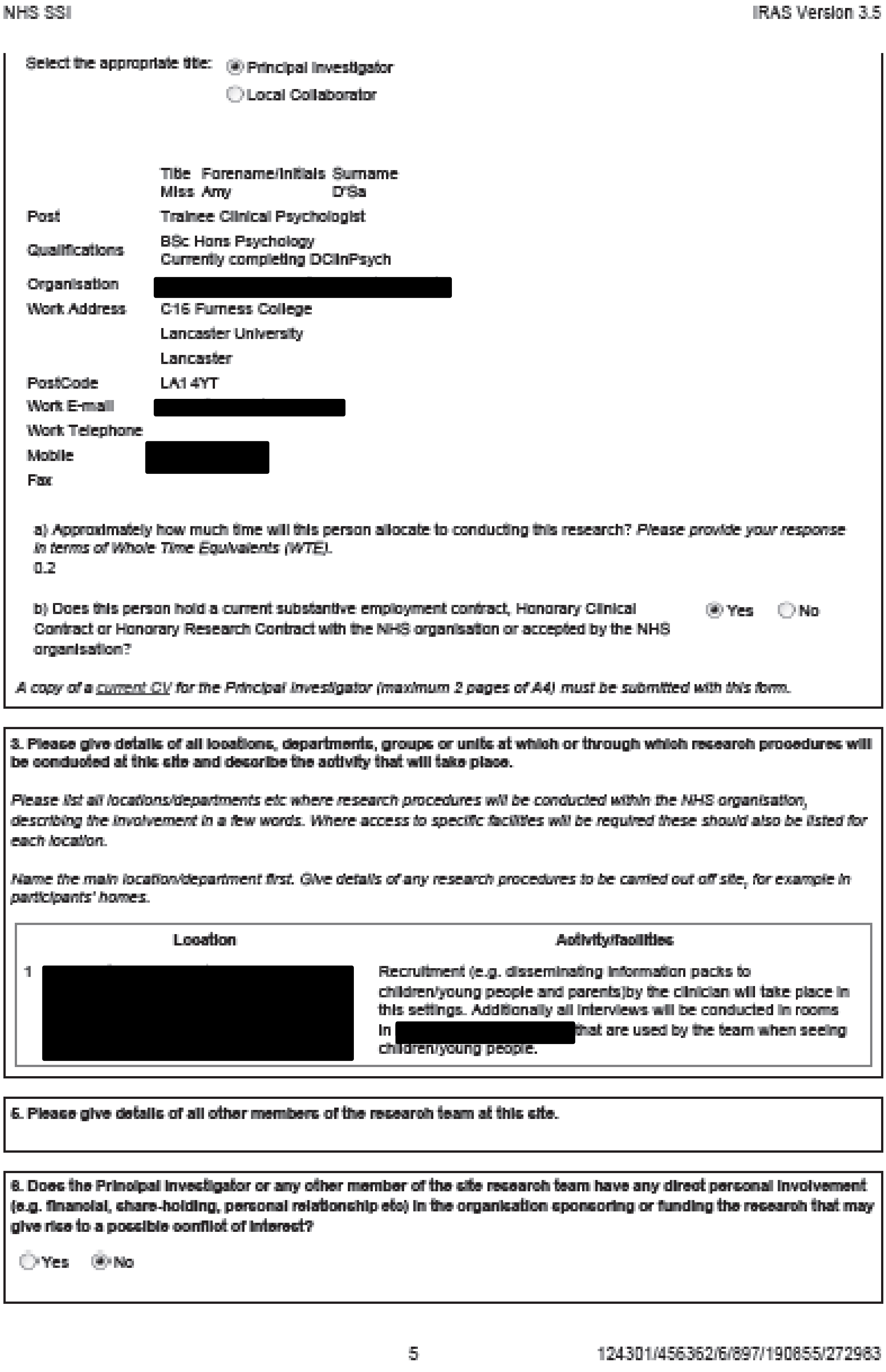
● England
○ Wales
○ Scotland
○ Northern Ireland

1-4. Is the research site a GP practice or other Primary Care Organisation?

○ Yes ● No

2. Who is the Principal Investigator or Local Collaborator for this research at this site?

4 124301/456362/6/897/190855/272983



Select the appropriate title: ● Principal Investigator
○ Local Collaborator

Title	Forename/Initials	Surname
Miss	Amy	D'Sa

Post	Trainee Clinical Psychologist
Qualifications	BSc Hons Psychology Currently completing DClinPsych
Organisation	[redacted]
Work Address	C16 Furness College Lancaster University Lancaster
PostCode	LA1 4YT
Work E-mail	[redacted]
Work Telephone	
Mobile	[redacted]
Fax	

a) Approximately how much time will this person allocate to conducting this research? *Please provide your response in terms of Whole Time Equivalents (WTE).*
0.2

b) Does this person hold a current substantive employment contract, Honorary Clinical Contract or Honorary Research Contract with the NHS organisation or accepted by the NHS organisation? ● Yes ○ No

A copy of a current CV for the Principal Investigator (maximum 2 pages of A4) must be submitted with this form.

3. Please give details of all locations, departments, groups or units at which or through which research procedures will be conducted at this site and describe the activity that will take place.

Please list all locations/departments etc where research procedures will be conducted within the NHS organisation, describing the involvement in a few words. Where access to specific facilities will be required these should also be listed for each location.

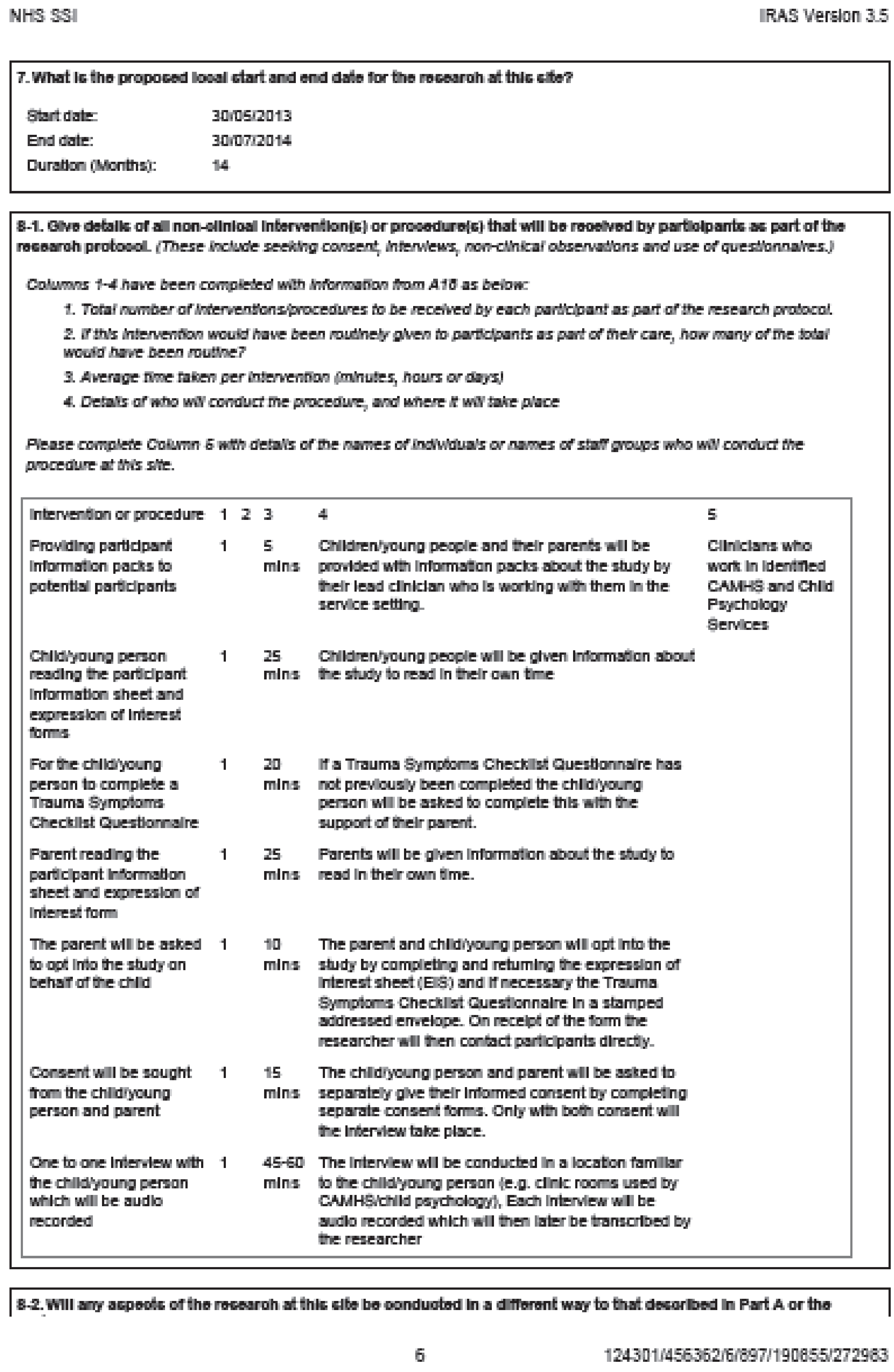
Name the main location/department first. Give details of any research procedures to be carried out off site, for example in participants' homes.

	Location	Activity/facilities
1	[redacted]	Recruitment (e.g. disseminating information packs to children/young people and parents)by the clinician will take place in this settings. Additionally all interviews will be conducted in rooms in [redacted] that are used by the team when seeing children/young people.

5. Please give details of all other members of the research team at this site.

6. Does the Principal Investigator or any other member of the site research team have any direct personal involvement (e.g. financial, share-holding, personal relationship etc) in the organisation sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ● No



7. What is the proposed local start and end date for the research at this site?

Start date:	30/06/2013
End date:	30/07/2014
Duration (Months):	14

8-1. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *(These include seeking consent, interviews, non-clinical observations and use of questionnaires.)*

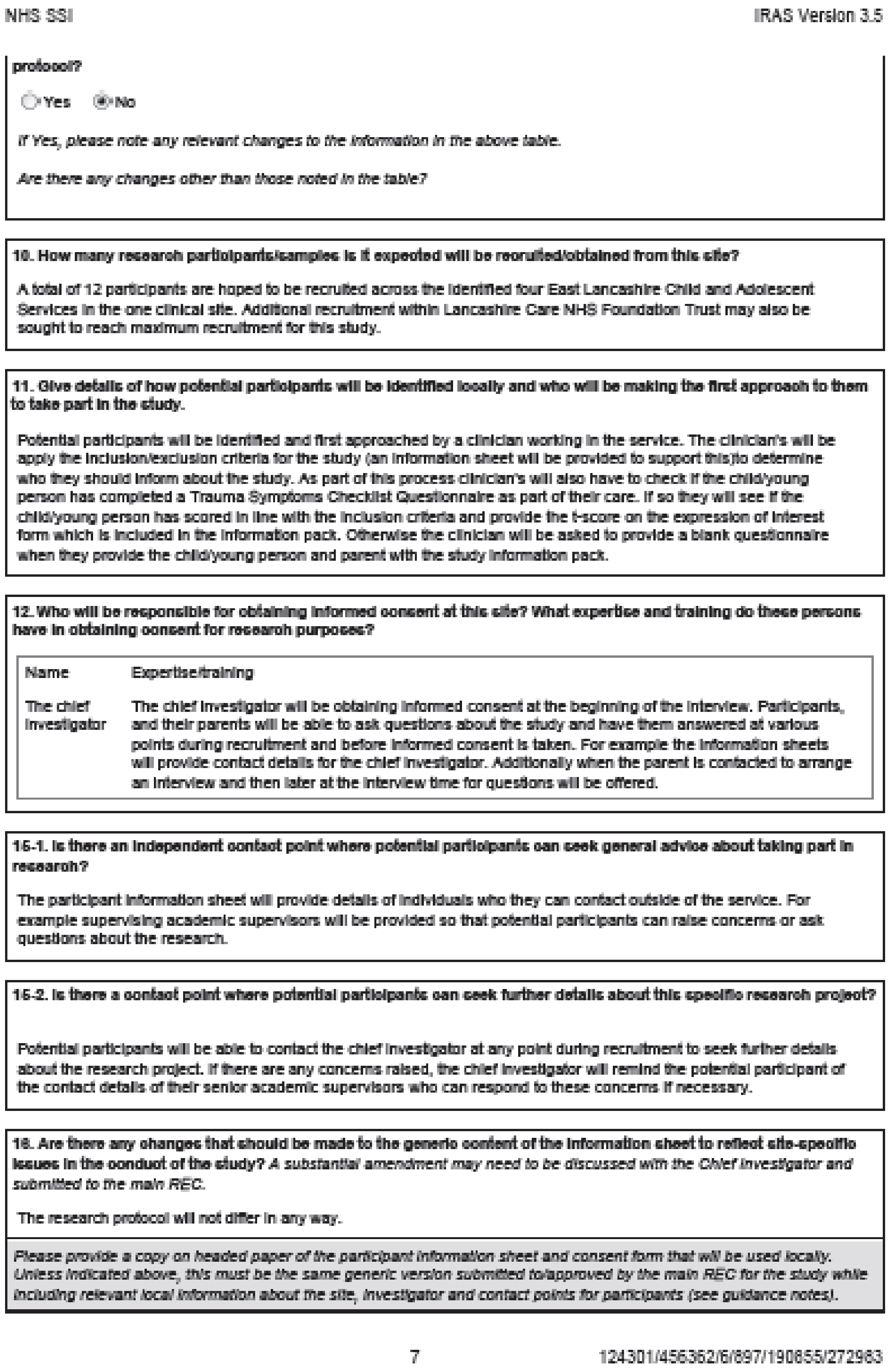
Columns 1-4 have been completed with information from A18 as below:

1. *Total number of interventions/procedures to be received by each participant as part of the research protocol.*
2. *If this intervention would have been routinely given to participants as part of their care, how many of the total would have been routine?*
3. *Average time taken per intervention (minutes, hours or days)*
4. *Details of who will conduct the procedure, and where it will take place*

Please complete Column 5 with details of the names of individuals or names of staff groups who will conduct the procedure at this site.

Intervention or procedure	1	2	3	4	5
Providing participant information packs to potential participants	1		5 mins	Children/young people and their parents will be provided with information packs about the study by their lead clinician who is working with them in the service setting.	Clinicians who work in identified CAMHS and Child Psychology Services
Child/young person reading the participant information sheet and expression of interest forms	1		25 mins	Children/young people will be given information about the study to read in their own time	
For the child/young person to complete a Trauma Symptoms Checklist Questionnaire	1		20 mins	If a Trauma Symptoms Checklist Questionnaire has not previously been completed the child/young person will be asked to complete this with the support of their parent.	
Parent reading the participant information sheet and expression of interest form	1		25 mins	Parents will be given information about the study to read in their own time.	
The parent will be asked to opt into the study on behalf of the child	1		10 mins	The parent and child/young person will opt into the study by completing and returning the expression of interest sheet (EIS) and if necessary the Trauma Symptoms Checklist Questionnaire in a stamped addressed envelope. On receipt of the form the researcher will then contact participants directly.	
Consent will be sought from the child/young person and parent	1		15 mins	The child/young person and parent will be asked to separately give their informed consent by completing separate consent forms. Only with both consent will the interview take place.	
One to one interview with the child/young person which will be audio recorded	1		45-60 mins	The interview will be conducted in a location familiar to the child/young person (e.g. clinic rooms used by CAMHS/child psychology). Each interview will be audio recorded which will then later be transcribed by the researcher	

8-2. Will any aspects of the research at this site be conducted in a different way to that described in Part A or the



NHS SSI IRAS Version 3.5

protocol?

○ Yes ● No

If Yes, please note any relevant changes to the information in the above table.

Are there any changes other than those noted in the table?

10. How many research participants/samples is it expected will be recruited/obtained from this site?

A total of 12 participants are hoped to be recruited across the identified four East Lancashire Child and Adolescent Services in the one clinical site. Additional recruitment within Lancashire Care NHS Foundation Trust may also be sought to reach maximum recruitment for this study.

11. Give details of how potential participants will be identified locally and who will be making the first approach to them to take part in the study.

Potential participants will be identified and first approached by a clinician working in the service. The clinician's will be apply the inclusion/exclusion criteria for the study (an information sheet will be provided to support this)to determine who they should inform about the study. As part of this process clinician's will also have to check if the child/young person has completed a Trauma Symptoms Checklist Questionnaire as part of their care. If so they will see if the child/young person has scored in line with the inclusion criteria and provide the t-score on the expression of interest form which is included in the information pack. Otherwise the clinician will be asked to provide a blank questionnaire when they provide the child/young person and parent with the study information pack.

12. Who will be responsible for obtaining informed consent at this site? What expertise and training do these persons have in obtaining consent for research purposes?

Name	Expertise/training
The chief investigator	The chief investigator will be obtaining informed consent at the beginning of the interview. Participants, and their parents will be able to ask questions about the study and have them answered at various points during recruitment and before informed consent is taken. For example the information sheets will provide contact details for the chief investigator. Additionally when the parent is contacted to arrange an interview and then later at the interview time for questions will be offered.

15-1. Is there an independent contact point where potential participants can seek general advice about taking part in research?

The participant information sheet will provide details of individuals who they can contact outside of the service. For example supervising academic supervisors will be provided so that potential participants can raise concerns or ask questions about the research.

15-2. Is there a contact point where potential participants can seek further details about this specific research project?

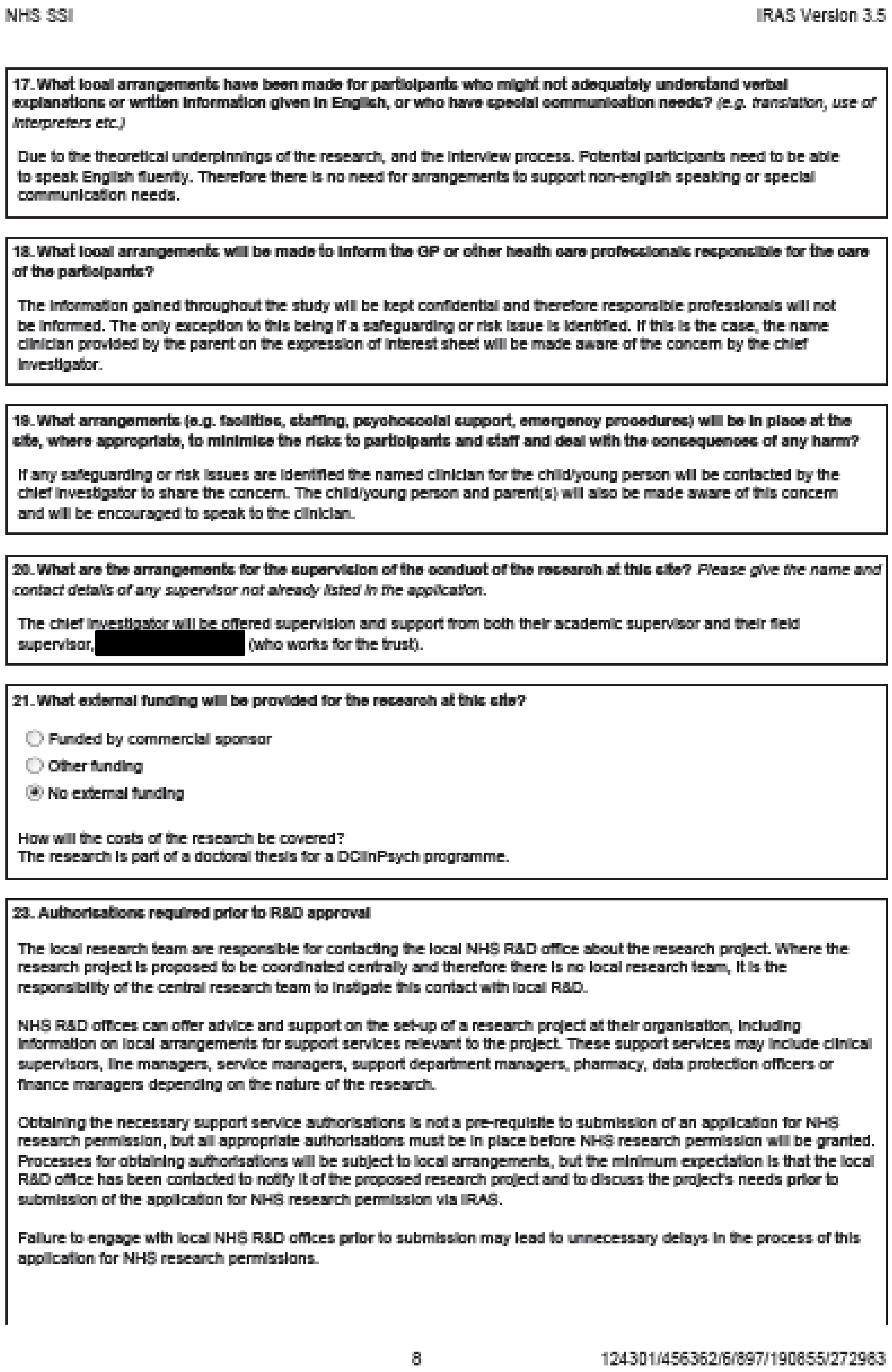
Potential participants will be able to contact the chief investigator at any point during recruitment to seek further details about the research project. If there are any concerns raised, the chief investigator will remind the potential participant of the contact details of their senior academic supervisors who can respond to these concerns if necessary.

16. Are there any changes that should be made to the generic content of the information sheet to reflect site-specific issues in the conduct of the study? *A substantial amendment may need to be discussed with the Chief Investigator and submitted to the main REC.*

The research protocol will not differ in any way.

Please provide a copy on headed paper of the participant information sheet and consent form that will be used locally. Unless indicated above, this must be the same generic version submitted to/approved by the main REC for the study while including relevant local information about the site, investigator and contact points for participants (see guidance notes).

7 124301/456362/6/897/190855/272963



NHS SSI IRAS Version 3.5

17. What local arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? *(e.g. translation, use of interpreters etc.)*

Due to the theoretical underpinnings of the research, and the interview process. Potential participants need to be able to speak English fluently. Therefore there is no need for arrangements to support non-english speaking or special communication needs.

18. What local arrangements will be made to inform the GP or other health care professionals responsible for the care of the participants?

The information gained throughout the study will be kept confidential and therefore responsible professionals will not be informed. The only exception to this being if a safeguarding or risk issue is identified. If this is the case, the name clinician provided by the parent on the expression of interest sheet will be made aware of the concern by the chief investigator.

19. What arrangements (e.g. facilities, staffing, psychosocial support, emergency procedures) will be in place at the site, where appropriate, to minimise the risks to participants and staff and deal with the consequences of any harm?

If any safeguarding or risk issues are identified the named clinician for the child/young person will be contacted by the chief investigator to share the concern. The child/young person and parent(s) will also be made aware of this concern and will be encouraged to speak to the clinician.

20. What are the arrangements for the supervision of the conduct of the research at this site? *Please give the name and contact details of any supervisor not already listed in the application.*

The chief investigator will be offered supervision and support from both their academic supervisor and their field supervisor, [redacted] (who works for the trust).

21. What external funding will be provided for the research at this site?

○ Funded by commercial sponsor
○ Other funding
● No external funding

How will the costs of the research be covered?
The research is part of a doctoral thesis for a DClinPsych programme.

23. Authorisations required prior to R&D approval

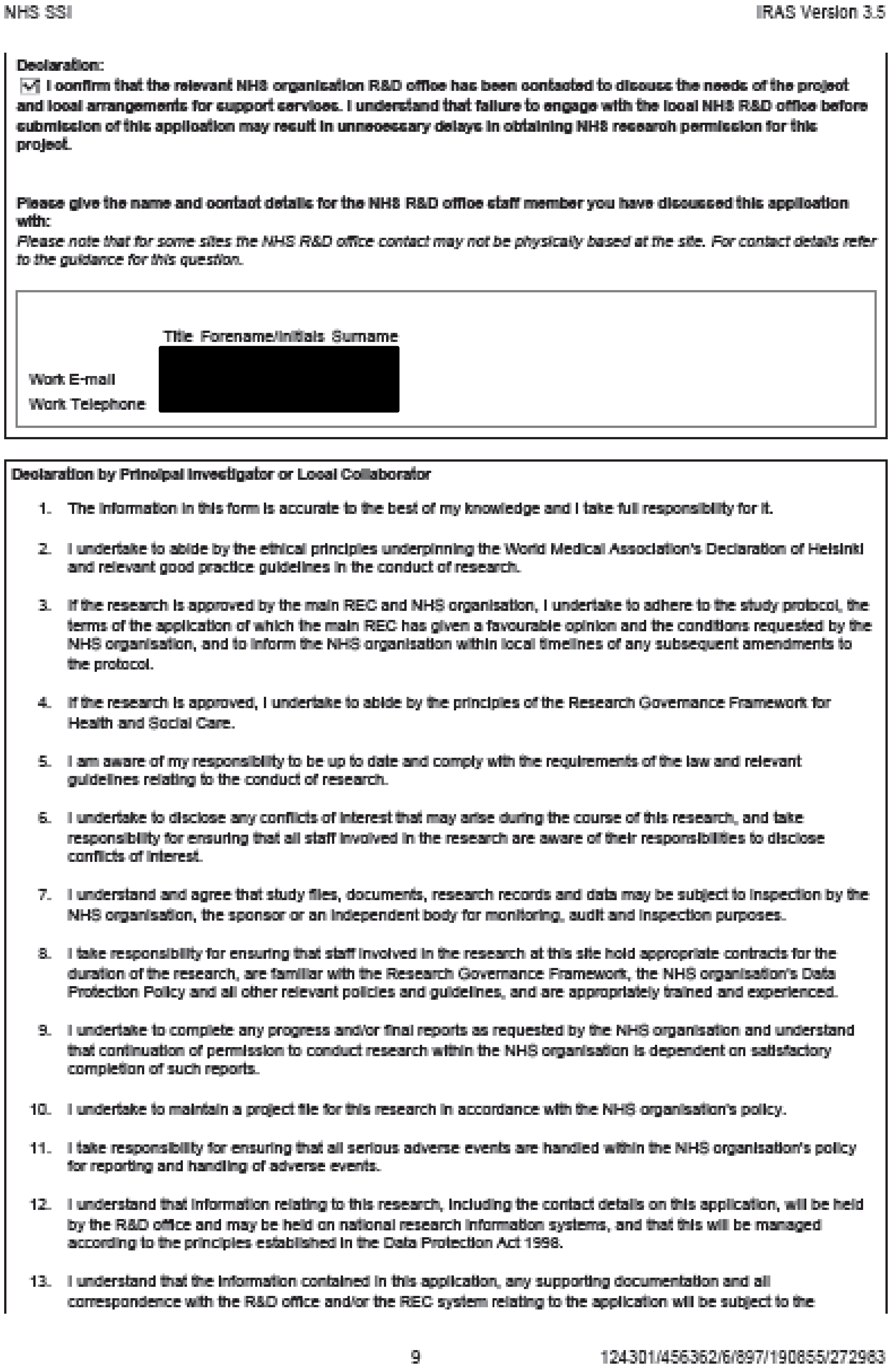
The local research team are responsible for contacting the local NHS R&D office about the research project. Where the research project is proposed to be coordinated centrally and therefore there is no local research team, it is the responsibility of the central research team to instigate this contact with local R&D.

NHS R&D offices can offer advice and support on the set-up of a research project at their organisation, including information on local arrangements for support services relevant to the project. These support services may include clinical supervisors, line managers, service managers, support department managers, pharmacy, data protection officers or finance managers depending on the nature of the research.

Obtaining the necessary support service authorisations is not a pre-requisite to submission of an application for NHS research permission, but all appropriate authorisations must be in place before NHS research permission will be granted. Processes for obtaining authorisations will be subject to local arrangements, but the minimum expectation is that the local R&D office has been contacted to notify it of the proposed research project and to discuss the project's needs prior to submission of the application for NHS research permission via IRAS.

Failure to engage with local NHS R&D offices prior to submission may lead to unnecessary delays in the process of this application for NHS research permissions.

8 124301/456362/6/897/190855/272983



Declaration:

☑ **I confirm that the relevant NHS organisation R&D office has been contacted to discuss the needs of the project and local arrangements for support services. I understand that failure to engage with the local NHS R&D office before submission of this application may result in unnecessary delays in obtaining NHS research permission for this project.**

Please give the name and contact details for the NHS R&D office staff member you have discussed this application with:

Please note that for some sites the NHS R&D office contact may not be physically based at the site. For contact details refer to the guidance for this question.

Title Forename/Initials Surname

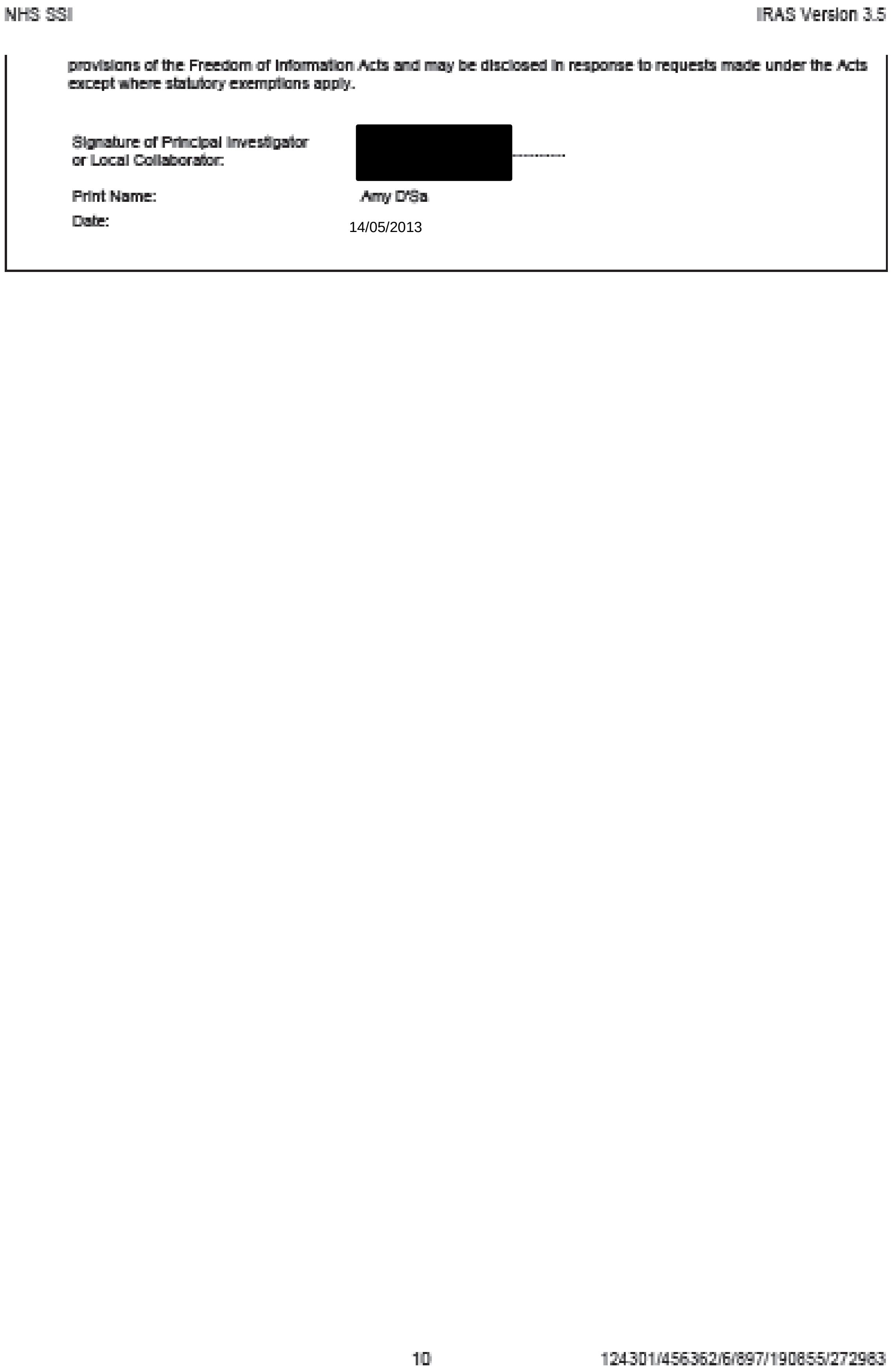
Work E-mail

Work Telephone

[redacted]

Declaration by Principal Investigator or Local Collaborator

1. The information in this form is accurate to the best of my knowledge and I take full responsibility for it.
2. I undertake to abide by the ethical principles underpinning the World Medical Association's Declaration of Helsinki and relevant good practice guidelines in the conduct of research.
3. If the research is approved by the main REC and NHS organisation, I undertake to adhere to the study protocol, the terms of the application of which the main REC has given a favourable opinion and the conditions requested by the NHS organisation, and to inform the NHS organisation within local timelines of any subsequent amendments to the protocol.
4. If the research is approved, I undertake to abide by the principles of the Research Governance Framework for Health and Social Care.
5. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to the conduct of research.
6. I undertake to disclose any conflicts of interest that may arise during the course of this research, and take responsibility for ensuring that all staff involved in the research are aware of their responsibilities to disclose conflicts of interest.
7. I understand and agree that study files, documents, research records and data may be subject to inspection by the NHS organisation, the sponsor or an independent body for monitoring, audit and inspection purposes.
8. I take responsibility for ensuring that staff involved in the research at this site hold appropriate contracts for the duration of the research, are familiar with the Research Governance Framework, the NHS organisation's Data Protection Policy and all other relevant policies and guidelines, and are appropriately trained and experienced.
9. I undertake to complete any progress and/or final reports as requested by the NHS organisation and understand that continuation of permission to conduct research within the NHS organisation is dependent on satisfactory completion of such reports.
10. I undertake to maintain a project file for this research in accordance with the NHS organisation's policy.
11. I take responsibility for ensuring that all serious adverse events are handled within the NHS organisation's policy for reporting and handling of adverse events.
12. I understand that information relating to this research, including the contact details on this application, will be held by the R&D office and may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.
13. I understand that the information contained in this application, any supporting documentation and all correspondence with the R&D office and/or the REC system relating to the application will be subject to the



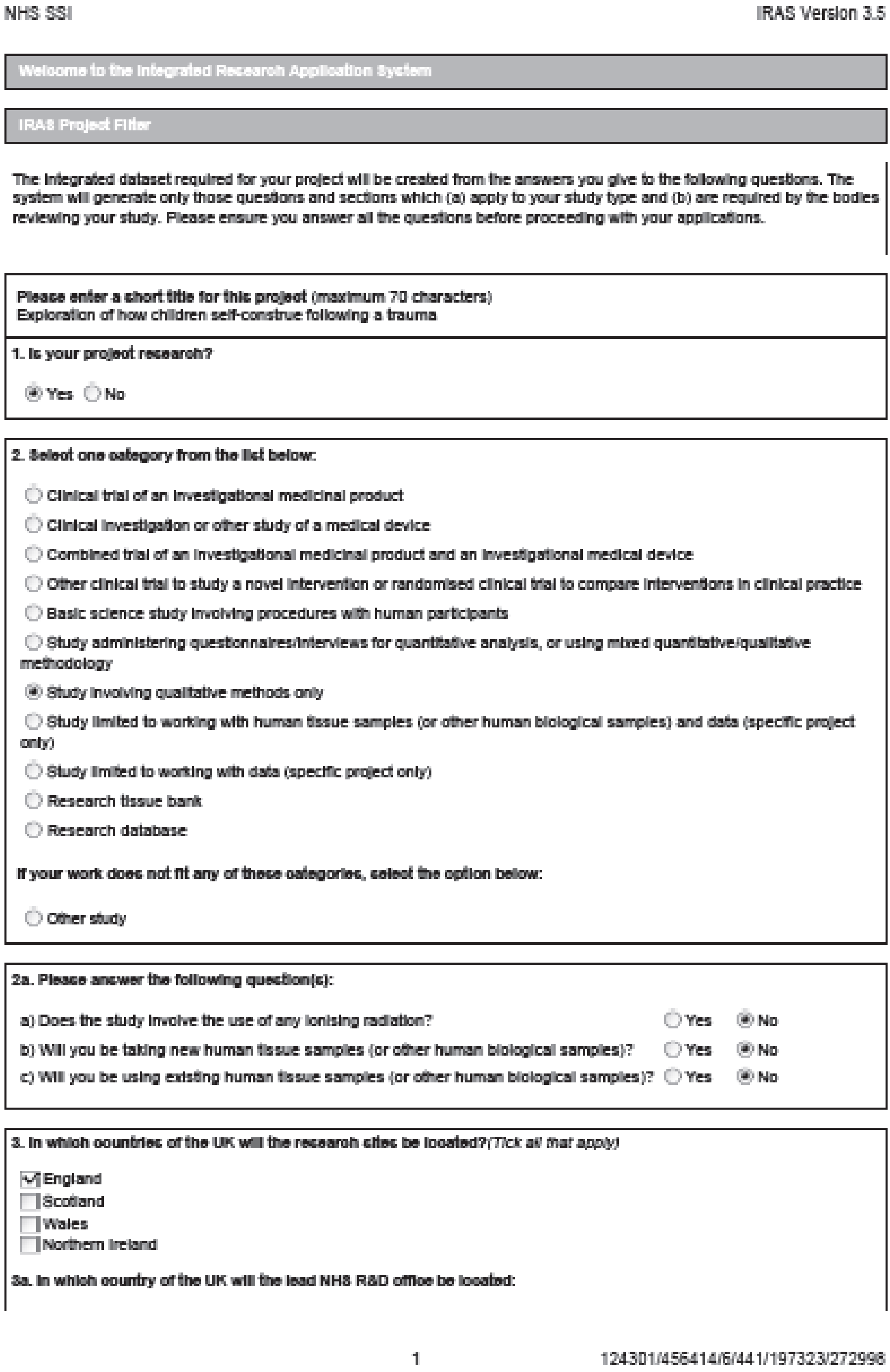
provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.

Signature of Principal Investigator or Local Collaborator: [redacted]............

Print Name: Amy D'Sa

Date: 14/05/2013

NHS Site-Specific Information (SS1) Application Form (Trust 2)



NHS SSI

IRAS Version 3.5

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
Exploration of how children self-construe following a trauma

1. Is your project research?

● Yes ○ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product
○ Clinical investigation or other study of a medical device
○ Combined trial of an investigational medicinal product and an investigational medical device
○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
○ Basic science study involving procedures with human participants
○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
● Study involving qualitative methods only
○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
○ Study limited to working with data (specific project only)
○ Research tissue bank
○ Research database

If your work does not fit any of these categories, select the option below:

○ Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	○ Yes	● No
b) Will you be taking new human tissue samples (or other human biological samples)?	○ Yes	● No
c) Will you be using existing human tissue samples (or other human biological samples)?	○ Yes	● No

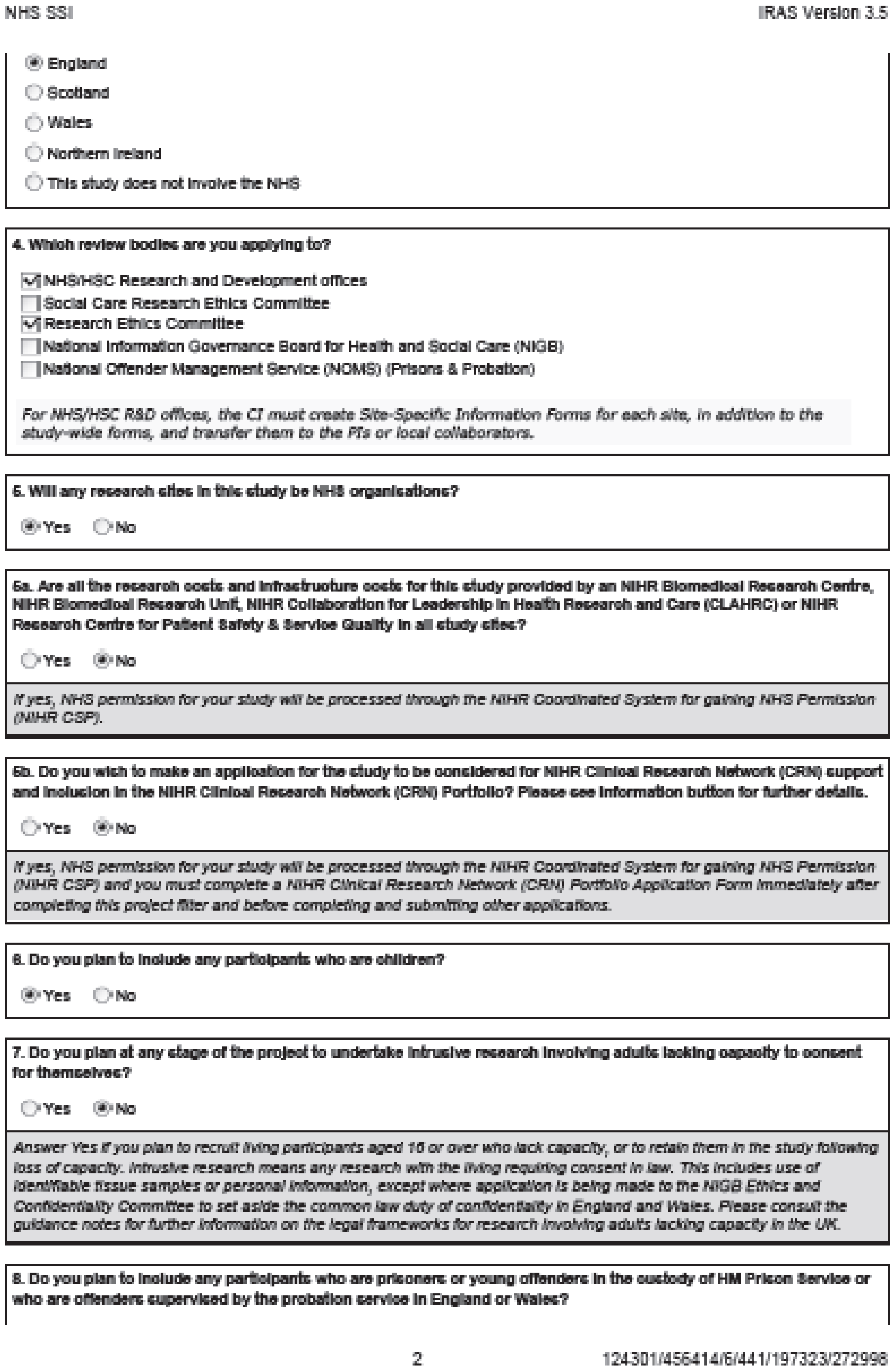
3. In which countries of the UK will the research sites be located?*(Tick all that apply)*

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

1

124301/456414/6/441/197323/272998



● England

○ Scotland

○ Wales

○ Northern Ireland

○ This study does not involve the NHS

4. Which review bodies are you applying to?

☑ NHS/HSC Research and Development offices
☐ Social Care Research Ethics Committee
☑ Research Ethics Committee
☐ National Information Governance Board for Health and Social Care (NIGB)
☐ National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D offices, the CI must create Site-Specific Information Forms for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.

5. Will any research sites in this study be NHS organisations?

● Yes ○ No

5a. Are all the research costs and infrastructure costs for this study provided by an NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC) or NIHR Research Centre for Patient Safety & Service Quality in all study sites?

○ Yes ● No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP).

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) support and inclusion in the NIHR Clinical Research Network (CRN) Portfolio? Please see information button for further details.

○ Yes ● No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP) and you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form immediately after completing this project filter and before completing and submitting other applications.

6. Do you plan to include any participants who are children?

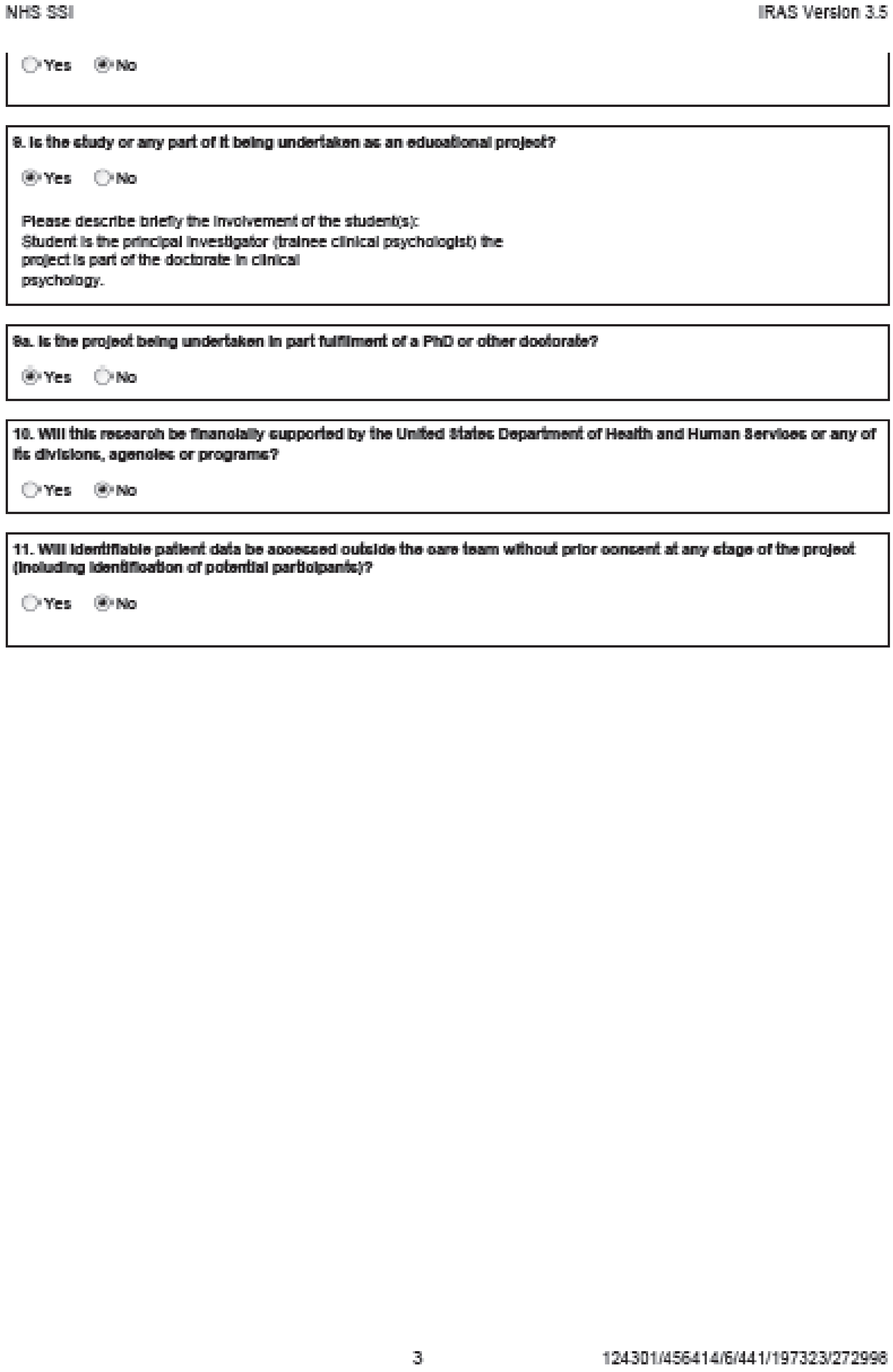
● Yes ○ No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ● No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the NIGB Ethics and Confidentiality Committee to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?



NHS SSI IRAS Version 3.5

○ Yes ● No

9. Is the study or any part of it being undertaken as an educational project?

● Yes ○ No

Please describe briefly the involvement of the student(s):
Student is the principal investigator (trainee clinical psychologist) the project is part of the doctorate in clinical psychology.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

● Yes ○ No

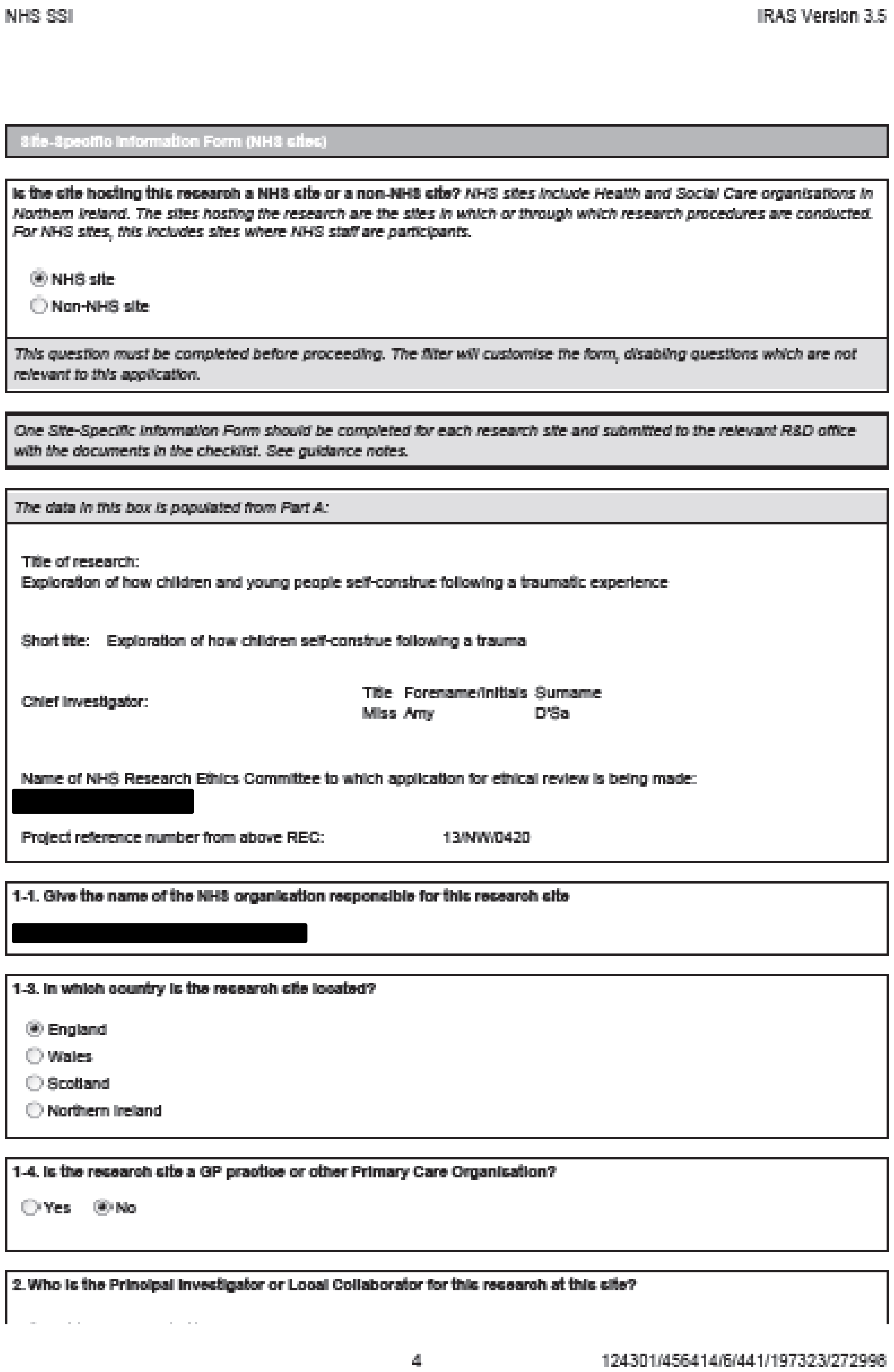
10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ● No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ● No

3 124301/456414/6/441/197323/272998



Site-Specific Information Form (NHS sites)

Is the site hosting this research a NHS site or a non-NHS site? *NHS sites include Health and Social Care organisations in Northern Ireland. The sites hosting the research are the sites in which or through which research procedures are conducted. For NHS sites, this includes sites where NHS staff are participants.*

● NHS site
○ Non-NHS site

This question must be completed before proceeding. The filter will customise the form, disabling questions which are not relevant to this application.

One Site-Specific Information Form should be completed for each research site and submitted to the relevant R&D office with the documents in the checklist. See guidance notes.

The data in this box is populated from Part A:

Title of research:
Exploration of how children and young people self-construe following a traumatic experience

Short title: Exploration of how children self-construe following a trauma

Chief Investigator:

Title	Forename/Initials	Surname
Miss	Amy	D'Sa

Name of NHS Research Ethics Committee to which application for ethical review is being made:
[redacted]

Project reference number from above REC: 13/NW/0420

1-1. Give the name of the NHS organisation responsible for this research site

[redacted]

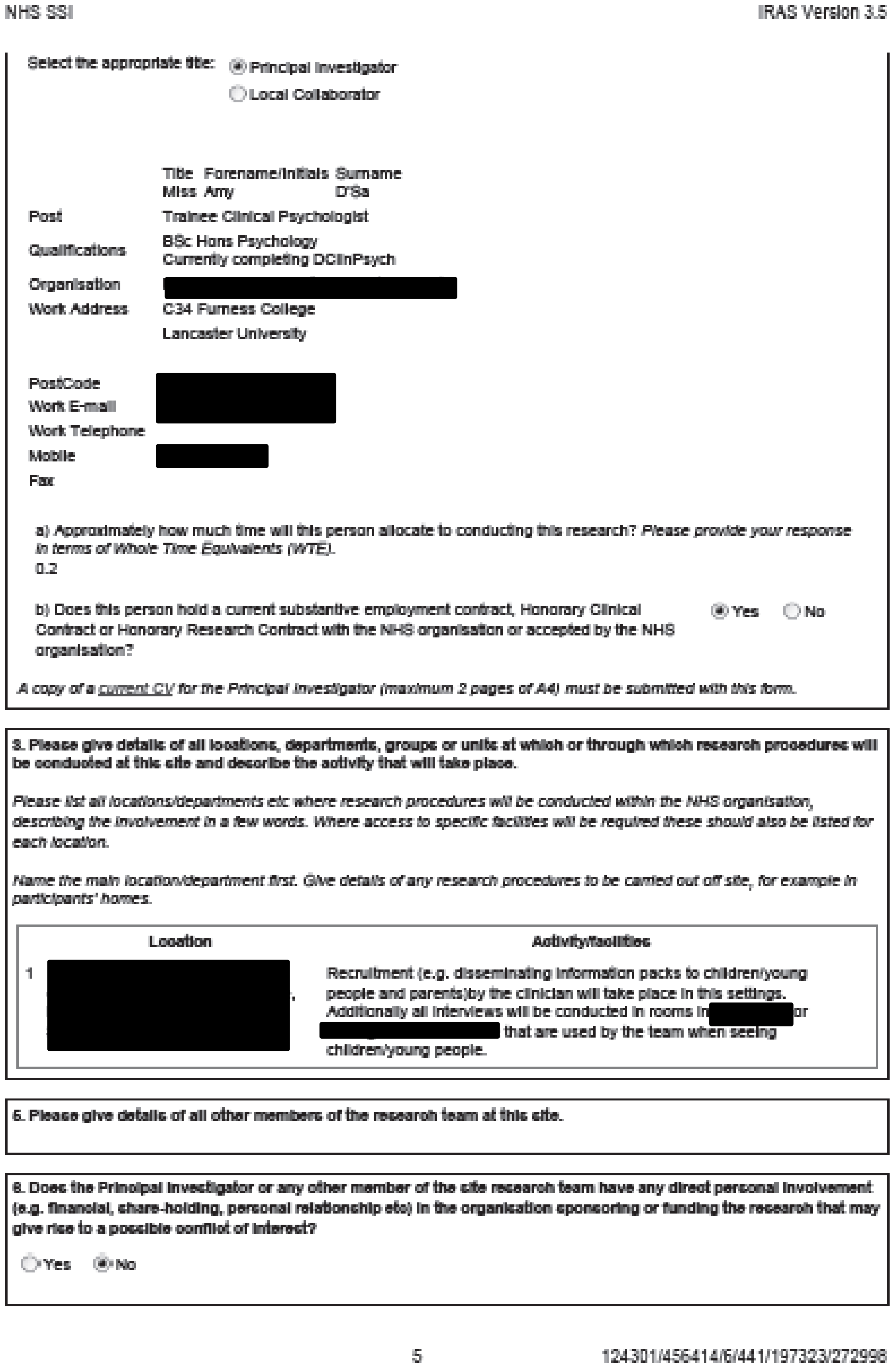
1-3. In which country is the research site located?

● England
○ Wales
○ Scotland
○ Northern Ireland

1-4. Is the research site a GP practice or other Primary Care Organisation?

○ Yes ● No

2. Who is the Principal Investigator or Local Collaborator for this research at this site?



NHS SSI IRAS Version 3.5

Select the appropriate title: ● Principal Investigator
○ Local Collaborator

	Title	Forename/Initials	Surname
	Miss	Amy	D'Sa

Post	Trainee Clinical Psychologist
Qualifications	BSc Hons Psychology Currently completing DClinPsych
Organisation	[redacted]
Work Address	C34 Furness College Lancaster University
PostCode	[redacted]
Work E-mail	
Work Telephone	
Mobile	[redacted]
Fax	

a) Approximately how much time will this person allocate to conducting this research? *Please provide your response in terms of Whole Time Equivalents (WTE).*
0.2

b) Does this person hold a current substantive employment contract, Honorary Clinical Contract or Honorary Research Contract with the NHS organisation or accepted by the NHS organisation? ● Yes ○ No

A copy of a *current CV* *for the Principal Investigator (maximum 2 pages of A4) must be submitted with this form.*

3. Please give details of all locations, departments, groups or units at which or through which research procedures will be conducted at this site and describe the activity that will take place.

Please list all locations/departments etc where research procedures will be conducted within the NHS organisation, describing the involvement in a few words. Where access to specific facilities will be required these should also be listed for each location.

Name the main location/department first. Give details of any research procedures to be carried out off site, for example in participants' homes.

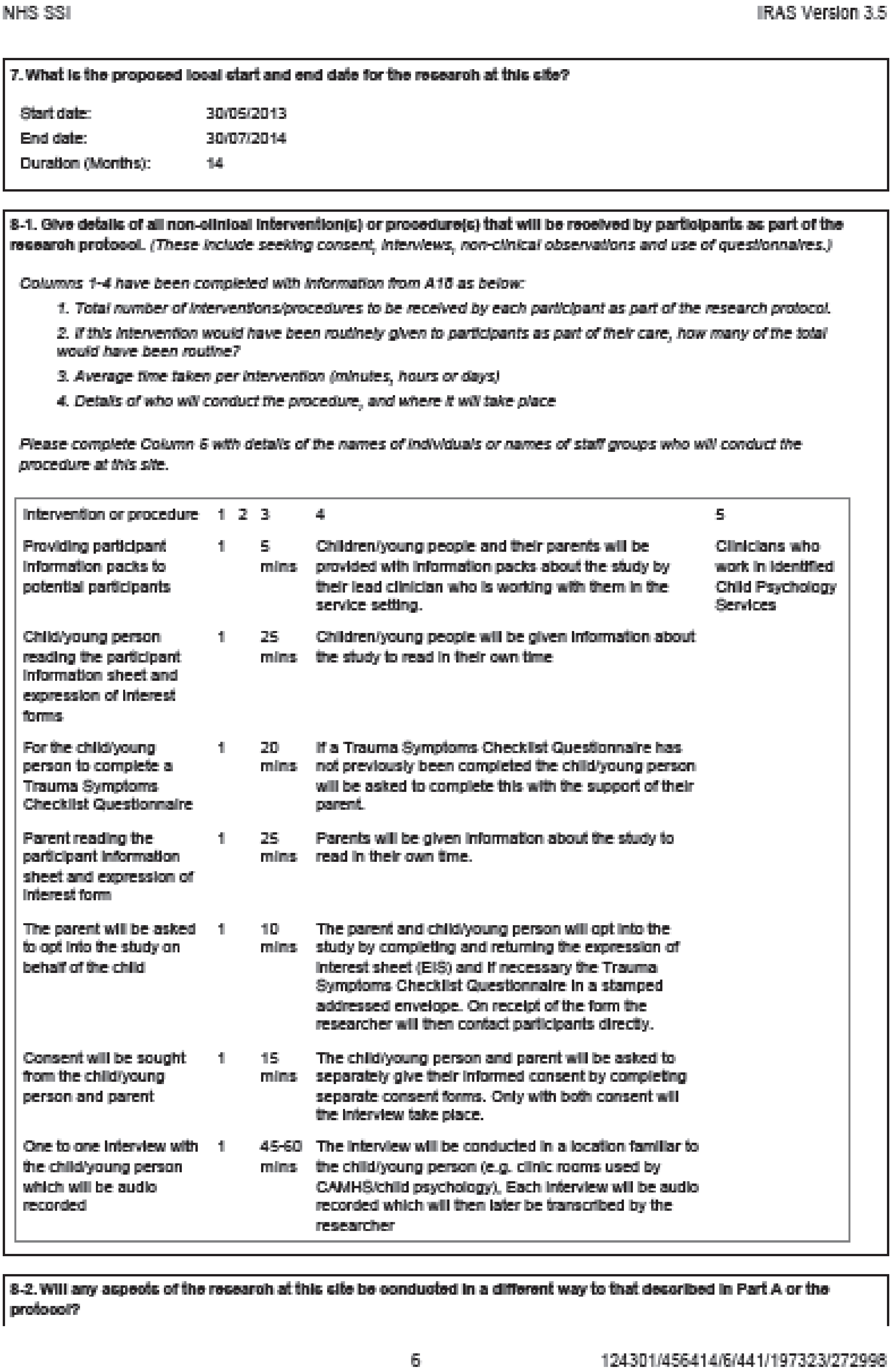
	Location	Activity/facilities
1	[redacted]	Recruitment (e.g. disseminating information packs to children/young people and parents)by the clinician will take place in this settings. Additionally all interviews will be conducted in rooms in [redacted] or [redacted] that are used by the team when seeing children/young people.

5. Please give details of all other members of the research team at this site.

6. Does the Principal Investigator or any other member of the site research team have any direct personal involvement (e.g. financial, share-holding, personal relationship etc) in the organisation sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ● No

5 124301/456414/6/441/197323/272998



7. What is the proposed local start and end date for the research at this site?

Start date:	30/05/2013
End date:	30/07/2014
Duration (Months):	14

8-1. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *(These include seeking consent, interviews, non-clinical observations and use of questionnaires.)*

Columns 1-4 have been completed with information from A18 as below:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.

2. If this intervention would have been routinely given to participants as part of their care, how many of the total would have been routine?

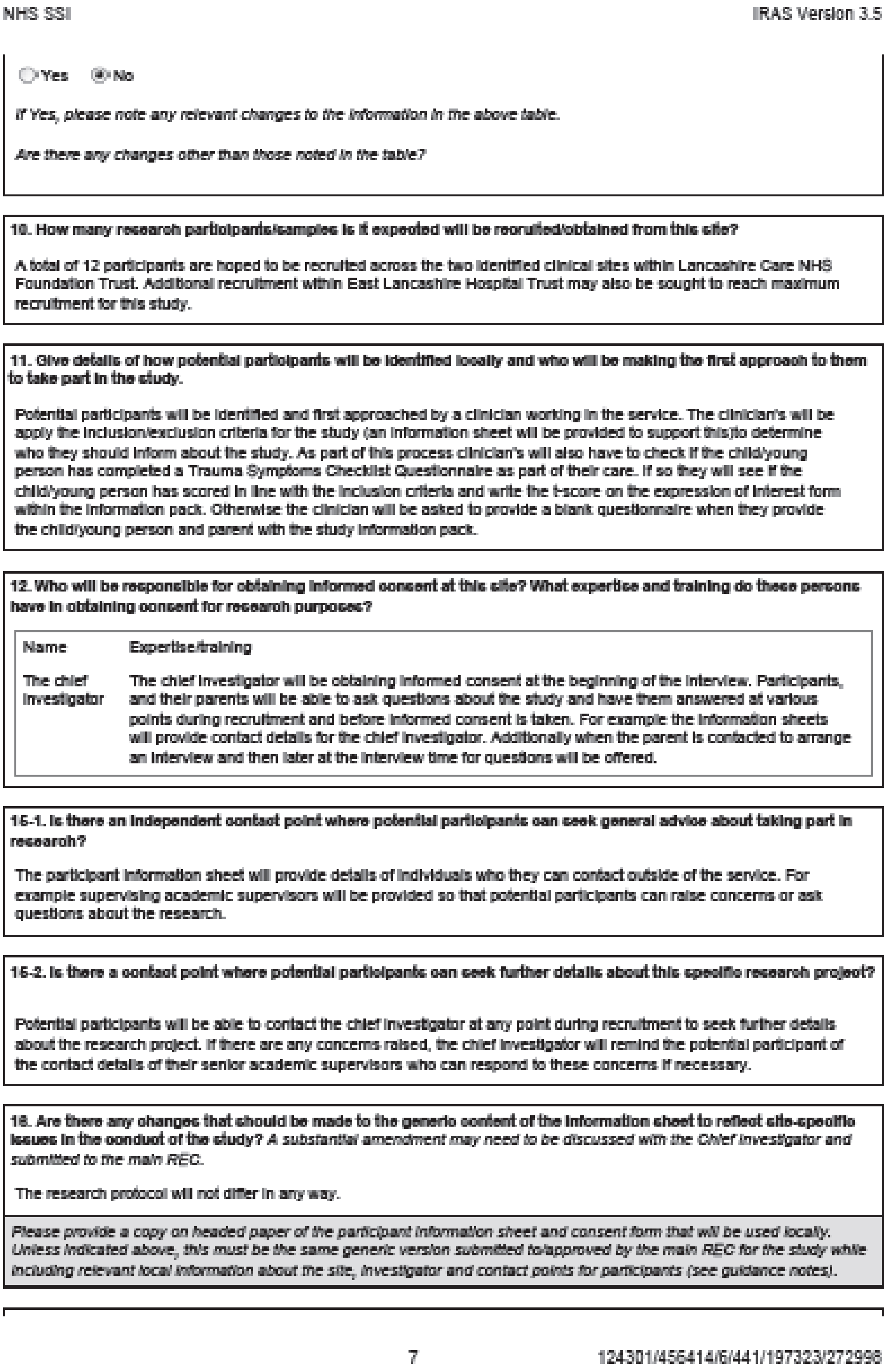
3. Average time taken per intervention (minutes, hours or days)

4. Details of who will conduct the procedure, and where it will take place

Please complete Column 5 with details of the names of individuals or names of staff groups who will conduct the procedure at this site.

Intervention or procedure	1	2	3	4	5
Providing participant information packs to potential participants	1		5 mins	Children/young people and their parents will be provided with information packs about the study by their lead clinician who is working with them in the service setting.	Clinicians who work in identified Child Psychology Services
Child/young person reading the participant information sheet and expression of interest forms	1		25 mins	Children/young people will be given information about the study to read in their own time	
For the child/young person to complete a Trauma Symptoms Checklist Questionnaire	1		20 mins	If a Trauma Symptoms Checklist Questionnaire has not previously been completed the child/young person will be asked to complete this with the support of their parent.	
Parent reading the participant information sheet and expression of interest form	1		25 mins	Parents will be given information about the study to read in their own time.	
The parent will be asked to opt into the study on behalf of the child	1		10 mins	The parent and child/young person will opt into the study by completing and returning the expression of interest sheet (EIS) and if necessary the Trauma Symptoms Checklist Questionnaire in a stamped addressed envelope. On receipt of the form the researcher will then contact participants directly.	
Consent will be sought from the child/young person and parent	1		15 mins	The child/young person and parent will be asked to separately give their informed consent by completing separate consent forms. Only with both consent will the interview take place.	
One to one interview with the child/young person which will be audio recorded	1		45-60 mins	The interview will be conducted in a location familiar to the child/young person (e.g. clinic rooms used by CAMHS/child psychology), Each interview will be audio recorded which will then later be transcribed by the researcher	

8-2. Will any aspects of the research at this site be conducted in a different way to that described in Part A or the protocol?



○ Yes ● No

If Yes, please note any relevant changes to the information in the above table.

Are there any changes other than those noted in the table?

10. How many research participants/samples is it expected will be recruited/obtained from this site?

A total of 12 participants are hoped to be recruited across the two identified clinical sites within Lancashire Care NHS Foundation Trust. Additional recruitment within East Lancashire Hospital Trust may also be sought to reach maximum recruitment for this study.

11. Give details of how potential participants will be identified locally and who will be making the first approach to them to take part in the study.

Potential participants will be identified and first approached by a clinician working in the service. The clinician's will be apply the inclusion/exclusion criteria for the study (an information sheet will be provided to support this)to determine who they should inform about the study. As part of this process clinician's will also have to check if the child/young person has completed a Trauma Symptoms Checklist Questionnaire as part of their care. If so they will see if the child/young person has scored in line with the inclusion criteria and write the t-score on the expression of interest form within the information pack. Otherwise the clinician will be asked to provide a blank questionnaire when they provide the child/young person and parent with the study information pack.

12. Who will be responsible for obtaining informed consent at this site? What expertise and training do these persons have in obtaining consent for research purposes?

Name	Expertise/training
The chief investigator	The chief investigator will be obtaining informed consent at the beginning of the interview. Participants, and their parents will be able to ask questions about the study and have them answered at various points during recruitment and before informed consent is taken. For example the information sheets will provide contact details for the chief investigator. Additionally when the parent is contacted to arrange an interview and then later at the interview time for questions will be offered.

15-1. Is there an independent contact point where potential participants can seek general advice about taking part in research?

The participant information sheet will provide details of individuals who they can contact outside of the service. For example supervising academic supervisors will be provided so that potential participants can raise concerns or ask questions about the research.

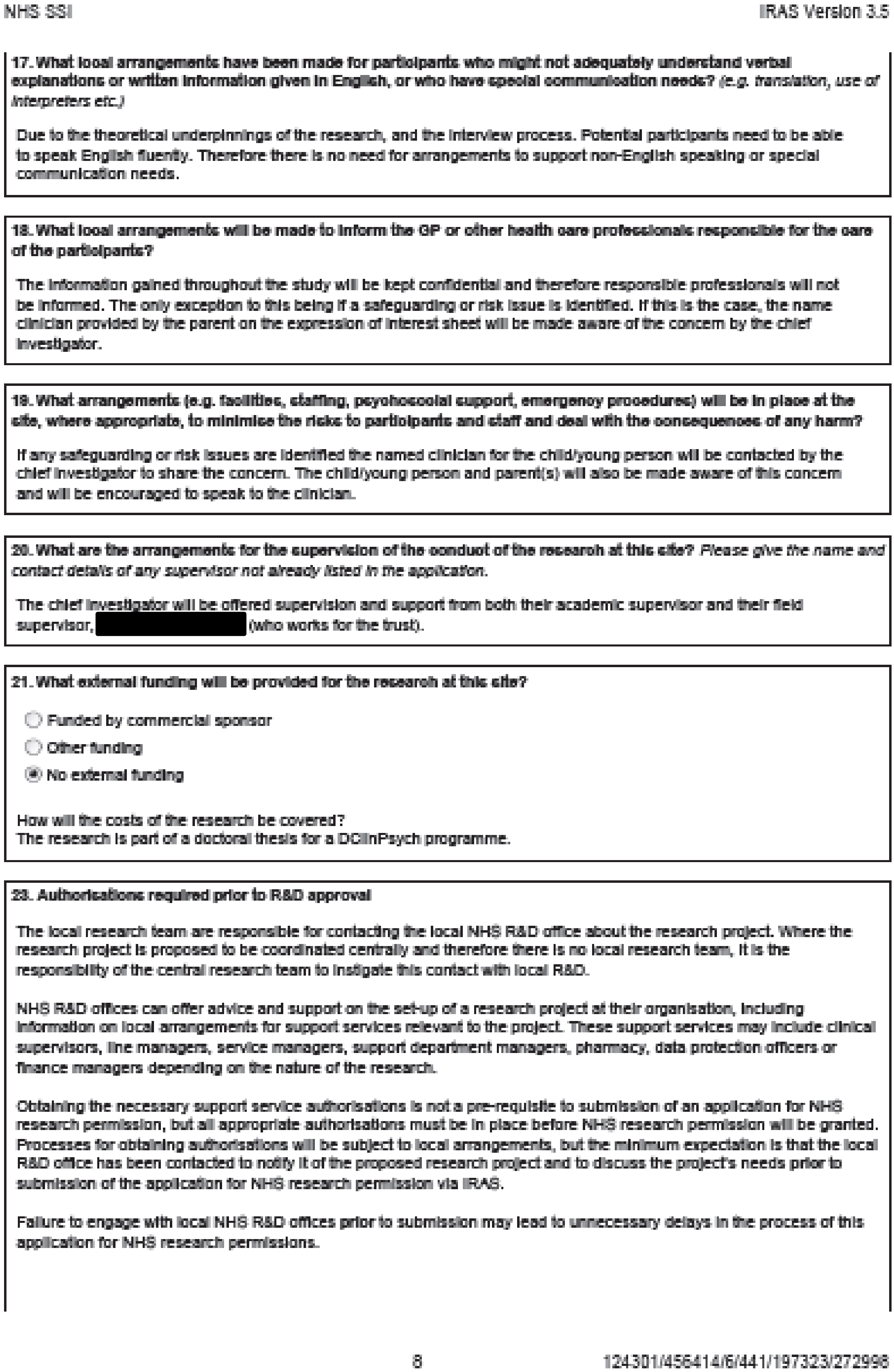
15-2. Is there a contact point where potential participants can seek further details about this specific research project?

Potential participants will be able to contact the chief investigator at any point during recruitment to seek further details about the research project. If there are any concerns raised, the chief investigator will remind the potential participant of the contact details of their senior academic supervisors who can respond to these concerns if necessary.

16. Are there any changes that should be made to the generic content of the information sheet to reflect site-specific issues in the conduct of the study? *A substantial amendment may need to be discussed with the Chief Investigator and submitted to the main REC.*

The research protocol will not differ in any way.

Please provide a copy on headed paper of the participant information sheet and consent form that will be used locally. Unless indicated above, this must be the same generic version submitted to/approved by the main REC for the study while including relevant local information about the site, investigator and contact points for participants (see guidance notes).



17. What local arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? *(e.g. translation, use of interpreters etc.)*

Due to the theoretical underpinnings of the research, and the interview process. Potential participants need to be able to speak English fluently. Therefore there is no need for arrangements to support non-English speaking or special communication needs.

18. What local arrangements will be made to inform the GP or other health care professionals responsible for the care of the participants?

The information gained throughout the study will be kept confidential and therefore responsible professionals will not be informed. The only exception to this being if a safeguarding or risk issue is identified. If this is the case, the name clinician provided by the parent on the expression of interest sheet will be made aware of the concern by the chief investigator.

19. What arrangements (e.g. facilities, staffing, psychosocial support, emergency procedures) will be in place at the site, where appropriate, to minimise the risks to participants and staff and deal with the consequences of any harm?

If any safeguarding or risk issues are identified the named clinician for the child/young person will be contacted by the chief investigator to share the concern. The child/young person and parent(s) will also be made aware of this concern and will be encouraged to speak to the clinician.

20. What are the arrangements for the supervision of the conduct of the research at this site? *Please give the name and contact details of any supervisor not already listed in the application.*

The chief investigator will be offered supervision and support from both their academic supervisor and their field supervisor, [redacted] (who works for the trust).

21. What external funding will be provided for the research at this site?

○ Funded by commercial sponsor
○ Other funding
● No external funding

How will the costs of the research be covered?
The research is part of a doctoral thesis for a DClinPsych programme.

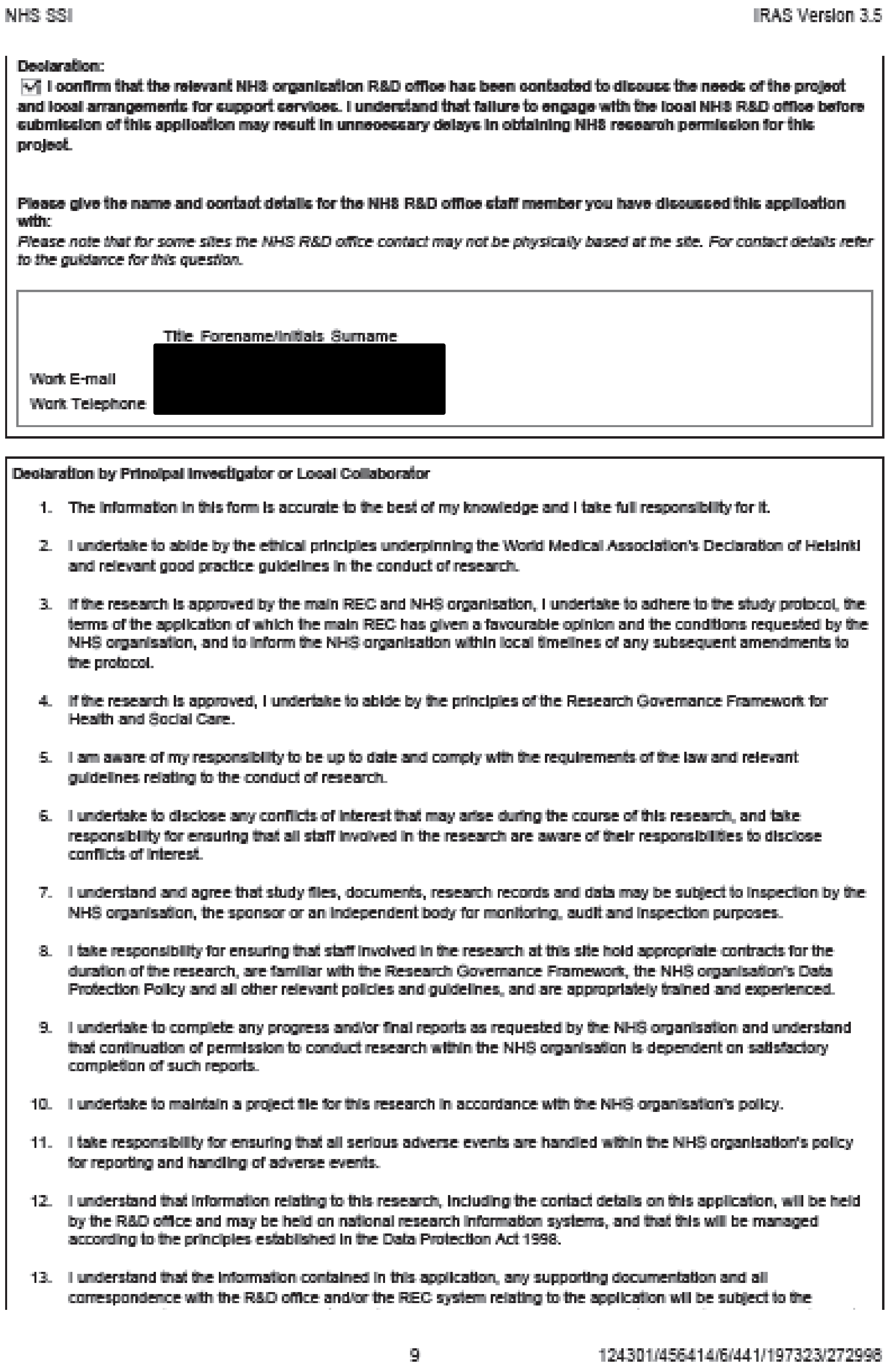
23. Authorisations required prior to R&D approval

The local research team are responsible for contacting the local NHS R&D office about the research project. Where the research project is proposed to be coordinated centrally and therefore there is no local research team, it is the responsibility of the central research team to instigate this contact with local R&D.

NHS R&D offices can offer advice and support on the set-up of a research project at their organisation, including information on local arrangements for support services relevant to the project. These support services may include clinical supervisors, line managers, service managers, support department managers, pharmacy, data protection officers or finance managers depending on the nature of the research.

Obtaining the necessary support service authorisations is not a pre-requisite to submission of an application for NHS research permission, but all appropriate authorisations must be in place before NHS research permission will be granted. Processes for obtaining authorisations will be subject to local arrangements, but the minimum expectation is that the local R&D office has been contacted to notify it of the proposed research project and to discuss the project's needs prior to submission of the application for NHS research permission via IRAS.

Failure to engage with local NHS R&D offices prior to submission may lead to unnecessary delays in the process of this application for NHS research permissions.



NHS SSI IRAS Version 3.5

Declaration:

☑ **I confirm that the relevant NHS organisation R&D office has been contacted to discuss the needs of the project and local arrangements for support services. I understand that failure to engage with the local NHS R&D office before submission of this application may result in unnecessary delays in obtaining NHS research permission for this project.**

Please give the name and contact details for the NHS R&D office staff member you have discussed this application with:

Please note that for some sites the NHS R&D office contact may not be physically based at the site. For contact details refer to the guidance for this question.

Title Forename/Initials Surname

Work E-mail

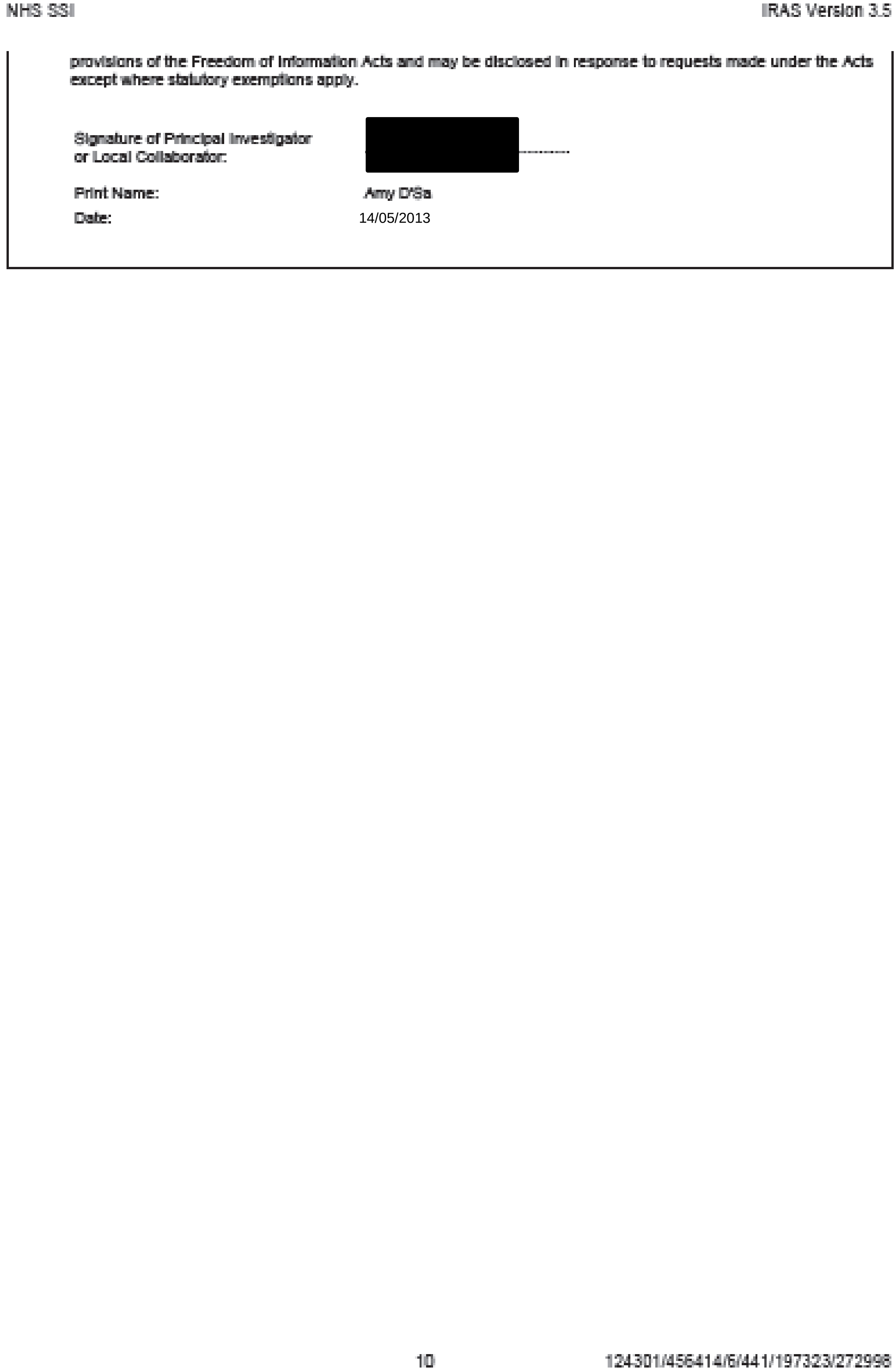
Work Telephone

[redacted]

Declaration by Principal Investigator or Local Collaborator

1. The information in this form is accurate to the best of my knowledge and I take full responsibility for it.
2. I undertake to abide by the ethical principles underpinning the World Medical Association's Declaration of Helsinki and relevant good practice guidelines in the conduct of research.
3. If the research is approved by the main REC and NHS organisation, I undertake to adhere to the study protocol, the terms of the application of which the main REC has given a favourable opinion and the conditions requested by the NHS organisation, and to inform the NHS organisation within local timelines of any subsequent amendments to the protocol.
4. If the research is approved, I undertake to abide by the principles of the Research Governance Framework for Health and Social Care.
5. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to the conduct of research.
6. I undertake to disclose any conflicts of interest that may arise during the course of this research, and take responsibility for ensuring that all staff involved in the research are aware of their responsibilities to disclose conflicts of interest.
7. I understand and agree that study files, documents, research records and data may be subject to inspection by the NHS organisation, the sponsor or an independent body for monitoring, audit and inspection purposes.
8. I take responsibility for ensuring that staff involved in the research at this site hold appropriate contracts for the duration of the research, are familiar with the Research Governance Framework, the NHS organisation's Data Protection Policy and all other relevant policies and guidelines, and are appropriately trained and experienced.
9. I undertake to complete any progress and/or final reports as requested by the NHS organisation and understand that continuation of permission to conduct research within the NHS organisation is dependent on satisfactory completion of such reports.
10. I undertake to maintain a project file for this research in accordance with the NHS organisation's policy.
11. I take responsibility for ensuring that all serious adverse events are handled within the NHS organisation's policy for reporting and handling of adverse events.
12. I understand that information relating to this research, including the contact details on this application, will be held by the R&D office and may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.
13. I understand that the information contained in this application, any supporting documentation and all correspondence with the R&D office and/or the REC system relating to the application will be subject to the

9 124301/456414/6/441/197323/272998



provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.

Signature of Principal Investigator or Local Collaborator: [redacted]

Print Name: Amy D'Sa

Date: 14/05/2013

Research Protocol for NHS Ethics Application

Version 1.0 13.04.13

Research Protocol

Title: Exploration of how children and young people self-construe following a traumatic experience

Name of applicant/researcher: Amy D'Sa
Position: Trainee Clinical Psychologist at Lancaster University
E-mail: a.dsa@lancaster.ac.uk
Telephone: 07870895230
Address: Division of Health Research, C16 Furness College,
Lancaster University, Lancaster, Lancashire, LA1 4YF, UK

Project supervisor(s), if different from applicant:

Name: Dr Pete Greasley (Teaching Fellow/ Thesis Supervisor)
Dr Pete Greasley, C12 Furness College, Lancaster University, DClinPsy programme
E-mail: greaslep@exchange.lancs.ac.uk

Name: Dr Joanne Robinson (Field Supervisor)
Dr Joanne Robinson, Senior Clinical Psychologist, Child Psychology and ELCAS (East Lancashire Child and Adolescent Service), Lancashire Care Foundation Trust and East Lancashire Hospital Trust Foundation Trust
E-mail: Joanne.Robinson@elht.nhs.uk

Introduction

The way a child thinks about themselves (self-construes) has a wide reaching impact on their mental health throughout their life, and their ability to form and maintain relationships (Evans, 1994). Therefore the way a child thinks about themselves is considered important in informing a their social and emotional growth (Kagen, Moore, & Bredekamp, 1995; Shavelson, Hubner and Stanton, 1976).The more positive a child or young person's self-concept is (e.g., I am a 'good' person), the better able they are to manage difficult circumstances that might arise (Elmer, 2001, Showers, 1992). Research on self-concept and overall well-being remains minimal (Marsh, Ellis & Craven, 2002) and focused on the developmental differences that influences how a child's or young person thinks about themselves (Evans, Brody & Noam, 2001).

Given the important role self-concept plays in a child's development, it is imperative to consider how this might be influenced, particularly for children and young people who have experienced some adverse or traumatic experience, and therefore are likely to access mental health services in line with national guidance (NICE, 2005). One definition of trauma states the individual will have had a ' unique experience of an event or enduring conditions in which the individual's ability to integrate his/her emotional experience is overwhelmed and the individual experiences (either objectively or subjectively) a threat to his/her life, overall integrity or that of a caregiver or family member (Saakvitne et al. 2000).

Traumatic experience, whether bullying or more extreme forms of abuse, have a meaningful impact on a child or young person. Finkelhor & Browne (198, p.531) argued trauma impacts a child's "cognitive and emotional orientation to the world, and create trauma by distorting children's self-concept, world view, and affective capacities." Therefore, research is needed to consider the specific and important ways a traumatic event might impact on how a child or young person thinks about themselves (e.g., develop their self-concepts). This could provide vital information which could inform clinical practice, such as interventions supporting children and young people developing more positive self-concepts.

Adult models that attempt to conceptualise the impact of trauma (e.g. Sewell, 1996) argue that trauma leads adults to have disconnected ways of thinking about themselves which are considered to be negative and invalidating (Sermpezi & Winter, 2009). Where thoughts about self-relating to traumatic experience (e.g. trauma specific self-constructs) are kept separate to other parts of self (non-trauma specific self-constructs). Additionally the quality of trauma related self-constructs (ways of thinking about oneself) are seen to be less rich and lack quality. In contrast to this argument, recent and opposing research suggests adults respond to trauma by thinking about themselves in ways that are directly and more globally influenced by the traumatic experience. This in turn is seen to negatively impact on the individuals emotional wellbeing and how they interaction with others and the world. For example the ways of thinking about themselves (e.g. I am worthless) will negatively influence the adult's emotional well-being (e.g. low mood) and relationships (e.g. isolate self).

Although research considering adult trauma models is evolving, a comparison of adult and child trauma responses have yet to me made, also more importantly, child specific trauma models are underdeveloped. By researching how a child or young person thinks about themselves following a trauma, this could help to articulate the impact trauma has which would be valuable in informing understanding and potentially highlighting the specific experiences and needs children and young people have that may differ meaningfully from adults. Therefore, in response to this, this study is interested in exploring how children and young people make sense of themselves (self-construe) following a difficult or traumatic experience.

This research will be informed by Personal Construct Theory (PCT) which suggests that the way a person thinks about themselves (self-construes) is complex and multi-dimensional (Harter, 1999). Similarly, Robinson (2012) defined a self-construct as "a means of whereby a child verbally makes discriminations about the world and in relation to self and others". PCT methodology will also be used during the interview as it has been developed specifically to identify an individual's self-constructs. PCT methodology has been seen to be especially useful when working with children (Hayhow, Lansdown, Maddick & Ravenette, 1988), partly because it considers the process of self-construing as ever changing, which fits with child development (Bell & Bell, 2008) and because its methods are creative and therefore appropriate and accessible for children.

Method:

Participants

Potential participants will be identified by applying the following inclusion and exclusion criteria. This will be done initially by clinicians who are working in the service (as requested in a covering letter to clinician's, see Appendix 1.) in accordance with the guidance set out in their clinician information sheets (CIS, see Appendix 2.).

Inclusion criteria

- The child/young person must be between the ages of 8-16
- The child must have attended 3 clinical appointments with the service which suggest engagement with the service and support networks
- An identified clinician must be named on the consent form; this relates to ways of responding to safeguarding or risk issues in the chance these were to be raised.
- Both the parent and child/young person must give their informed consent (signed consent forms)
- The child/young person must have completed a Trauma Symptoms Checklist and scored below a cut-off point of
- The child/young person is identified by a clinician as being appropriate to take part.

Exclusion Criteria

- Children/young people who do not speak English will be excluded from the study
- Children/young people are not in a 'stable' environment (e.g. cared for children, not attending mainstream school, active safeguarding issues) will be excluded from the study
- Children/young people scoring highly on the Trauma Symptoms Checklist will be excluded from the study
- The child/young person is identified by a clinician as not being appropriate to take part.

Design

This study will employ a qualitative design by conducting developmentally appropriate semi-structured interviews with children and young people aged 8-16 years of age. Using a qualitative methodology will allow for a rich exploration of how a child or young person thinks about themselves, allowing their language to inform the studies themes and giving them a voice to inform understanding about the impact traumatic experiences has on them.

Materials

A Trauma Symptom Checklist for Children – Alternate (TSCC-A, Briere, 1996) is a validated self-report measure that measures trauma-related symptoms and can be administered to children between 8-16 years of age. A TSCC-A (see Appendix 7.) will be used as inclusion criteria as a way of determining if the child/young person has experienced a traumatic event and as a way of managing concern that a child/young person might get distressed during taking part. Only children/young people who score under an identified cut of point will be provided with the information pack.

An example Interview Schedule (see Appendix 10.) has been developed to outline of how the interview will be conducted and to show the types of questions and prompts that will be used to explore the child/young person's self-concepts through elaborating on their picture (which within Personal Construct Theory is called a self-characterisation). This may be adapted at a later date.

Procedure

To support recruitment the researcher will plan to attend different professional forums to promote the research and raise clinician awareness of how they can inform appropriate children, young people and their parent(s) about the research. This may include attending team meetings, Trauma SPIG and a Post-trauma clinic.

Recruiting Participants:

The clinician working with the child/ young person will be asked to initially identify those they feel are appropriate to take part (e.g. appear to meet inclusion criteria). As part of this process (See diagram, Appendix 15) the clinicians will be asked to check if a Trauma Symptoms Checklist (TSCC-A) has been completed as routine within the service. If the TSCC-A has been carried out and the child/young person is under the cut off high score (part of inclusion criteria), the clinician will provide a copy of information pack to the child/young person and parent(s) which informs them to complete the Expression of Interest Form (EIS) if they wish to take part. However if a TSCC-A has not been completed then a blank copy will be included in the information pack about the study.

The information pack provided to the child/young person and parent(s) will include:

- Covering letter to parent (see Appendix 3.)
- Participant information sheets (PIS two versions)
    - A child/young person information sheet (see appendix 4):
    - A parent information sheet (see appendix 5.)
- Expression of Interest Form (EIS, see Appendix 6.), for the parent to provide details so they can be contacted to take part.
- Trauma Symptoms Checklist (TSCC-A, see Appendix 7.) either blank if not completed or the clinician will have written the t-score on the EIF before giving the pack to the family.

Both versions of the PIS will articulate clearly that the study is interested in 'how the child or young person thinks about themselves following a scary experience'. However it will be explicit that the interviewer is not going to ask about the scary experience at any point during the process of the child/young person taking part.

Once the chief investigator has received a completed EIS and TSCC-A score (e.g. completed form or t-score on the EIS) that meet with the study's inclusion and exclusion criteria, they will contact the potential participant's parent. In the case that a TSC has been completed for the first time and the child/young person scores is above the cut off high score the family will be contacted and informed that the child/young person will not be able to take part in an appropriate and sensitive way. If the child/young person is being asked to take part, this phone contact will offer an opportunity for the parent and child/young person to ask any questions or concerns they have about the study. An interview time will then be arranged with consent from both the parent and child/young person.

Formal consent will be recorded on separate consent forms before the interview takes place (Child/young person consent form and Parental consent form). Confidentiality will be explicitly stated in the PIS's so that the child/young person and parent are not concerned that information shared in the interview will be disclosed to professionals or family members unless risk is identified.

During the 45-60 minute interview the child/young person will be asked to creatively engage in a process of exploring the way they think about themselves (self-construe) in a safe and age appropriate manner. For example, Robinson (2012) argued for mixed methods to meet the needs of child/young person taking part in research. Also by using PCT informed questioning, this will allow for the child/young person to be supported in gaining a full understanding of how they think about themselves (express their self-constructs, Bell & Bell, 2008).

The child/young person will then be asked to complete a drawing as a form of a pictorial self-characterisation (drawing e.g. 'think about yourself and draw a picture', see example Interview Schedule). Ravenette (2003), an educational psychologist, developed this method of appropriately eliciting self-concepts with children. According to the PCT approach what or how the child chooses to draw is irrelevant, it provides a context for understanding and exploring the child's world including themselves through discussion that follows (Bell & Bell, 2008). For example, the theory underpinning this approach would argue that the way a child thinks about themselves (e.g. I am a 'good' person), will reflect how they see others (e.g. others are 'good'), and the world (e.g. the world is a 'good' place).

The semi-structured interview following the drawing will allow the researcher to support the child in safely exploring what the child symbolically produces. To illustrate this, Bell and Bell (2008) described their analysis of Tim's drawing which included a giraffe and koala. Their PCT informed questions included; what would be good about being a giraffe? How are the koala and the giraffe different? Do you think you are more like a giraffe or a koala? Through this exploration they were able to explore how Tim thought about himself, his world and others. Using this creative method of drawing might feel safer for a child/young person as a process they are familiar with (e.g. school) and might also feel more comfortable than solely using conversation (Marsh et al, 2002; Ravenette, 1997). To complete the interview process the child/young person will be supported debriefed to make sure that they are ok to end the interview and are not distressed. A fun exercise may be used with younger children to facilitate the debriefing process.

The interviews will be audio recorded to allow the researcher to be able to full attend to the child's/young person's needs and the material generated during the interview process. All the data from the interviews, including the drawing, will be fully anonymised; also recordings will be encrypted and stored safely on a password protected computer. Only the researcher will be responsible for transcribing the interviews.

If recruitment is problematic or consent is declined at any time, recruitment will continue. Reminders to take part in the study will not be sent directly to the families as recruitment is occurring within a therapeutic contact with a clinician and this could make taking part feel more pressured. Instead clinician's will be sent reminders to encourage them to consider who they feel might be suitable to take part. Also asking them to use their discretion with the families they have already approached if it is felt to be appropriate and not detrimental for them to remind families of the study.

Proposed analysis

The data will undergo a Thematic Analysis which will allow for a flexible approach to analysis that will provide rich accounts of the child/young person's experience. It will allow for patterns of themes to be identified, analysed and reported. This will be informed by guidance offered by Braun and Clarke (2006). This will include a process of becoming familiar with the data through transcribing the interview verbatim, reading and re-reading the data and noting down initial thoughts on the transcript. Then slowly codes will be introduced and linked to the raw data, this process will highlight aspects of interest from each transcript. Codes will then be collated across transcripts to identify potential themes. Evidence to support the emerging themes will be gathered, these will aim to define aspects of the interview that represent something of perceived importance to the research question. A process of checking and reviewing themes within individual transcripts and across all transcripts will take place. This will be followed by a continued process of naming and renaming themes to create a clear, comprehensive and representative name for each. Sub themes will be created to demonstrate the diversity and complexity within themes. Themes developed will then be checked by both research and field supervisors to ensure that they represented the data collected.

Practical issues:

Data will be stored electronically on a password protected computer and adhere to Data Protection Act and Caldicotts Principles. It has been checked with the local Research and Development team that this will also meet their requirements. All information provided is confidential and will be held by the interviewer/main researcher. The audio record of the interview will be destroyed after being transcribed by the interviewer. All data will be automatically anonymised and saved securely on a password protected computer.

The chief investigator will have to book rooms in the relevant clinician sites as and when interviews can be arranged.

Ethical concerns

Due to the nature of the study, and that it is recruiting children and young people who have experienced some type of traumatic event (e.g. bullying), this might concern the children/young people who are being asked to take part, as well as their parent(s) or clinicians. Therefore several measures have been taken to address these concerns while being transparent about why the child/young person has been asked to take part.

Firstly, in all interactions with individuals who are being asked to contribute to this study, including all information provided, it will be explicit that the interviewer is not going to explicitly discuss or promote the child/young person discussing their traumatic experiences, nor is the research a form or alternative to a therapeutic intervention. For example, the child or young person will not be asked to make sense of or disclose details of their traumatic experience or identify how they subsequently cope. Although this will be stated at various points in setting up the project, recruitment and the interview process, potential participants and their parent(s) will also be encouraged and offered time to ask and have answered any questions before giving or continuing to give their consent.

Through applying the inclusion and exclusion criteria for this study, it is hoped that this will reduce the possibility of children/young people finding the process to upsetting. For example by only recruiting children/young people who have attended three appointments suggests that engagement has been established with the clinician in the service, and that the child/young person has a support network available to them. Similarly, by excluding children/young people who are cared for, not attending mainstream school, or have active safeguarding issues raised, it is hoped that children/young people who are in less ‘stable’ environments and therefore are potentially more vulnerable to distress are not asked to take part. Lastly, by having the child or young person complete a Trauma Symptoms Checklist Questionnaire before taking part in the interview, those scoring highly will not be included. Therefore those who may still be more affected by the trauma (e.g. score highly), or where the trauma maybe less processed, will not be asked to take part.

Importantly, the boundaries of the interview will be articulated at the beginning of the interview to allow children/young people to be reminded firstly, that they will not be asked to talk about the ‘scary’ thing that happened, and secondly, that the interview is different to the types of conversations they have with their clinician. To promote the child or young person feeling able to actively engage or disengage during the process, they will be encouraged to ask to have a break or stop the interview at any point if they feel they want to. The child or young person will also be aware that their parents will be available outside of the interview room.

Although the reason for recruiting the child or young person is potentially emotive, it is not anticipated that interview will cause distress to participants. In the case that a child/young person does become distressed or that they talk about their difficult emotions, the interviewer will manage this in a sensitive way. Firstly, this will be done by acknowledging the child/young person’s distress while bringing the interview to a close. The child/young person will then be asked if they wish to continue or if they want to withdraw their participation. The emotive material raised by the child/ young person will lead the interviewer to emphasis their researcher’s role while encouraged the child/young person to discuss their distress with their clinician and or parent. With the child or young person’s permission their parent and or clinician will be informed in general and nonspecific terms that they had got upset during the interview process so that this may be followed up.

The Participant Information Sheets (PIS) provided by in the information pack will make potential participants aware that only the researcher/chief investigator will be involved in the interview and the following research process. Additionally, the Expression of Interest Form (EIF) will ask for the EIF to be returned to the investigator before arranging an interview can take place. Although a named clinician will be identified for the purposed of responding to any safeguarding issues in the chance this may occur, confidentiality will be explained in all versions of the participant information and signed consent forms. Confidentiality will be explained to apply to all information generated in the interview unless risk is identified. The information sheets will also outline the processes that will take place if the researcher is required to break confidentiality.

As recruitment will involve a clinician providing information packs to the family, and given interviews will take place in the clinical sites that the child/young person receives their input from (e.g. CAMHS and child psychology services) this may lead families to be concerned about the impact participation may or may not have on the care they receive. In order to manage this difficulty, the PIS will clearly state that participation is voluntary and that this will have no impact on care received. This will be reiterated on the consent form and in person at the interview. Additionally the participants will be made aware that the researcher is not an employee of the CAMHS or child psychology services.

All data and information collected throughout this project will be fully anonymised, remain confidential and be kept safely and securely on password protected computers as encrypted files. No one from the clinical sites will have access to any of this information, for example only the researcher and academic supervisor will have access to the transcripts. All children/young people who take part will be encouraged to choose their own pseudonym to be used when writing up the research.

The potential sample pool is across 2 clinical sites and 6 teams. Trauma presentations are being specifically considered in a current Trauma Audit of referrals across services. Anecdotally, one team has approximately 10 referrals a week, where 4 of the 10 are expected to involve a trauma experience. Although it is hoped that 12 participants will give their consent to take part, it is possible that the young persons, their parents and clinicians will decide not to take part. Nevertheless it is felt that a smaller participant pool would still offer valuable data and insight that could suggest how children or young people self-concepts are informed by difficult and traumatic experiences.

Additionally the researcher has been informed by guidance that considers interviewing children and young people. This allowed the researcher to thinking around the ethical issues that might be raised and how these might be managed. This included considering; ten topics for considerations in ethical research with children as defined by Alderson (1995), Alderson & Morrow (2004), the practical guidance on consulting and conducting research and working in participative ways with children and young people experiencing domestic abuse (Scottish Government Social Research, 2009), A guide to actively involving young people in research (Kirby, 2004), Developing ethical guidelines for safeguarding children during research (Furey et al, 2010), MRS Guidelines for Research with Children and Young People (MRS, 2012).

Timescale:

Following ethical approval the following proposed timescales will be followed:

April-June 2013:

- Finalise and gain ethical approval and R& D approval/Amendments if necessary

June-October 2013:

- Data collection/pilot study if necessary
- Develop strategy for coding data

October-December 2013:

- Transcription and analysis.

March 2014:

- Hand in complete draft of research paper by end of March

April 2014:

- Making revisions
- Submit thesis for soft binding by end of April

May 2014: Final submission.

June 2014: Viva

References

Alderson, P. (1995). Listening to children. *Children, ethics and social research*. London: Barnardo's

Alderson, P. & Morrow, V.(2004). *Ethics, social research and consulting with children and young people.* Barkingside: Barnado's

Bell, S.J. & Bell, R.C. (2008). An illustration of self-characterisation in a child's drawing: the importance of the process. *Personal Construct Theory*. London: Wiley-Blackwell

Butler, R.J. (2001). *The self-image profiles*. London: The Psychological Corporation.

Butler, R.J. & Green, S.L. (1998). *A child within*. Oxford: Butterworth-Heninemann

Briere, J. (1996). *A Trauma Symptom Checklist for Children (TSCC) professional manual.* Odessa, FL: Psychological Assessment Resources.

Elmer, N. (2001). *Self-esteem: The costs and causes of low self-worth*. York: Joseph Rowntree Foundation, York Publishing Service Ltd

Evans, D.W, Brody, L., & Noam, G.G. (2001). Ego Development, Self-Perception, and Self-Complexity in Adolescence: A Study of Female Psychiatric Inpatients. *American Journal of Orthopsychiatry*, 71(1), 79-86. doi:10.1037//0002-9432.71.1.79

Evans, D.W. (1994). Self-complexity and its relation to development, symptomatology and self-perception during adolescence. *Child Psychiatry and Human Development,* 24(3), 120-127. doi:10.1007/BF02353194

Fiukelhor, D.. & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualisation. *American*
Journal of Orthopsychiatry, 66(4), 530 541.

Furey, R., Kay, J., Barley, R., Cripps, C., Shipton, L. and Steill, B. (2010). Developing ethical guidelines for safeguarding children during research. *Research Ethics Review, 6(4), 120-127.*

Hayhow,R., Lansdown, R., Maddick, J. & Ravenette, T. (1988). PCP and children. In Fransella, F. & Thomas, L. (Eds). *Experimenting with personal construct psychology*. London: Routledge & Keegan Paul (pp. 199-209).

Harter, S. (1999). *The construction of the self: A developmental perspective.* New York: Guilford Press.

Kagen, S. L., Moore, E., & Bredekamp, S. (1995). *Considering children's early development and learning: Toward common views and vocabulary* (Report No. 95-03). Washington, DC: National Education Goals Panel.

NICE (2005). Quick Reference Guide: Post-traumatic stress disorder (PTSD):The management of PTSD in adults and children in primary and secondary care. London. Retrieved from: http://www.nice.org.uk/nicemedia/pdf/CG026quickrefguide.pdf

Marsh, H.W. Ellis, L.A. & Craven, R.G. (2002). How Do Preschool Children Feel About Themselves? Unravelling Measurement and Multidimensional Self-Concept Structure. *Developmental Psychology*, 38(3), 376-393. DOI: 10.1037//0012-1649.38.3.376.

M.R.S. (2012). M.R.S. Guidelines for Research with Children and Young People. Retrieved from: http://www.mrs.org.uk/pdf/2012-02 23%20Children%20and%20Young%20People%20Research %20Guidelines.pdf

Ravenette, A.T. (2003). Constructivist intervention when children are presented as problems. Ch 28 in Fransella, F. (Ed.) *International handbook of personal construct psychology*. Chichester: Wiley (pp.283-293).

Ravenette, A.T. (1997). Selected papers. Personal construct psychology and the practice of an educational psychologist. Great Britain: ECPA Publications.

Robinson, J. (2012). Understanding how Young Children View Themselves: A Personal Construct Approach. Cited in: Giliberto, M., Dell'Aversano, C.,Velicogna, F. (2012*). PCP and Constructivism: ways of working, learning and living.* Proceedings of the XVIIIth International Congress on personal construct psychology. Libri:Liberisrh.

Saakvitne, K. W., Gamble, S., Pearlman, L., & Lev, B. (2000). Risking connection: A training curriculum for working with survivors of childhood abuse. Lutherville, MD: Sidran Press.

Sermpezis, C. & Winter, D.A. (2009) Is Trauma the Product of Over- or Under-Elaboration? A Critique of the Personal Construct Model of Posttraumatic Stress Disorder, *Journal of Constructivist Psychology, 22*, 306 — 327.

Sewell, K., W., Cromwell, R.L., Farrell-Higgins, J., Palmer, R., Ohlde, C., & Patterson, T.W. (1996). Hierarchical elaboration in the conceptual structure of Vietnam veterans. *Journal of Constructivist Psychology, 9*, 79-96.

Sermpezis, C. & Winter, D.A. (2009) Is Trauma the Product of Over- or Under-Elaboration? A Critique of the Personal Construct Model of Posttraumatic Stress Disorder, *Journal of Constructivist Psychology, 22*, 306 — 327.

Shavelson, R.J. Hubner, J.J. & Stanton, G.C. (1976). Self-Concept: Validation of Construct Interpretations. *Review of Educational Research*, 46(3), 407-441. doi:10.2307/1170010

Showers, C. (1992). Compartmentalization of positive and negative self-knowledge: Keeping bad apples out of the bunch. *Journal of Personality and Social Psychology.* 62, 1036-1049. doi:10.1037//0022-3514.62.6.1036

Stafford, A., & Smith, C. (2009). Practical guidance on consulting, conducting research and working in participative ways with children and young people experiencing domestic abuse. Scottish Government Social Research. Retrieved from: http://www.scotland.gov.uk/Resource/Doc/284756/0086482.pdf

Appendix 4-A: Covering letter to clinician's Version 1.0 13.04.13

LANCASTER
UNIVERSITY

DIVISION OF HEALTH RESEARCH
Doctorate In Clinical Psychology

Address:

Date:

Dear Colleague/Mental Health Professional,

My name is Amy D'Sa and I am a Trainee Clinical Psychologist who is studying for my Doctorate in Clinical Psychology at Lancaster University. As part of this I am undertaking a research project looking at **how children and young people self-construe (think about themselves) following a traumatic experience**. The purpose of the study is to provide insight and understanding into the effects of a traumatic experience on children and young people (8-16 years old) and how this might influence their concept of self. This is particularly important as how a child thinks about themselves informs the way they express their emotions and develop relationships.

I would therefore like to inform you about the project and ask for your support in identifying children/young people who may be appropriate to take part. I have attached an information sheet and checklist to explain what I am hoping you will be able to do to support me in recruiting for this study.

If you have any questions about this study please feel free to contact me on the above number, details are on the information sheet provided.

Thank you for your time,

Yours sincerely,

Amy D'Sa
Trainee Clinical Psychologist

Appendix 4-B: Clinician Information Sheet Version 1.0 13.04.13

Clinician's Information Sheet

LANCASTER UNIVERSITY
DIVISION OF HEALTH RESEARCH
Doctorate In Clinical Psychology

Study Title: 'Exploration of how children and young people self-construe following a traumatic experience'

My name is Amy D'Sa and I am a Trainee Clinical Psychologist who is conducting this research as part of the Doctoral Clinical Psychology course at Lancaster University, Lancaster, United Kingdom.

What is the study about?
The purpose of the study is to provide an insight and understanding into the effects of a traumatic experience on children and young people (8-16ys) and how this might influence their concept of self. Research looking at adult responses to trauma suggested this has a negative impact on how adults think about themselves and their emotional wellbeing. Unfortunately, little research has been conducted to understand how children and young people are affected.

Children and young people are developing all the time, and one important aspect of this is their 'self-concept' or the way they think (construe) about themselves. The way a child/young person thinks about themselves is important as it informs the way they interact, manage their emotions and form relationships. Therefore this study is extremely interested on exploring how children/young people see themselves following these experiences.

Why have I been approached?
I am aiming to recruit children/young people who have experienced some form of trauma (e.g. bullying to more complex abuse) to take part in this study. However I want to make sure that this is done in a thoughtful way, where more vulnerable children/young people are not included. Therefore it feels extremely important to asking you, as the clinician involved, to consider who may be more appropriate to take part.

The study aims to recruit children/young people who have experienced a life event that has impact on emotional wellbeing, and meet the following criteria:

- Are between the ages of 8-16
- Have attended 3 or more clinical appointments within the service
- Have identified a named clinician on their consent form
- Where both the parent and child/young person have given their informed consent (signed consent form)
- Where the child/young person has completed a Trauma Symptom Checklist and scored below a maximum cut of point (this is available within your services resources).
- You, as a clinician feel the child/young person is appropriate to take part

Please exclude children/young people who meet the following criteria:

- Are not in a stable environment (e.g. are a cared for child/young person, are not attending mainstream school, there are active safeguarding issues).
- Do not speak English fluently

What am I being asked to do?

All you are being asked to do is identify appropriate participants by applying the above criteria and then providing them with information packs (please see attached flowchart). Importantly, this includes checking if the child/young person has completed a Trauma Symptom Checklist for Children and scoring it;

a. If the measure has been completed and the PTS T-score is the lower that the cut of score of 80, please provide the family with the information pack having already written on the t-score on the expression of interest form.
If you have any questions about administering or scoring the TSCC-A please contact me or ask Dr Joanne Robinson, Clinical Psychologist in the Blackburn with Darwen ELCAS team who is the trauma lead for the service.

b. If the measure has not been completed, please provide a new copy of the TSCC-A with the information pack.

c. BUT, if the measure has been completed and the PTS T-score matches the same or higher than the cutoff point of 80, please do not provide the child and family with the information pack as the child will not be able to take part.

How will the child and family indicate they want to take part?
The information pack you will give to the child/young person and parent will provide them with information sheets about the study. If the child/young person and parent are happy to take part they will be instructed to complete the expression of interest form. This will provide contact details which will allow for them to be contacted toarrange a suitable interview.

Why will the parent(s) be asked to identify a clinician on the expression of interest form?
This information will be collected but only used for two reasons:

1. In the case that any safeguarding issues are raised during the interview process. I will then contact that clinician to inform them of the concern. Otherwise all information generated during the research will remain confidential.
2. If the child/young person had to complete a Trauma Symptoms Checklist Questionnaire. They will be returned to me with the expression of interest form. Once scored I will return this original and only copy of the questionnaire to the named clinician to be placed in the child/young person's clinical notes.

What will the child/young person be asked to do in the interview?
The child will then be asked to take part in a one to one interview with myself, which could take up to 45-60 minutes and will take place in the building where the child/young person receives support from your service. Their parent(s) will be asked to stay in the building during this time.

On the day of the interview both the child/young person and their parent will be given an opportunity to ask any questions before completing a consent form.

Following this the child/young person's interview will include:

- The child/young person being reminded that the interview is about 'how you think about yourself. Although one of the reasons you have been asked is because something scary or worrying may have happened I will not be asking you to tell me about this'.
- The child/young person being asked to draw a picture in response to the prompt: 'Think about yourself and draw a picture'
- The child/young person will then be supported in discussing their picture
- As the interview comes to an end the child/young person will be debriefed and may take part in a fun activity.

What will happen to the results of this study?
The results will be fully anonymised and summarised to form part of a Thesis which may be submitted for publication in an academic or professional journal. The child/young person and parent will be asked if they would like a summary sheet of findings. If so details will be taken so that this information can be sent directly. At no point during feeding back of findings will the child/young person be identifiable as having taken part.

What happens if the child/young person becomes distressed while taking part? Are there any risks in taking part?
As the interview is looking at how the child/young person thinks about themselves, it is not anticipated to be distressing. However it is possible that they could become upset during the process. If this is the case, I will manage this sensitive way using my skills from my training and the interview will be stopped. This will allow the child/young person to return to their parent if necessary and or decide if they wish to continue. I will be asking the child/young person for permission about sharing information about what upset during the process and encourage them to talk to you, or their parent about this. However the content of the interview will be remain confidential.

The exception to confidentiality is if the child/young person tells me anything that makes me think that they are or someone else is at significant risk of harm, I will then be obligated to break confidentiality and speak to named clinician identified on the expression of interest form. Wherever possible, I will tell the child/young person and parent about any concerns before taking this information to the named clinician. This will be discussed with the child/young person and parent in person before the interview but will be explicit on the participant information sheets and consent forms.

Are there any benefits of a child taking part?
Although I hope taking part will be interesting for the child/young person, there will be no direct benefits to them taking part. It is hoped that this study will help to inform theory and practice by exploring how children think about themselves following a trauma experience.

Who has reviewed the study?
The study has been reviewed and approved by the North West REC Committee. Additionally the Lancashire Care NHS Foundation Trust and East Lancashire Hospital Trust's Research and Development teams have given their approval.

Where can I obtain further information about the study if I need it?
If you have any questions about the study, please contact the main researcher:

Main Researcher: Amy D'Sa, Trainee Clinical Psychologist.
Email: a.dsa@lancaster.ac.uk
Phone: 07908613777

Or you may wish to contact my supervisors:

What do I do if I have any concerns about the research?
If you would like to voice any concerns or complaints about this study, you may contact:

Dr Craig Murray, Acting Research Director for Clinical Psychology Doctorate Programme at Lancaster University
Tel: (01524) 593378
Email: murrayc@exchange.lancs.ac.uk

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:
Professor Paul Bates Tel: (01524) 593718
Associate Dean for Research, Faculty of Health and Medicine, Lancaster University
Email: p.bates@lancaster.ac.uk

Thank you very much for your time.

Appendix 4-C: Covering letter to parent and child/young person Version 1.0 13.04.13

LANCASTER UNIVERSITY
DIVISION OF HEALTH RESEARCH
Doctorate In Clinical Psychology

Address:

Date:

Dear Parent/Guardian,

My name is Amy D'Sa and I am a Trainee Clinical Psychologist who is studying for my Doctorate in Clinical Psychology at Lancaster University. As part of this I am undertaking a research project looking at how children and young people think about themselves following a traumatic experience. Your child's clinician has provided you with this information pack because I would like to invite your son/daughter to take part in my study. Within this information pack are two information sheets, one for yourself, the other for your son/daughter to read. I would very much appreciate if you could read through this letter and the other information in this pack and discuss this with your son/daughter before deciding if your son/daughter would like to take part.

I have also enclosed an 'expression of interest form' and a stamped addressed envelope. Please return this form to me if you are happy to be contacted about your child taking part.

If you have any questions about this study please feel free to contact me using the details provided on the information sheet.

Thank you for your time,

Yours sincerely,

Amy D'Sa
Trainee Clinical Psychologist

Appendix 4-C: Child/young person information sheet Version 1.0 13.04.13

(To be shown/read to younger children and given to the young person by the parent)

LANCASTER UNIVERSITY
DIVISION OF HEALTH RESEARCH
Doctorate In Clinical Psychology

Child/Young Person Information Sheet

Study title

How children and young people think about themselves after something scary or worrying has happened.

You are being asked to take part in this research project. Please read or listen to this information which tells you what the study is about.

It is important that you understand what you will be asked to do. If there is anything that doesn't make sense or you would like to know more about, you can contact me as I am happy to tell you about this. You have time to decide if you would like to take part.

What is the study about?

The purpose of the study is to look at how children/young people think about themselves after something scary or worrying happens. Through you taking part and me listening we hope to understand this better.

Why have I been chosen?

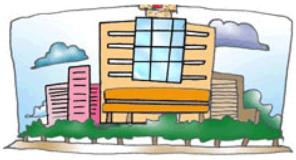
We would like to talk to children/young people, like you, who have been through something worrying or scary. Even though this is important reason for asking you to take part, you will not be asked to talk about this scary or worrying thing if you decide to take part.

Do I have to take part?

No. You do not have to take part if you don't wish to. It is up to you to choose and this is something to discuss with your parent(s). Even if you give your consent, you can stop taking part at any time, you don't have to say why.

What will happen to me if I take part?

You might be asked to complete a questionnaire called the 'Trauma Symptoms Checklist Questionnaire'. This is to help me know a little about the scary or worrying thing that happened before we meet.



Amy D'Sa will then arrange to meet with you in person. This will be in a familiar place, where you go to get support from the CAMHS/Child Psychology service. When you meet Amy she will not be asking you to tell her anything about the scary or worrying thing that happened.

Whoever brings you to this meeting will stay in the waiting area while you meet Amy.

So what will I have to do?

On the day you can ask Amy any questions before taking part and will be asked to write your name on a different sheet called a consent form.

Following this you will be asked to draw a picture. This picture can be of anything and can be drawn in any way. Amy will then spend some time with you talking about your picture. Then you will be asked to do a fun activity before the end.

Amy will audio record what you say to help her remember what you tell her.

Anything you say about yourself or your picture is private and won't be told to anyone else, unless you become upset. If you do become upset Amy will ask you if you want to go and be with your mum or dad and will make sure you are OK before going home. Amy will also ask you to let your mum/dad or someone at CAMHS/Child psychology know that you got upset. Amy will tell you if she needs to share any other information before she does.

How do I get to take part?
If you decide you would like to take part and have discussed this with your mum/dad, your mum/dad will be asked to follow the instructions on the *'Expression of Interest Form'*. This provides me with details so I can get in touch to arrange a time to meet you. This form also will ask your mum and dad to tell me your age, and a little about the scary or worrying thing that happened. This is up to you if you want to help fill this in.

Will I help anyone if I take part?
Taking part will not help you although we hope that it will help adults understand how you think about yourself a bit better. This could help kids like you in the future.

Will my taking part be kept private?
Yes. Anything you tell Amy will be keep private. Your answers might be written up for publication so I will ask you to tell me a name you want me to use instead of your own. All the information will be kept safe.

Who has looked at this project?
The study has been looked at I was told it was OK for me to do this research by the North West REC Committee. Additionally the Lancashire Care NHS Foundation Trust and East Lancashire Hospital Trust's Research and Development teams have given their approval.

If you have any questions about the study, please contact Amy D'Sa:

Email: **a.dsa@lancaster.ac.uk** **Phone:** 07908613777

Thank you very much for taking the time to read this.

Appendix 4-E: Parent Information Sheet Version 1.0 13.04.13

Parent Information Sheet

Study Title: 'Exploration of how children and young people think about themselves following a traumatic experience'

My name is Amy D'Sa and I am a Trainee Clinical Psychologist who is conducting this research as part of the Doctoral Clinical Psychology course at Lancaster University, Lancaster, United Kingdom.

Your child is being invited to take part in this study. The information below will explain what will be involved and how you can get in touch with me if you have any questions.

What is the study about?
The purpose of the study is to provide an insight and understanding into the effects of a traumatic experience on children and young people (8-16ys) and how this might influence their concept of self.

Children are developing all the time, and one important aspect of this is their 'self-concept' or the way they think about themselves. The way a child thinks about themselves is important as it informs the way they interact, manage their emotions and form relationships. Therefore this study is extremely interested on exploring how children see themselves following these experiences.

Why have my child and I been approached?
Your child's clinician has given this information pack to you on my behalf. This is because your child has experienced something scary or difficult and this may relate to the support they are receiving from the service. However, although this is a reason for your child being identified to take part in this study I am only interested in how your child thinks about themselves following this experience. Therefore your child will not be asked to discuss what 'scary' thing happened during any part of taking part in this research.

Does my child have to take part?
No. Your child is in no way obligated to take part in this study. Your child's decision to participate or not will have no impact on the care they receive or continue to receive within the service. Although your child's clinician provided you with the information about the study, they will not be involved in any further aspect of this study. Additionally, I am not employed by the service, and therefore will have no direct contact with your child in a clinical capacity.

What would taking part involve?
Before your child is invited to take part in the interview, they might be asked to complete a questionnaire. This is called the 'Trauma Symptoms Checklist Questionnaire'. As the interview is not going to involve talking to your child about the scary or difficult experience, this will provide the study with some background information. The questionnaire will be returned to your child's clinician to be kept safely and securely in their notes after the interview.

Your child will be asked to take part in a one to one interview with myself, which could take up to 45-60 minutes and will take place in the building where your child receives support from the service. You will be asked to stay in the building during this time. On the day of the interview you and your child will be given an opportunity to ask any questions before taking part and will be asked to both complete a consent form.

In the interview I will simply be asking your child to "think about yourself and draw a picture". It can be a picture of anything and, once they have completed it, we will talk about the picture they have drawn. At the end of the interview there will be asked about how they found the interview and will be asked to engage in a fun activity.

What do I need to do if my child wants to take part?
If you and your child both decide to take part, you will be asked to follow the instructions on the *'Expression of Interest Form'* within this pack. This provides me with contact details so I can get in touch to arrange an interview at a convenient time for you and your child. As soon as I receive this

information, I will be in touch. If your child is asked to complete the Trauma Symptoms Checklist Questionnaire, this is also to be returned with the Expression of Interest Form.

Lastly, you will be asked to name a clinician who is known to your child on the form. The information is essential for two reasons, firstly it is needed if your child completes the Trauma Symptoms Checklist Questionnaire this can be sent to your child's clinician to store safely. The second reason is stated below in the *'Limits to confidentiality'* section in blue.

If my child and I want to take part, do I need to send the form back by a certain date?
If your child would like to take part, please return the form as soon as possible, or within the next month. This will allow me to get in contact with you, and answer any questions as quickly as possible.

What will happen to the information collected if my child takes part?
All information is confidential. The interview will be audio recorded so that I can give my full attention to your child during the interview. This recording will be destroyed after it has been transcribed. All information provided during the study will be made anonymous and saved securely on an encrypted computer that only the researcher has access to. Any personalized information you provide will also be saved securely and destroyed when the project is submitted for academic marking. Only my Academic Supervisor and I will have access to the data, no clinical staff who worked in the service will have access to any of this information.

What will happen to the results of this study?
The results will be summarised and form part of a Thesis which may be submitted for publication in an academic or professional journal. I will ask you and your child if you would like a summary sheet of findings. If so I will take details of how you wish me to directly send you this information after the interview. All direct quotes used from your child's interview will be anonymous, and they will be encouraged to give me a name they wish me to use instead of their own. At no point you during the study or the feeding back of findings will your child be identified as having taken part.

Are there any risks in my child taking part?
As the interview is looking at how your child thinks about themselves, it is not anticipated to be distressing. However it is possible that your child could become upset during the process. If this is the case, I will manage this sensitively and the interview will be stopped. This will allow your child to return to you if necessary and or decide if they wish to continue. I will be asking your child for permission about how much they want me to share about them getting upset during the process and encourage them to talk to you, or their clinician in the service about this.

Are there any benefits to taking part?
Although I hope taking part will be interesting for you and your child, there will be no direct benefits to your child taking part. It is hoped that this study will help to inform professionals by learning more about how children think about themselves after a traumatic or distressing experience.

What do I do if I don't want my child's information or interview to be used?
You need to email or phone me, the main researcher (Amy D'Sa) using the details below within two week of your child's interview. All you need to do is state your name and that you want your data not to be used. A confirmation phone call will be made to let you know the action has been taken.

Who has reviewed the study?
The study has been reviewed and approved by the North West REC Committee. Additionally the Lancashire Care NHS Foundation Trust and East Lancashire Hospital Trust's Research and Development teams have given their approval

Where can I obtain further information about the study if I need it?
If you have any questions about the study, please contact the main researcher:

Main Researcher: Amy D'Sa, Trainee Clinical Psychologist.
Email: a.dsa@lancaster.ac.uk
Phone: 07908613777

Or you may wish to contact my supervisors:

What do I do if I have any concerns about the research?
If you would like to voice any concerns or complaints about this study, you may contact:

Dr Craig Murray, Acting Research Director for Clinical Psychology Doctorate Programme at Lancaster University
Tel: (01524) 593378
Email: murrayc@exchange.lancs.ac.uk

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:
Professor Paul Bates Tel: (01524) 593718
Associate Dean for Research, Faculty of Health and Medicine, Lancaster University
Email: p.bates@lancaster.ac.uk

Thank you very much for your time.

Appendix 4-F: Expression of interest form Version 1.0 13.04.13

LANCASTER
UNIVERSITY
DIVISION OF HEALTH RESEARCH
Doctorate In Clinical Psychology

Expression of Interest Form

Study Title: 'Exploration of how children and young people think about themselves following a traumatic experience'

Please reading and agree to the following before completing the rest of this form

- I have read and understood the 'Parent Information Sheet'.
- I have discussed this project with my son/daughter and supported them in reading the 'Child/Young Person Information Sheet'
- I would like to express my own and my son/daughter's interest in taking part in this study.
- I am aware that taking part is separate to and not therapy/additional support for my son/daughter.

Please complete the following:

Name of parent who wishes to be contacted on behalf of their child:	
N.B: please only provide contact details that you are happy to share.	
	Contact phone number:

Please complete the following details:

Your son/daughter's name	
Your son/daughter's current age	
Clinician (from CAMHS, Child Psychology) who gave you the information pack for this study/or is providing care for your son/daughter. [***essential]**	Name:
Please **either** enclose a completed Trauma Symptoms Checklist Questionnaire or make sure the named clinician has provide the **TSCC-A T-score** in the box **[*essential]**	**t-score:**

Returning the form

Please note that this form needs to be returned **as soon as possible** in the pre-paid envelope**.**

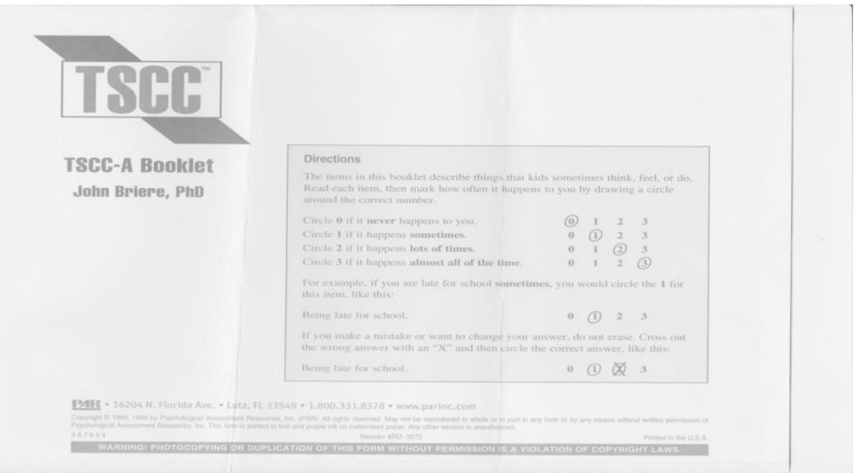
What to include in the envelope:

1. This form
2. Also if your son/daughter has been asked to complete the Trauma Symptoms Checklist Questionnaire please include this in the envelope. I will score this and then send it onto the clinician you name above who will put it safely in your son/daughters notes.

On receipt of this form I will contact you to arrange a suitable time for the interview. Information provided by this form or email will be kept safe and confidential.

Thank you for your time.

Appendix 4-G: Trauma Symptom Checklist for Children – Alternate 13.04.13



TSCC™

TSCC-A Booklet

John Briere, PhD

Directions

The items in this booklet describe things that kids sometimes think, feel, or do. Read each item, then mark how often it happens to you by drawing a circle around the correct number.

Circle **0** if it **never** happens to you.	⓪	1	2	3
Circle **1** if it happens **sometimes**.	0	①	2	3
Circle **2** if it happens **lots of times**.	0	1	②	3
Circle **3** if it happens **almost all of the time**.	0	1	2	③

For example, if you are late for school **sometimes**, you would circle the **1** for this item, like this:

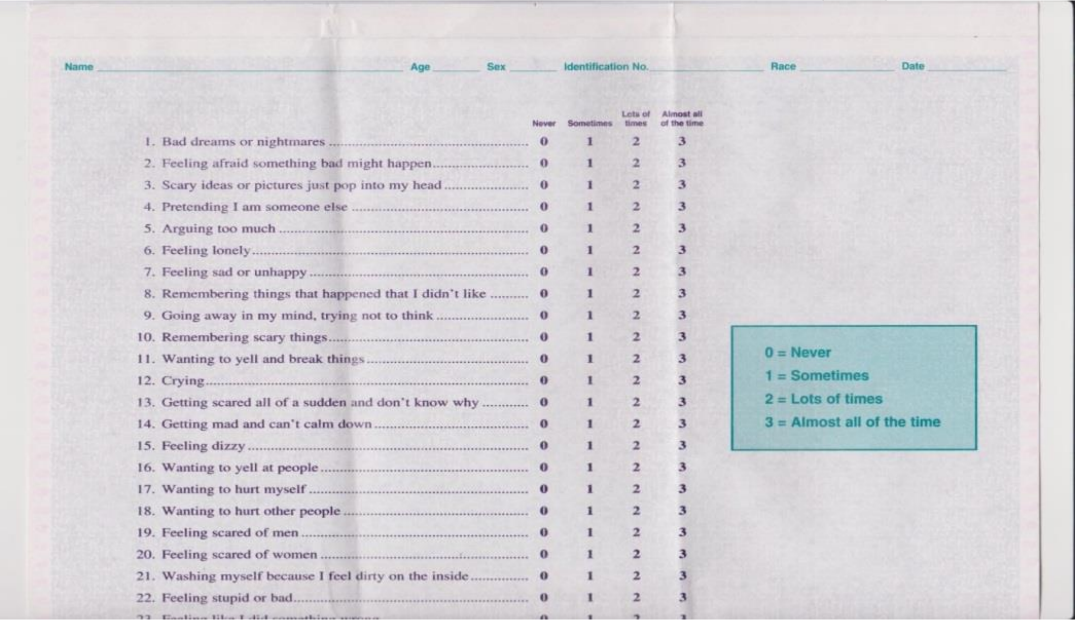
Being late for school.	0	①	2	3

If you make a mistake or want to change your answer, do not erase. Cross out the wrong answer with an "X" and then circle the correct answer, like this:

Being late for school.	0	①	~~②~~	3

PAR • 16204 N. Florida Ave. • Lutz, FL 33549 • 1.800.331.8378 • www.parinc.com

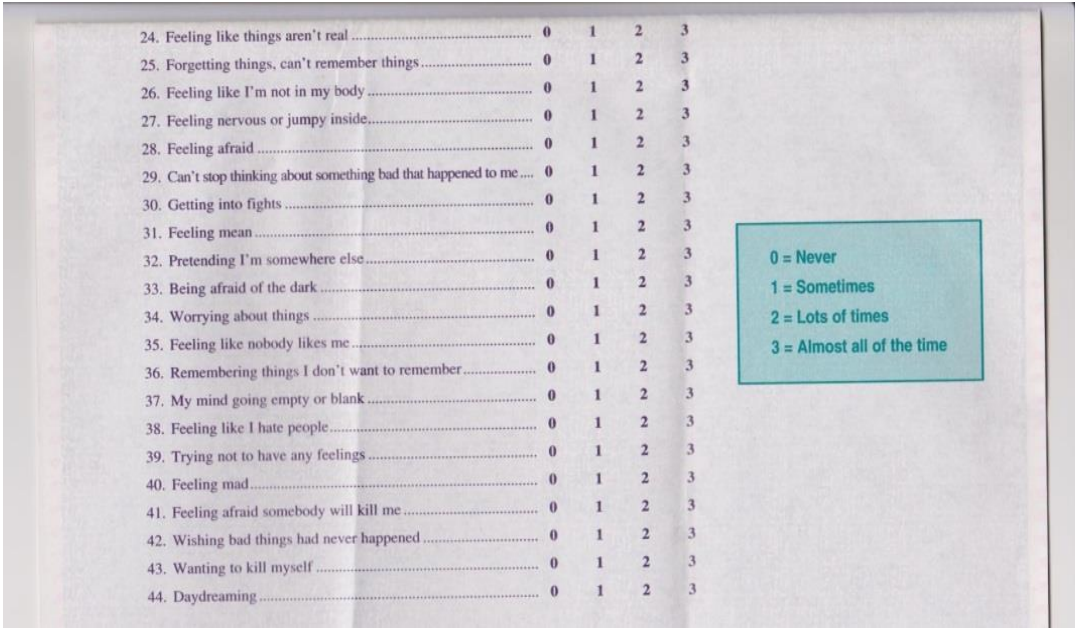
987654 Reorder #RO-3275 Printed in the U.S.A.



Name ______ Age ______ Sex ______ Identification No. ______ Race ______ Date ______

	Never	Sometimes	Lots of times	Almost all of the time
1. Bad dreams or nightmares	0	1	2	3
2. Feeling afraid something bad might happen	0	1	2	3
3. Scary ideas or pictures just pop into my head	0	1	2	3
4. Pretending I am someone else	0	1	2	3
5. Arguing too much	0	1	2	3
6. Feeling lonely	0	1	2	3
7. Feeling sad or unhappy	0	1	2	3
8. Remembering things that happened that I didn't like	0	1	2	3
9. Going away in my mind, trying not to think	0	1	2	3
10. Remembering scary things	0	1	2	3
11. Wanting to yell and break things	0	1	2	3
12. Crying	0	1	2	3
13. Getting scared all of a sudden and don't know why	0	1	2	3
14. Getting mad and can't calm down	0	1	2	3
15. Feeling dizzy	0	1	2	3
16. Wanting to yell at people	0	1	2	3
17. Wanting to hurt myself	0	1	2	3
18. Wanting to hurt other people	0	1	2	3
19. Feeling scared of men	0	1	2	3
20. Feeling scared of women	0	1	2	3
21. Washing myself because I feel dirty on the inside	0	1	2	3
22. Feeling stupid or bad	0	1	2	3

0 = Never
1 = Sometimes
2 = Lots of times
3 = Almost all of the time



24. Feeling like things aren't real	0	1	2	3
25. Forgetting things, can't remember things	0	1	2	3
26. Feeling like I'm not in my body	0	1	2	3
27. Feeling nervous or jumpy inside	0	1	2	3
28. Feeling afraid	0	1	2	3
29. Can't stop thinking about something bad that happened to me	0	1	2	3
30. Getting into fights	0	1	2	3
31. Feeling mean	0	1	2	3
32. Pretending I'm somewhere else	0	1	2	3
33. Being afraid of the dark	0	1	2	3
34. Worrying about things	0	1	2	3
35. Feeling like nobody likes me	0	1	2	3
36. Remembering things I don't want to remember	0	1	2	3
37. My mind going empty or blank	0	1	2	3
38. Feeling like I hate people	0	1	2	3
39. Trying not to have any feelings	0	1	2	3
40. Feeling mad	0	1	2	3
41. Feeling afraid somebody will kill me	0	1	2	3
42. Wishing bad things had never happened	0	1	2	3
43. Wanting to kill myself	0	1	2	3
44. Daydreaming	0	1	2	3

0 = Never
1 = Sometimes
2 = Lots of times
3 = Almost all of the time

Appendix 4-H: Consent form for child/young person Version 1.0 13.04.13

LANCASTER UNIVERSITY
DIVISION OF HEALTH RESEARCH
Doctorate In Clinical Psychology

Child and Young Person Consent/Assent Form

You are being asking if you would like to take part in a research project called: **How children and young people think about themselves after something scary or worrying has happened.**

Researchers name: Amy D'Sa

Please read the following questions and circle 'yes' if you agree..

1. Have you read (or had read to you) information about this project? **YES/NO**

2. Have you had anyone else explained the project to you? **YES/NO**

3. Do you understand what the project is about? **YES/NO**

4. Have you asked any questions you want? **YES/NO**

5. Have you had your questions answered in a way that makes sense? **YES/NO**

6. Do you understand that it is OK if you want to stop taking part at any time? **YES/NO**

7. Are you happy to take part? **YES/NO**

If any of your answers are "no", or you do not want to take part that is ok.

If you do want to take part, please write your name and the date below.

Name: ____________________________

Date: ____________________________

Your parent must write their name here if there are happy for you to take part.

Parent name (Printed): ________________________________

Appendix 4-I: Consent form for parent Version 2.0 17.06.13

Parent Consent Form

LANCASTER UNIVERSITY

DIVISION OF HEALTH RESEARCH
Doctorate In Clinical Psychology

You are being asked to give your consent for you son/daughter to take part in a research project called: **'Exploration of how children and young people think about themselves following a traumatic experience'**

Before giving consent for your son/daughter to participating in the study we ask that you read the following and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the main researcher, Amy D'Sa.

	Please initial
I confirm that my son/daughter and I have read the relevant Information Sheets and fully understand what my child will be asked to do within this study.	
I confirm that my son/daughter and I have had the opportunity to ask any questions and to have them answered to my satisfaction.	
I understand that my son/daughters interview will be audio recorded and then made into an anonymised transcript	
I understand that audio recordings will be kept until the interview had been transcribed and saved securely.	
I understand that my son/daughter is not obliged to take part in this study and can withdraw their willingness to participate before and during the interview. I also understand that my son/daughter and I can withdraw consent for my interview data to be used during, or up to 2 weeks after this interview.	
I consent to anonymised information and quotations from my son/daughters interview being used in any reports, including publications.	
I understand that any information my son/daughter gives will be anonymous unless it is thought that there is a risk of harm to them or others. In which case the main researcher will need to share this information with the named clinician I have identified on the expression of interest form.	
I consent to Lancaster University securely keeping written transcriptions of the interview for 5 years after the study has finished.	
I am aware that my child's care will not be affected by them taking part/not taking part in this study.	
I am aware that taking part is separate to and not therapy/additional support for my son/daughter.	
I consent to my child ………………………….taking part in the above study	
I understand that data from the study may be looked at by regulatory authorities and by persons from the Trust where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data	

Name of Parent:……………………………………..

Name of Child…………………………………………

Parent Signature:…………………………………………...

Date……………………………………………

Appendix 4-J: Example interview schedule Version 1.0 13.04.13

Draft Interview Schedule

This example interview schedule has been informed by Personal Construct Theory and research papers by Bell & Bell (2008) and Ravenette (1977) which provide examples of adapting self-characterisation to child drawings.

Introduction to Interview:

Before we get started I wanted to tell you a few things and see if you have questions.

- This interview is going to last up to 60 minutes.
- Your mum/dad is going to wait outside if you need them
- You can stop or have a break at any time you just let me know
- Everything you say to me will stay strictly private. However if I am worried about your safety or that of someone else I have to tell someone. I will always tell you if I need to share what you say before I do.
- Do you have any questions about any of that?

We are here to see how you think about yourself. Although one of the reasons you have been asked is because something scary or worrying may have happened, I will not be asking you to tell me about this.

Instead I am going to start by asking you to draw me a picture(s).

Instructions:
Here is some paper and some materials, you can use whatever you like and draw whatever you like. There are no right or wrong things to draw in here, it’s your space to draw. Just think about yourself and draw a picture. You can talk out loud if you want but when you are done we can spend some time talking about what you drew. Ok?

Example questions to discuss/elaborate on the drawing as used by Bell & Bell (2008) and or Ravenette (1977)
Tell me about your drawing….
What’s it like being ….?
How come…?
What would be good about …..?
How are ….. and ….. different? (using information from the picture)
Do you think you are more like …..or ……?(using information from the picture)

I wondered if there is anything else you would like to tell me about your drawing before we do one last activity and then we will finish?

Debriefing :
How did you find that ? Do you have any questions?

Option al fun activity:
Drawing
Boardgame
Lego

End of interview
Thank you for taking part and being so enthusiastic
Do you have any other questions before we end?

Remind the parent that contact details are on the Parent Information Sheet

Appendix 4-K: Reminder and thank you letter to clinicians Version 1.0 13.04.13

Address:

Date:

Dear Colleague/Mental Health Professional,

A quick reminder and thank you

My name is Amy D’Sa and I am a Trainee Clinical Psychologist who is studying for my Doctorate in Clinical Psychology at Lancaster University. As you will already be aware, I am undertaking a research project looking at how children and young people self-construe following a traumatic experience.

I would therefore like to take this opportunity to remind you about the project I am carrying out and asked for your support me in identifying children/young people who may be appropriate to take part. I have attached another copy of the information sheet and checklist.

I appreciate that you have already been considering this project and may have given out information packs to the child/young person and parents already. If at all possible, I would ask you to remind any families who you feel may be interested in taking part. Also for you to consider if any other children/young people may now be eligible to take part due to their changing circumstances and ongoing involvement with your service.

If you have any questions about this study please feel free to contact me on the above number.

Thank you for your time,

Yours sincerely,

Amy D’Sa
Trainee Clinical Psychologist

Appendix 4-L: Researchers/Chief Investigators CV Version 1.0 13.04.13

CURRICULUM VITAE

Name:

Amy D'Sa

Present appointment: *(Job title, department, and organisation.)*

Trainee Clinical Psychologist, Doctoral Programme in Clinical Psychology, Lancaster University & Lancashire Care NHS Trust

Address: *(Full work address.)*

Doctoral Programme in Clinical Psychology, Whewell Building, Lancaster University, LANCASTER
LA1 4YT

Telephone number:	**Email address:**
07870895230	a.dsa@lancaster.ac.uk

Qualifications:

BSc Hons Psychology (Lincoln University)

Professional registration: *(Name of body, registration number and date of registration.)*

British Psychological Society (member no.)

Previous and other appointments: *(Include previous appointments in the last 5 years and other current appointments.)*

Assistant Psychologist, Psychotherapy/Complex Cases Team, Beech Lodge, Carleton Clinic Cumbria. Cumbria Partnership Foundation Trust

Occupational Therapy Technician, Oak Wards, The Cavell Centre, Peterborough. Peterborough and Cambridgeshire Foundation Trust.

Graduate Mental Health Worker, IAPT/Primary Care Team, Peterborough District Hospital. Peterborough and Cambridgeshire Foundation Trust.

Nursing Assistant, Oak Wards The Cavell Centre, Peterborough. Peterborough and Cambridgeshire Foundation Trust.

Research experience: *(Summary of research experience, including the extent of your involvement. Refer to any specific clinical or research experience relevant to the current application.)*

2008- Conducted quantitative study looking at parent and teacher's perceptions and attributions of ADHD behaviour for my undergraduate dissertation.

2011- Conducted qualitative study looking at how the Department of Health Pilot PD sites have incorporated service user involvement. I was the primary investigator for this project and submitted it for publication.

Research training: *(Details of any relevant training in the design or conduct of research, for example in the Clinical Trials Regulations, Good Clinical Practice or other training appropriate to non-clinical research. Give the date of the training.)*

The DClinPsy programme I am currently undertaking contains extensive training in research methods.

Relevant publications: *(Give references to all publications in the last two years plus other publications relevant to the current application.)*

D'Sa, A. & Rigby, M. (2011). The effectiveness of the service user consultant role in specialist personality disorder services. Mental Health Review Journal, 16(4), pp186-196

Appendix 4-M: Thesis Academic Supervisor's CV 13.04.13

Research CV

Dr Pete Greasley
Doctorate in Clinical Psychology Programme
Division of Health Research
C12 Furness College
Lancaster University
LA1 4YG

Telephone: 01542 593535
Email: p.greasley@lancaster.ac.uk

EDUCATION

University of Bradford (2007)
    Post Graduate Certificate in Higher Education Practice
University of Manchester University, Department of Psychology (1990)
    PhD in psychology (pragmatics, language and social interaction)
Huddersfield University (1985)
    BSc (Hons) Behavioural Sciences

RESEARCH/TEACHING EXPERIENCE

University of Bradford, Health Studies (2005-2013)
    Lecturer
University of Bradford, Graduate School (2003-2005)
    Lecturer (0.25)
University of Bradford (2000-2005)
    Research Fellow
Wakefield & Pontefract Community Health NHS Trust (1997-2000)
    Research Associate
University of Leeds (1994-1996)
    Research Fellow, Department of Psychology

PUBLICATIONS

Torn, A. & Greasley, P. (in prep) *Psychology for Nursing and the Health Professions*. Co-editor. Polity Press.

Greasley, P. (2011) *Doing Essays and Assignments: Essential Tips for Students.* Sage Publications.

Greasley, P. (2010) Is the evaluation of complementary & alternative medicine equivalent to evaluating the absurd? *Evaluation & the Health Professions*, 33(2), 127-139.

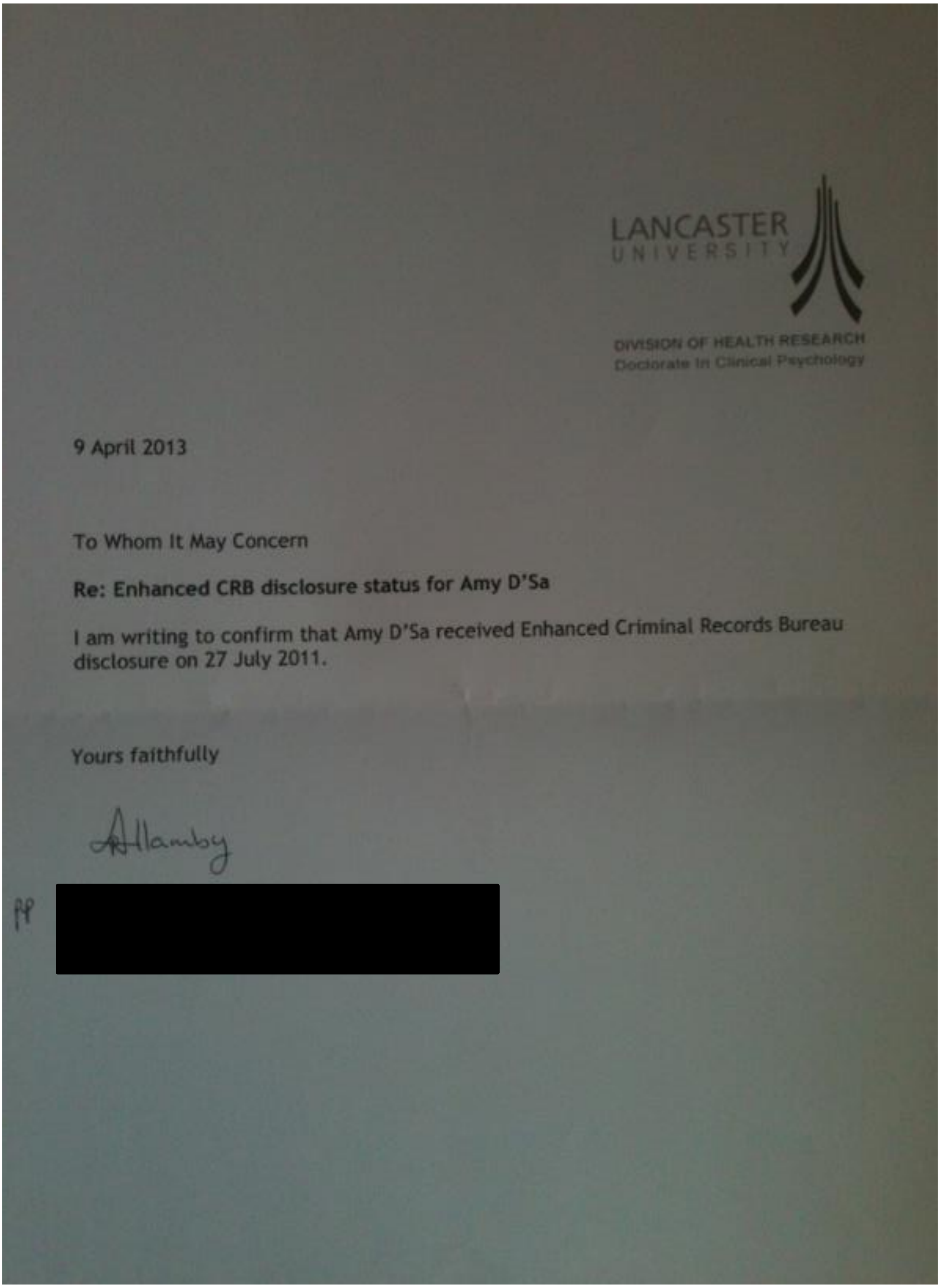
Owens, M., Dearnley, C., Plews, C., Greasley, P. (2010) Developing Interprofessional Education: An Evaluation Study. *Journal of Interprofessional Care*, 24(4): 460-462.

Dearnley, C. Owens, M., Greasley, P., Plews, C. (2010) Mixing students mixing methods: A study examining the effectiveness of using a blended approach to interprofessional education. Chapter in: A. Bromage, L. Clouder, J. Thistlethwaite, J. & F. Gordon (Eds) *Interprofessional E-Learning and Collaborative Work: Practices and Technologies*. New York: Information Science Reference/IGI Global.

Greasley, P. & Cassidy, A. (2010) When it comes round to marking assignments: how to impress and how to 'distress' lecturers. *Assessment & Evaluation in Higher Education*. 35(2), 173-189.

Greasley, P. (2008) *Quantitative Data Analysis Using SPSS: An Introduction for Health and Social Science.* McGraw-Hill/Open University Press.

Appendix 4-N: Letter confirming Chief Investigator’s CRB clearance 13.04.13



LANCASTER UNIVERSITY

DIVISION OF HEALTH RESEARCH
Doctorate in Clinical Psychology

9 April 2013

To Whom It May Concern

Re: Enhanced CRB disclosure status for Amy D’Sa

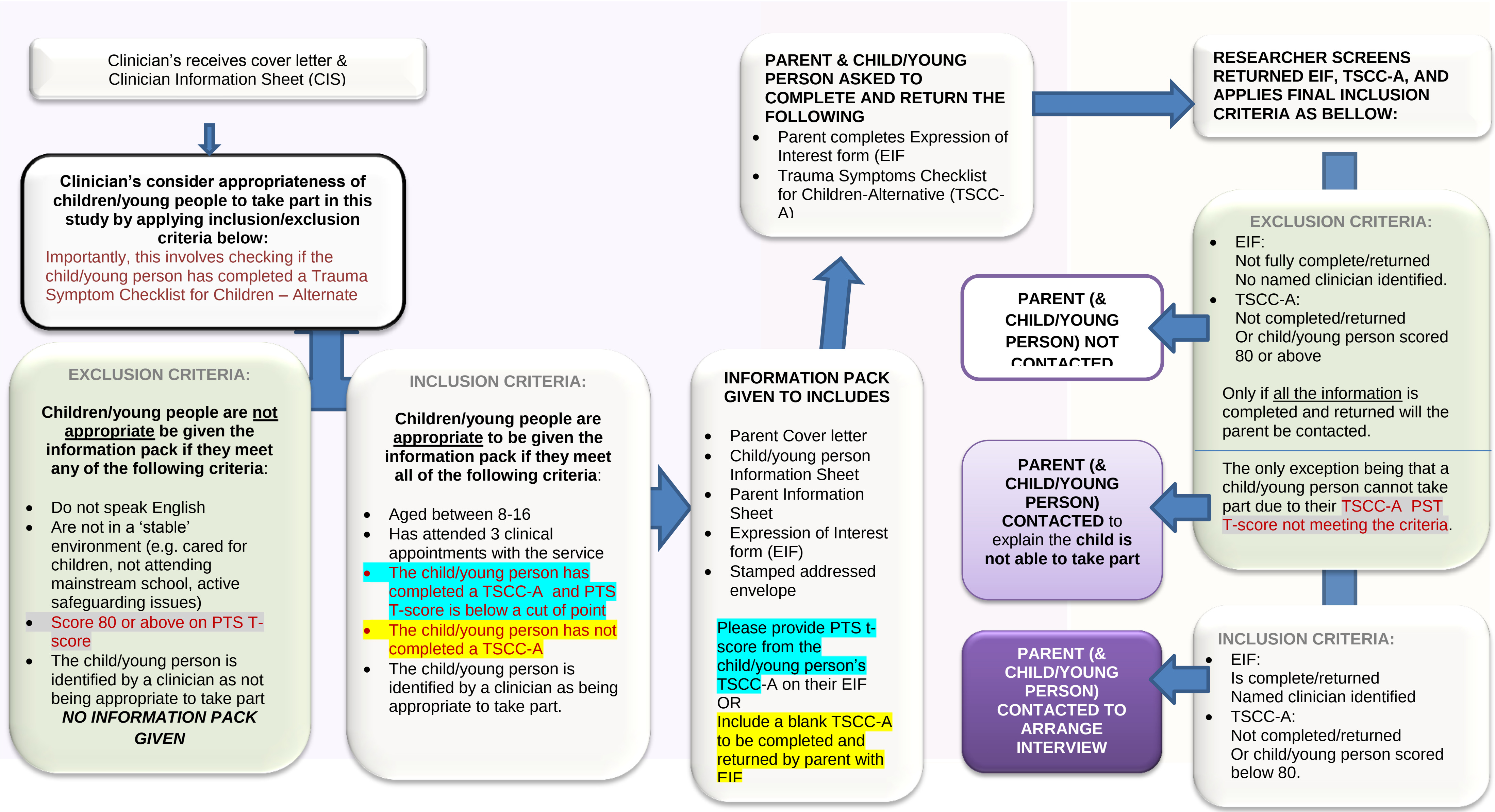
I am writing to confirm that Amy D’Sa received Enhanced Criminal Records Bureau disclosure on 27 July 2011.

Yours faithfully

AHamby

pp [redacted]

Appendix 4-0: Diagram of Recruitment Process Version 1.0 13.04.13



CLINICIAN RECRUITMENT & DISSEMINATING INFORMATION PACKS

Clinician's receives cover letter & Clinician Information Sheet (CIS)

Clinician's consider appropriateness of children/young people to take part in this study by applying inclusion/exclusion criteria below:
Importantly, this involves checking if the child/young person has completed a Trauma Symptom Checklist for Children – Alternate

EXCLUSION CRITERIA:

Children/young people are <u>not appropriate</u> be given the information pack if they meet any of the following criteria:

- Do not speak English
- Are not in a 'stable' environment (e.g. cared for children, not attending mainstream school, active safeguarding issues)
- Score 80 or above on PTS T-score
- The child/young person is identified by a clinician as not being appropriate to take part

NO INFORMATION PACK GIVEN

INCLUSION CRITERIA:

Children/young people are <u>appropriate</u> to be given the information pack if they meet all of the following criteria:

- Aged between 8-16
- Has attended 3 clinical appointments with the service
- The child/young person has completed a TSCC-A and PTS T-score is below a cut of point
- The child/young person has not completed a TSCC-A
- The child/young person is identified by a clinician as being appropriate to take part.

INFORMATION PACK GIVEN TO INCLUDES

- Parent Cover letter
- Child/young person Information Sheet
- Parent Information Sheet
- Expression of Interest form (EIF)
- Stamped addressed envelope

Please provide PTS t-score from the child/young person's TSCC-A on their EIF
OR
Include a blank TSCC-A to be completed and returned by parent with EIF

PARENT & CHILD/YOUNG PERSON EXPRESS INTEREST

PARENT & CHILD/YOUNG PERSON ASKED TO COMPLETE AND RETURN THE FOLLOWING

- Parent completes Expression of Interest form (EIF
- Trauma Symptoms Checklist for Children-Alternative (TSCC-A)

RESEARCHER APPLIES CRITERIA

RESEARCHER SCREENS RETURNED EIF, TSCC-A, AND APPLIES FINAL INCLUSION CRITERIA AS BELLOW:

EXCLUSION CRITERIA:

- EIF:
  Not fully complete/returned
  No named clinician identified.
- TSCC-A:
  Not completed/returned
  Or child/young person scored 80 or above

Only if <u>all the information</u> is completed and returned will the parent be contacted.

The only exception being that a child/young person cannot take part due to their TSCC-A PST T-score not meeting the criteria.

PARENT (& CHILD/YOUNG PERSON) NOT CONTACTED

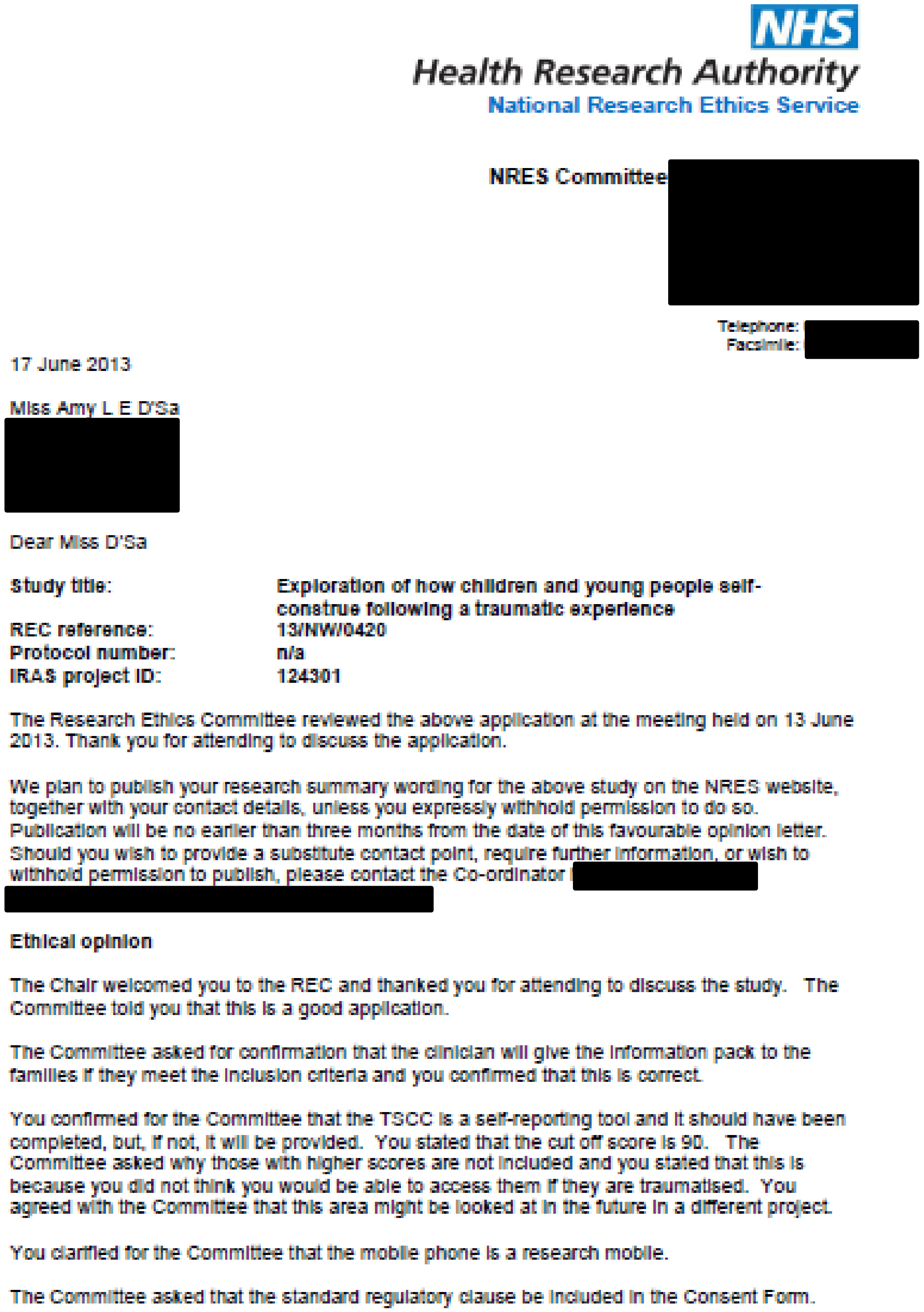
PARENT (& CHILD/YOUNG PERSON) CONTACTED to explain the **child is not able to take part**

INCLUSION CRITERIA:

- EIF:
  Is complete/returned
  Named clinician identified
- TSCC-A:
  Not completed/returned
  Or child/young person scored below 80.

PARENT (& CHILD/YOUNG PERSON) CONTACTED TO ARRANGE INTERVIEW

Appendix 4-P: Letter of Conditional Approval from REC



NHS
Health Research Authority
National Research Ethics Service

NRES Committee [redacted]

Telephone:
Facsimile: [redacted]

17 June 2013

Miss Amy L E D'Sa
[redacted]

Dear Miss D'Sa

Study title:	**Exploration of how children and young people self-construe following a traumatic experience**
REC reference:	**13/NW/0420**
Protocol number:	**n/a**
IRAS project ID:	**124301**

The Research Ethics Committee reviewed the above application at the meeting held on 13 June 2013. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator [redacted]
[redacted]

Ethical opinion

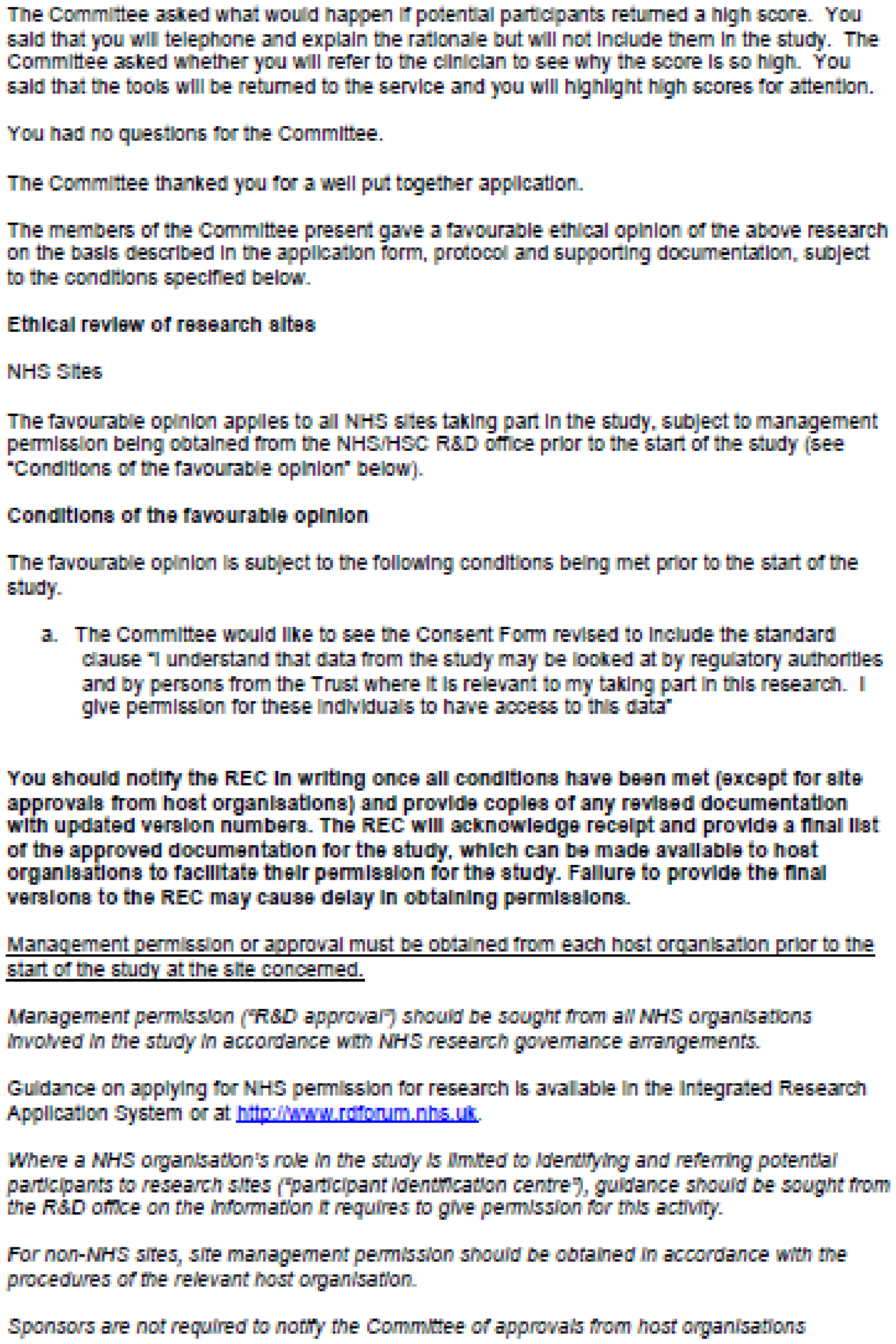
The Chair welcomed you to the REC and thanked you for attending to discuss the study. The Committee told you that this is a good application.

The Committee asked for confirmation that the clinician will give the information pack to the families if they meet the inclusion criteria and you confirmed that this is correct.

You confirmed for the Committee that the TSCC is a self-reporting tool and it should have been completed, but, if not, it will be provided. You stated that the cut off score is 90. The Committee asked why those with higher scores are not included and you stated that this is because you did not think you would be able to access them if they are traumatised. You agreed with the Committee that this area might be looked at in the future in a different project.

You clarified for the Committee that the mobile phone is a research mobile.

The Committee asked that the standard regulatory clause be included in the Consent Form.



The Committee asked what would happen if potential participants returned a high score. You said that you will telephone and explain the rationale but will not include them in the study. The Committee asked whether you will refer to the clinician to see why the score is so high. You said that the tools will be returned to the service and you will highlight high scores for attention.

You had no questions for the Committee.

The Committee thanked you for a well put together application.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

a. The Committee would like to see the Consent Form revised to include the standard clause "I understand that data from the study may be looked at by regulatory authorities and by persons from the Trust where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data"

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

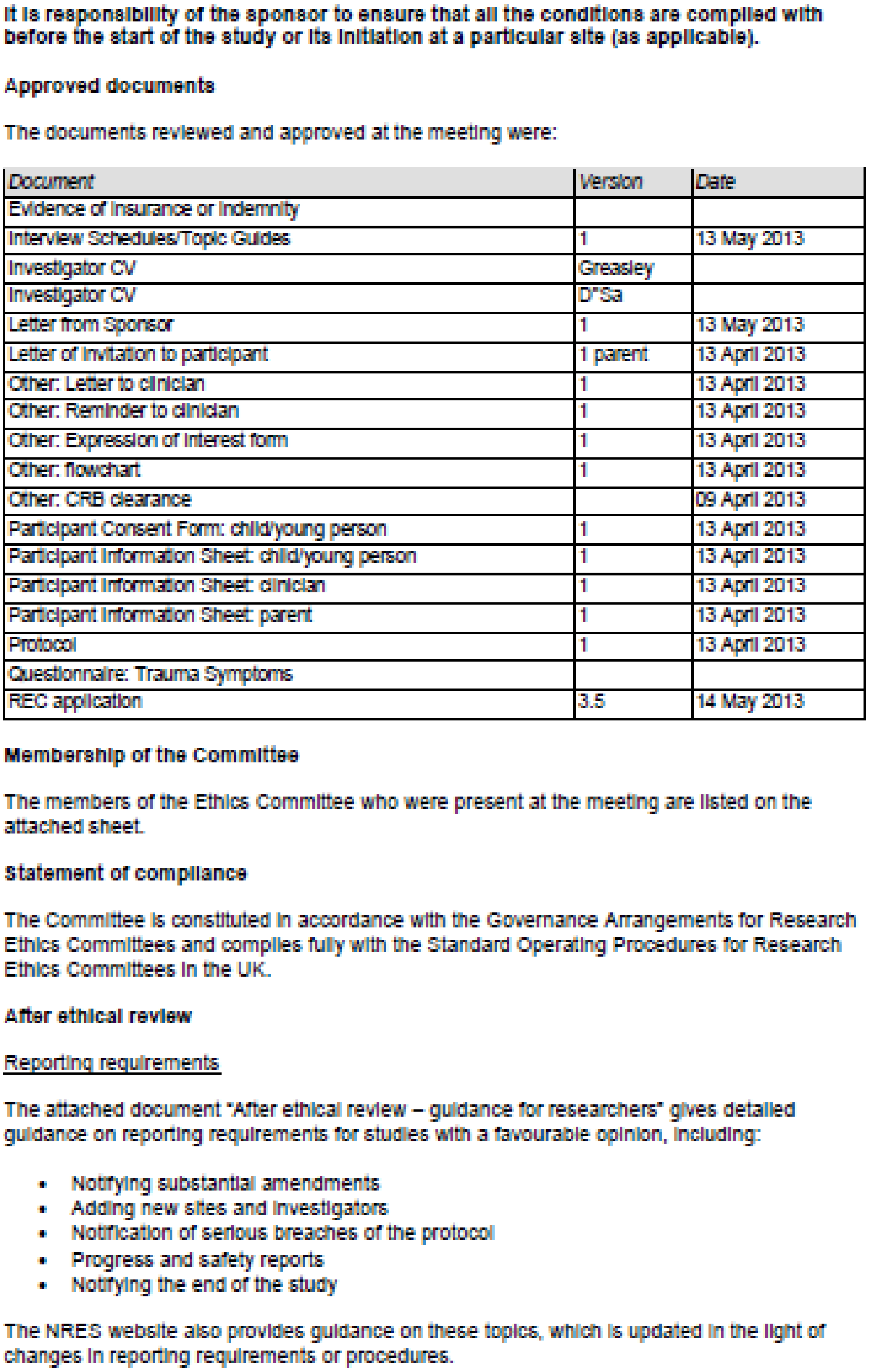
Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations



It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Evidence of Insurance or Indemnity		
Interview Schedules/Topic Guides	1	13 May 2013
Investigator CV	Greasley	
Investigator CV	D"Sa	
Letter from Sponsor	1	13 May 2013
Letter of invitation to participant	1 parent	13 April 2013
Other: Letter to clinician	1	13 April 2013
Other: Reminder to clinician	1	13 April 2013
Other: Expression of interest form	1	13 April 2013
Other: flowchart	1	13 April 2013
Other: CRB clearance		09 April 2013
Participant Consent Form: child/young person	1	13 April 2013
Participant Information Sheet: child/young person	1	13 April 2013
Participant Information Sheet: clinician	1	13 April 2013
Participant Information Sheet: parent	1	13 April 2013
Protocol	1	13 April 2013
Questionnaire: Trauma Symptoms		
REC application	3.5	14 May 2013

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

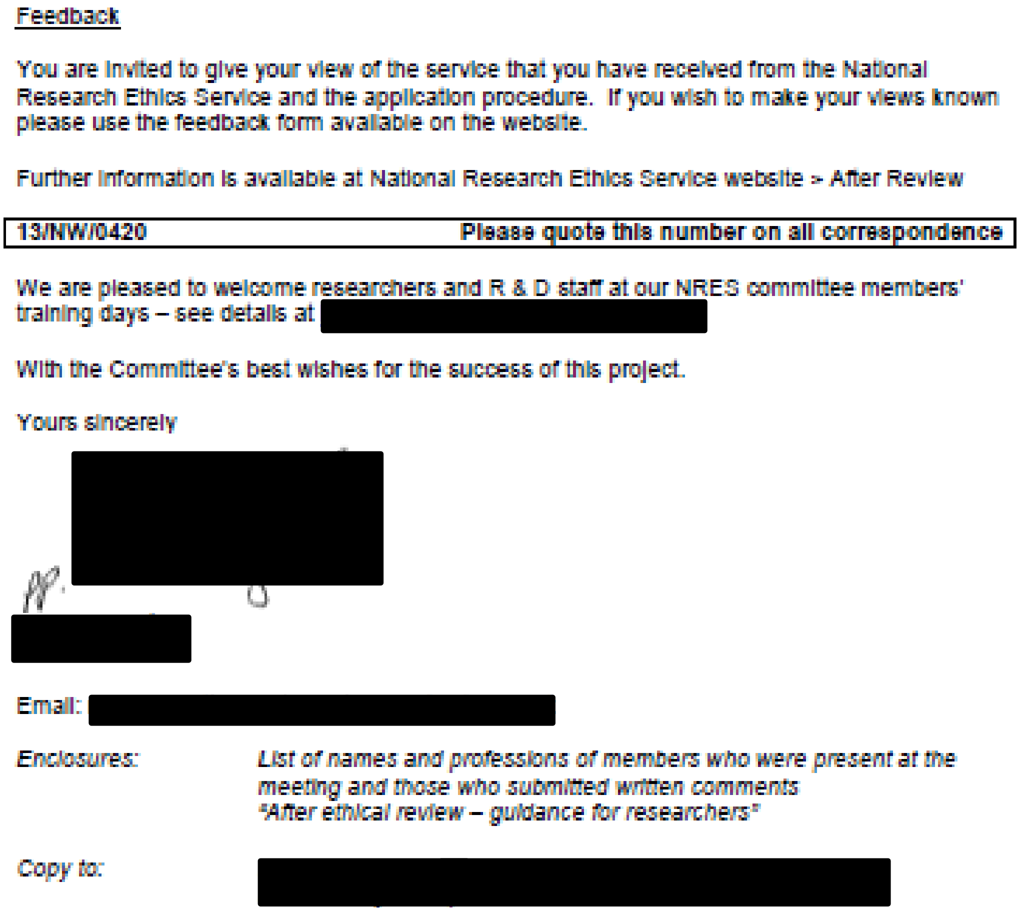
After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.



Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

13/NW/0420 **Please quote this number on all correspondence**

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at [redacted]

With the Committee's best wishes for the success of this project.

Yours sincerely

[redacted]

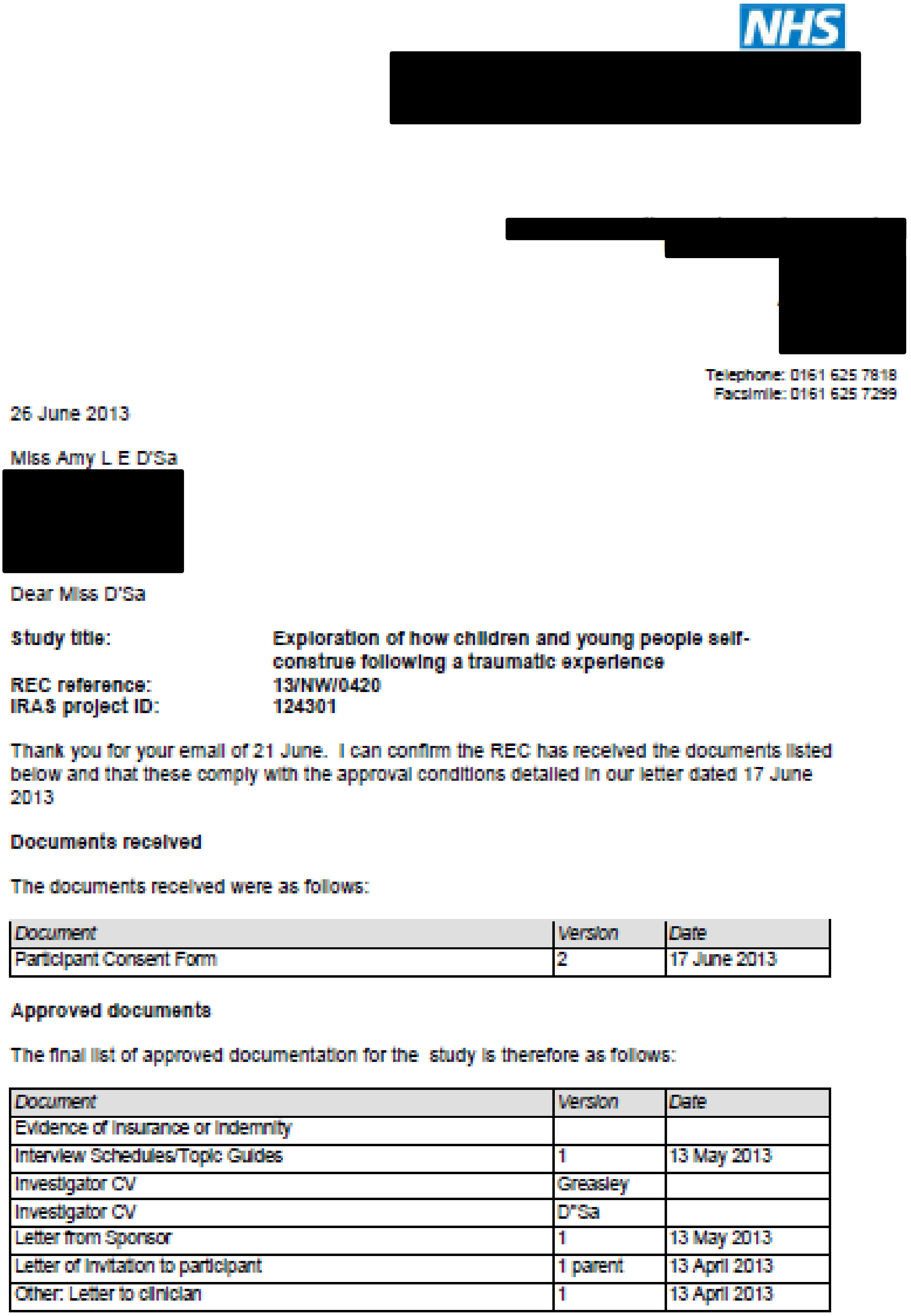
[redacted]

Email: [redacted]

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*
"After ethical review – guidance for researchers"

Copy to: [redacted]

Appendix 4-Q: Letter of Final Approval from REC



[redacted]

[redacted]

Telephone: 0161 625 7818
Facsimile: 0161 625 7299

26 June 2013

Miss Amy L E D'Sa
[redacted]

Dear Miss D'Sa

Study title: **Exploration of how children and young people self-construe following a traumatic experience**
REC reference: **13/NW/0420**
IRAS project ID: **124301**

Thank you for your email of 21 June. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 17 June 2013

Documents received

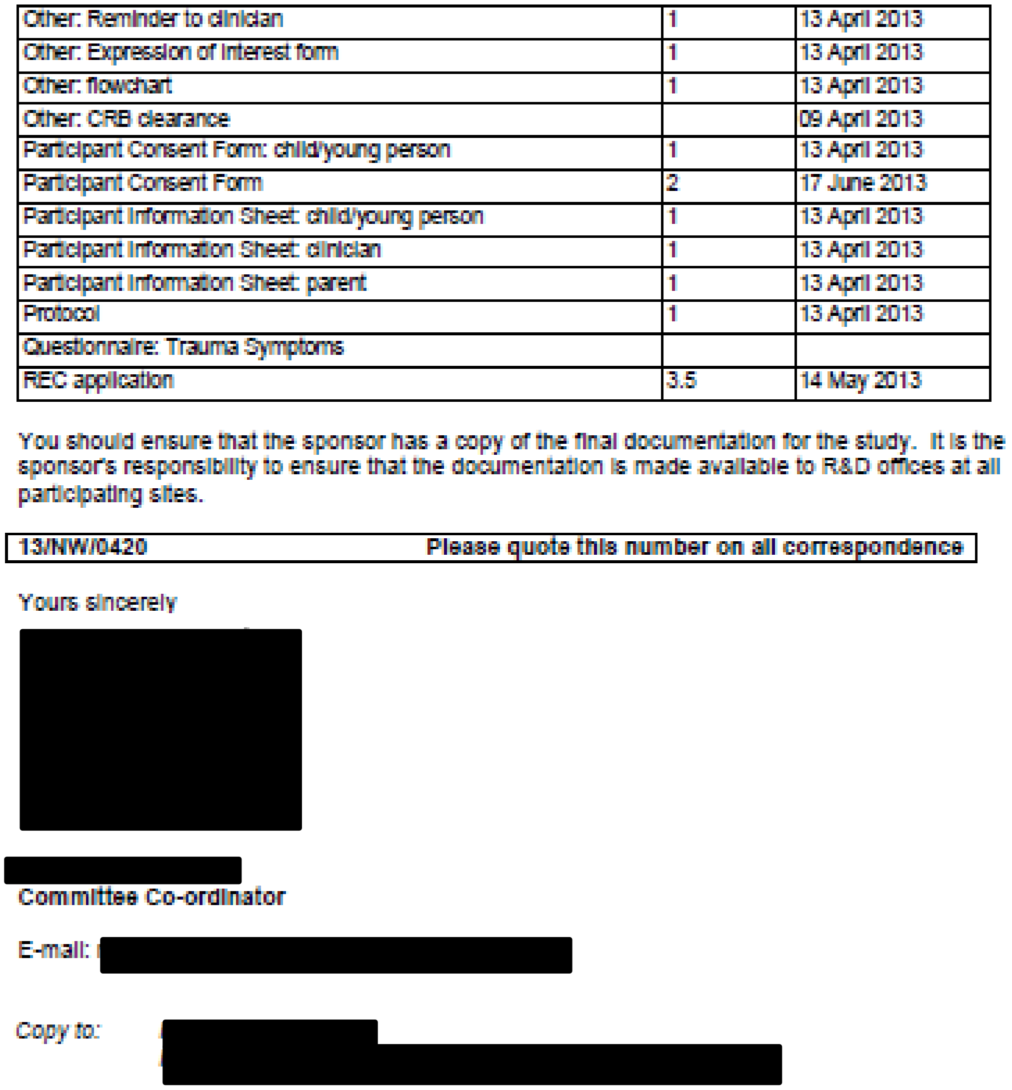
The documents received were as follows:

Document	*Version*	*Date*
Participant Consent Form	2	17 June 2013

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	*Version*	*Date*
Evidence of insurance or indemnity		
Interview Schedules/Topic Guides	1	13 May 2013
Investigator CV	Greasley	
Investigator CV	D'Sa	
Letter from Sponsor	1	13 May 2013
Letter of invitation to participant	1 parent	13 April 2013
Other: Letter to clinician	1	13 April 2013



Other: Reminder to clinician	1	13 April 2013
Other: Expression of interest form	1	13 April 2013
Other: flowchart	1	13 April 2013
Other: CRB clearance		09 April 2013
Participant Consent Form: child/young person	1	13 April 2013
Participant Consent Form	2	17 June 2013
Participant Information Sheet: child/young person	1	13 April 2013
Participant Information Sheet: clinician	1	13 April 2013
Participant Information Sheet: parent	1	13 April 2013
Protocol	1	13 April 2013
Questionnaire: Trauma Symptoms		
REC application	3.5	14 May 2013

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

13/NW/0420 **Please quote this number on all correspondence**

Yours sincerely

[redacted]

[redacted]

Committee Co-ordinator

E-mail: [redacted]

Copy to: [redacted]

Appendix 4-R: Letter of Approval from R&D (Trust 1)

[redacted] NHS

[redacted]

Ref No. 2013/034
Our Ref:

Tel: [redacted]
Fax:
E-Mail: [redacted]

1 July 2013

Miss Amy L E D'Sa
[redacted]

Dear Miss D' Sa

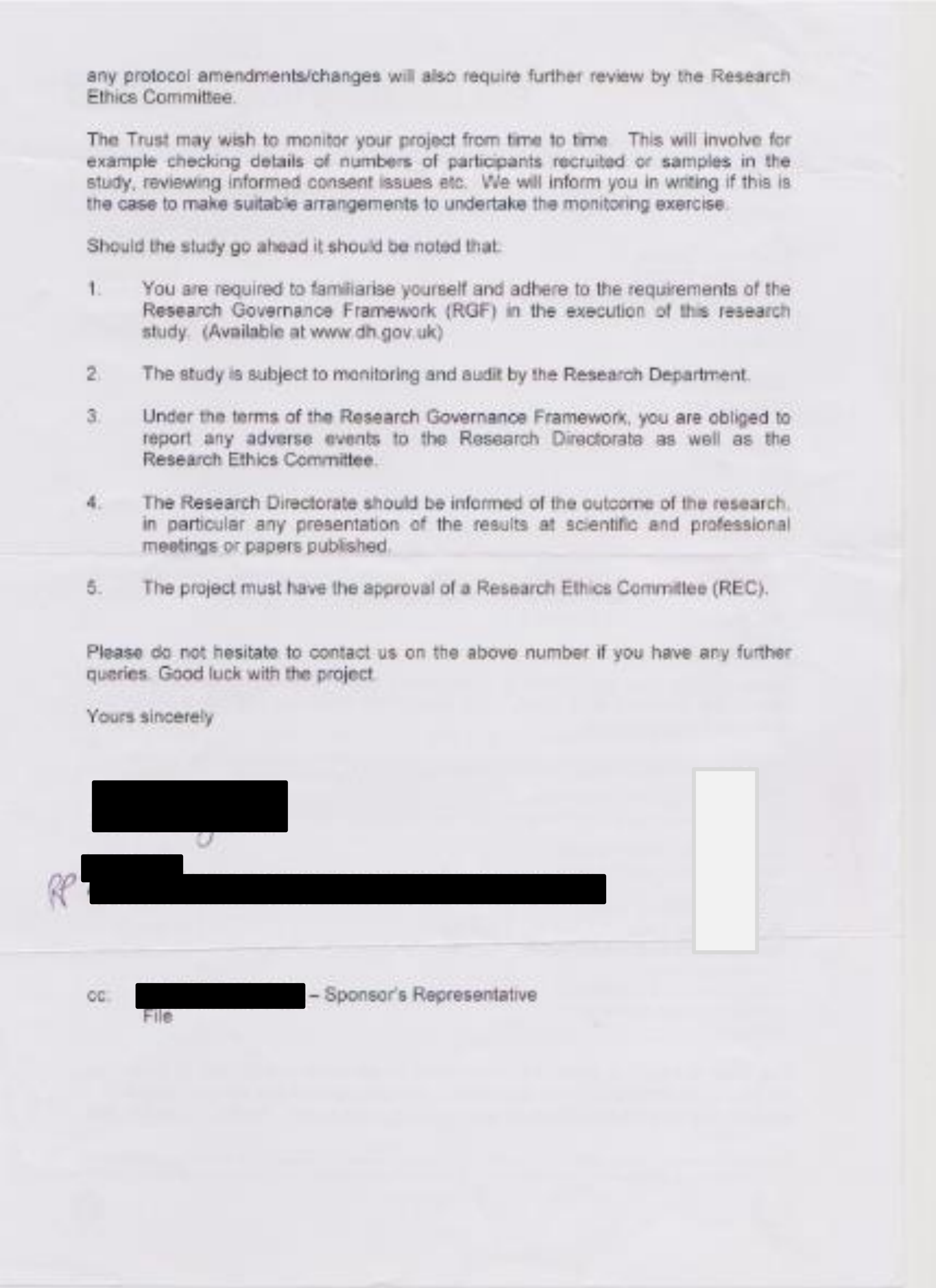
Study Title:	**Exploration of how children and young people self-construe following a traumatic experience**
REC Ref:	**13/NW/0420**

Thank you for your application to undertake a piece of research within the [redacted] [redacted] Trust. The documents reviewed and approved by the Committee are as follows:

Main Documents reviewed	Version	Date
R&D Application Form	124301/456392/14/83	
SSI form	124301/456362/6/897/190855/272983	
Protocol	1	13 April 2013
Participant Information Sheets: parent, clinician, child/young person	1	13 April 2013
Participant Consent Form:	2	17 June 2013
REC Approval Letter	13/NW/0420	26 June 2013
Participant Consent Form: child/young person	1	13 April 2013
Other:flowchart, Expression of interest form and Reminder to clinician	1	13 April 2013

The Trust is happy to grant NHS permission for research and for you to undertake the project as specified in your application. If for any reason you need to amend your study in any way please inform us before this is undertaken. Please remember that

[redacted]



any protocol amendments/changes will also require further review by the Research Ethics Committee.

The Trust may wish to monitor your project from time to time. This will involve for example checking details of numbers of participants recruited or samples in the study, reviewing informed consent issues etc. We will inform you in writing if this is the case to make suitable arrangements to undertake the monitoring exercise.

Should the study go ahead it should be noted that:

1. You are required to familiarise yourself and adhere to the requirements of the Research Governance Framework (RGF) in the execution of this research study. (Available at www.dh.gov.uk)
2. The study is subject to monitoring and audit by the Research Department.
3. Under the terms of the Research Governance Framework, you are obliged to report any adverse events to the Research Directorate as well as the Research Ethics Committee.
4. The Research Directorate should be informed of the outcome of the research, in particular any presentation of the results at scientific and professional meetings or papers published.
5. The project must have the approval of a Research Ethics Committee (REC).

Please do not hesitate to contact us on the above number if you have any further queries. Good luck with the project.

Yours sincerely

[redacted]

RP [redacted]

cc: [redacted] – Sponsor's Representative
File

Appendix 4-S: Letter of Approval from R&D (Trust 2)

[redacted] NHS

25th September 2013

Miss Amy D'Sa
Trainee Clinical Psychologist
C16 Furness College
Lancaster University
Lancaster
LA1 4YT

Dear *Miss D'Sa*,

Re: NHS Trust Permission to Proceed

Project Reference: 13/06

Project Title: *Exploration of how children and young people self-construe following a traumatic experience*

Thank you for submitting your responses following the research governance review of your research project. I am pleased to inform you that the Chair of the Research Governance Sub-Committee has granted permission and you can now recruit from all sites listed on your SSI.

Please take the time to read through this letter carefully and contact me if you would like any further information. You will need this letter as proof of your permission.

Trust R&D permission covers all locations within the Trust; however you will only be allowed to recruit from the sites/services you have indicated in section 3 of the SSI application form. If you would like to expand recruitment into other services in the Trust that are not on the original SSI then you must contact the R&D department immediately to discuss this before doing so.

You also must ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing recruitment in that service and you must contact the relevant service/ward managers prior to accessing the service to make an appointment to visit before you can commence your study in the trust.

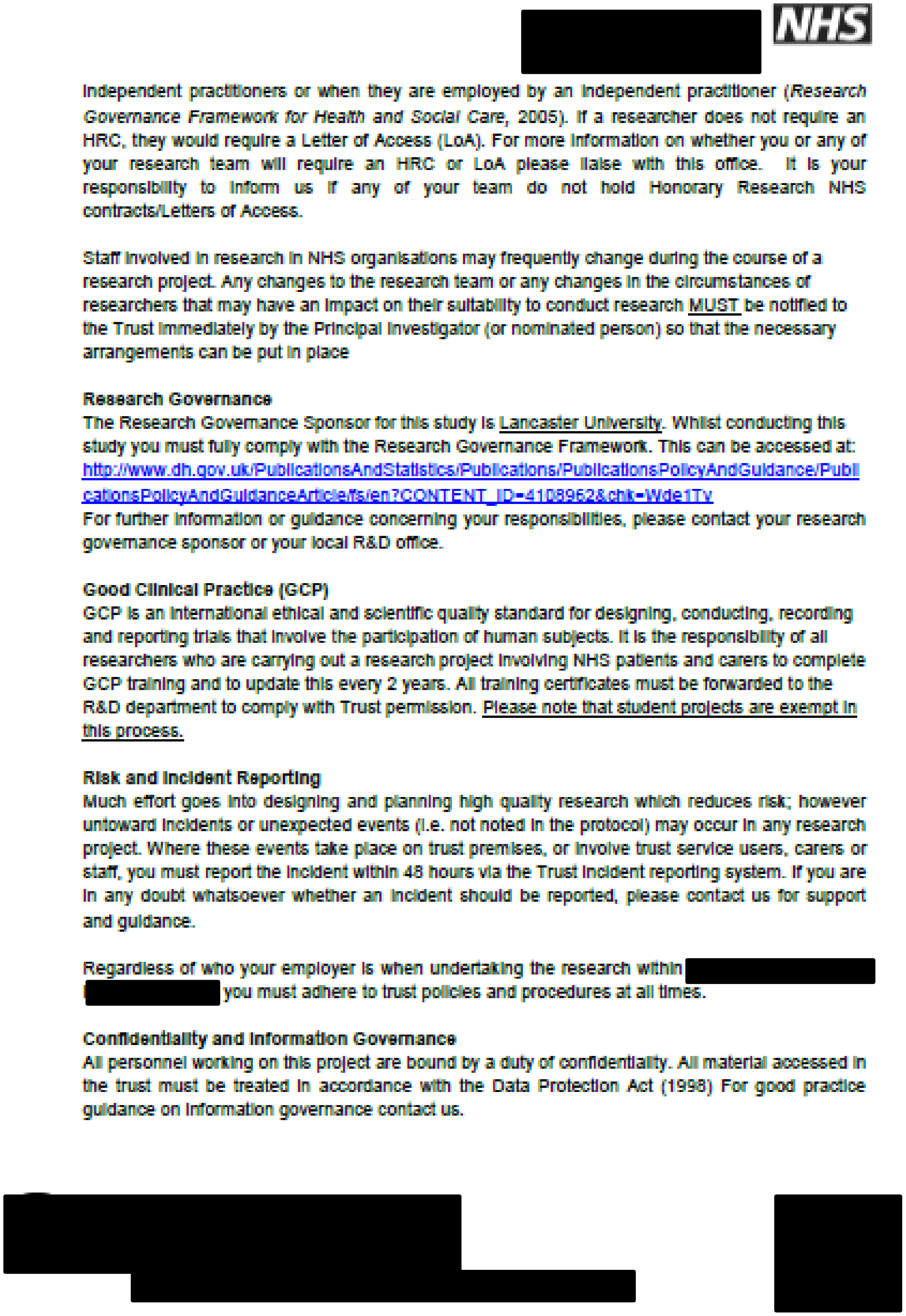
Honorary Research contracts (HRC)

All researchers with no contractual relationship with any NHS body, who are to interact with individuals in a way that **directly affects the quality of their care**, should hold Honorary Research NHS contracts. Researchers have a contractual relationship with an NHS body either when they are employees or when they are contracted to provide NHS services, for example as

[redacted]

[redacted]

[redacted]



[redacted] NHS

independent practitioners or when they are employed by an independent practitioner (*Research Governance Framework for Health and Social Care*, 2005). If a researcher does not require an HRC, they would require a Letter of Access (LoA). For more information on whether you or any of your research team will require an HRC or LoA please liaise with this office. It is your responsibility to inform us if any of your team do not hold Honorary Research NHS contracts/Letters of Access.

Staff involved in research in NHS organisations may frequently change during the course of a research project. Any changes to the research team or any changes in the circumstances of researchers that may have an impact on their suitability to conduct research MUST be notified to the Trust immediately by the Principal Investigator (or nominated person) so that the necessary arrangements can be put in place

Research Governance

The Research Governance Sponsor for this study is Lancaster University. Whilst conducting this study you must fully comply with the Research Governance Framework. This can be accessed at: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=Wde1Tv

For further information or guidance concerning your responsibilities, please contact your research governance sponsor or your local R&D office.

Good Clinical Practice (GCP)

GCP is an international ethical and scientific quality standard for designing, conducting, recording and reporting trials that involve the participation of human subjects. It is the responsibility of all researchers who are carrying out a research project involving NHS patients and carers to complete GCP training and to update this every 2 years. All training certificates must be forwarded to the R&D department to comply with Trust permission. Please note that student projects are exempt in this process.

Risk and Incident Reporting

Much effort goes into designing and planning high quality research which reduces risk; however untoward incidents or unexpected events (i.e. not noted in the protocol) may occur in any research project. Where these events take place on trust premises, or involve trust service users, carers or staff, you must report the incident within 48 hours via the Trust incident reporting system. If you are in any doubt whatsoever whether an incident should be reported, please contact us for support and guidance.

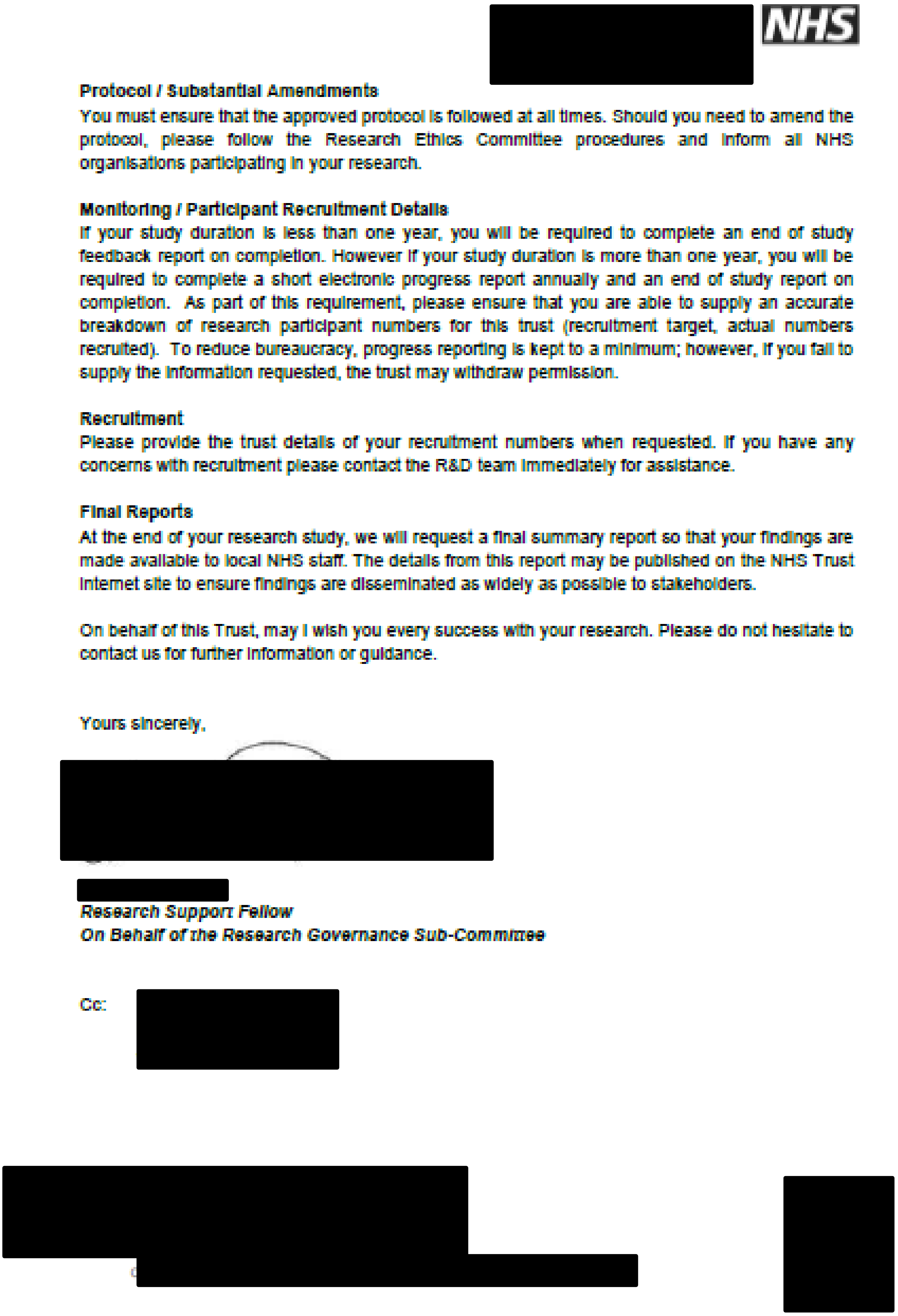
Regardless of who your employer is when undertaking the research within [redacted] you must adhere to trust policies and procedures at all times.

Confidentiality and Information Governance

All personnel working on this project are bound by a duty of confidentiality. All material accessed in the trust must be treated in accordance with the Data Protection Act (1998) For good practice guidance on information governance contact us.

[redacted]

[redacted]



[redacted] NHS

Protocol / Substantial Amendments

You must ensure that the approved protocol is followed at all times. Should you need to amend the protocol, please follow the Research Ethics Committee procedures and inform all NHS organisations participating in your research.

Monitoring / Participant Recruitment Details

If your study duration is less than one year, you will be required to complete an end of study feedback report on completion. However if your study duration is more than one year, you will be required to complete a short electronic progress report annually and an end of study report on completion. As part of this requirement, please ensure that you are able to supply an accurate breakdown of research participant numbers for this trust (recruitment target, actual numbers recruited). To reduce bureaucracy, progress reporting is kept to a minimum; however, if you fail to supply the information requested, the trust may withdraw permission.

Recruitment

Please provide the trust details of your recruitment numbers when requested. If you have any concerns with recruitment please contact the R&D team immediately for assistance.

Final Reports

At the end of your research study, we will request a final summary report so that your findings are made available to local NHS staff. The details from this report may be published on the NHS Trust internet site to ensure findings are disseminated as widely as possible to stakeholders.

On behalf of this Trust, may I wish you every success with your research. Please do not hesitate to contact us for further information or guidance.

Yours sincerely,

[redacted]

[redacted]

Research Support Fellow
On Behalf of the Research Governance Sub-Committee

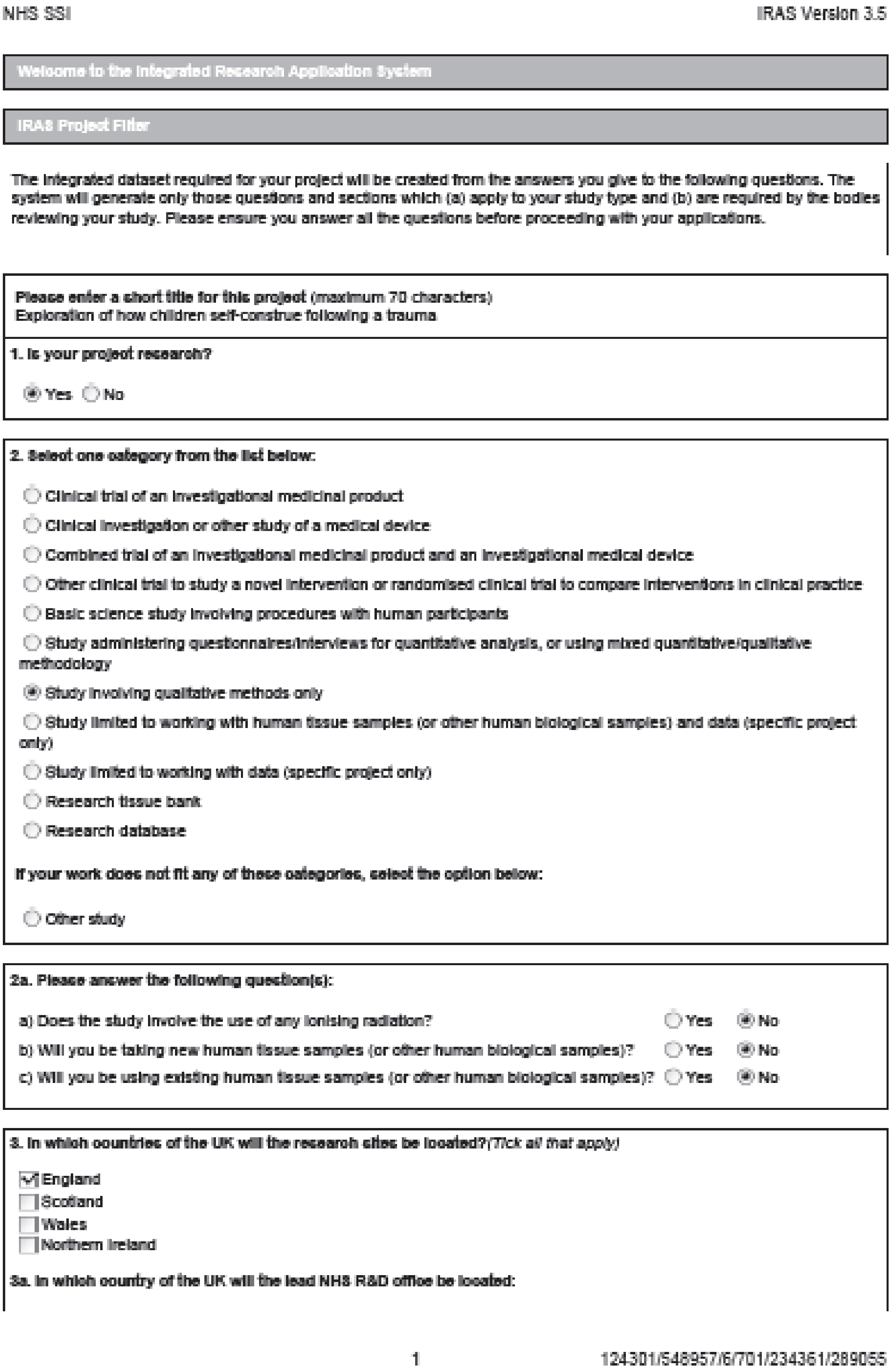
Cc: [redacted]

[redacted]

[redacted]

[redacted]

Appendix 4-T: New NHS Site- Specific Information (SSI) Application Form (Trust 2)



NHS SSI IRAS Version 3.5

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
Exploration of how children self-construe following a trauma

1. Is your project research?

● Yes ○ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product
○ Clinical investigation or other study of a medical device
○ Combined trial of an investigational medicinal product and an investigational medical device
○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
○ Basic science study involving procedures with human participants
○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
● Study involving qualitative methods only
○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
○ Study limited to working with data (specific project only)
○ Research tissue bank
○ Research database

If your work does not fit any of these categories, select the option below:

○ Other study

2a. Please answer the following question(s):

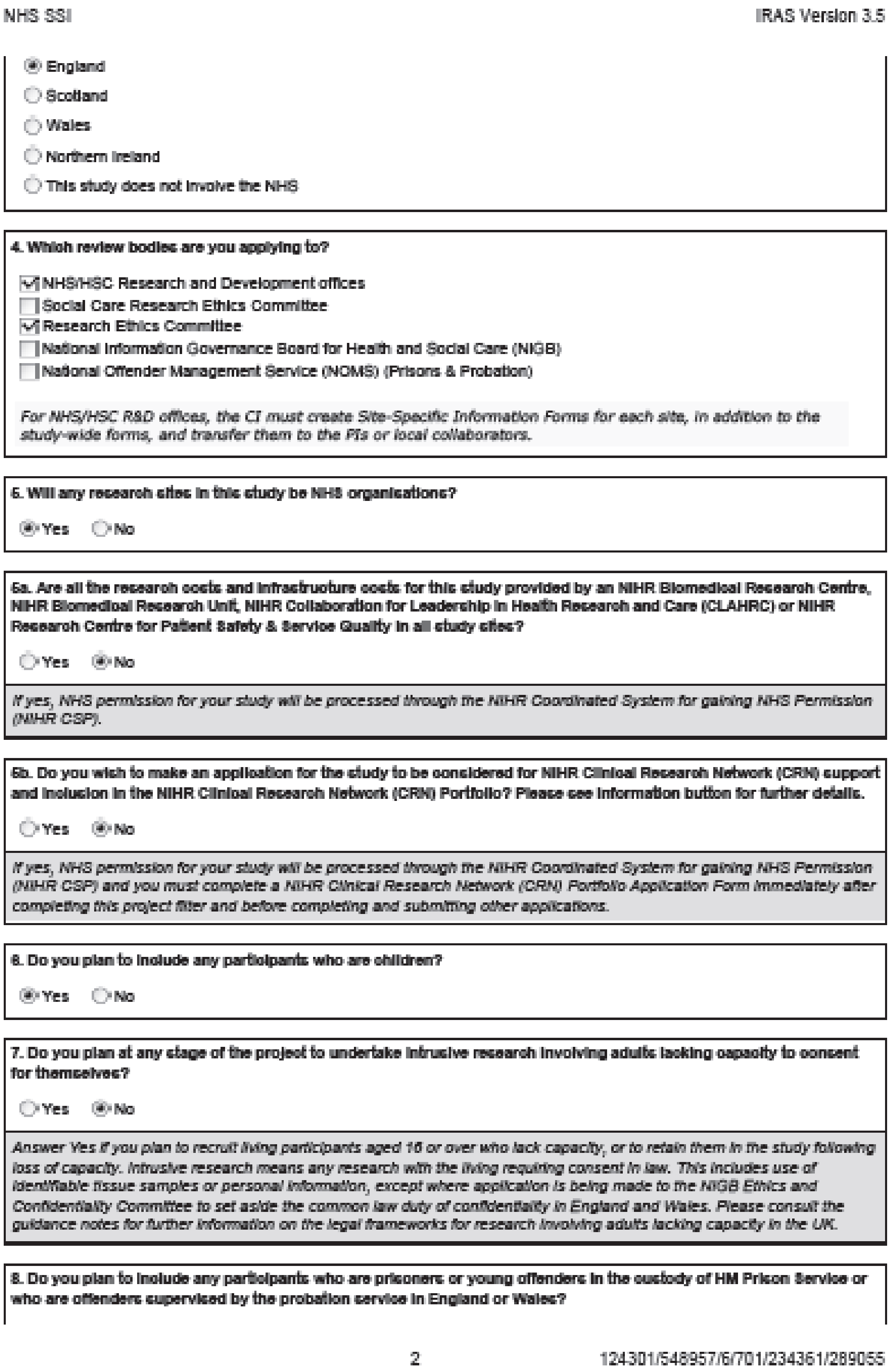
a) Does the study involve the use of any ionising radiation?	○ Yes	● No
b) Will you be taking new human tissue samples (or other human biological samples)?	○ Yes	● No
c) Will you be using existing human tissue samples (or other human biological samples)?	○ Yes	● No

3. In which countries of the UK will the research sites be located?*(Tick all that apply)*

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

1 124301/548957/6/701/234361/289055



NHS SSI IRAS Version 3.5

● England
○ Scotland
○ Wales
○ Northern Ireland
○ This study does not involve the NHS

4. Which review bodies are you applying to?

☑ NHS/HSC Research and Development offices
☐ Social Care Research Ethics Committee
☑ Research Ethics Committee
☐ National Information Governance Board for Health and Social Care (NIGB)
☐ National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D offices, the CI must create Site-Specific Information Forms for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.

5. Will any research sites in this study be NHS organisations?

● Yes ○ No

5a. Are all the research costs and infrastructure costs for this study provided by an NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC) or NIHR Research Centre for Patient Safety & Service Quality in all study sites?

○ Yes ● No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP).

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) support and inclusion in the NIHR Clinical Research Network (CRN) Portfolio? Please see information button for further details.

○ Yes ● No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP) and you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form immediately after completing this project filter and before completing and submitting other applications.

6. Do you plan to include any participants who are children?

● Yes ○ No

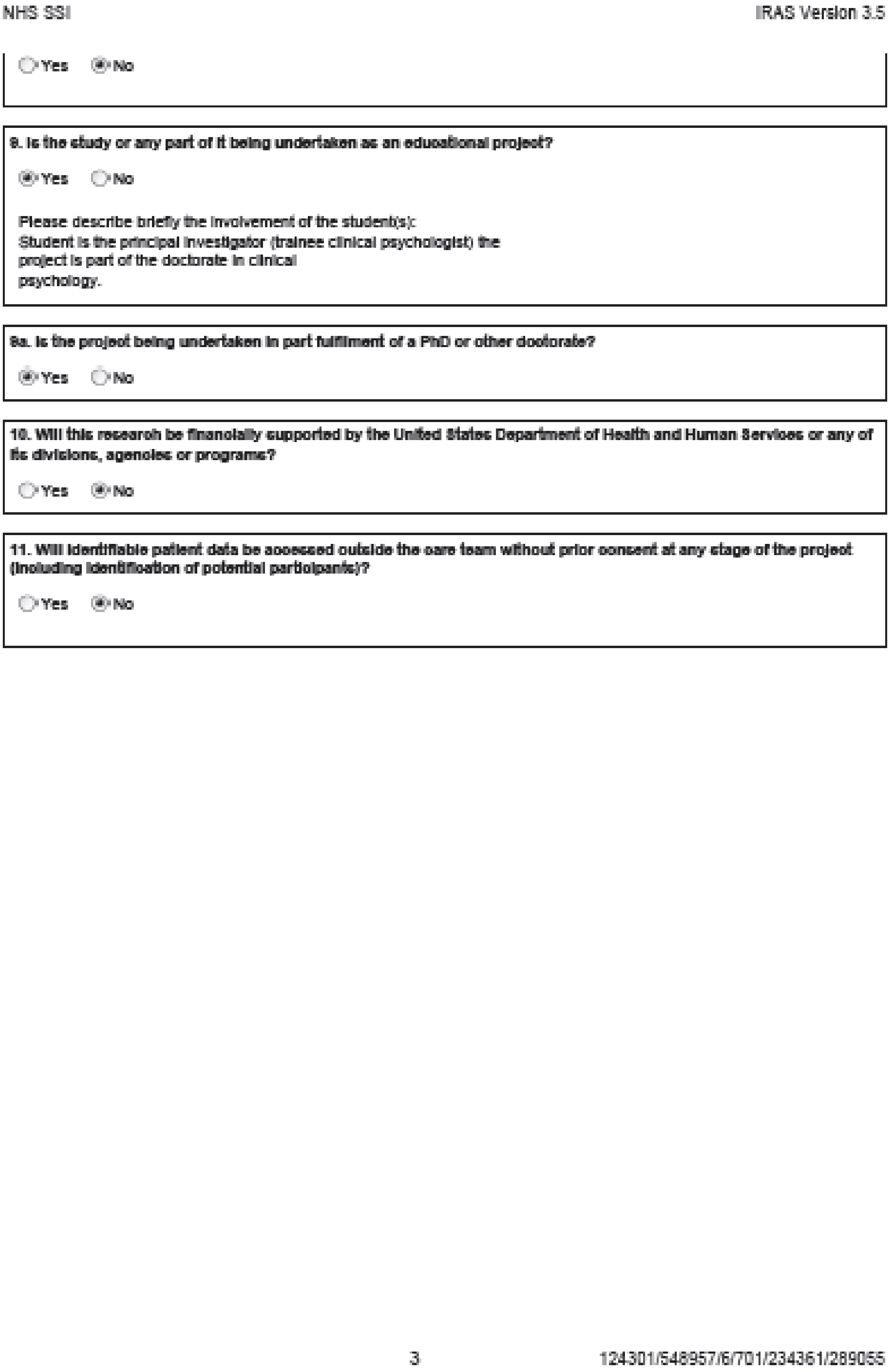
7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ● No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the NIGB Ethics and Confidentiality Committee to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

2 124301/548957/6/701/234361/289055



NHS SSI IRAS Version 3.5

○ Yes ● No

9. Is the study or any part of it being undertaken as an educational project?

● Yes ○ No

Please describe briefly the involvement of the student(s):
Student is the principal investigator (trainee clinical psychologist) the
project is part of the doctorate in clinical
psychology.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

● Yes ○ No

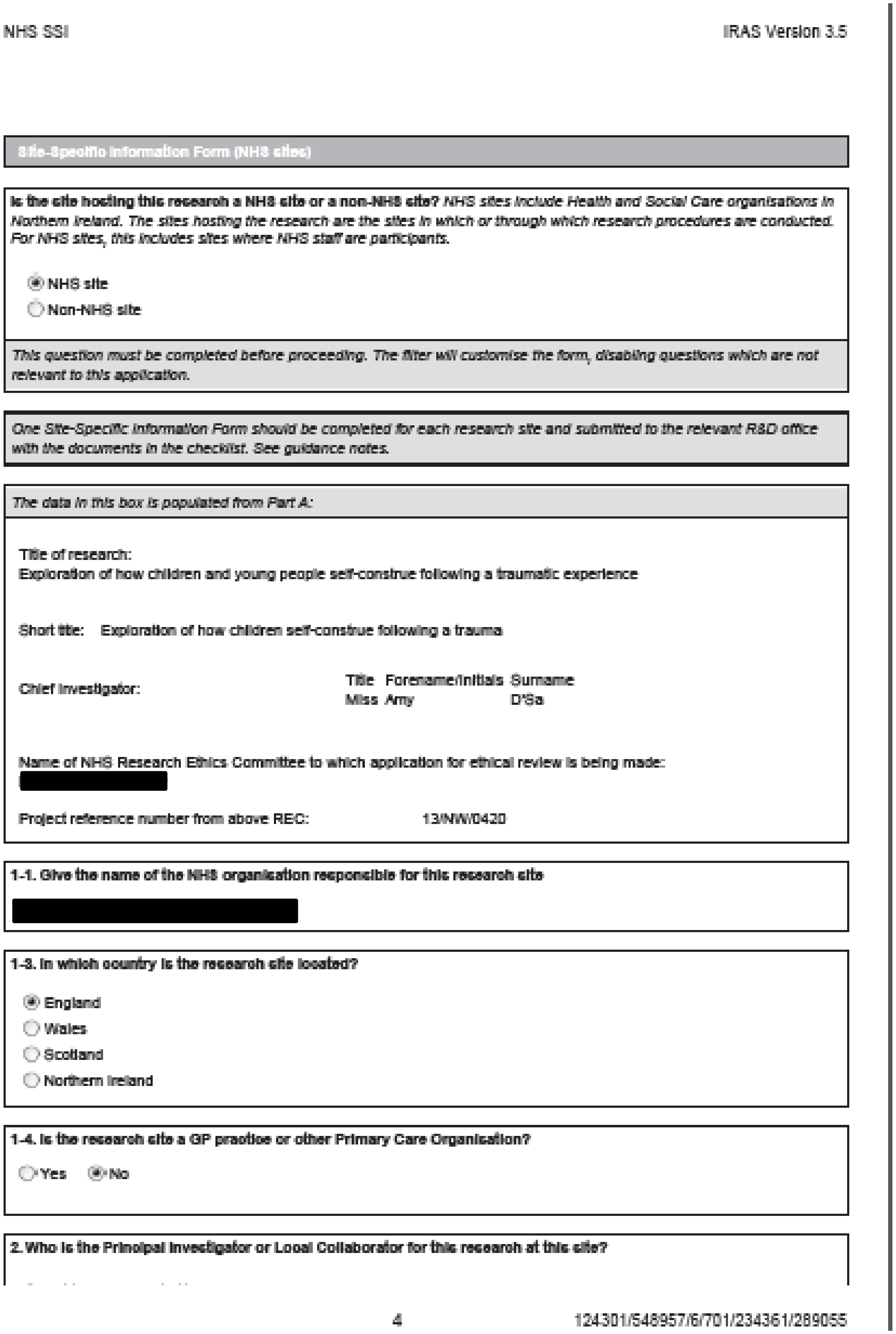
10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ● No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ● No

3 124301/548957/6/701/234361/289055



Site-Specific Information Form (NHS sites)

Is the site hosting this research a NHS site or a non-NHS site? *NHS sites include Health and Social Care organisations in Northern Ireland. The sites hosting the research are the sites in which or through which research procedures are conducted. For NHS sites, this includes sites where NHS staff are participants.*

● NHS site
○ Non-NHS site

This question must be completed before proceeding. The filter will customise the form, disabling questions which are not relevant to this application.

One Site-Specific Information Form should be completed for each research site and submitted to the relevant R&D office with the documents in the checklist. See guidance notes.

The data in this box is populated from Part A:

Title of research:
Exploration of how children and young people self-construe following a traumatic experience

Short title: Exploration of how children self-construe following a trauma

	Title	Forename/Initials	Surname
Chief Investigator:	Miss	Amy	D'Sa

Name of NHS Research Ethics Committee to which application for ethical review is being made:
[redacted]

Project reference number from above REC: 13/NW/0420

1-1. Give the name of the NHS organisation responsible for this research site

[redacted]

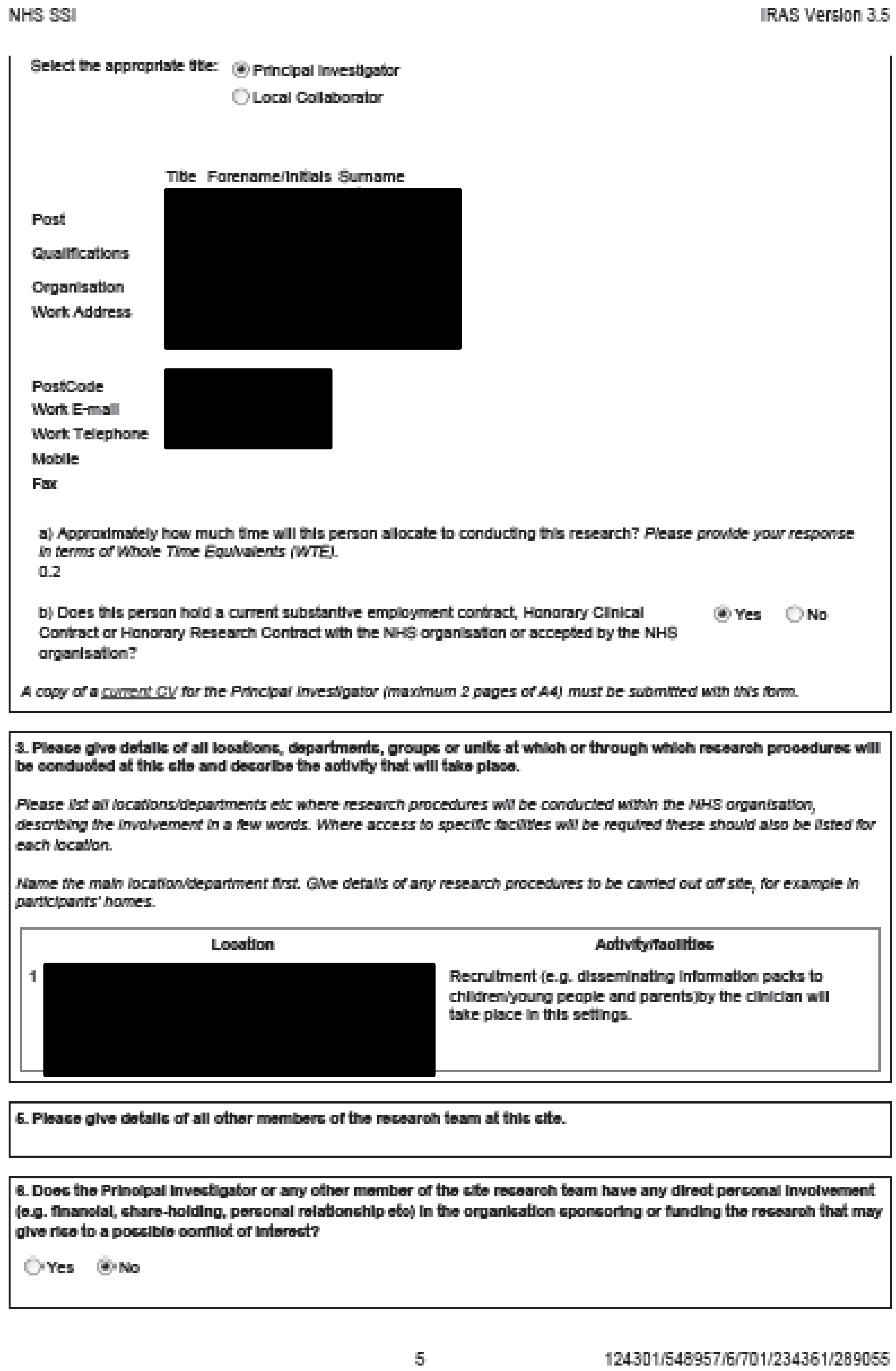
1-3. In which country is the research site located?

● England
○ Wales
○ Scotland
○ Northern Ireland

1-4. Is the research site a GP practice or other Primary Care Organisation?

○ Yes ● No

2. Who is the Principal Investigator or Local Collaborator for this research at this site?



NHS SSI IRAS Version 3.5

Select the appropriate title: ● Principal Investigator
○ Local Collaborator

Title Forename/Initials Surname
Post
Qualifications
Organisation
Work Address
[redacted]

PostCode
Work E-mail
Work Telephone
Mobile
Fax
[redacted]

a) Approximately how much time will this person allocate to conducting this research? *Please provide your response in terms of Whole Time Equivalents (WTE).*
0.2

b) Does this person hold a current substantive employment contract, Honorary Clinical Contract or Honorary Research Contract with the NHS organisation or accepted by the NHS organisation? ● Yes ○ No

A copy of a current CV for the Principal Investigator (maximum 2 pages of A4) must be submitted with this form.

3. Please give details of all locations, departments, groups or units at which or through which research procedures will be conducted at this site and describe the activity that will take place.

Please list all locations/departments etc where research procedures will be conducted within the NHS organisation, describing the involvement in a few words. Where access to specific facilities will be required these should also be listed for each location.

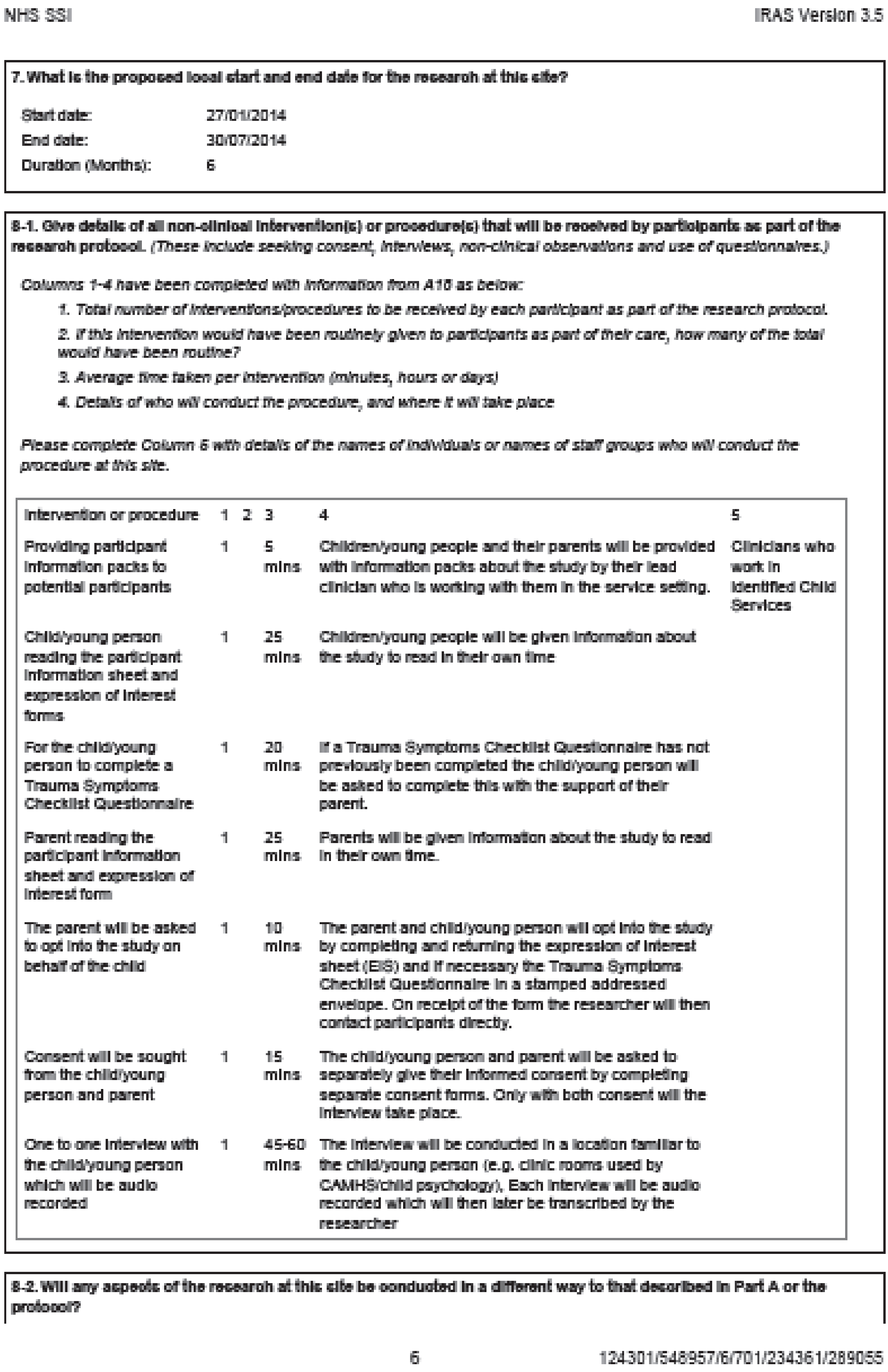
Name the main location/department first. Give details of any research procedures to be carried out off site, for example in participants' homes.

	Location	Activity/facilities
1	[redacted]	Recruitment (e.g. disseminating information packs to children/young people and parents)by the clinician will take place in this settings.

5. Please give details of all other members of the research team at this site.

6. Does the Principal Investigator or any other member of the site research team have any direct personal involvement (e.g. financial, share-holding, personal relationship etc) in the organisation sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ● No



7. What is the proposed local start and end date for the research at this site?

Start date: 27/01/2014
End date: 30/07/2014
Duration (Months): 6

8-1. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *(These include seeking consent, interviews, non-clinical observations and use of questionnaires.)*

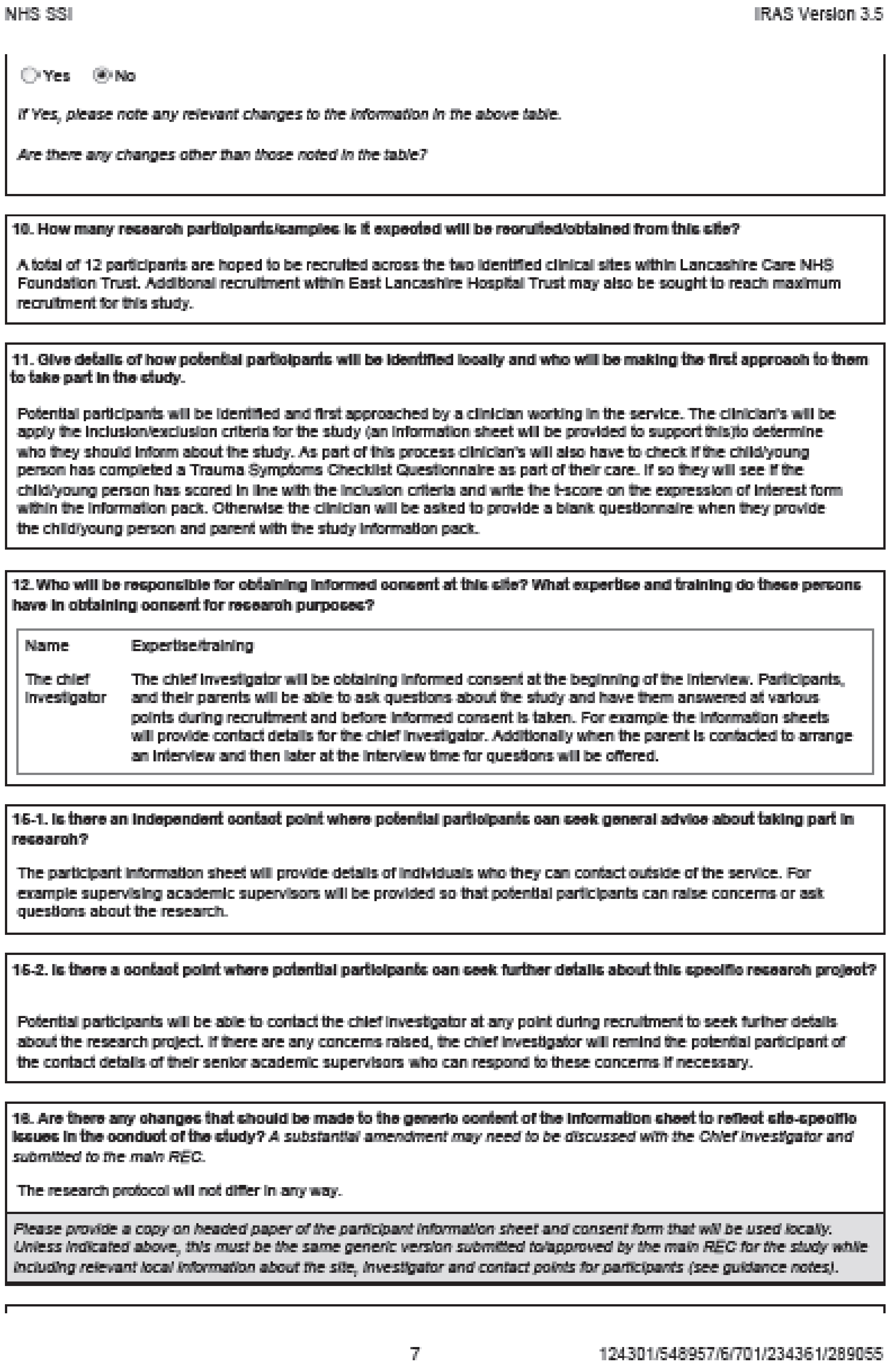
Columns 1-4 have been completed with information from A18 as below:

1. *Total number of interventions/procedures to be received by each participant as part of the research protocol.*
2. *If this intervention would have been routinely given to participants as part of their care, how many of the total would have been routine?*
3. *Average time taken per intervention (minutes, hours or days)*
4. *Details of who will conduct the procedure, and where it will take place*

Please complete Column 5 with details of the names of individuals or names of staff groups who will conduct the procedure at this site.

Intervention or procedure	1	2	3	4	5
Providing participant information packs to potential participants	1		5 mins	Children/young people and their parents will be provided with information packs about the study by their lead clinician who is working with them in the service setting.	Clinicians who work in identified Child Services
Child/young person reading the participant information sheet and expression of interest forms	1		25 mins	Children/young people will be given information about the study to read in their own time	
For the child/young person to complete a Trauma Symptoms Checklist Questionnaire	1		20 mins	If a Trauma Symptoms Checklist Questionnaire has not previously been completed the child/young person will be asked to complete this with the support of their parent.	
Parent reading the participant information sheet and expression of interest form	1		25 mins	Parents will be given information about the study to read in their own time.	
The parent will be asked to opt into the study on behalf of the child	1		10 mins	The parent and child/young person will opt into the study by completing and returning the expression of interest sheet (EIS) and if necessary the Trauma Symptoms Checklist Questionnaire in a stamped addressed envelope. On receipt of the form the researcher will then contact participants directly.	
Consent will be sought from the child/young person and parent	1		15 mins	The child/young person and parent will be asked to separately give their informed consent by completing separate consent forms. Only with both consent will the interview take place.	
One to one interview with the child/young person which will be audio recorded	1		45-60 mins	The interview will be conducted in a location familiar to the child/young person (e.g. clinic rooms used by CAMHS/child psychology). Each interview will be audio recorded which will then later be transcribed by the researcher	

8-2. Will any aspects of the research at this site be conducted in a different way to that described in Part A or the protocol?



NHS SSI IRAS Version 3.5

○ Yes ● No

If Yes, please note any relevant changes to the information in the above table.

Are there any changes other than those noted in the table?

10. How many research participants/samples is it expected will be recruited/obtained from this site?

A total of 12 participants are hoped to be recruited across the two identified clinical sites within Lancashire Care NHS Foundation Trust. Additional recruitment within East Lancashire Hospital Trust may also be sought to reach maximum recruitment for this study.

11. Give details of how potential participants will be identified locally and who will be making the first approach to them to take part in the study.

Potential participants will be identified and first approached by a clinician working in the service. The clinician's will be apply the inclusion/exclusion criteria for the study (an information sheet will be provided to support this)to determine who they should inform about the study. As part of this process clinician's will also have to check if the child/young person has completed a Trauma Symptoms Checklist Questionnaire as part of their care. If so they will see if the child/young person has scored in line with the inclusion criteria and write the t-score on the expression of interest form within the information pack. Otherwise the clinician will be asked to provide a blank questionnaire when they provide the child/young person and parent with the study information pack.

12. Who will be responsible for obtaining informed consent at this site? What expertise and training do these persons have in obtaining consent for research purposes?

Name	Expertise/training
The chief investigator	The chief investigator will be obtaining informed consent at the beginning of the interview. Participants, and their parents will be able to ask questions about the study and have them answered at various points during recruitment and before informed consent is taken. For example the information sheets will provide contact details for the chief investigator. Additionally when the parent is contacted to arrange an interview and then later at the interview time for questions will be offered.

15-1. Is there an independent contact point where potential participants can seek general advice about taking part in research?

The participant information sheet will provide details of individuals who they can contact outside of the service. For example supervising academic supervisors will be provided so that potential participants can raise concerns or ask questions about the research.

15-2. Is there a contact point where potential participants can seek further details about this specific research project?

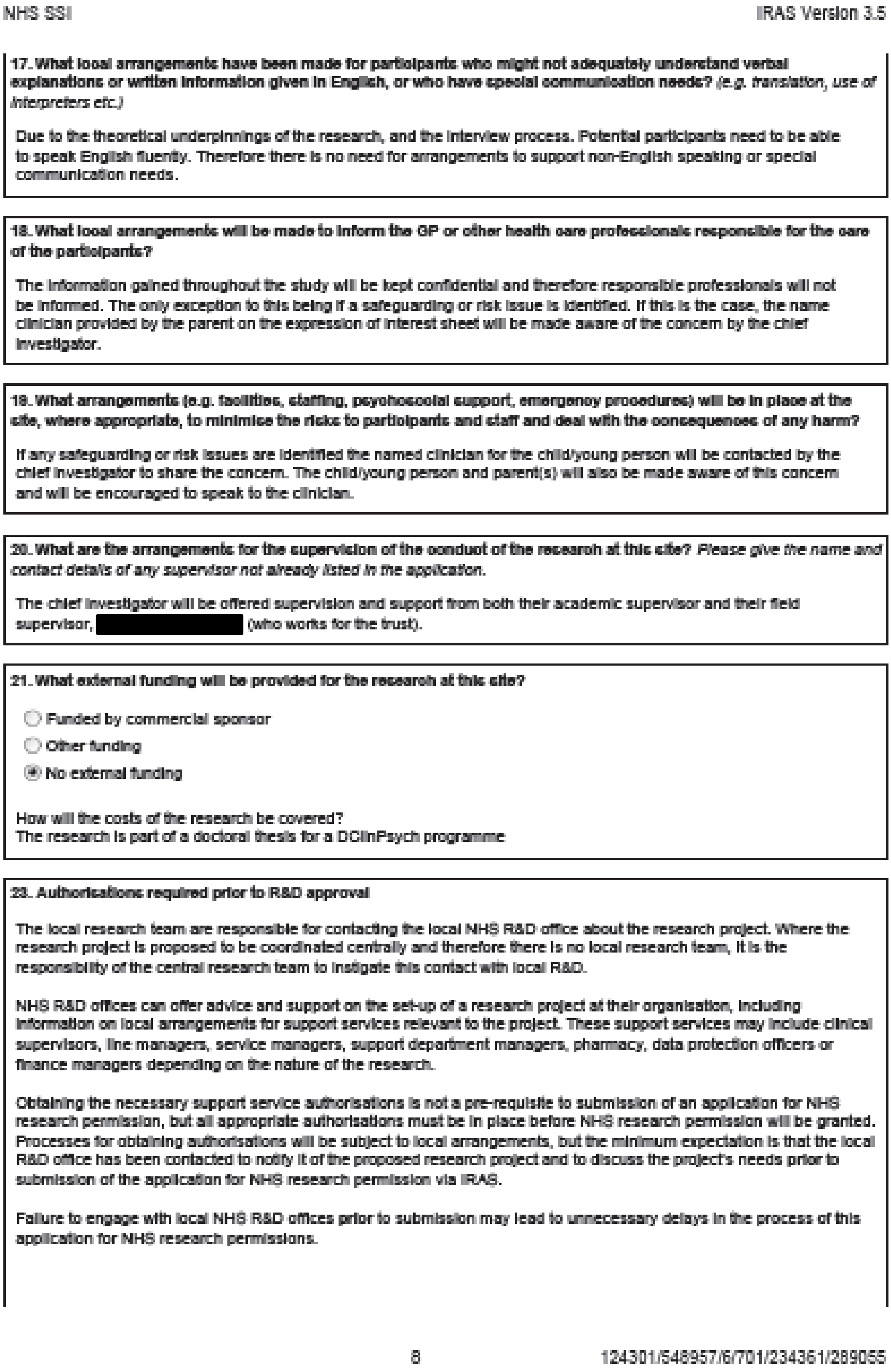
Potential participants will be able to contact the chief investigator at any point during recruitment to seek further details about the research project. If there are any concerns raised, the chief investigator will remind the potential participant of the contact details of their senior academic supervisors who can respond to these concerns if necessary.

16. Are there any changes that should be made to the generic content of the information sheet to reflect site-specific issues in the conduct of the study? *A substantial amendment may need to be discussed with the Chief Investigator and submitted to the main REC.*

The research protocol will not differ in any way.

Please provide a copy on headed paper of the participant information sheet and consent form that will be used locally. Unless indicated above, this must be the same generic version submitted to/approved by the main REC for the study while including relevant local information about the site, investigator and contact points for participants (see guidance notes).

7 124301/548957/6/701/234361/289055



17. What local arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? *(e.g. translation, use of interpreters etc.)*

Due to the theoretical underpinnings of the research, and the interview process. Potential participants need to be able to speak English fluently. Therefore there is no need for arrangements to support non-English speaking or special communication needs.

18. What local arrangements will be made to inform the GP or other health care professionals responsible for the care of the participants?

The information gained throughout the study will be kept confidential and therefore responsible professionals will not be informed. The only exception to this being if a safeguarding or risk issue is identified. If this is the case, the name clinician provided by the parent on the expression of interest sheet will be made aware of the concern by the chief investigator.

19. What arrangements (e.g. facilities, staffing, psychosocial support, emergency procedures) will be in place at the site, where appropriate, to minimise the risks to participants and staff and deal with the consequences of any harm?

If any safeguarding or risk issues are identified the named clinician for the child/young person will be contacted by the chief investigator to share the concern. The child/young person and parent(s) will also be made aware of this concern and will be encouraged to speak to the clinician.

20. What are the arrangements for the supervision of the conduct of the research at this site? *Please give the name and contact details of any supervisor not already listed in the application.*

The chief investigator will be offered supervision and support from both their academic supervisor and their field supervisor, [redacted] (who works for the trust).

21. What external funding will be provided for the research at this site?

○ Funded by commercial sponsor
○ Other funding
● No external funding

How will the costs of the research be covered?
The research is part of a doctoral thesis for a DClinPsych programme

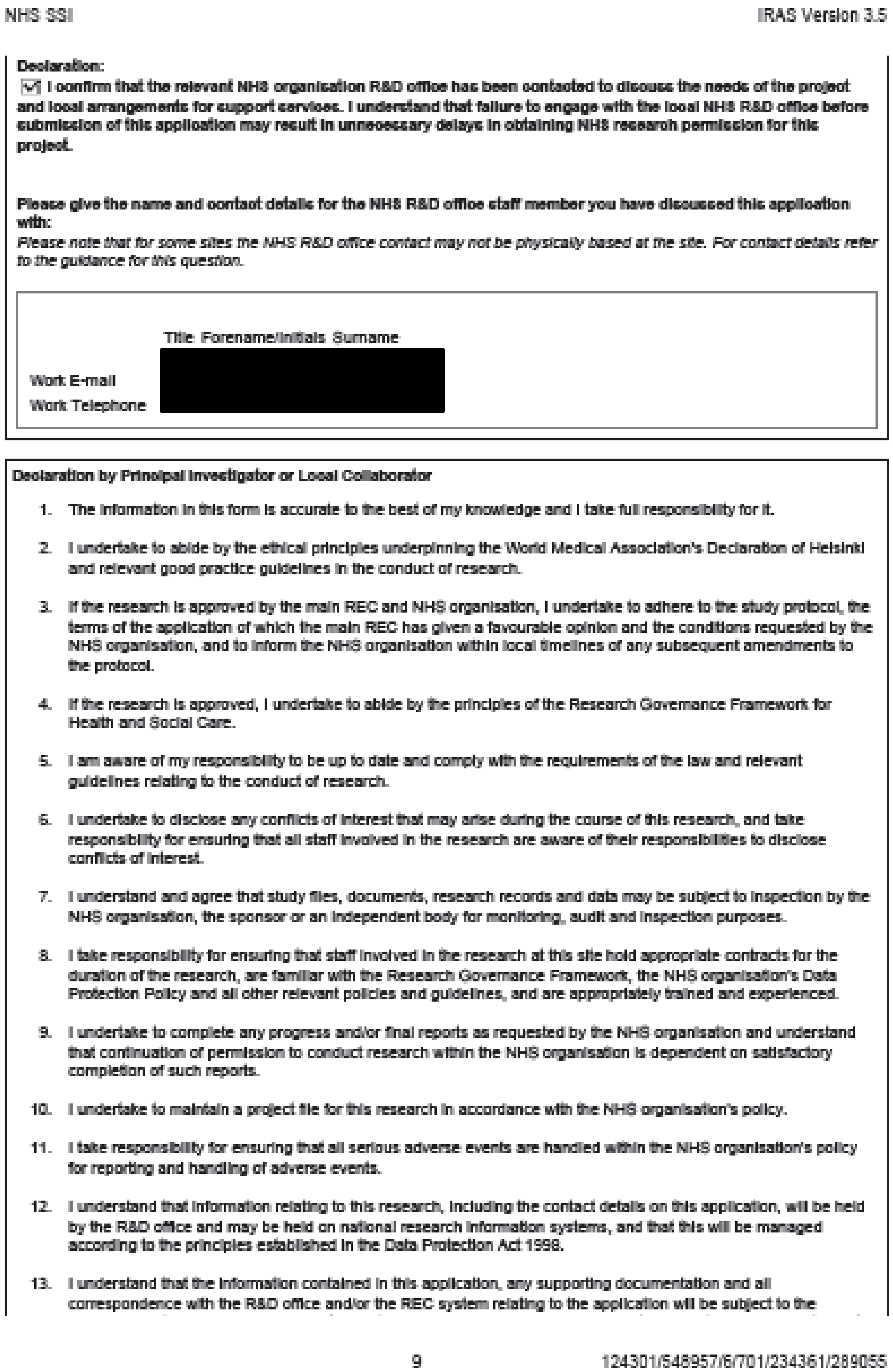
23. Authorisations required prior to R&D approval

The local research team are responsible for contacting the local NHS R&D office about the research project. Where the research project is proposed to be coordinated centrally and therefore there is no local research team, it is the responsibility of the central research team to instigate this contact with local R&D.

NHS R&D offices can offer advice and support on the set-up of a research project at their organisation, including information on local arrangements for support services relevant to the project. These support services may include clinical supervisors, line managers, service managers, support department managers, pharmacy, data protection officers or finance managers depending on the nature of the research.

Obtaining the necessary support service authorisations is not a pre-requisite to submission of an application for NHS research permission, but all appropriate authorisations must be in place before NHS research permission will be granted. Processes for obtaining authorisations will be subject to local arrangements, but the minimum expectation is that the local R&D office has been contacted to notify it of the proposed research project and to discuss the project's needs prior to submission of the application for NHS research permission via IRAS.

Failure to engage with local NHS R&D offices prior to submission may lead to unnecessary delays in the process of this application for NHS research permissions.



Declaration:

☑ **I confirm that the relevant NHS organisation R&D office has been contacted to discuss the needs of the project and local arrangements for support services. I understand that failure to engage with the local NHS R&D office before submission of this application may result in unnecessary delays in obtaining NHS research permission for this project.**

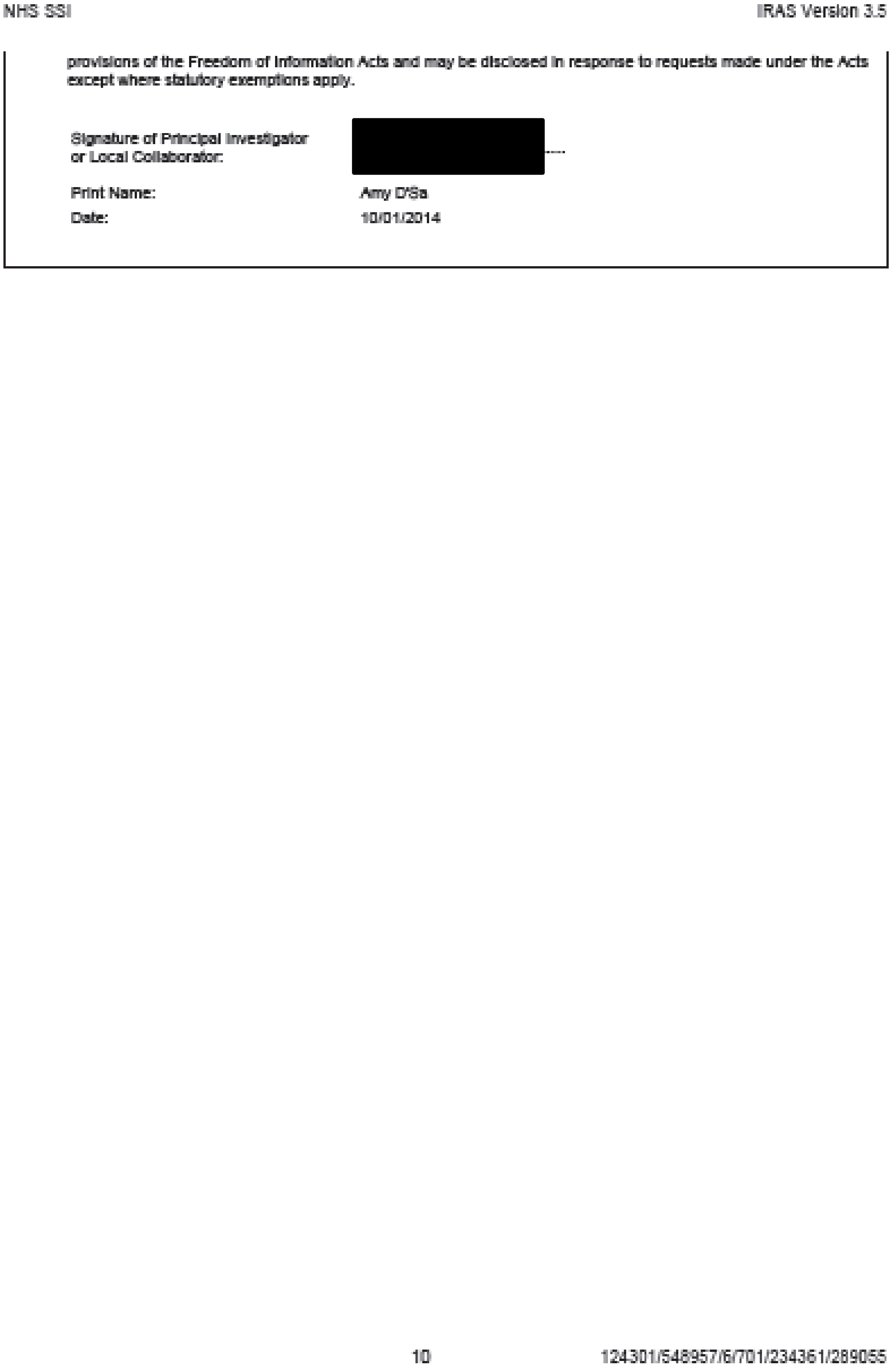
Please give the name and contact details for the NHS R&D office staff member you have discussed this application with:

Please note that for some sites the NHS R&D office contact may not be physically based at the site. For contact details refer to the guidance for this question.

Title Forename/Initials Surname
Work E-mail
Work Telephone
[redacted]

Declaration by Principal Investigator or Local Collaborator

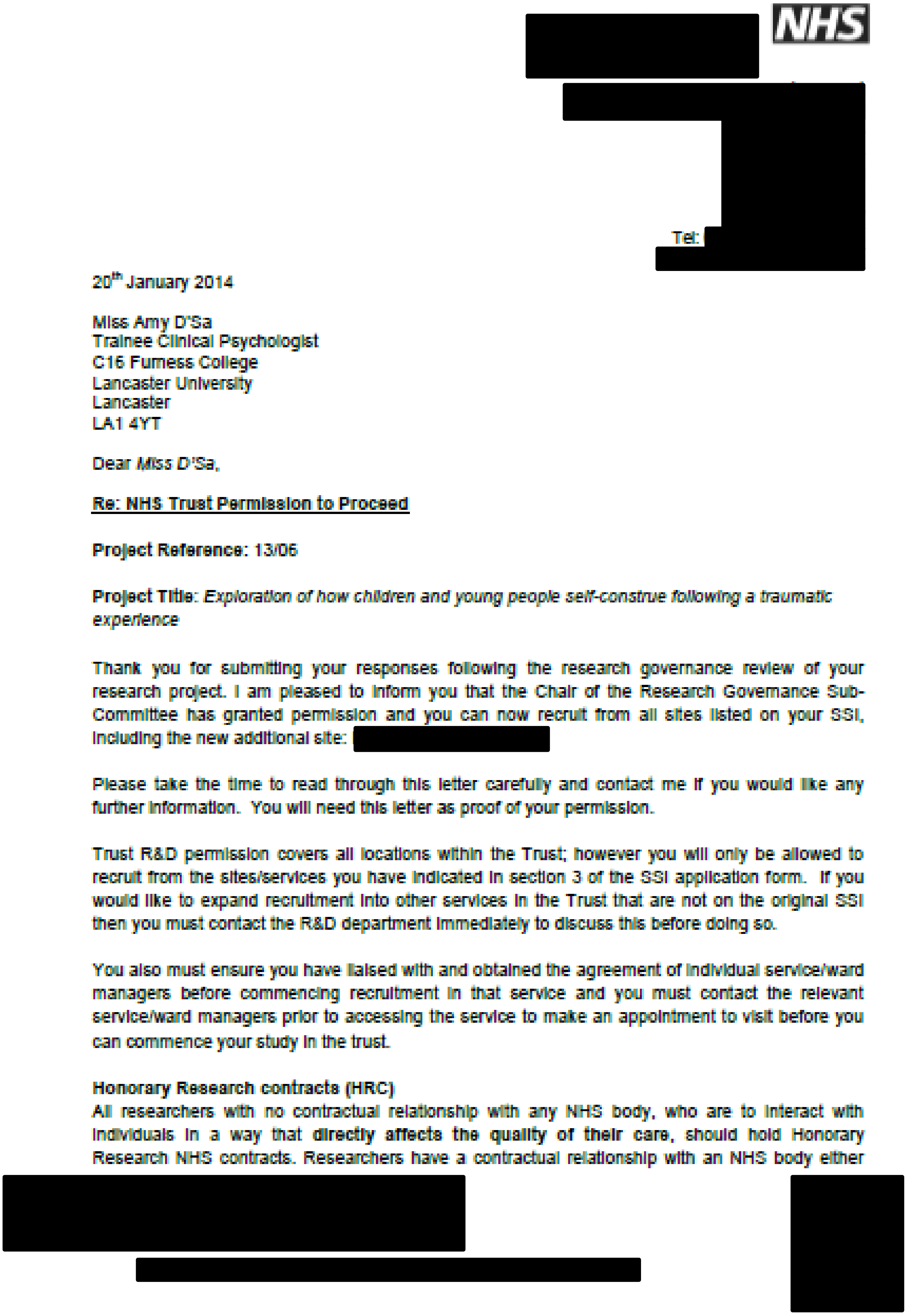
1. The information in this form is accurate to the best of my knowledge and I take full responsibility for it.
2. I undertake to abide by the ethical principles underpinning the World Medical Association's Declaration of Helsinki and relevant good practice guidelines in the conduct of research.
3. If the research is approved by the main REC and NHS organisation, I undertake to adhere to the study protocol, the terms of the application of which the main REC has given a favourable opinion and the conditions requested by the NHS organisation, and to inform the NHS organisation within local timelines of any subsequent amendments to the protocol.
4. If the research is approved, I undertake to abide by the principles of the Research Governance Framework for Health and Social Care.
5. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to the conduct of research.
6. I undertake to disclose any conflicts of interest that may arise during the course of this research, and take responsibility for ensuring that all staff involved in the research are aware of their responsibilities to disclose conflicts of interest.
7. I understand and agree that study files, documents, research records and data may be subject to inspection by the NHS organisation, the sponsor or an independent body for monitoring, audit and inspection purposes.
8. I take responsibility for ensuring that staff involved in the research at this site hold appropriate contracts for the duration of the research, are familiar with the Research Governance Framework, the NHS organisation's Data Protection Policy and all other relevant policies and guidelines, and are appropriately trained and experienced.
9. I undertake to complete any progress and/or final reports as requested by the NHS organisation and understand that continuation of permission to conduct research within the NHS organisation is dependent on satisfactory completion of such reports.
10. I undertake to maintain a project file for this research in accordance with the NHS organisation's policy.
11. I take responsibility for ensuring that all serious adverse events are handled within the NHS organisation's policy for reporting and handling of adverse events.
12. I understand that information relating to this research, including the contact details on this application, will be held by the R&D office and may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.
13. I understand that the information contained in this application, any supporting documentation and all correspondence with the R&D office and/or the REC system relating to the application will be subject to the



provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.

Signature of Principal Investigator or Local Collaborator:	[redacted]
Print Name:	Amy D'Sa
Date:	10/01/2014

Appendix 4-U: Letter of Approval from R&D for Additional Recruitment Site Trust 2



[redacted] NHS

[redacted]

Tel: [redacted]

20th January 2014

Miss Amy D'Sa
Trainee Clinical Psychologist
C16 Furness College
Lancaster University
Lancaster
LA1 4YT

Dear *Miss D'Sa*,

Re: NHS Trust Permission to Proceed

Project Reference: 13/06

Project Title: *Exploration of how children and young people self-construe following a traumatic experience*

Thank you for submitting your responses following the research governance review of your research project. I am pleased to inform you that the Chair of the Research Governance Sub-Committee has granted permission and you can now recruit from all sites listed on your SSI, including the new additional site: [redacted]

Please take the time to read through this letter carefully and contact me if you would like any further information. You will need this letter as proof of your permission.

Trust R&D permission covers all locations within the Trust; however you will only be allowed to recruit from the sites/services you have indicated in section 3 of the SSI application form. If you would like to expand recruitment into other services in the Trust that are not on the original SSI then you must contact the R&D department immediately to discuss this before doing so.

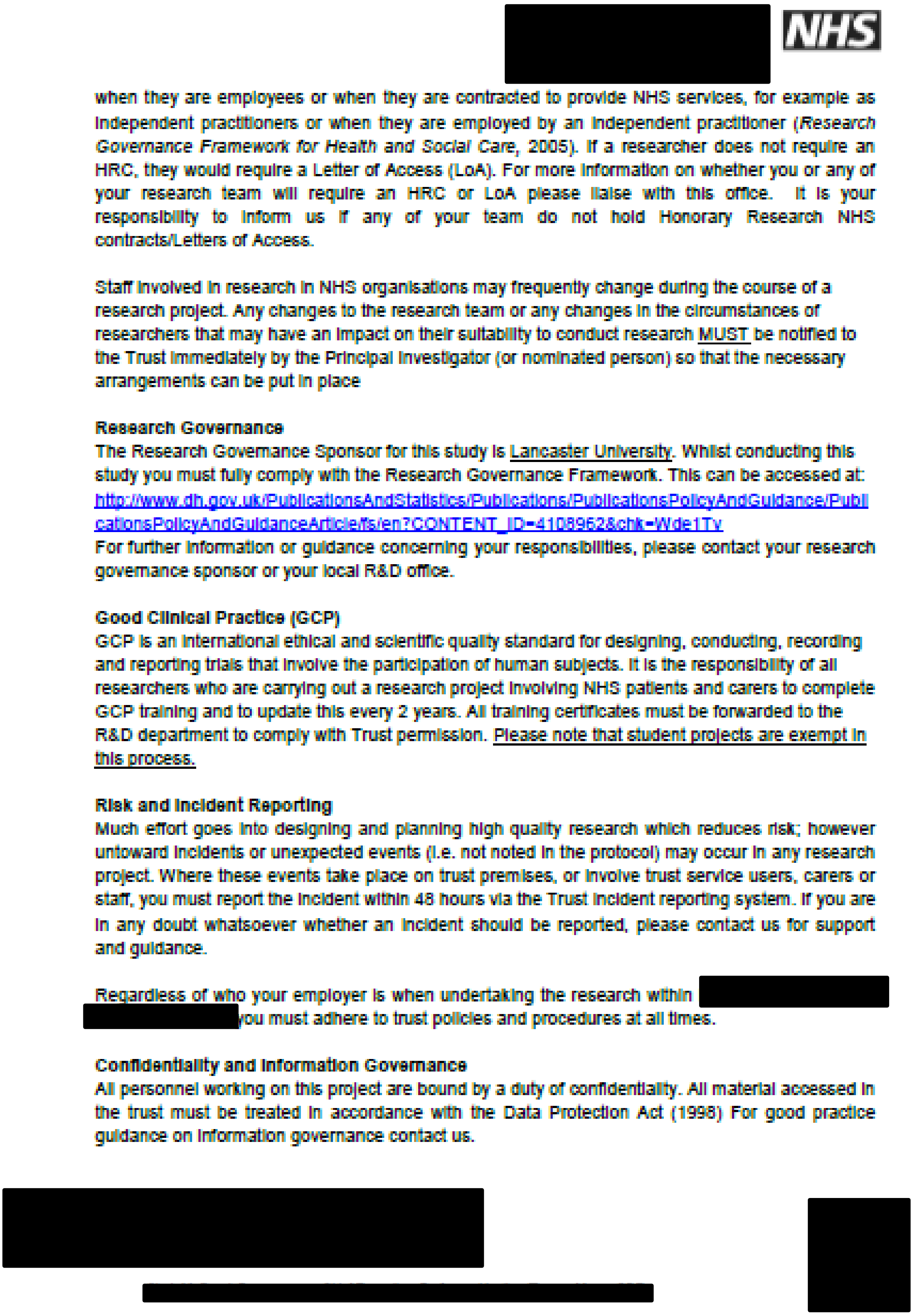
You also must ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing recruitment in that service and you must contact the relevant service/ward managers prior to accessing the service to make an appointment to visit before you can commence your study in the trust.

Honorary Research contracts (HRC)
All researchers with no contractual relationship with any NHS body, who are to interact with individuals in a way that **directly affects the quality of their care**, should hold Honorary Research NHS contracts. Researchers have a contractual relationship with an NHS body either

[redacted]

[redacted]

[redacted]



[redacted] NHS

when they are employees or when they are contracted to provide NHS services, for example as independent practitioners or when they are employed by an independent practitioner (*Research Governance Framework for Health and Social Care*, 2005). If a researcher does not require an HRC, they would require a Letter of Access (LoA). For more information on whether you or any of your research team will require an HRC or LoA please liaise with this office. It is your responsibility to inform us if any of your team do not hold Honorary Research NHS contracts/Letters of Access.

Staff involved in research in NHS organisations may frequently change during the course of a research project. Any changes to the research team or any changes in the circumstances of researchers that may have an impact on their suitability to conduct research MUST be notified to the Trust immediately by the Principal Investigator (or nominated person) so that the necessary arrangements can be put in place

Research Governance

The Research Governance Sponsor for this study is Lancaster University. Whilst conducting this study you must fully comply with the Research Governance Framework. This can be accessed at: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=Wde1Tv

For further information or guidance concerning your responsibilities, please contact your research governance sponsor or your local R&D office.

Good Clinical Practice (GCP)

GCP is an international ethical and scientific quality standard for designing, conducting, recording and reporting trials that involve the participation of human subjects. It is the responsibility of all researchers who are carrying out a research project involving NHS patients and carers to complete GCP training and to update this every 2 years. All training certificates must be forwarded to the R&D department to comply with Trust permission. Please note that student projects are exempt in this process.

Risk and Incident Reporting

Much effort goes into designing and planning high quality research which reduces risk; however untoward incidents or unexpected events (i.e. not noted in the protocol) may occur in any research project. Where these events take place on trust premises, or involve trust service users, carers or staff, you must report the incident within 48 hours via the Trust incident reporting system. If you are in any doubt whatsoever whether an incident should be reported, please contact us for support and guidance.

Regardless of who your employer is when undertaking the research within [redacted] you must adhere to trust policies and procedures at all times.

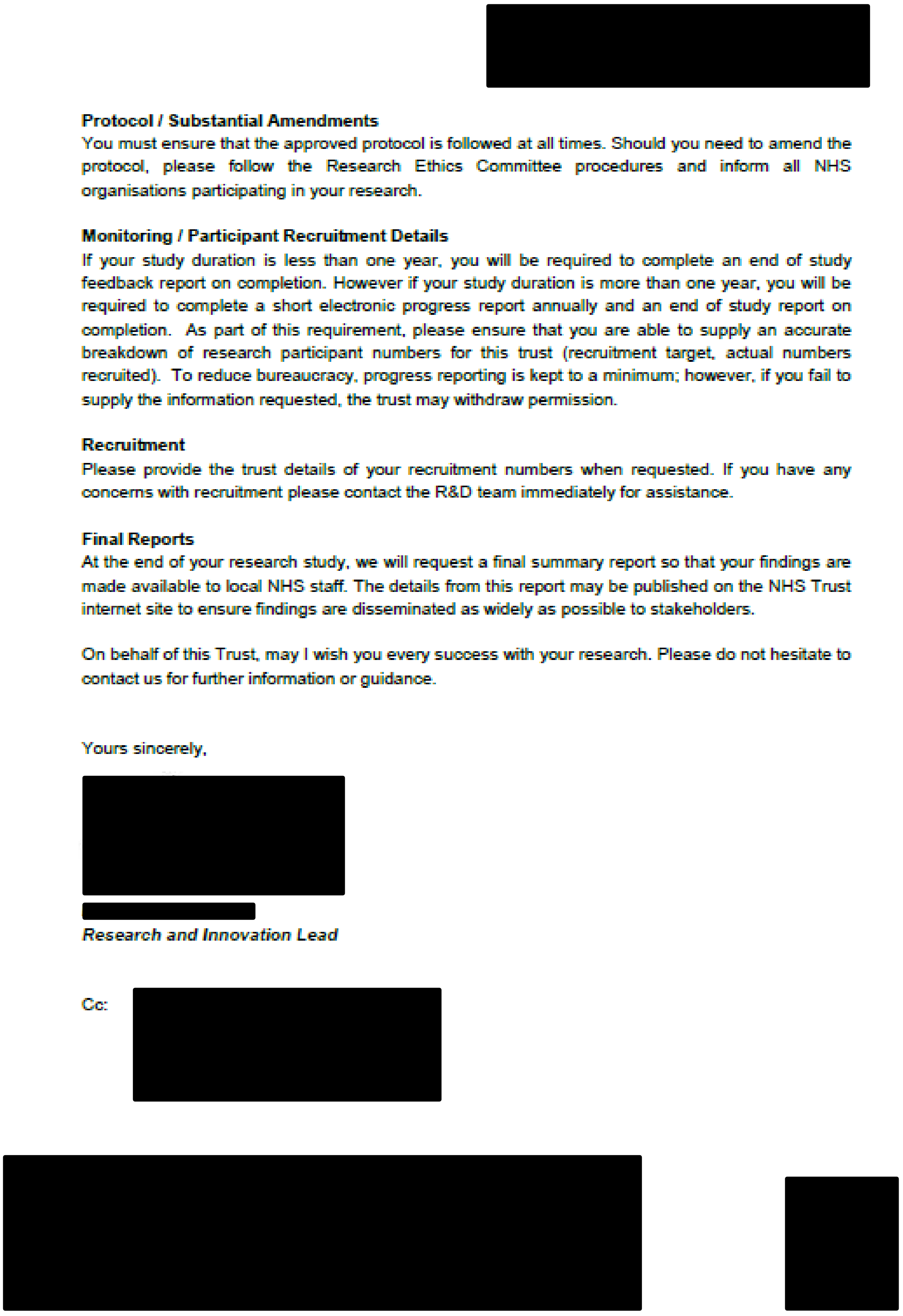
Confidentiality and Information Governance

All personnel working on this project are bound by a duty of confidentiality. All material accessed in the trust must be treated in accordance with the Data Protection Act (1998) For good practice guidance on information governance contact us.

[redacted]

[redacted]

[redacted]



[redacted]

Protocol / Substantial Amendments
You must ensure that the approved protocol is followed at all times. Should you need to amend the protocol, please follow the Research Ethics Committee procedures and inform all NHS organisations participating in your research.

Monitoring / Participant Recruitment Details
If your study duration is less than one year, you will be required to complete an end of study feedback report on completion. However if your study duration is more than one year, you will be required to complete a short electronic progress report annually and an end of study report on completion. As part of this requirement, please ensure that you are able to supply an accurate breakdown of research participant numbers for this trust (recruitment target, actual numbers recruited). To reduce bureaucracy, progress reporting is kept to a minimum; however, if you fail to supply the information requested, the trust may withdraw permission.

Recruitment
Please provide the trust details of your recruitment numbers when requested. If you have any concerns with recruitment please contact the R&D team immediately for assistance.

Final Reports
At the end of your research study, we will request a final summary report so that your findings are made available to local NHS staff. The details from this report may be published on the NHS Trust internet site to ensure findings are disseminated as widely as possible to stakeholders.

On behalf of this Trust, may I wish you every success with your research. Please do not hesitate to contact us for further information or guidance.

Yours sincerely,

[redacted]

[redacted]
Research and Innovation Lead

Cc: [redacted]

[redacted]

[redacted]