10

Qualitative Evidence on Psychological Trauma

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10.1 Overview of the Chapter

Psychological trauma has been a burgeoning field of research since the inception of Posttraumatic Stress Disorder (PTSD) as a diagnostic classification in the 1980 Diagnostic and Statistical Manual for Mental Disorders (APA 1980). Over three decades of scientific inquiry into traumatic stress has influenced theoretical approaches, clinical practice, and research methods in this field. In this chapter we address the question: "What is the qualitative evidence on the topic of psychological trauma?" We begin by defining posttraumatic stress according to the *DSM-V* (APA 2012) and provide prevalence rates, followed by a review of the qualitative research in various domains of trauma such as disasters, refugees, military, physical and sexual violence, and first responder groups. The literature on cancer and motor vehicle accidents were thoroughly reviewed, however we found very little evidence of qualitative research in these domains. A decision was made to not include these topics in this chapter as there was not sufficient evidence to provide a strong analysis. We provide recommendations for knowledge transfer strategies and conclude with a discussion of possible future directions for qualitative trauma research.

10.2 Definition of Terms and Prevalence Rates for Posttraumatic Stress Disorder

Posttraumatic stress is a serious psychological condition that can have chronic and debilitating effects on human functioning as a result of exposure to a single or multiple traumatic events. Although 50–90 % of the population in America may be exposed to traumatic events in their lifetime, most individuals do not develop PTSD (Breslau 2009; Kessler et al. 1995). Published prevalence rates estimate that 7.8–14 % of the US population has a diagnosis of PTSD; women are twice likely to develop PTSD than men (Breslau 2009; Foa and Feeny 2013; Kessler et al. 1995). The types of traumatic events are too numerous to name, but most important is the criterion that the traumatic event was experienced or witnessed as involving actual death or serious injury to self or others and that the person's response involved intense fear, helplessness, or horror (APA 2012). The three diagnostic

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symptom domains are intrusive imagery, hypervigilance, and avoidance behaviors. There are several comorbid symptom categories that usually accompany a diagnosis of PTSD such as generalized anxiety, depression, substance misuse, and panic attacks.

10.3 A Systematic Review of Qualitative Trauma Research

In order to discern the current qualitative evidence in trauma research, we conducted a review of several trauma journals and qualitative health journals. We also searched databases in trauma organizations (www.istss.org; www.apa.org) and indexes (ISI Web of Knowledge Social Science Citation Index, psychArticles, psychINFO, PubMed, and Web of Science), using the subject terms "posttraumatic stress," "posttraumatic stress disorder," "trauma," and "psychological trauma" with qualitative filters—"qualitative research," "qualitative study," and "qualitative research study." In the journals that we reviewed, we excluded book reviews, theoretical or conceptual manuscripts, reviews of the literature, memoirs and biographies, and quantitative research studies. Our analysis included only empirical research studies that used a qualitative research method to investigate topics on posttraumatic stress. We also included mixed methods research if a qualitative component was included in the study. We now present the qualitative evidence on psychological trauma within the following topic domains: disaster trauma, the trauma of refugees, military trauma, physical and sexual violence trauma, and the trauma of first responder populations.

10.3.1 Disaster Trauma

Disaster response has been a burgeoning field of inquiry over the last two decades. The history of the study of disaster began with the Geneva Convention and the work of the International Committee of the Red Cross in response to the devastation caused by WWII and the holocaust. However, in Canada and the USA disaster mental health "focuses on the mental health needs of those directly affected by disaster, of disaster relief personnel, and of those indirectly affected by disaster (secondary victims). The field can be broadly divided into three areas: preparation, direct services, and research" (Jacobs 1995, p. 544). In his report on a national plan for disaster mental health, Jacobs (1995) comments: "Disaster mental health is a young and burgeoning field; hence, it is critical that researchers study and evaluate the impact of disaster, the needs of those affected, and strategies for management and intervention" (p. 544).

Since Jacob's recommendation almost 20 years ago, research on disaster mental health has expanded from responses to war conflict to natural, human-made and technological disasters. Several historical disasters were responsible for the development of national plans to address mental health concerns in the wake of a disaster. In our review of the literature the following qualitative studies on disaster trauma were found: *the Asian tsunami of 2004* (Ekanayake et al. 2013; Jensen et al. 2013), *the 2010 earthquake in Haiti* (Ghose et al. 2012; Raviola et al. 2012), *a train crash in Sweden* (Forsberg and Saveman 2011), *wildfires* (Cox and Perry 2011), *tornados* (Miller et al. 2012), and *hurricanes* (Dass-Brailsford et al. 2011; Putman et al. 2012; Rivera 2012). These qualitative studies describe the conditions post-disaster, the experiences of disaster survivors, the coping strategies employed by survivors, and the management of disaster relief, in particular, the provision of mental health services. To address the need for effective interventions for disaster mental health, National Disaster Response Teams have been developed and training in Critical Incident Stress Management and Psychological First Aid are now standard practices for first responders and disaster personnel. The Sphere Project (Batniji et al. 2006) was launched by NGO's in response to criticism of aid provided during the Rwandan conflict. This handbook provides standards for mental and social health during disaster and conflict crises and involves assessment through 12 intervention checks (Batniji et al. 2006). Additionally, the American Psychological Association has a web page in their help center on *Disasters and Terrorism* that is an excellent resource: (http://www.apahelpcenter.org/articles/topics.php?id=4).

Research on disasters has commonly been studied using quantitative research methods. As in the other domains of psychological trauma, very few qualitative studies have been conducted on the psychological trauma resulting from disaster events. In our systematic review of the disaster literature, we discovered three studies investigating the risks to mental health relief workers/humanitarian aid workers (Agazio 2010; Sweifach et al. 2012; Wang et al. 2013). These three studies were exemplary with regard to the rigor of their qualitative research design and are presented for their contributions to knowledge in disaster trauma.

Agazio studied the challenges faced by 75 army nurses in humanitarian and wartime missions using a "descriptive qualitative design" and employing telephone interviews that were thematically analyzed. In this study, we learn about the environmental challenges for humanitarian aid workers dealing with extreme weather conditions, from the heat, dust, and sandstorms in Iraq and Afghanistan to the mud and cold in Bosnia. Agazio also reports the difficulty in providing treatment when there are language barriers and no infrastructure for providing health care in host countries due to lack of supplies and equipment. "The pace, difficult environmental conditions, threat level and brutality of the injuries all took their toll on staff" (2010, p. 173). In this study we learn the importance of effective training and preparation before deployment in order to handle the breadth of care needed in conflict and disaster areas that are environmentally challenging.

Sweifach et al. investigated social workers' personal responses to disaster work using a focus group design to understand post-disaster reactions in this population. They recruited 102 social workers from three different countries (the USA, Canada, and Israel) and conducted 14 focus group interviews that were analyzed using grounded theory's constant comparative method. They found that most respondents:

> […] experienced dynamic tension between grasping the disaster from a professional perspective, while attempting to assimilate the disaster within themselves […] expressing difficulty in reconciling their own personal and professional cognitions, emotions and behaviours, and maintaining professionally focused feelings/thoughts/composure, while others expressed little difficulty […] Respondents did seem to indicate that in general, personal needs and emotions should not play a role during disaster response; however, a fail-safe model to assure this, does not exist.
> (2012, pp. 7–8)

This struggle between the personal self as a victim of a disaster and the professional self is made apparent in this article as both identities are completely involved in the disaster experience (Sweifach, p. 8). Implications for professional practice are notable and the ethics of care both to self and other are also significant.

Wang et al.'s (2013) study of the 2008 Sichuan earthquake in China using semi-structured interviews with 25 local relief officials (e.g., health care workers, teachers, and social workers) using a thematic analysis provides insight into the coping strategies used by local relief workers and how these workers' own traumatic bereavement, housing and financial difficulties and work–family conflicts were the main causes of their traumatic stress. Local relief workers differ from provincial or national disaster responders, as "they are also disaster survivors and are likely to be suffering from trauma and loss" (p. 207). There are competing demands from the community and the personal demands from family members. This study provides a detailed account of the perceived sources of stress in local relief workers professional duties and their personal and family life. They describe their coping experiences as: finding meaning and purpose in life through relief work; receiving support from coworkers; suppressing and avoiding their grief through distractions; having a greater appreciation for life; being optimistic and making up for loss by moving forward in their lives. The authors point to the necessity to attend to the immediate grief and loss of workers, as they may be at risk for delayed or prolonged grief if their bereavement is not addressed. They recommend that managers of disaster response be flexible in the work schedule so that relief workers are also able to attend to their personal and family needs. Self-care should always be part of the mandate of disaster response to prevent worker trauma post-disaster.

From these three exemplary studies we learn that post-disaster care needs to be available to disaster relief workers and volunteers. This care needs to be provided by professionals trained in posttraumatic stress and secondary traumatic stress interventions. Further, preparation through education and training of local relief workers is essential in the prevention of posttraumatic stress from disaster response work. Sweifach et al. (2012) recommend that:

> Agencies ought to implement strategies that strengthen the ability of personnel to better navigate through issues inhibiting best professional practices during and after disasters, such as emergency drills that incorporate worst-case scenarios, and include psychological debriefing; employing a buddy system in which co-workers are paired together in case one worker becomes impaired; in-service trainings that review and test disaster protocols; and conducting exercises that are designed to strengthen resilience to primary and secondary trauma.
> (Sweifach 2012, p. 8)

The qualitative evidence in these studies is helpful in the administration of disaster relief and can assist in the development of the management of mental health risks to national and local disaster responders. Given the descriptive accounts provided by participants in these qualitative studies, we can learn how to effectively function in challenging settings. From their experiences, we are able to develop effective coping strategies and resources for individuals and teams responding to natural and human-made disasters. We also learn lessons on how to maintain a balance in responding to client needs and personal family needs simultaneously during a disaster. There are many quantitative studies in the research literature, however, they do not provide a contextualized view of those experiencing disaster events. Without an understanding of the local context, interventions and disaster response efforts are hampered. Qualitative research evidence informs us that disaster experiences are complex and varied and that western interventions cannot be assumed to be useful across all settings. In their discussion of the Sphere Project, Batniji and colleagues (2006) recommend that social interventions need further qualitative research:

> These include mass communication in disasters; family re-unification; misuse of the classroom to incite hatred; community consultation to guide decision-making; and recording, recognizing and addressing rights violations as part of the aid response […] A fundamental question that needs further assessment is whether (non co-morbid) PTSD is associated with impaired daily functioning in non-Western, resource-poor settings […] Through research, social scientists may play a key role in promoting socially appropriate mental health responses and contribute to a more balanced interpretation of the biopsychosocial clinical model.
> (Batniji et al. 2006, p. 1861)

The field of disaster trauma warrants much more research. We are just beginning to understand the importance of context in disaster response. We need to build a better understanding of how religion, ethnicity, culture, age, and gender, for example, affect one's response to disaster and the effects of these factors on one's resilience. We also need to investigate the experiences of children in disaster zones and the experiences of survivors of multiple disasters.

10.3.2 Refugee Trauma

> Today's wars, whose main casualties are civilians, often occur within the confines of a country, pitting country-men, friends, and neighbors against each other. Tensions and violence commonly arise between neighbouring ethnolinguistic or religious groups, and it is not uncommon for a government to wage war against a segment of its own population.
> (Magid and Boothy 2013)

As of 2011, there were an estimated 26.4 million internally displaced persons and 10.5 million refugees around the world (UNHCR 2013). Almost half of the world's refugees are children.

In a review of the trauma literature, five qualitative studies emerged that report on the traumatic experiences of refugees and asylum seekers.

The first study is a 2013 study of posttraumatic growth among 12 Tibetan refugees residing in India. Hussain and Bhushan (2013) interviewed the participants using an interpretive phenomenological method. The major themes found were: "positive changes in outlook toward the world and people, realization of personal strengths, and the experience of more intimate and meaningful relationships" (p. 204). The authors explain that Tibetan culture and religion provide "intrinsic resources for coping and thriving" (p. 206). This phenomenological study provides understanding of how participants make meaning of their lives and provides information about their process of developing posttraumatic growth within the specific contexts of their lives. Most research on posttraumatic growth is conducted with western populations and little research exists on non-western populations. The results of this study are very useful to clinicians working with refugee populations.

Simich et al. (2010) conducted a mixed methods design using a survey of 220 Sudanese refugees in Ontario and Alberta in Canada, followed by in-depth qualitative interviews with 30 community members in three sites. Their qualitative results reveal how "meanings of home emerged as a key concept linking social support, resettlement, and mental health" (p. 199). The authors note that mental health practitioners and other health care providers need to take into account the qualities of home that are lacking in Sudanese resettlement experiences and that social support is a necessary component for successful resettlement in Canada and to the mental health of this refugee population.

Maier and Straub (2011) studied the experiences and treatment expectations of 13 traumatized migrants and asylum seekers from Bosnia, Kosovo, Turkey, Iran, Afghanistan, Cameroon, Sudan and Chechnya. Using a qualitative generic research design and a content analysis, they found that "most participants had no clear or defined expectations concerning appropriate treatment" (p. 232). The authors discuss the issues of language barriers that lead to misunderstandings about the nature of health concerns as well as gaps in respective concepts of illness and mental health treatment. They state that most refugees do not ask for psychological help because they are unfamiliar with this form of treatment and they may be suspect about this form of health care (Maier and Straub 2011). However, once informed and given the opportunity to receive psychological services, the migrants in this study supported the idea of psychological treatment. Maier and Straub recommend specialized training of counselors to work with this population as well as financing for the availability of interpreters.

Somasundaram (2010) investigated the displaced and interned Vanni civilians during the civil war in Sri Lanka. The author interviewed a large sample of people in the internment camps as well as health care providers and NGO's. We learn from first-hand accounts the massive destruction and horror experienced by civilians. The author provides a rich in-depth description of the mental health of internally displaced people and the meaning of their collective trauma—the violent destruction of home, family, village and community. This study explains the importance of international interventions that are context-sensitive in the resettlement and reparation phases of rebuilding community.

Thomas et al. (2011) examined the mental health of 24 refugees who resettled in Nepal. In-depth individual interviews, focus group interviews and a photovoice method were used to understand coping strategies and resilience amongst these refugees from Pakistan and Somalia. The main finding on active coping revealed that refugees seek support through primary relationships. The authors highlight the importance of the provision of legal and social networks in refugee resettlement and recovery from traumatic stress.

These qualitative studies make a significant contribution to knowledge in the development of appropriate interventions and understanding of the breath of refugee trauma. Almost all of these studies were conducted in internment camps with researchers living among their interviewees.

These researchers give voice to the silenced and provide contextual meanings to the experience of collective trauma. We learn first-hand the experience of what it means to lose one's community and traditions as well as the complications of cultural bereavement. Their findings provide important recommendations for clinical practice and health care at an international level. Since the general medical practitioner (family physician) was the most trusted health care contact, it is imperative that family physicians in resettlement countries have skill in assessing posttraumatic stress symptoms. Also important is knowledge about valuable resources such as the Inter-agency Standing Committee (IASC 2007) *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* that emphasize the importance of cultural sensitivity, local ownership, and religious contextualization. The guidelines recognize that the best support comes from within the community itself.

10.3.3 Military Trauma

In this section of the chapter, we review the qualitative evidence on military trauma (e.g., veterans, soldiers, peacekeepers, spouses of military personnel). The qualitative evidence we found covers the effects of war-related trauma with these populations over the last decade.

Most of the qualitative evidence on military trauma describes the experiences of military personnel who have been diagnosed with PTSD due to traumatic events while serving their countries. This evidence is significant for psychologists working with returning soldiers, as they need to be informed about their personal experiences in order to implement appropriate treatment plans for their clients. Shaw and Hector (2010) employed phenomenological interviews with ten male military members who had recently returned from Iraq and/or Afghanistan. The overall thematic structure reveals that psychologists working with returning soldiers need to help their clients explore what their deployment meant to them and how they derive meaning from it. As the new form of insurgency warfare grows (war that makes it difficulty to discern enemies from civilians), the experiences of soldiers in these contexts require expanded knowledge by health care providers. The authors state that qualitative research provides this contextual knowledge.

Ellison et al. (2012), using a participatory research design and thematic analysis, gathered the perceptions of 29 veterans about the educational barriers of Vets with PTSD. This study is very informative for outreach and support services for Vets. The authors describe the barriers to services and the personal experiences of veterans who struggle upon release from their service to get the information they need to make a healthy adjustment back into society. This study provides important suggestions for veteran transition programs. In a similar study, Sayer et al. (2009) employed semi-structured interviews with veterans who were deployed in military conflicts that ranged from the Vietnam War to Afghanistan. They investigated factors that influence treatment initiation and help-seeking strategies. Lack of knowledge about PTSD and an invalidating sociocultural environment following a traumatic event were the main barriers to seeking treatment. As such, "[t]he findings suggest that facilitators located within the health care system and veterans' social networks can lead to help seeking despite individual barriers […]. Understanding how and why veterans initiate treatment for PTSD is particularly crucial" (Sayer et al. 2009, p. 240).

Burnell et al. (2011) interviewed 30 veterans who were deployed during a time between WWII to Iraq in 2009. They asked the veterans to share their own moral evaluation of their deployment. Using a thematic analysis, they found that the deployment experience is "mediated by the cultural atmosphere in which the conflict takes place" (p. 36). The authors point out that PTSD is not a timeless, universal or cross-culturally valid construct. Mental health care providers need to take into account the complexity of responses to traumatic events and to explore with clients the personal meaning of their experiences.

The last two studies focus on veteran's spouses and family members of soldiers with PTSD. The first study by Sherman and Fischer (2012) examined the perspectives of health care providers, veterans and family members regarding family education in community-based outpatient facilities. Five health care providers and 49 family members participated in qualitative interviews that were analyzed using a content analysis. Veterans Affairs have mandated family consultation, education and psychoeducation since 2008. Very few families, especially those living in rural areas, receive psychoeducation or support. The three main barriers found in this study were distance (travel costs, child care, work release time), group issues (confidentiality in a small community, personal conflicts), and embarrassment/shame for family members and veterans with PTSD. The findings point to the significant issues facing veterans and their families living in rural areas.

Hayes et al. (2010) identified and measured assessment batteries to examine the wellbeing of spouses of veterans with PTSD. The strain on veterans' families who are the main sources of support in dealing with the PTSD of their family member is a serious concern and "[t]he potential for intimate partner violence is greater when the veteran has PTSD" (p. 826). Using a panel of experts and focus group interviews to determine appropriate measures on the well-being of spouses supporting veterans' recovery, the authors found important implications in terms of the family burden, health and mental status of spouses, effects of alcohol and substance abuse of veterans and their spouses, marital and parental conflict, marital satisfaction, role discrepancy, self-efficacy (a changed person) and social support (because of strain, no time for family, friends or social networking). As the authors state, "[f]ocus group interviews yielded valuable input on the domains of experience and key questions that should be included in an assessment battery designed to assess well-being and areas where assistance is needed" (p. 838).

In the only qualitative study on Canadian peacekeeping soldiers, Ray (2009) conducted a phenomenological study on the experience of contemporary peacekeepers healing from trauma. She interviewed ten soldiers who had served in Somalia, Rwanda and the former Yugoslavia. Three main themes were discovered that describe participants' process of healing from PTSD: "the centrality of brotherhood and grieving loss of the military family; the centrality of time and the body in healing from trauma; and the military response as betrayal and creating trauma from within" (p. 55).

> All of the peacekeepers expressed a sense of betrayal by their home-front government, politicians and their military family. Upon their return home, the response of stigma by the military and subsequent release as the response to their suffering created further betrayal and trauma from within their military family. All the peacekeepers in this study felt that they were more affected by the negative reaction from their military family than from the trauma itself.
> (Ray 2009, pp. 60–61)

The author recommends that more Operational Stress Injury Social Support (OSISS) groups be established throughout Canada. She further suggests that there needs to be more training in compassion and self-compassion training within the military among those who provide services to peacekeepers and veterans with PTSD.

Qualitative research studies provide an in-depth richly contextualized understanding of the experience of trauma and healing from trauma from the perspectives of the survivors. The qualitative studies on military trauma point to key areas for future research. Most of the samples in the studies above were conducted with white male military personnel; we need to know more about the experiences of women soldiers and soldiers from other ethnic groups. We also need to know more about the experiences of children whose parent has PTSD due to military trauma. The current breath of knowledge from the findings of qualitative research is very small—more research on the topic of military trauma is warranted. We are just beginning to understand the meaning of these experiences.

10.3.4 Sexual Abuse Trauma

Sexual abuse comes in many forms (e.g., forced sexual intercourse, unwanted sexual touching or threats, incest, child molestation, drug facilitated), and is perpetrated on anyone from any type of cultural population, young or old, female or male. The impacts of these types of assaults are varied and widespread with research focusing on many aspects of this violating crime. Because of the pervasiveness of sexual abuse trauma, it is often accompanied by physical abuse as noted in many of the studies we reviewed (e.g., Clum et al. 2009; Jager et al. 2010; Ungar et al. 2009). Due to the large number of qualitative studies on sexual abuse trauma that include physical abuse, we focus here on our learning from the sexual abuse literature in general.

Also, of note, we excluded mixed method studies in this section. We concur with Creswell and Zhang (2009), in their attempt to clarify some of the ambiguity around mixed methods approaches noting the studies they reviewed were "not called mixed methods, do not use explicit systematic mixed methods procedures, and have not been analyzed to use as models for designing mixed methods research on trauma topics" (p. 612). In the sexual abuse literature, we saw how "qualitative data" (interviews) were used to enhance quantitative findings or qualitative data was quantitatively analyzed (e.g., Deering and Mellor 2011). Thus, we focus solely on studies that used clear qualitative methods in their methodological descriptions.

Researchers have used qualitative methods in the field of sexual abuse for a number of reasons. Some studies used qualitative methods to develop quantitative measures (e.g., Giraldo-Rodríguez and Rosas-Carrasco 2013) in order to study sexual abuse phenomena in more depth for new information, meanings, and understanding. One author (Ullman 2005) described her transition from quantitative to qualitative methods in order to study female advocates and clinicians who provided services for sexual assault survivors. She was interested in the possibilities for depth of knowledge and the inductive theory-building qualitative methods can offer. Additionally, a number of authors discussed the best qualitative methods to use in the field and the best ways of using those qualitative methods to study abuse (e.g., Hall 2011 discussed a constructivist, narrative, feminist perspective to study women surviving childhood maltreatment; Morrow 2006 wrote about feminist collaborative research with sexually abused women; Sorsoli and Tolman 2008 discussed a narrative "listening guide" method analyzing interview data about sexuality and sexual abuse). Teram et al.'s study concerned with counselors developing research sensitivity when working with survivors suggested integrating grounded theory and participatory action research methods to promote the possibility of empowering sexual abuse survivors to voice their perspectives on how to best meet their needs and inform professional practice in the area.

In terms of the specific qualitative methods used in this field, we found that the three most common, in this order, were phenomenology (e.g., interpretative phenomenological analysis, hermeneutical-phenomenological, existential phenomenology), grounded theory, and narrative methodologies (e.g., life story construction, critical narrative, narrative content analysis). Although focus group methods were noted in some studies, they tended to be used in research in international settings or for topics that involved cultural issues (e.g., Moreno 2007; Williams et al. 2012). There was only one actual ethnographic study; it explored the experience of numbing emotional pain for African American women (see Ehrmin 2001). Other random qualitative methods included a cross-case analysis looking at patterns of adolescence dating violence (Martsolf et al. 2012), the content analysis of therapy transcripts and participant diaries (Lev-Wiesel 2006), and analysis of "free listing" and "key informant" interviews (see Murray et al. 2006).

From the review of sexual abuse literature citing qualitative methods, we noted a very wide variety of topics in the area, with the most common topics being some aspect of *childhood sexual abuse* (CSA) (e.g., Stige et al. 2013, on help-seeking among women who suffered childhood trauma; Isely et al. 2008, on how clergy-perpetrated CSA affects adult men survivors; Kisanga et al. 2010, on legal system perceptions of CSA) or *domestic violence* (e.g., Band-Winterstein and Eisikovits 2009, on intimate partner violence [IPV] over a life span; Davis

2002, on the inner resources of abused women; Hogan et al. 2012, on counselors' experiences of working with male victims of female-perpetrated domestic abuse). Additionally, researchers looked at many different populations affected by sexual abuse; for example, Puerto Rican addicts (Hardesty and Black 1999); homeless adolescents (Haldenby et al. 2007); romantic partners of CSA survivors (Del Castillo and Wright 2009), and pregnant mothers (Coles and Jones 2009) to name just a few. Researchers also explored the experiences of service providers for sexual abuse and domestic violence survivors such as nurses' experiences of, and role as health care provider for, women experiencing IPV (Häggblom and Möller 2007); the impact of vicarious trauma on professionals involved in child sexual abuse cases in Malaysia (Nen et al. 2011), and professionals involved in high-profile CSA controversies such as "practitioners and/or academics in the fields of psychology, social work, psychiatry, sociology, and law" (Mildred 2004, p. 102).

From these and other studies reviewed, we note specific contributions to the field in understanding therapeutic issues around sexual and physical abuse (e.g., sexual abuse experiences, issues arising, effectiveness of treatment programs); impacts on individual and family life; health care issues that arise for survivors and service providers; coping and resilience; and the effects of prevention and treatment programs. Although most studies we reviewed had smaller numbers of participants (an average of about 30 with 88 being the largest group and four being the smallest) and the results are not generalizable to the greater population, some important insights were reported.

The most common research topic was in the area of CSA and the impact on family relationships. Researchers found that abuse has a strong developmental impact that creates systemic problems throughout life (Isely et al. 2008), with abused participants struggling to trust others or to give and receive love (Roberts 1999). This gap creates significant problems for families; especially when it came to the processes of motherhood. From the moment some abused women conceive, they report how their partners are sexually coercive, failing to understand or accept pregnancy and its nuances (Shamu et al. 2012). There are also impacts for service providers when assisting survivors of CSA to cope with medical care related to perinatal examinations (Coles and Jones 2009) and other types of sexual and reproductive health care (Ackerson 2012). When children are born and raised by CSA survivors, mothers may sometimes feel repressed emotions arise when they see their young children's innocence at a similar age to when they were abused as children (Erdmans and Black 2008). Some daughters found their mothers (CSA survivors) to lack maturity and struggled with feeling affectionate towards their mothers, or differentiating from them (Voth et al. 1999). If there are repeated patterns of sexual or physical abuse in the family, children's disclosure of abuse becomes more risky and difficult especially if they witness the same abuser assaulting their mother (Alaggia and Turton 2005). Researchers noted the importance of children disclosing abuse (i.e., non-disclosure leading to self-destructive behaviors, greater risk of teen pregnancy) and the need for them to have a receptive and supportive audience so that protection can be given (see; Alaggia and Turton 2005; Erdmans and Black 2008; Lev-Wiesel 2006). This protection is also critical to prevent adolescents from being silent or complacent to dating violence (Martsolf et al. 2012). According to Ungar and colleagues (2009), there is a high rate of non-reported abuse in youth due to their fears of the negative consequences of disclosure. This leads to the second most common research area in the sexual abuse literature: the processes and efficacy of therapy.

There are a number of studies looking at the participants' experiences of therapy and the developments that take place in the process. The most prominent finding in these studies is the importance of survivors telling their story and the different ways that researchers have conceptualized the processes around disclosure from participant experiences (see Del Castillo and Wright 2009; Hirakata 2009; Martsolf and Draucker 2008; Nehls and Sallmann 2005). For example, Del Castillo and Wright discuss three types of experiences in the process of disclosing CSA to a romantic partner to emphasize the risks survivors take in telling a partner about their history: struggling in private about the disclosure; the experience of disclosing, and the aftereffects of disclosure. As shown above, the risk of disclosing is lessened with the presence of a receptive audience. Researchers have also explored the types of therapeutic conditions necessary in a strong alliance because prolonged periods of self-reliance are common before help-seeking takes place (Stige et al. 2013). For example, Hirakata (2009) names a number of factors participants in her study emphasized for a safe and trusting relationship where the therapists:

> (a) reciprocate a sense of trust and confidence in their clients, (b) allow periods of conflict that provide an opportunity for clients to experience interpersonal tension in a healthy and reparative manner, and (c) simply be there for clients in a way that communicates a sense of support and commitment to the clients' reparative journey [… and] having their therapist (a) challenge old patterns and beliefs; (b) know them in a manner that extended beyond words; and (c) model a new way of being that enabled them to better connect with themselves, others, and the world.
> (Hirakata 2009, p. 309)

Alliance is also emphasized for families of children who have disclosed abuse, with a specific emphasis on building an alliance with the caregivers so that they are able to support the child in the process of therapy (see Jensen et al. 2010).

Another aspect of the therapeutic process is the qualitative study of selfhood and identity. For example, Hardesty and Black (1999) found that motherhood provided a grounding identity and lifeline for some women who were challenged by poverty, marginalization, and abuse. Saha and colleagues (2011) found that through the therapy process, participants moved from articulating a traumatized self to a more enduring sense of self. In another study where Spermon and colleagues (2013) were studying child maltreatment in relation to interventions and training, they specifically noted the importance of supporting the development of a positive selfhood.

Qualitative studies have also investigated how abuse survivors cope with their experiences of abuse. Highlighting a few studies in particular, Clum and colleagues (2009) looked at CSA survivors' coping in relation to their sexuality; Draucker (1999) explored how women used practical everyday tasks to cope with family violence; Darlington (1996) investigated both physical and mental *escape* as important aspects of coping; Wang and Heppner (2011) conceptualized a model for coping to support culturally appropriate interventions for survivors from collectivist contexts; and Williams and colleagues (2012) explored *transactional sex* as a survival strategy used mostly by girls in Rwanda to cope with adversity and its implications in terms of child protection.

In terms of health issues and abuse in particular, there are qualitative contributions to the literature showing a clear link between HIV/AIDS infection and domestic violence (Clum et al. 2009; Moreno 2007; Murray et al. 2006; Shamu et al. 2012). These studies all emphasize education about disclosing an infection, debunking some of the myths and superstitions about HIV/AIDS that create the grounds for infection of young girls specifically, and working in culturally appropriate ways to reduce the stigma and stereotypes about the disease.

There are also a number of studies looking at perpetrators of sexual and physical abuse crimes. For example, Bletzer and Koss (2012) are interested in the outcomes of restorative justice and noted the importance of remorse and empathy during an apology when perpetrators had increased knowledge about their victim/survivor. Other research has looked at perpetrator characteristics in both male (e.g., Moulden et al. 2010) and female abusers (e.g., Flinck and Paavilainen 2010; Gannon et al. 2008). Qualitative researchers also investigated the experiences survivors reported from specific types of perpetrators such as clergy (Isely et al. 2008) and teachers (Moulden et al. 2010). There are also a number of studies looking at the effects of participating in the legal system and its failings when persecuting the accused (e.g., Kisanga et al. 2010).

Future considerations for gathering qualitative evidence for sexual abuse trauma should include researchers writing clearer descriptions and more elaborate explanations of their methodological approach, as it was less common for us to see a thorough overview of procedures or explanations of methodology. For example, Coles and Jones (2009), and Isely et al. (2008) described their qualitative method as a "thematic analysis" without a framework for how they approached, understood, or decided on the themes they developed from their interview data. Also, there were very few studies that looked at program evaluation or treatment efficacy from a qualitative perspective, although many of the studies we noted in this section focus on implication for practice as part of their conclusions (e.g., policy/program change for studies done in international settings in the developing world, studies related to cultural aspects suggest cultural considerations for practice). Finally, there were vary few studies of men as survivors of physical or sexual abuse and this area can certainly be expanded.

10.3.5 First Responders and Trauma

As noted in some sections above, professionals on the frontline have multiple challenges when working with survivors or victims in a traumatic context and have a much higher risk (5–40 %) of developing psychological distress, PTSD, and other types of psychopathology than the general population (Thompson and Wild 2012). Generally, these first responders are professionals who arrive first at the scene of an emergency, conflict, or disaster and can provide some kind of service related to the crisis including prehospital care (Shakespeare-Finch 2012). For example, nurses arriving to a disaster event would need to determine "where to begin their relief efforts and what skills are going to be required" (Yin et al. 2012, p. 265). Professionals in this category are most commonly medical personnel (e.g., doctors, nurses, paramedics), firefighters, police, and soldiers. More recently, journalists and photojournalists have also been recognized as first responders on the scene to report these types of events and who face considerable risk for traumatization as a result (Newman and Ochberg 2012).

The vast majority of studies on first responders use quantitative methods, with some beginning to use a mixed methodology approach. For those studies that use only qualitative methods, the research designs vary considerably and it is rare that researchers offer a clear description of their methods or rationale for their approach. Individual interviews (with some type of content analysis) and focus groups were most common formats for gathering data. There were a very small number of researchers who used textual data such as participants' written accounts (e.g., Jonsson and Segesten 2003; Wolf and Zuzelo 2006) or workplace observations (e.g., Keats and Buchanan 2013; McGibbon et al. 2010). The common topics researchers explored include the professionals' experiences of stress, traumatic stress, and coping with some studies focusing on specific events (e.g., Sloand et al. 2012, looking at nurses experiences in the recent Haitian earthquake), or specific subgroups of the profession (e.g., Menendez et al. 2006, looking at New York City firefighters and their spouses). Below we outline the qualitative evidence we gathered from the studies in this trauma-related area of first responders.

Medical professionals were the most highly studied group of first responders for qualitative researchers. First, the medical profession has recently recognized physicians' stress more formally and discussed it in relation to the pressures physicians feel as a result of acute patient care (Meier et al. 2001). Meier and colleagues (2001) described the risk factors and effects of vicarious traumatization and secondary trauma with a suggested model for self-regulation and encouraging physicians to "take an active role in identifying and controlling those emotions" (p. 3007). In a more recent study, Woolhouse et al. (2012) asked family physicians about the emotional impact of patient care related grief (e.g., sorrow, isolation, joy), experiences recounting patients' death or tragedies, and coping strategies (e.g., developing different practice styles, relying on teamwork). In a similar vein, Hadfield and colleagues (2009) explored physicians' experiences of working with patients who self-harm in emergency units and noted how they attended to the harm to patients' bodies, and either expressed or silenced their own values and beliefs about patients' behaviors. All of these studies incorporate the doctor–patient relationship and the necessity of self-care around stress affects.

Second, the nursing profession has done much work on understanding the aftermath of nurses' responses to traumatic events involving patient care (e.g., McGibbon et al. 2010; Wolf and Zuzelo 2006). From qualitative studies (e.g., phenomenological, grounded theory, narrative), we note some specific areas of research related to nurses' work such as dealing with women who have been violently assaulted (e.g., Gates and Gillespie 2008; Häggblom and Möller 2007; Maier 2011), nursing children after a disaster (Sloand et al. 2012), dealing with organ donation (Regehr et al. 2004), or in the aftermath of a terror attack (Somer et al. 2004). These researchers note how difficult these events are for nurses, sometimes leaving them feeling hopeless, incompetent, isolated, unsafe, or experiencing burnout. Most studies emphasize the organizational culture and hierarchical structure of the medical profession as being key factors in nurses' experiences of stress. Strong teamwork between peers and supervisors; appropriate care for patients; and organizational changes were all highlighted as helpful in coping with traumatic events.

Finally, within the emergency medical services, professionals such as ambulance drivers, paramedics, and emergency medical technicians experience traumatic stress. Specifically, researchers have explored aspects of traumatic stress for professionals who work in ambulance services such as looking at occupational stressors (Mahony 2001), the meanings and effects of traumatic events (Jonsson and Segesten 2003), and how workers cope with resuscitation attempts on patients in traumatic events (Davies et al. 2008). These studies also point to organizational issues as a barrier to coping leaving the professional to develop more personal aspects of coping such as expressing feelings in a safe environment, supporting one another after a critical incident, taking brief time-outs, and accepting their own limitations in the work. Regehr (2005) notes the spouse and family as important coping resources for these professionals and suggests adding programs to enhance family relationships into organizational support systems. Finally of note for these professionals is a study by Halpern and colleagues (2009) who looked at the repercussions of debates around critical incident stress debriefing for EMT professionals. Without clear emotional support after a critical incident, workers are left feeling vulnerable and stigmatized if there is no affective intervention for assistance. These researchers suggest that supervisors and front-line workers be educated to recognize these types of events and responses, and then act supportively to the professionals involved.

Police officers are also an important profession of first responders. Although there are few qualitative studies in the field, there are some important findings generated through a number of the research projects we found. Policing is a male-dominated profession and, as such, researchers have noted that officers tend to speak less often about traumatic situations and their effects with each other (Backteman-Erlanson et al. 2011; Tehrani and Piper 2011) and more often with a close family member or friend (Evans et al. 2013). Interactions with fellow officers tend to be more on the level of black humor rather than emotional talk (Evans et al. 2013; Shakespeare-Finch 2012). One study (critical incident technique) of officers on police teams investigating Internet child exploitation showed the importance of collegial relationships and organizational supports, such as stress inoculation, to assist coping with this traumatic material (Burns et al. 2008). Finally, there were a number of unpublished doctoral dissertation studies using qualitative methods to explore police or police services and traumatic stress. For example, Ferguson (2005) explored the trauma effects of police officers' working crime scenes; Troxell (2009) investigated the experiences of 9-1-1 telecommunicators; Picore (1997) looked at women officers and stress; and Pickens (2011) studied coping strategies from critical incidents in law enforcement.

Firefighters are also included in the first responder group. Reviewing the literature for qualitative studies, we only found two published papers. De Soir (2012) and colleagues looked at the disaster-related experiences of both fire and emergency medical professionals. Using a phenomenological approach, firefighters reported more concern for threats and exposure to death than medical personnel likely due to the differences in their training. In addition to the shock of the magnitude of the event (the 2004 Ghislenghien gas explosion in Belgium), they were affected by the death of colleagues, the involvement of friends and family, and their exposure to burn victims (over 150 people hospitalized with burns). Menendez and colleagues (2006) studied the effects on spouses and families of firefighters after the 2001 attacks on the World Trade Center in New York using focus groups. They found women depending on each other to cope with the emotional impact of the event and being more vigilant in helping family members manage the impacts.

Finally, qualitative studies of journalists and photojournalists who report and photograph trauma, disaster, and conflict show similar struggles to those found in other organizations of first responders. Most qualitative studies we found looked at the trauma effects for journalists in and after their work (Keats 2012; Keats and Buchanan 2011, 2013). These professionals were shown to be resilient and resourceful with a unique set of coping strategies such as managing well with frequent exposure to the abnormal and unusual, yet reacting strongly to more common events where they could personally identify the circumstance as similar to their own life situations (Keats and Buchanan 2011). They also had similar issues found in other first responder groups such as anxiety, depression, PTSD, lack of communication about trauma events among peers, organizational difficulties related to workplace stress, and lack of help-seeking (Buchanan and Keats 2011). Much work has been done to support news workers in recent years through the development of the Dart Center for Journalism and Trauma (see www.dartcentre.org) which offers a myriad of resources, peer support, and training for students, working journalists, and journalism educators. For example, Dworznik and Grubb (2007) explored trauma training in journalism programs in order to prepare students for their own emotional reactions as well as those of witnesses and traumatized survivors they would interview or photograph on the job.

10.4 Knowledge Transfer Strategies

How can qualitative evidence about trauma issues be translated to or influence health policy and practices in the field of traumatic stress? *Knowledge translation* (KT) is defined by the Canadian Institutes of Health Research (CIHR) as a dynamic and iterative process that includes *synthesis*, *dissemination*, *exchange*, and *ethically sound application of knowledge* to improve the health of Canadians, provide more effective health services and products and strengthen the health care system. Using this definition, we outline below issues arising regarding the dissemination of qualitative research findings.

It is common for qualitative researchers to disseminate the results of their studies through conference presentations and publications in peer-reviewed journals. It is also common for researchers to present their qualitative findings in other more creative and accessible formats that are tailored to the specific audiences interested in, and influenced by, the questions explored. For example, media formats such as books, pamphlets, and photography have been used to translate topics like self-care and resources available for journalists, and films that translate knowledge about treatment for soldiers and veterans have been produced (see the films “War in the Mind” at http://www.judyfilms.com or “The Difficult Return” by M. Balfour at Griffiths University, Australia). Research participants have been part of a research team who develop and present research findings at academic conferences or public performances (e.g., women prisoners’ productions from a CIHR grant on prison health in Mo Korchinski’s YouTube video “The Revolving Door” at http://www.youtube.com or visit the website designed by incarcerated women at http://www.Womenin2Healing.org). Other examples include vicarious witnessing in concentration camps (see http://www.ccfi.educ.ubc.ca/publication/insights/v13n02/articles/keats/index.html) and artistic displays of drawings, paintings, or sculpture that show the impact of interventions that developed out of research work into domestic violence and sexual abuse.

Qualitative research is also leading the way in welcoming knowledge users—or stakeholders—to engage in the full research process through action-based research. Through methods such as collaboration, action-orientation, and co-production participants are highly involved in helping to shape relevant research questions, connecting with potential participants, collecting and analyzing data, and participating in disseminating the findings to their peers and other interested and influenced parties.

According to Ciliska (2012) there is a clear hierarchy in evaluating quantitative studies in the literature as the "best evidence" in health research. This hierarchy moves down the ladder from systematic reviews of randomized controlled trials, through such evidence as randomized controlled trials; systematic reviews of nonrandomized or cohort studies; cohort studies; case control studies; case studies; case reports; ideas, editorials, opinions; and animal research, to in vitro (test tube) research as the final type of literature on the ladder. She notes specifically how this ladder does not include qualitative research and contends that this is because qualitative evidence "answers questions about experience or meaning" which has its own parallel hierarchy (albeit one that she does not define). She also notes that queries about answers to qualitative research questions have been misclassified in PubMed under the rubric of *health service research* and therefore, not a likely place where most people would look for qualitative answers.

Finally, Murphy et al. (2011) emphasize the importance of qualitative research in providing information that is essential in fully informing people involved in making health policy decisions. Specifically, they mention how the findings from qualitative research can be useful: findings can include such information as richly descriptive data from different perspectives (e.g., providers, clients) about health-related interventions (and their implementation); effects of health-related programs; experiences of different populations; or the meaning and experience of environmental factors such as diversity, culture, and context. This type of evidence-based information is a critical contribution for informing the planning of health-related programs and interventions for diverse population groups experiencing traumatic stress.

10.5 Future Directions

The value of qualitative research is well known in the social and human sciences (Creswell et al. 2011; Denzin and Lincoln 2005). Qualitative research brings "real world" issues into the clinical setting, assisting practitioners working with trauma survivors. It brings in-depth understanding and has the potential to illuminate the complexity of personal experience. As Creswell and colleagues report for the Office of Behavioral and Social Sciences:

> A salient strength of qualitative research is its focus on the contexts and meaning of human lives and experiences for the purpose of inductive or theory-development driven research. It is a systematic and rigorous form of inquiry that uses methods of data collection such as in-depth interviews, ethnographic observations, and review of documents. Qualitative data help researchers understand processes, especially those that emerge over time, provide detailed information about setting or context, and emphasize the voices of participants through quotes. Qualitative methods facilitate the collection of data when measures do not exist and provide a depth of understanding of concepts […]. (Creswell et al. 2011, p. 4)

Bessel van der Kolk and Christine Courtois, world-renowned traumatologists, contend that "omitting or marginalizing qualitative research may impede scientific progress" (2005, p. 6). We agree that there is an urgent need to promote the benefits of qualitative evidence to the field of traumatic stress studies. This text is a beginning, and hopefully trauma journals will reconsider their mandates on publishing only quantitative studies. Now is the time for qualitative researchers in the field of trauma to give serious consideration to producing a qualitative journal on traumatic stress studies to address the inequitable balance of quantitative knowledge over qualitative evidence. As this chapter confirms, there is much to learn from qualitative research about psychological trauma.

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