Independent Evaluation of RoadPeace Resilience Building Programme

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1 Executive Summary

1.1 Introduction

1.1.1 RoadPeace's Resilience Building Programme is a six week support programme for those bereaved by road crashes. Working in small groups, assisted by trained facilitators, participants learn about the physiological impacts of their bereavement whilst also benefiting from contact with others bereaved by crashes. The aim is to reduce the distressing symptoms and increase resilience of participants.

1.1.2 Research indicates that various severe and long-lasting psychological difficulties can result from traumatic bereavement including Post Traumatic Stress Disorder (PTSD), depression, anxiety and complicated grief. PTSD consists of a number of clusters of symptoms, including:

- Re-experiencing the memory of the event in a distressing and unwanted way (e.g. nightmares, intrusive images, flashbacks)
- Avoiding anything related to the event (e.g. thoughts, conversations, people, places)
- Physiological arousal (e.g. being on edge, sleep problems, irritability)

1.1.3 Symptoms of PTSD are sometimes considered to drive other difficulties such as depression and anxiety; this means that PTSD symptoms may be an important target for any intervention.

1.2 Criteria for Success

1.2.1 Overall, there was a substantial improvement in the average scores on all of the following symptom scales:

- Anxiety
- Depression
- Re-experiencing
- Arousal

1.2.2 These improvements were substantial enough to be deemed *statistically significant* (i.e. unlikely to have happened by chance). Such results would usually be taken as evidence that an intervention is effective.

1.2.3 There was also an overall substantial decrease in the average cigarette smoking and caffeine consumption, which again were substantial enough to be deemed *statistically significant* (i.e. unlikely to have happened by chance)

1.2.4 97% of participants said that they would definitely recommend the programme to other bereaved families. On this criterion, the programme has clearly succeeded. This far exceeds the success criteria that RoadPeace set of 75%.

1.2.5 On one important symptom scale (re-experiencing) 71% of participants reported an improvement. The percentage of participants reporting an improvement on other symptom scales (anxiety, depression, arousal, avoidance) and on the life-style scales ranged from 17% to 57%. This falls just short of the success criteria that RoadPeace set of 75% or participants reporting an improvement.

1.3 Key Lessons for Future Programmes

Social Support

1.3.1 Research demonstrates the importance of social support and particularly highlights its importance following traumatic bereavement. There is some indication that support from those similarly bereaved is of particular importance. This was borne out very clearly in the responses of both the participants and the facilitators. There can be little doubt that enabling social support by others in a similar situation is one of the key therapeutic aspects of the Resilience Programme.

Facilitators

1.3.2 Facilitators need to be chosen, trained and supported very well. It might be that bereavement specialists would be better received than trauma specialists, but changes were made before this evaluation by RoadPeace to use bereavement counsellors.

1.3.3 One facilitator felt that there should be some form of debriefing at the end of each session. This process is already in place and facilitators are expected to meet at the end of each session. Following consultation with the facilitators it might be considered appropriate to design a short form that the facilitators complete to ensure that the process of support and supervision is adhered to more routinely, alternatively it might simply be sufficient to remind current

facilitators of its importance and to ensure that new facilitators are made aware that it should be a routine part of each session.

Content

1.3.4 Participants might benefit from having more information in advance of the group about what to expect from the programme and what will be expected of them.

1.3.5 Some would prefer the psycho-education elements of the programme to be simplified.

1.3.6 If it were possible to extend the programme, or remove some of the content, it would be worth considering adding a section on managing strong feelings such as anger, and behavioural activation

1.3.7 Some requested some form of follow up in order to stay in touch. RoadPeace already provide bi-monthly meetings in the London area to enable people to continue to benefit from informal social support. Providing this in other areas might not be viable depending on numbers who would be interested. But as increasing numbers complete the programme in areas outside of London this might become more realistic. RoadPeace could specifically address ongoing support in the final session of the programme and both gauge participants' desire for an ongoing meeting facilitated by RoadPeace, but also encourage them to think how they might continue to support each other independent of RoadPeace.

Evaluation

1.3.8 Using a brief feedback form at the end of each session would enable participants to ask questions anonymously and would enable facilitators to respond rapidly to any concerns.

1.3.9 The data provided by the questionnaires is such a rich source of information that increasing the return rates could be hugely beneficial. RoadPeace might consider aiming for complete data for 90% of participants.

1.3.10 The depression and anxiety measures could be changed so that they are in line with other services, however this would make it difficult to integrate the data that has already been collected.

1.3.11 Given that many of the participants showed no change on the life-style scales, the life-style questionnaire is probably not sensitive enough to identify subtle but nevertheless positive changes.

1.3.12 Ensuring, during the programme, that participants understand the importance of the follow up questionnaire sent 6 months after the programme and using electronic methods might improve response rates which would enable RoadPeace to evaluate meaningfully whether any changes had been maintained, and whether any improvements had occurred after the end of the programme.

1.3.13 Including time since death in the dataset would eventually enable some analysis to be undertaken to examine whether there is an “optimum time” between bereavement and attending a group.

Research

1.3.14 RoadPeace could be very well placed to conduct more research in this under-researched area, and it may be able to explore collaborations with universities, particular those that run training for clinical psychologists.

2 Introduction

2.1 RoadPeace Resilience Building Programme

2.1.1 RoadPeace is a national UK charity for road crash victims. It is a membership organisation; members include those who have been bereaved or injured in road crashes and also those who are concerned about road danger.

2.1.2 RoadPeace provides emotional and practical support to those bereaved or injured in a road crash, this support can include clarification and guidance through legal processes, talking to a befriender who has survived a similar loss providing ideas for day to day coping strategies and hope.

2.1.3 RoadPeace's Resilience Building Programme is a six week support programme for those bereaved by road crashes. The programme was adapted by RoadPeace Patron Dr Noreen Tehrani from material developed by Patrick Smith, Atle Dyregrov and Bill Yule. Working in small groups, assisted by trained facilitators, participants learn about the physiological impacts of their bereavement whilst also benefiting from contact with others bereaved by crashes. The first programme was held in 2009. Since the Ministry of Justice started funding the programmes in 2010 RoadPeace have held 12 programmes:

- 7 in London
- 1 in Oxford
- 1 in Newbury
- 2 in Bristol
- 1 in Liverpool

2.1.4 Participants attend the programme at different times after their bereavement, usually at least 6 months after the bereavement. Most participants attend 8-12 months after the bereavement.

2.2 Evaluation

2.2.1 The Resilience programme is funded by the Ministry of Justice (MoJ) and as part of the funding agreement, RoadPeace is committed to conducting an

independent evaluation of the Resilience programme in the third and final year of the programme.

2.2.2 Bids were invited to complete the evaluation, and the contract was awarded to David Trickey, Lead Consultant of The Trauma Service. The Trauma Service is provided by a Social Enterprise in Luton and Bedford (CHUMS) with a great deal of experience of working with traumatised and bereaved families. David Trickey is an experienced clinical psychologist who has specialised in trauma and bereavement since 2000 and has experience of evaluating other services.

2.2.3 Success criteria are:

- At least 75% of participants show signs of improvement in their symptoms and in their coping skills beyond that expected over the same period in the absence of support.
- At least 75% of participants would definitely recommend the programme to other bereaved families.

3 Brief Literature Review

3.1 Methodology

3.1.1 A search of relevant databases (psychinfo and PILOTS) was conducted using various different search strategies and terms, mainly based on combinations of the following terms

> Motor vehicle collision OR road traffic collision OR road traffic accident OR motor vehicle accident
>
> Trauma OR PTSD OR Post Traumatic Stress
>
> Bereavement OR grief
>
> Support OR intervention OR treatment

3.1.2 This only generated one article; which was then deemed to be irrelevant. This may indicate that this is an area in need of research or that the search terms were too restricted.

3.1.3 Subsequently the search was broadened and did not specify the cause of the traumatic loss i.e. search terms including motor vehicle collisions etc. were removed. This produced 817 articles, which were then further reduced by placing the following restrictions on the search:

- Date of publication 2005 to 2014
- Articles published in peer-reviewed journals
- Adult participants

3.1.4 These restrictions lead to a total of 126 articles which were sorted by hand, those that were relevant were read and synthesized into the following review together with other articles and books that were known to the authors but were not identified in the search.

3.2 Review

Bereavement and grief

3.2.1 Bereavement per se is not uncommon, usually leading to a period of intense distress associated with increased risk of both psychological and physical health problems. However, over time most bereaved people adjust to their loss and the distress increases. That process of adjustment varies considerably between individuals and across cultures (Stroebe et al., 2007).

Complex reactions to bereavement

3.2.2 If the bereavement is sudden, unexpected and traumatic, reactions understandably are likely to be more severe, more complicated and last longer. In a study of parents bereaved suddenly and traumatically (by “accidents”), 18 months after their loss, participant showed severe reactions on a number of measures of psycho-social distress. 72% of them scored above the clinical cut-off score for psychosocial and physical complaints on the General Health Questionnaire, 51% scored above the clinical cut-off score for PTSD on the Impact of Events Scale and 78% scored above the clinical cut-off score for complicated grief on the ICG (Dyregrov et al., 2003).

3.2.3 Breen & O’Connor (2009) in reviewing the few studies that specifically examine those bereaved by traffic deaths, and found high levels of depression (30%), PTSD (33-62%), medical complaints, anxiety, and insomnia several years after the death.

3.2.4 Many academics have argued for a diagnostic category to describe a reaction to bereavement, which is particularly distressing and prolonged. Such a reaction has been given various labels including “traumatic grief”, “pathological grief”, “prolonged grief”, and “complicated grief”. In 2013, the American Psychiatric Association (APA) published revised diagnostic criteria in the 5th Edition of the Diagnostic and Statistical Manual (DSM-5). Contrary to the opinions of very many academics and clinicians the APA considered that there was insufficient evidence to warrant inclusion of a new diagnostic criteria for clinical use; however it did include a new diagnosis worthy of further study: "Persistent Complex Bereavement Disorder" (PCBD), which has to be ongoing for 12 months after the death (6 months if the patient is a child) and consists of symptoms such as persistent yearning, intense sorrow, preoccupation with the

deceased or the death, difficulty accepting the death, disbelief, difficulty with positive reminiscing, bitterness or anger, excessive avoidance, a desire to die, difficulty trusting others, feeling life is empty, reluctance to pursue interests etc.

3.2.5 Some of those who are bereaved do not consider that their reaction should be "diagnosed" as a "disorder". This is particularly true outside of the US, where it is not usually necessary to have a diagnosis in order to receive support or help. Therefore, the term "Complicated Grief (CG)" will be used for the purposes of this report.

3.2.6 There is much evidence that CG is a separate entity from other mental health problems such as depression, anxiety and Post-traumatic Stress Disorder (PTSD) (e.g. Lichtenthal et al., 2005; Golden & Dalgleish, 2010; Bonano et al., 2007). PTSD tends to be associated predominantly with emotions of fear and panic, whereas CG is defined by profound separation Evidence based Interventions.

3.2.7 There is further evidence that CG is more likely following sudden, unexpected or traumatic deaths. Breen & O'Connor (2009) specifically considered those bereaved by traffic crash fatalities, and concluded that the fact that such deaths were sudden, traumatic, violent, preventable and untimely make such bereavements more likely to be fraught with psychological difficulty. Breen & O'Connor go on to note the other additional elements that make such deaths even more difficult for the bereaved: "In addition, crash fatalities usually involve the negotiation of police investigations, coronial processes, insurance claims, court (criminal and civil) proceedings, hospital and medical systems, and media attention,… which could potentially obfuscate and exacerbate the grief experience further" (p.42).

3.2.8 This study specifically of suddenly bereaved parents, found that being female was a small risk factor for PTSD; this is consistent with a large body of research (e.g. Brewin et al., 2000). The Murphy study also discovered that "repressive coping" (e.g. denial and disengagement) did not predict poorer outcomes and therefore concluded that such coping was not necessarily to be avoided in terms of PTSD.

Social Support

3.2.9 There is some debate about the impact of social support on bereaved people. Although it is generally accepted that social support is associated with less distress, there is some respected research that demonstrates that presence of social support does not enhance adjustment to bereavement (Stroebe et al., 2005) and this has cast some doubt on the importance of social support. However this research was with "non-traumatically" bereaved adults. More specific research indicates that social support does lead to a faster decrease in symptoms of PTSD in parents whose children had died suddenly and unexpectedly. For example Dyregrov and colleagues (2003), surveyed a large sample of parents bereaved suddenly and traumatically and found that social isolation was the biggest predictor of psycho-social distress. Murphy and colleagues (2003) examined the role of a number of factors on PTSD in bereaved parents and found that "over time, only parents' gender and perceived social support significantly affected the reduction of self reported symptoms of PTSD." (p.23).

3.2.10 Breen & O'Connor (2009) interviewed 21 adults who had been bereaved by road traffic death and found a number of consistent themes in their report of their grief experiences. They found that many of the bereaved found it hard to feel socially supported by their usual support networks, such that they avoided certain people that had previously been friends and ended up relying on themselves instead. The study found that the participants "turned to others with similar experiences to access support they were not getting from elsewhere. Seeking out others with a similar experience provided a safe psychological space where they could be themselves and say what they wanted and needed to say, rather than being judged or given empty platitudes. Peer support provides a reprieve from the day-to-day isolation because of the shared experience, understanding, and sensitivity".

3.2.11 Umphrey and Cacciatore (2011), found in their qualitative research of support groups for bereaved parents, that one of the vital aspects of receiving support from those similarly bereaved was the acceptance of strong emotional expression: "People within the group seemed to possess a mutual comfortableness with painful emotional expression. This is a tolerance that

parents did not often experience outside the support group, even with their therapists." (p.153).

3.2.12 This research supports enhancing social support as part of an intervention for traumatically bereaved people, particularly parents.

Therapeutic interventions

3.2.13 There have been attempts to use Cognitive Behavioural Therapy (CBT) to conceptualise and help with CG (e.g. Boelan, 2006). But the evidence base is still in its infancy.

3.2.14 There is some support for behavioural activation in the treatment of CG (Papa et al., 2013). Such an intervention addresses the disengagement, avoidance, and passive coping that are assumed to be a part of depression, PTSD and pathological grief. Behavioural activation involves activity scheduling "to increase approach behavior as an alternative to ruminative and avoidant behaviors that disconnect bereaved individuals from psychosocial resources and sources of positive reinforcement. Treatment consists of identifying goal-directed, rewarding activities spe- cific to the individual client; identifying behaviors and contexts that can be shaped to promote change; and identifying patterns of avoidance and practical roadblocks that interfere with completion of the identified activities and goals during activities scheduling and shaping those behaviors so that they are more effective." (Papa et al., 2012, p. 641).

3.2.15 Shear et al. (2005) conducted a randomised controlled trial and found that Complicated Grief Treatment (CGT) was more effective than Interpersonal Psychotherapy (IPT) for adults with complicated grief reactions and that 51% of those receiving CGT responded. CGT consisted of a number of aspects over 16 sessions including: i) providing information about normal and complicated grief and describing the dualprocess model of adaptive coping, ii) Focusing on personal life goals, iii) techniques to promote a sense of positive connection to the deceased, iv) confronting the story of the death, v) confrontation of avoided situations, vi) future plans.

4 Qualitative Interviews and Feedback

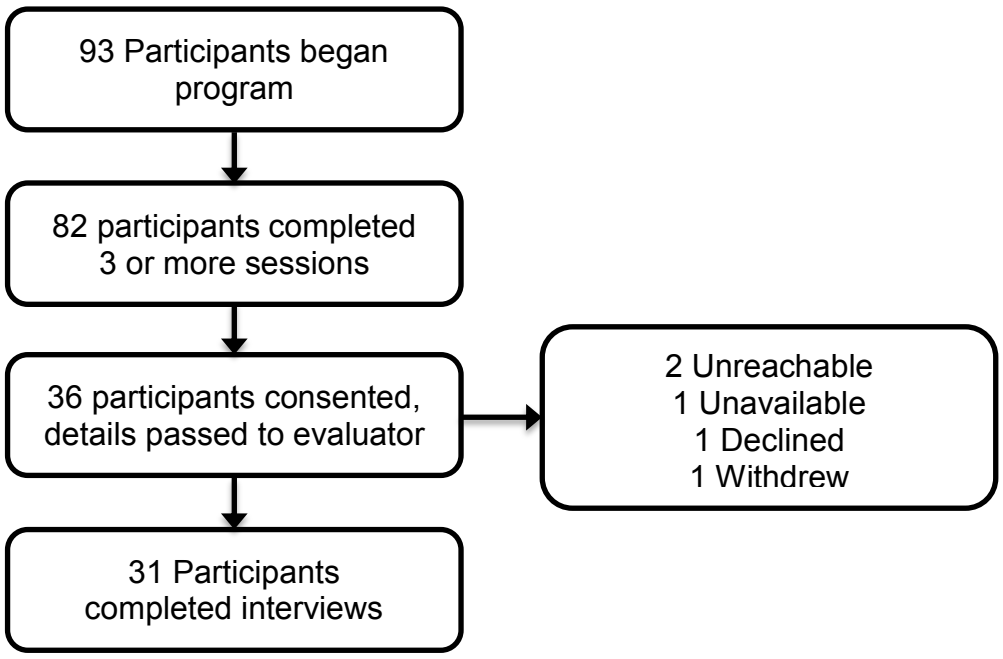
4.1 Methodology

Clients

4.1.1 A semi-structured interview schedule was developed by the evaluators to obtain the views, ideas and opinions of the participants' experiences of attending a RoadPeace Resilience Building Program. The aim of the interview was to elicit qualitative feedback about how helpful the participants considered the program to be, and any ways in which they thought the program could be improved. Open-ended questions were used to allow the participants to highlight any important thoughts and feelings that they had about the program, and some closed questions were used in order to obtain a quantitative response to certain questions.

4.1.2 A draft interview schedule was sent to staff at RoadPeace to ensure that the questions were considered appropriate for the participants and the facilitators. The final schedule is included in the appendix.

4.1.3 RoadPeace contacted participants who had attended programs from 2010 to 2013 and sought their consent to be contacted by the evaluators. A list of 36 names and contact details of those that did consent was passed to the evaluators. Semi-structured telephone interviews lasting up to 20 minutes were completed with 31 of the participants.



Facilitators

4.1.4 A semi-structured interview schedule was designed by the evaluator for the facilitators of the RoadPeace Resilience Building Program (included in the appendix). The aim of this interview was to collate qualitative feedback about how the facilitators found the participants responded to the program, why they thought the program was helpful or unhelpful and how the program could be improved.

4.1.5 Semi-structured telephone interviews lasting up to 20 minutes were arranged with 9 of the 14 facilitators who facilitated different programs across London and Oxford.

4.1.6 All clients and facilitators gave consent for their answers to be used in the report, and anonymity was ensured.

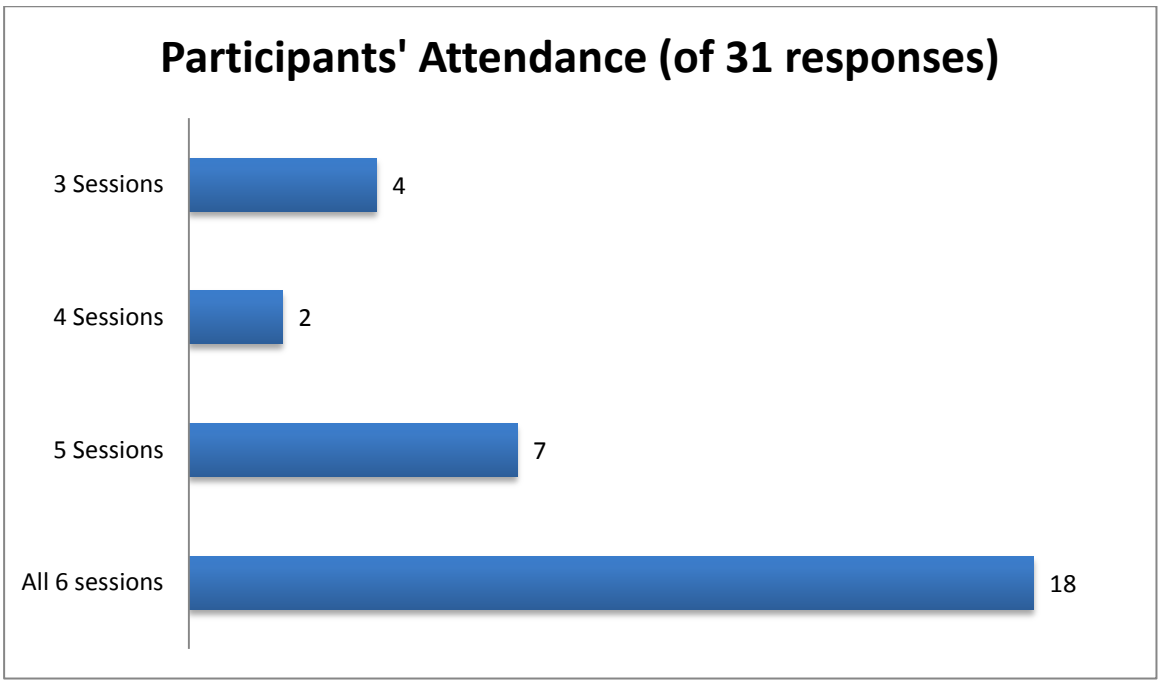
4.2 Results

4.2.1 The themes that emerged from the open-ended questions are described below and illustrated with quotes. Overall, the response was very positive, with only a few negative points. However, since these negative points tended to be more specific, it was considered that they were likely to be of more use in developing the program in the future, so the volume of positive or negative comments given in response to questions were not represented proportionally in the report.

Interviews with Clients

Attendance

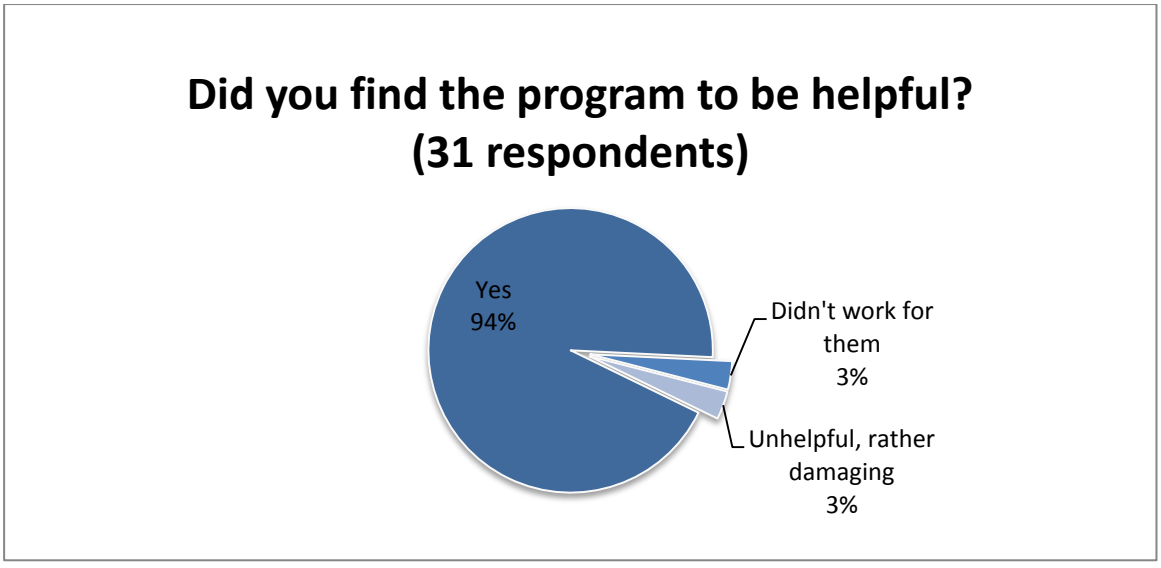
4.2.2 As shown in the table, of the 31 clients interviewed, 18 attended all 6 sessions. 9 clients attended between 4 and 5 sessions, offering typical reasons for not attending, such as prior engagements, holiday or health issues. 1 participant found the program too difficult, suggesting it was perhaps because it was too soon since their bereavement, and 1 participant found they '*didn't take to the program'*, so dropped out after 3 sessions.



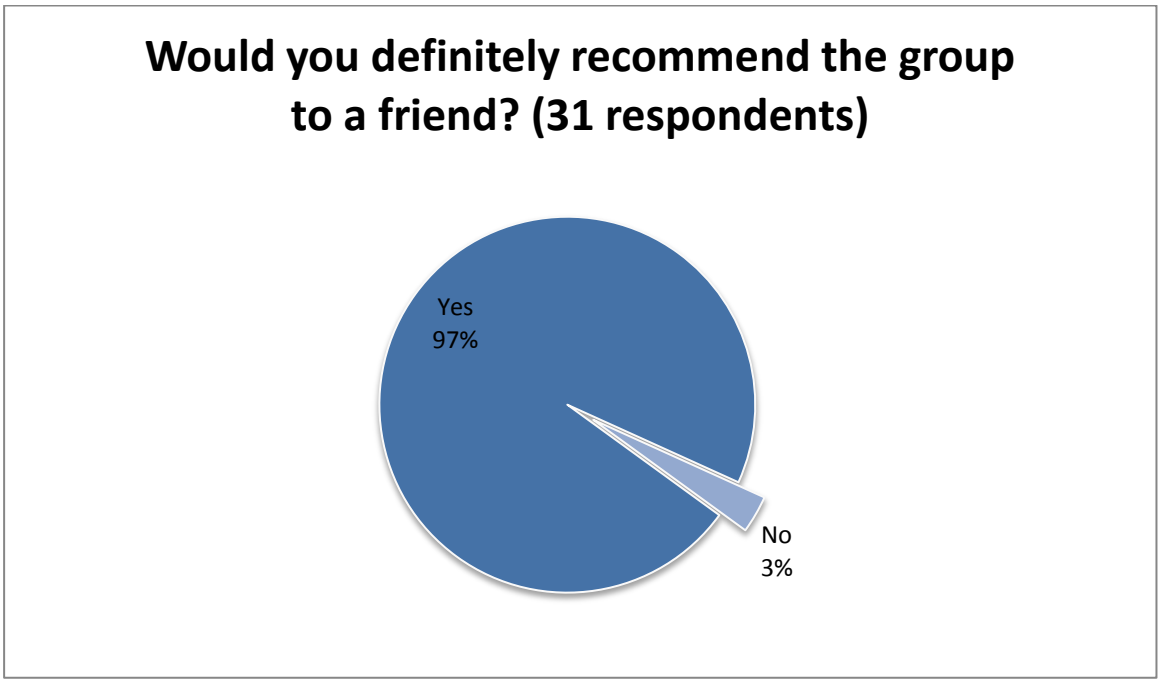
4.2.3 Of those 6 that only attended 3 or 4 sessions, one person stopped coming because they had had a positive experience and had got enough out of it. One person did not "take to the group", and one found it difficult because they did not get on with someone else in the group. The others simply could not make or did not intend to attend all of the sessions.

Impact of the program

4.2.4 29 of the 31 participants reported finding the program to be helpful, explaining it was '*absolutely amazing*' and '***extremely helpful***'. 1 participant did not find the program worked for them, and 1 participant found it to be unhelpful and found it '*rather damaging'*.



4.2.5 All but one of the participants would recommend the group to a friend.



4.2.6 Participants were asked if any changes had been noted in themselves following the program.

Did you or others notice any differences in yourself after the program? (30 respondents)		
Yes – positive change	20	67%
Did not notice a change	9	30%
More upset	1	3%

4.2.7 One participant reported that it made her '*more upset'* and explained that she found it stressful, especially because of a long drive, and suggested perhaps she was not ready for the program. One participant stated: '*before (the program), the trauma owned me. I felt totally out of control, with no idea if I would ever feel normal again'*. Other positive changes included feeling: '*reassured*', '*more confident*', '*calmer*', *'a sense of relief*', '*coping better'*, '*brought a closeness between the family'*, '*felt I had turned a corner', 'felt I had a lifeline'.*

4.2.8 The strong overall response was that being with other people in a similar situation was incredibly helpful, as it offered support which was '*much needed*' at that time and enabled the clients to be able to *'talk openly'* in an '*understanding', 'non-judgemental'* and *'confidential'* environment. One

participant explained that it was much easier to talk about what happened in the RoadPeace meetings rather than in bereavement counselling, as other people opening up encourages you to do the same. Another participant agreed, saying it was '*easy to be open in that environment, it's very friendly; it gave an opportunity to say things I couldn't say at home'*. Several participants reported that the program helped them to feel '*less isolated'*. One lady reported that sharing her story and listening to others '*broadened my outlook and took me out of my gloomy shell*.'

4.2.9 19 of the 31 participants have stayed in contact with other clients that they met through the program, and several others have stayed in touch with RoadPeace following the program, reporting that the program offers '*useful contacts'*.

4.2.10 However, one participant found that the presence of the others in the group meant that there was an incredibly high amount of anger and emotion in the room, and the participant felt that '*there was no place for the emotions to be expressed'* and it '*wasn't possible to let the emotions out and deal with them*'*.* This meant that there was no room for the techniques to be picked up, so in this case she felt that she did not benefit from interacting with the other people in the group. This participant suggested that it may be more helpful to have one-to-one counselling prior to entering the group, and felt the facilitators were not trained well enough to deal with the emotion in the group.

4.2.11 The second main response was that the experience of being with others in the same situation and learning about what happens in the brain following a trauma enabled the participants to feel '*normalised*', which was '*really important, as you don't recognize how you feel*'. Two participants did comment that some of the information on the brain was '*too technical'*, and suggested '*bringing it down a step'.*

4.2.12 The tools provided in the program had mixed responses, 11 people reported finding the breathing and relaxation techniques helpful, 7 people said they found the visualization techniques helpful, however several people found they couldn't cope with the visualization and relaxation techniques; '*I couldn't think of a happy time- all happy times now make me sad*'. For 2 participants the ladder technique proved to be especially helpful for dealing with a specific problem that they had not been able to deal with since the death. One participant reported that they

came '*away with a selection of tools that are always there to use for the rest of your life*'; 8 participants report still using the techniques they learnt at the program now (up to 16 years after the bereavement). 7 participants reported that the techniques helped them to deal with their anxiety and flashbacks, and one participant said they '*felt better equipped to deal with triggers'*. It was reported by several participants that the program gave them the tools to be able to deal with grief, allowing them to '*feel more in control'*. Two participants did not like the diary, but one participant found the diary incredibly useful. Two participants found that the drawing and imagery work did not work for them. 6 participants didn't find any of the techniques to be helpful for them, and one participant described the techniques as '*patronizing and simplistic'*, and explained that *'when you have lost your child, it's not appropriate to have someone say 'catch this ball think of something nice this week".*

4.2.13 When the participants were asked why they think the program helped / did not help them, the most common response was that being with people in the same situation was incredibly helpful. Several people commented that the fact that it was specifically for road traffic collisions was important, '*Because you have nowhere to turn…nice to find there was something that is dedicated and specific to road traffic trauma*.'

4.2.14 The participants were asked if they could think of any ways the program could be improved. 8 participants could not think of any ways of improving the program, one participant said '*No, (the program) is put together very well. Very beneficial…this is exactly what newly bereaved people need.'* However one participant commented that they '*really respect the RoadPeace organization but the program needs to be changed completely- it is inappropriate*' and went on to explain how she was the only woman in a group of men, and wanted the opportunity to speak to other mothers. It was also explained that they had no natural time to interact, and instead kept being passed back to the facilitators. She said that a friend of hers who was also very newly bereaved '*was appalled and very upset by the program*', and was '*made worse by meditation'*.

4.2.15 Several participants expressed gratitude towards the facilitators, describing them as *'the right balance of informative and supportive', 'lovely people…can always rely on them', 'flexible…Guided us through the program brilliantly',*

'professional and gentle'. Other participants had different views on the facilitators and commented '*they were telling us how to feel'*, '*seemed as though the trainers were unfamiliar with the content'*. Some participants expressed the opinion that the facilitators '*didn't have any experience of grief*' and '*weren't trained to deal with anger and emotion*'. The suggestion was made that '*might be helpful if they had been through the same thing as it is such a difficult situation to understand'*. Another participant agreed with this idea stating that the program '*should be run by bereavement counsellors/therapists- people who have been bereaved relate much better to people who have been bereaved themselves'*.

4.2.16 Several of the participants commented on group size, suggesting it may have been more beneficial to be in a bigger group as there were only 2/3 participants in some of the groups, and people often drop out or cannot attend every session. One participant was in a group of 15 people who were at various stages of the grieving process; they suggested '*perhaps a smaller group of people at similar stages may be more useful'*. Another participant found a couple in the group difficult and suggested splitting up couples in the future, another participant agreed with this idea: '*Initially sad to be split up from family but this turned out to work well'.* But there was a couple that attended together and found the program incredibly useful for opening up to one another, and they addressed issues that they didn't even know they had.

4.2.17 2 participants suggested offering aftercare or a follow up program, and 1 participant wanted the program to be longer, she described the program as '*something to lean on in my very dark days*' and explained she found it '*distressing not going anymore'*. Several participants suggested that more flexibility within the program would be useful, and the facilitators should respond to what works for the group, and spend more time on areas that are received well. They explained that its '*not about getting a point across, it's about responding to needs*'.

4.2.18 Participants seemed to find talking to others to be incredibly helpful, and wanted more opportunity for this in the sessions e.g. '*talking and sharing with one another would be much more supportive*', and '*opportunity to meet people in the other groups*'. However one participant explained how they were '*not allowed to*

talk about your story and who you had lost, if we had all started explaining our stories it would have been too emotional. This is a very good way to do it. I wouldn't have been able to cope if not'.

4.2.19 5 participants suggested that it would be useful if there were more programs available across the country, as some had to travel for several hours, which they found rather difficult. Several participants commented that more information before the beginning of the program would be useful so they know what to expect, and also that more notice could be given before the beginning of the program, in order for people to be fully available for all 6 sessions.

4.2.20 2 of the participants had experienced road traffic bereavement abroad, and they both commented how difficult this was. They both suggested how incredibly useful it would be to have a RoadPeace program specifically for this type of bereavement, since the justice system and police procedures are so different in this type of situation.

Interviews with Facilitators

4.2.21 A total of 9 facilitators were interviewed. 6 facilitated all 6 sessions, 1 facilitated 7 sessions as they added an extra session for people who had started the program late, and 2 facilitated 4 sessions, 1 due to prior commitments and 1 because they decided not to facilitate the final 2 as the group '*responded so poorly'*.

4.2.22 6 facilitators reported that the participants '*responded well*' to the program, one facilitator commented that participants '*made good use of the time and reported very positive things'*. 1 facilitator found they had mixed responses, and went on to explain '*I think that some people were not ready at that point. Some were confused as to what to expect, one or 2 really grasped the concept and took to it'*. 3 other facilitators agreed that some of the participants were sceptical to begin with, but '*all got something out of it'*. One facilitator found that the participants '*had poor attitudes, did not believe that the program would help them, were stubborn in their views and questioned a lot of the program*'.

4.2.23 The facilitators found that the technique most positively responded to was learning about how the brain reacts to trauma; *'…perhaps the main thing taken away. It provided relief that symptoms of trauma are normal and natural*'.

Relaxation and the ladder technique were also received well, it was suggested that relaxation techniques should be taught first, as they are useful skills for the rest of the program. Several of the facilitators found that the visualization and imagery techniques were not received well. One facilitator reported that '*'find a safe place' provoked a strong arousing reaction as they couldn't find a safe place and felt there was no longer a safe place. We changed it to a 'comfortable place''.* Overall they found that not every technique worked for everyone, but reported there was '*enough flexibility for this not to be a problem*'.

4.2.24 When asked if they thought the program was helpful for the participants, 8 strongly agreed. One facilitator commented *'had they given it a chance it may have been, but it came down to poor group dynamics*.'

4.2.25 All 9 facilitators reported that they noticed a positive change in the participants over the course of the program. Several facilitators found that they became more confident and open: '*they became more confident with one another and confident to speak up about the way they felt*'. Other changes were noted, for example '*one man significantly reduced his drinking*' and '*difference in clothes- brighter colours as they became lighter in themselves*'. Also they noticed that the group became '*closer*' and there was '*bonding between participants*'.

4.2.26 One facilitator found that '*poor group dynamics lead to a lack of change in the participants*', but all 8 other facilitators reported that the experience of being in a group was helpful: '*The group was the best bit of the program. The peer group became stronger and stronger; they began talking to each other rather than facilitators and communicating between themselves, which was very useful. They began to feel it was more about them*.' Another facilitator agreed, '*they felt comfortable talking to people who knew how they felt, they were able to put some of the exercises into practice because they felt supported by one another*.'

4.2.27 When asked why they felt the program worked / did not work, the facilitator with the group with poor dynamics explained there was '*one aggressive male individual and three passive females. The male was very dominant and continually expressed his opinion without allowing the others to express themselves'*, which meant they all '*shut down and were unreceptive*'. 3 of the group members had lost a child and one lost a spouse, so there was also a '*lack of understanding and appreciation of each loss',* for example the male

often said 'each to their own loss' and discussed the age of the deceased. It was suggested that '*Had there been another male in the group who was open and willing it may have balanced the group and made the program helpful.*' Another facilitator commented that it '*Helped having mixed male and female participants as it enables them to understand how partners are feeling'*.

4.2.28 Another reason for why the program worked was the experience of being in a group and being able to express feelings '*Gives the opportunity to talk about what you're going through and share it with people in similar situations, it seemed to help to know that others are feeling the same way'.* Several of the other facilitators commented how useful the group was in reducing isolation '*Previously stuck in isolated bubble of grief*' and providing understanding into why they are feeling the way they are '*explaining what happens to the brain gives people something to latch onto, they understand what's happening to them. You can see a change in the participants instantly*.' Another reason for why the program worked was the program's structure: '*Structure was very good and really worked - the way they were only able to tell small bits of their story each week, built them up so they engaged more each week'.* The facilitators also commented that the wide range of tools that '*covered all learning styles*' and coping mechanisms provided were helpful, and '*could be used in everyday life'*.

4.2.29 8 of the facilitators felt that the participants benefited from the social aspect of the program. They found that they '*became caring of one another'* and *'found strength in each other'*. The facilitators described how they began to stay before and after sessions to talk to one another, and swapped details to keep in touch following the program. However one facilitator found the social aspect hindered the group and '*made it a poor experience for the other group members'*.

4.2.30 The facilitators had a number of ideas for how the program could be improved:

- Facilitators must be trauma therapists: '*some of it was very challenging, the dynamics of group needed to be held, must be facilitated by trained specialist'.*

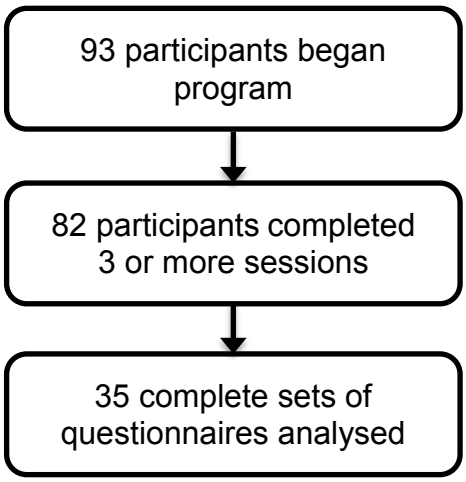
- Program could be made longer: '*Some weeks were too heavy and could be split in 2, and if people missed a week it was difficult, possibly 8/9 weeks would be better, it would give more time to practice tools*'.
- The right amount of people in the group: '*6-8 participants with 2 facilitators would have been ideal'.*
- Preparation and planning: *'setting up of program was very late, unable to properly assess the people coming and had to keep workshop slots free until the last minute*.'
- Dealing with anger could be included 'this was a large issue in the group, anger with justice system that was preventing them moving on with their lives.'
- More flexibility in the group
- Screening process: '*Minimal of 6-8months after bereavement as they may be more stable', 'there was a mentally unstable participant who was not suitable for the program'*
- Groups divided: '*People who had lost their children should be grouped separately to people who had lost their spouses. Groups should have something in common.*'
- Training for facilitators: *'Unaware that I was in charge of timekeeping when the first session over-ran', 'make it clear to be careful of use of words- they are very receptive to what you say. No death is worse than another'*.
- De-briefing for facilitators: *'felt like I was going home with a lot on my shoulders- would be helpful to talk it over with someone.'*
- Summer courses '*requires people to drive in the dark due to winter nights*'
- Better advertising *'so many people could benefit', 'The program is invaluable. It makes a huge difference to people's lives and is incredibly helpful.'*

4.2.31 All 9 of the facilitators agreed that they would recommend the program to a friend, but several of them commented '*provided it was run by trauma therapists'*. All of the facilitators agreed that the evaluation of the program has been useful, although it could be done sooner after the program, and some of the questionnaires wording could be changed, '*They felt very sensitive and judgemental 'of course I'm horrified I'm here'. Perhaps the wording could be toned down*.'

5 Routine Questionnaire Feedback

5.1 Methodology

5.1.1 Participants completed standard questionnaires before starting the programs and again at the final session of each program.



5.1.2 During the interviews, participants were asked if they would be prepared to complete these questionnaires again. They were given the choice of completing the questionnaires as part of the telephone interview, completing them on-line, or being sent them through the post. Unfortunately despite these choices, very few questionnaires were actually completed which makes it impossible to analyse this follow up data at present. As more questionnaires are returned, it may become possible to complete some further analyses.

Measures

Impact of Events Scale – Extended (IES-E)

5.1.3 This is a 22-item questionnaire that is used to measure reactions to traumatic events in the three domains that were key to PTSD (Tehrani, Cox & Cox, 2002):

- Re-experiencing
- Avoidance
- Arousal

Goldberg Depression and Anxiety Scales (GDAS)

5.1.4 This is an 18-item questionnaire that has been shown to be related to anxiety and depression (Goldberg et al., 1988).

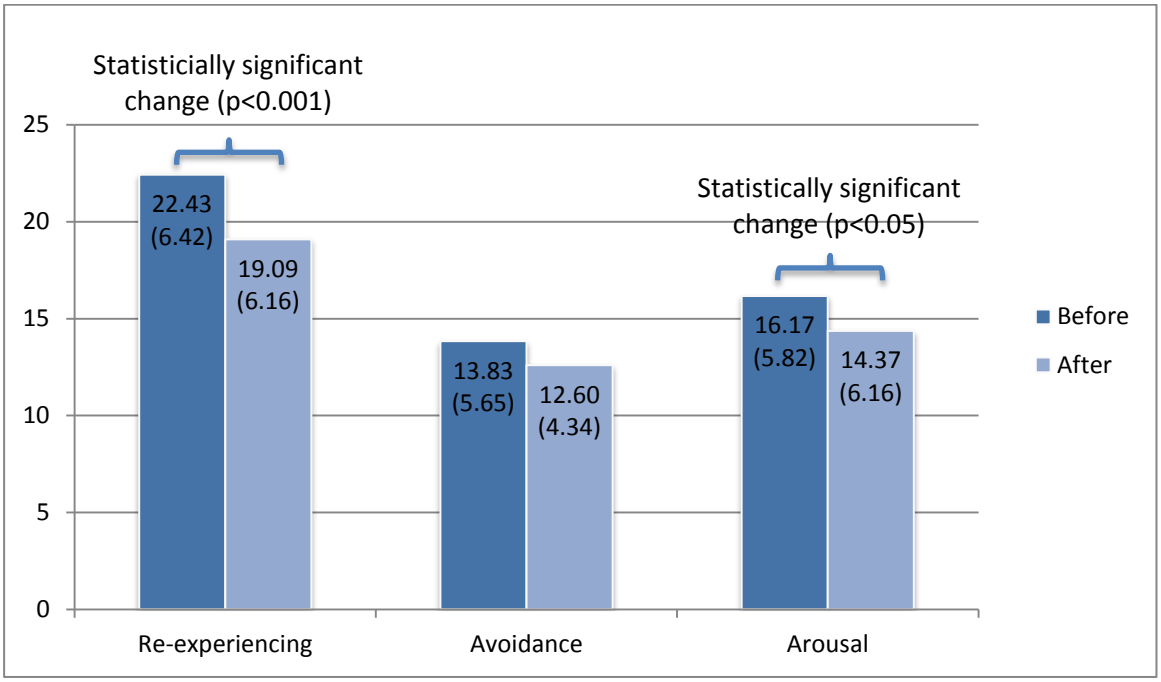
Lifestyle Questionnaire

5.1.5 This is a brief questionnaire that gathers information about participants' lifestyle by asking one question about each of the following areas with a choice of 3 responses which are interpreted as "good", "reasonable", "concerning":

- Eating
- Caffeine consumption
- Alcohol consumption
- Exercise
- Activities
- Sleep
- Socialising
- Smoking cigarettes

5.2 Results

IES-E Mean Average Scores (and standard deviations)



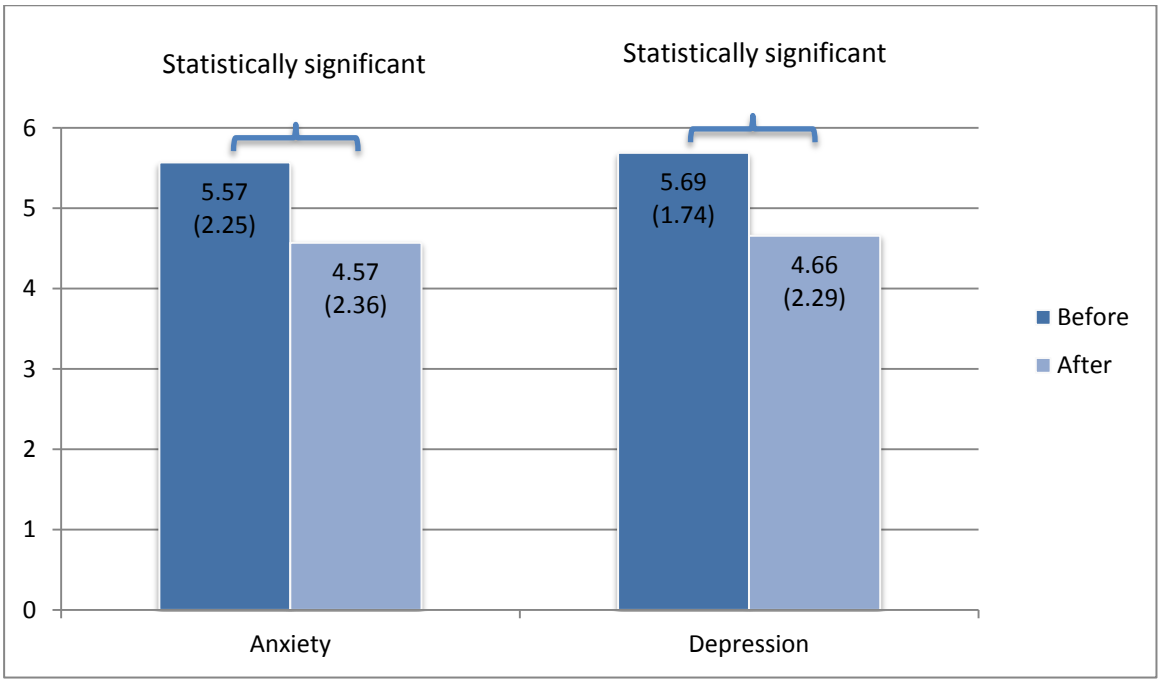
It is likely that reported scores would change a certain amount over time just as a result of random fluctuation. Therefore a statistical test (paired T-Test, one tail) was carried out to calculate the probability ("p-value") that changes of this size would be reported just as a result of random fluctuation even if there were no real change. By convention, p-values of <0.05 are considered "statistically significant" because it is unlikely (i.e. less than 20% or a 1 in 20 chance) that such differences would be observed if there were not genuine change. Significant p-values are categorised as p<0.05, p<0.01, or p<0.001, the smaller the number, the less likely it is that such a change would be evident in the absence of real change.

5.2.1 The graph shows that the mean average scores for all subscales of the IES-E had reduced at the end of the program.

5.2.2 The reduction in the average score on the arousal subscale was large enough to be considered statistically significant (p<0.05). The reduction in the average

score on the re-experiencing subscale was large enough to be considered highly statistically significant (p>0.001).

GDAS Mean Average Scores (and standard deviations)



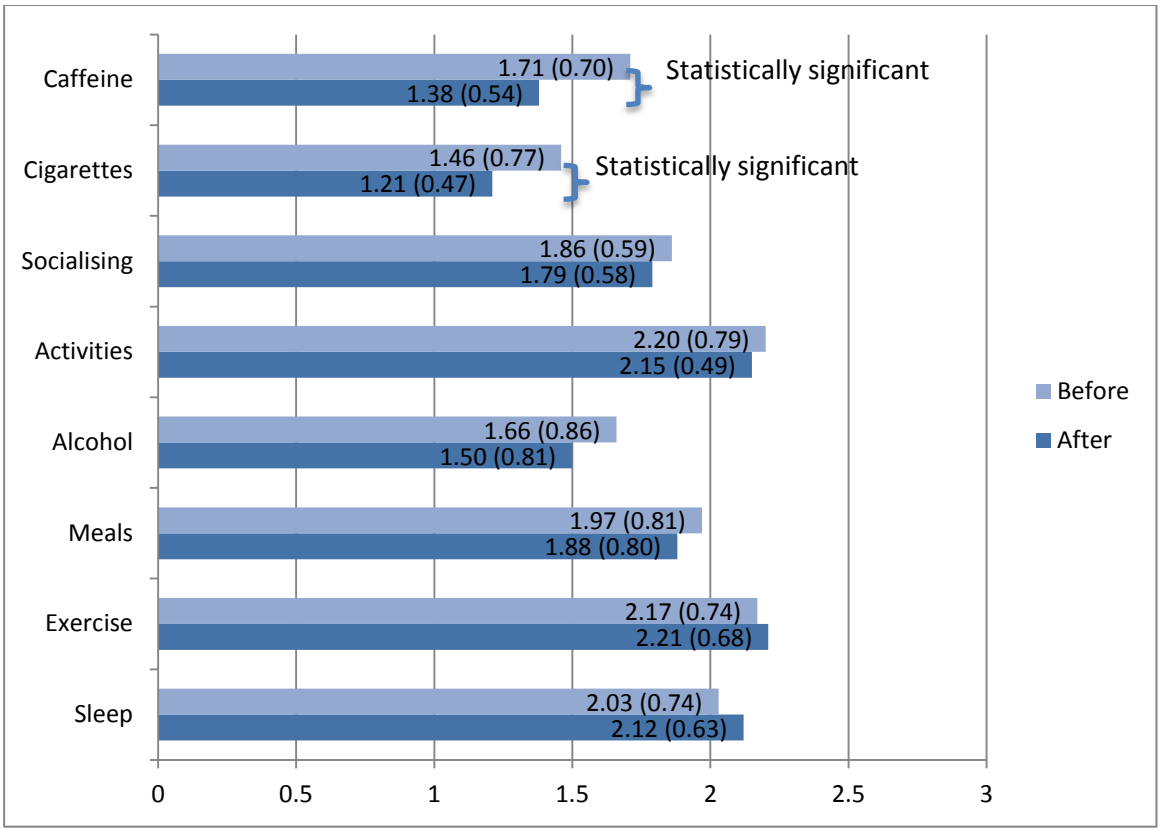
It is likely that reported scores would change a certain amount over time just as a result of random fluctuation. Therefore a statistical test (paired T-Test, one tail) was carried out to calculate the probability ("p-value") that changes of this size would be reported just as a result of random fluctuation even if there were no real change. By convention, p-values of <0.05 are considered "statistically significant" because it is unlikely (i.e. less than 20% or a 1 in 20 chance) that such differences would be observed if there were not genuine change. Significant p-values are categorised as p<0.05, p<0.01, or p<0.001, the smaller the number, the less likely it is that such a change would be evident in the absence of real change.

5.2.3 The graph shows that the mean average scores for both anxiety and depression have reduced by the end of the program.

5.2.4 The reduction in the average score on the anxiety subscale was large enough to be considered highly statistically significant (p<0.001).

5.2.5 The reduction in the average score on the depression subscale was large enough to be considered very statistically significant (p>0.01).

Lifestyle Questionnaire Average Mean Scores (standard deviations)



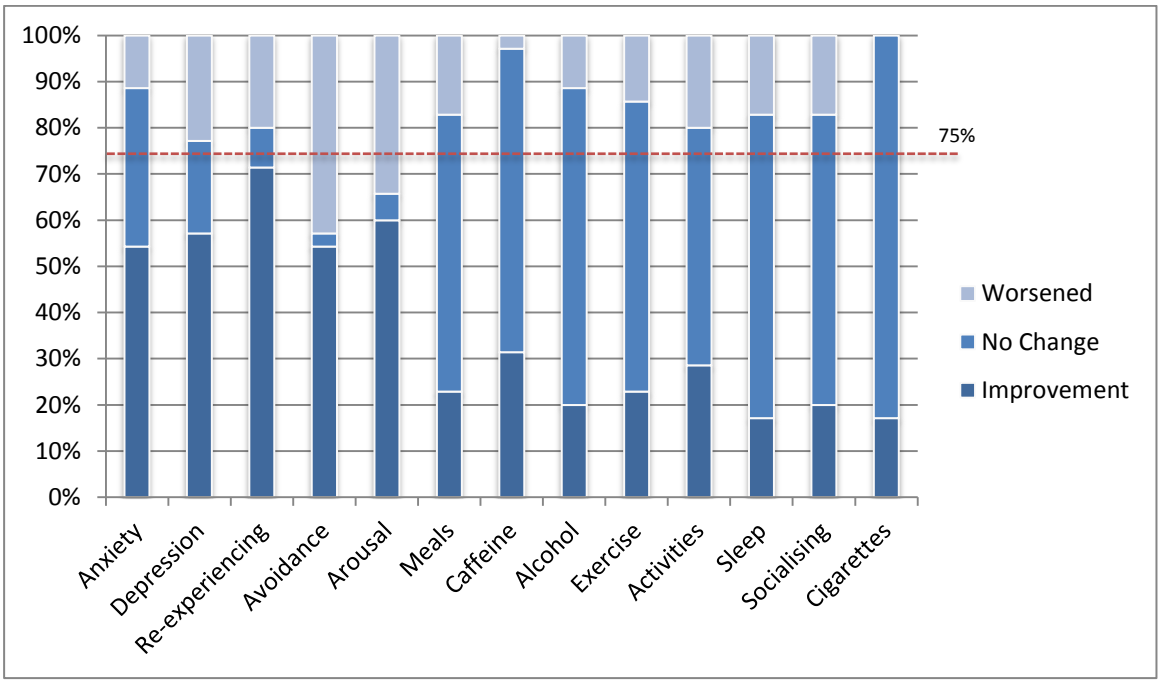
It is likely that reported scores would change a certain amount over time just as a result of random fluctuation. Therefore a statistical test (paired T-Test, one tail) was carried out to calculate the probability ("p-value") that changes of this size would be reported just as a result of random fluctuation even if there were no real change. By convention, p-values of <0.05 are considered "statistically significant" because it is unlikely (i.e. less than 20% or a 1 in 20 chance) that such differences would be observed if there were not genuine change. Significant p-values are categorised as p<0.05, p<0.01, or p<0.001, the smaller the number, the less likely it is that such a change would be evident in the absence of real change.

5.2.6 The graph shows that the average scores have changed in a positive direction for all of the lifestyle factors except exercise and sleep.

5.2.7 However, with the exception of caffeine and use of cigarettes, the changes in these factors were not large enough to be considered statistically significant. In other words there is a reasonable chance that the observed changes are simply due to random fluctuation rather than represent genuine changes in behaviour.

5.2.8 However, the reduction in caffeine was very statistically significant (p<0.01) and the reduction in smoking cigarettes was statistically significant (p<0.05).

Percentage of participants who showed signs of improvement



5.2.9 One of the criteria for success was that 75% of participants would show signs of improvement in their symptoms. Although this was not achieved, the chart shows that most participants reported an improvement on all of the symptom scales (anxiety, depression, re-experiencing, avoidance and arousal).

5.2.10 On the symptom scale re-experiencing, 71% of participants report an improvement. Re-experiencing is often considered to be the cardinal symptom of PTSD (World Health Organisation), and PTSD is often the driving force causing depression and anxiety (NICE, 2005). Furthermore poor life-style choices are sometimes in response to the re-experiencing symptoms of PTSD. Therefore re-experiencing is an important symptom cluster to target for improvement because of the potential impact that it might have subsequently on other symptoms and lifestyle. With more follow up information it would be possible to explore whether an initial improvement in re-experiencing does have an impact on other symptoms and lifestyle factors.

5.2.11 Although the Resilience Programme is aimed at increasing resilience rather than “treating” mental health problems, it is of note that most therapy trials do not report the number of participants who show any sort of improvement. Most would report overall improvement of the average score (as above), and some might report the number of participants who are deemed to have “recovered” as

well as those that showed reliable change. For example in the very large NHS IAPT programme, less than half of the first 1 million patients were deemed to have recovered and only two thirds showed reliable improvement. Therefore it could be considered that 75% of participants to show an improvement is a very high threshold to achieve.

5.2.12 The percentage of participants reporting an improvement on the life-style scales ranged from 17% to 31%.

6 Key lessons for future programmes

6.1 Implementation

Facilitators

6.1.1 Despite the manualised nature of the programme, it is important that all of the facilitators have adequate experience, training, skill and support. This program is different from running a group for those bereaved by other means and is different from running a group for those traumatised but not bereaved; the reactions of the participants are likely to be more complex and more intense and therefore the facilitators need to be more highly skilled. One facilitator clearly had a very difficult experience and found the group difficult and unreceptive. Participants and facilitators noted that the facilitators must be well trained in order to contain the emotions of the group. It is of note that RoadPeace has already identified the need to use facilitators who were particularly sensitive to the needs of bereaved participants and from Autumn 2013 RoadPeace stopped using trauma counsellors and used experienced bereavement counsellors and volunteers to run the programmes.

6.1.2 A couple of participants expressed a view that facilitators should be bereaved themselves to increase their understanding. However this was in contrast to the majority of comments about the facilitators. It might be possible to consider recruiting some past-participants as facilitators in the future; there is no doubt that they can be a source of great expertise and empathy. However, they would need to be very carefully chosen and very well trained, supervised and supported. They could perhaps be paired with experienced co-facilitators. Alternatively there may be other ways in which facilitators could feed into training of the facilitators.

6.1.3 One facilitator suggested some form of de-briefing for them after each group. This comment is somewhat surprising given that facilitators should already meet at the end of each session to discuss how the session has gone and offer peer support and supervision. It might be that this process would be adhered to more consistently if a short form were adopted for the facilitators to complete at the end of each session as a way of recording their thoughts and also processing what had occurred in the session. However such an addition might also be considered overly bureaucratic. RoadPeace could consult the facilitators to see

if they would be in favour of such a form. If such a form were felt to be unnecessary or even unhelpful, it might simply be sufficient to remind current facilitators of the importance of a short period of peer-support and peer-supervision at the end of each session, and to ensure that it is a part of the training of new facilitators.

Group Selection

6.1.4 One facilitator considered that there was one person who was not suitable for the program and should have been screened out. And indeed one participant noted that the programme had made things worse; however that participant noted that the long journey to the group did not help and noted that they considered that they themselves were not ready for the programme.

6.1.5 It might be possible to improve the screening of participants in order to identify those that require a more intense service, or who are not suitable for the program. Facilitators and participants noted that timing since the death is an important factor in ensuring that participants are open and available to accept and take on techniques, so that the program is helpful.

6.1.6 As expected from the review of the literature, many of the participants appreciated the support offered by those similarly bereaved, and several commented that it was important that it was not simply “traumatic bereavement” but bereaved by a road death. This has important implications for future groups; it might be tempting for those funding such programmes to assume that they would work for those bereaved by any traumatic death and therefore to group different types of traumatic bereavement together. However the feedback here should be taken as a warning against such amalgamation, supporting the need for specificity.

6.1.7 Two participants commented that being bereaved by a road death abroad was different to the UK and suggested that a separate program would have been useful. This is not an uncommon finding (for example in order to accommodate the different needs of those bereaved by murder and manslaughter abroad, an organisation called Support After Murder and Manslaughter – Abroad (SAMM-Abroad) was set up because many families did not feel that their needs were met by the existing organisation Support After Murder and Manslaughter (SAMM)). However, such a separate group would only be viable if there were

sufficient numbers that were able to meet together. The one participant who felt that the programme has been unhelpful noted that the long journey may have been a factor in this; it might therefore be important not improve specificity at the cost of accessibility.

6.1.8 There were a number of comments about the size of the groups – some saying that the groups were too small, and one saying that it was too big. Similarly the facilitators commented that it was important to get the numbers in the group right and they suggested 6-8 participants with 2 facilitators. RoadPeace should now have sufficient data to be able to broadly predict attendance, and therefore wherever possible, to form groups that are large enough to be viable even when some participants do not attend all of the sessions, but are small enough to be intimate and supportive. There is some broad agreement between facilitators, participants and clinicians generally that approximately 7-10 is considered to be a suitable number of participants for a group (Yalom, 1995; Grantham, Budnik & Musham, undated.)

6.1.9 Two participants suggested that couples should not be in the same group, but this should be balanced with the comment by a couple that they had found the program useful for opening up to each other. Unfortunately the group's limited number of sessions, and focus means that there is not time to address such issues within the group. In reality it is difficult to conceive of how to avoid having couples attend a programme together unless RoadPeace were to simply allow only one member of any couple to attend; but if both members of a couple wanted to benefit from attending a group it could be considered unethical to only offer the programme to one member. However it might be possible to specifically warn couples that the programme is not intended to improve their communication and if their relationship is impacted (positively or negatively) at all then this should not be addressed inside the group. They could be signposted to other organisations such as Relate.

Content and structure of program

6.1.10 It is clear from the comments of the overriding majority of those interviewed that the program is well received. There were one or two comments that were not positive, some of which have clear implications for future groups. The programme could be slightly amended to try to address the comments, but this

should not be at the expense of the aspects of the program that were found to be so useful by the majority of participants.

6.1.11 The psycho-education aspects of the program (in particular the neuropsychology aspects) could be simplified and participants encouraged to ask questions if they do not understand anything. Sometimes it can be very intimidating to ask such questions in the larger group and perhaps the participants could have a few moments to discuss what they have discovered in small groups and then questions can appear to come from the small group rather than the individual.

6.1.12 Kaufman suggests that traumatic loss is largely about having one's expectations and assumptions shattered (Kaufman, 2002), it is therefore particularly important with this client group to manage their expectations of attending the group. Several participants wanted more information before the beginning of the group so that they knew what to expect. This could easily be provided in the future. Managing expectations appropriately might help the participants to arrive in a frame of mind that will enable them to make the most of what the group has to offer.

6.1.13 There were some comments that the facilitators should be more flexible in how the time was spent. However the program is based on evidence-based therapeutic techniques delivered within a socially supportive environment, rather than provide cathartic emotional self-expression. So given the time-limited and focused nature of the program, it might be difficult to be flexible without increasing the time available for such "diversions". The time available could be extended to allow for more free discussion of the content of the program or more time could be made available for participants to share more individually with each other if they wished to.

6.1.14 One facilitator commented that participants reacted aversely to the imagery technique that involves finding a safe place, and so they changed it to finding a "comfortable" place. This difficulty on the part of the participants is not surprising given that very many of them will have had their assumptions of the world as "safe-enough" shattered and would now find it impossible to find any place safe. This change could very easily be made to the program to avoid future participants having this same difficulty - facilitators could talk about a place that

is “comfortable and calm”. However the fact that the participants might find it hard to imagine a “safe place” could also be considered as a therapeutic opportunity to note how their bereavement may have changed their view of the whole world.

6.1.15 Anger was unsurprisingly an issue and some facilitators suggested that this should be included in the program. It would be quite straight-forward to add a component on coping with strong emotions such as anger, however this would require either extending the time of group, or removing some other element of the content.

6.1.16 Although there was a statistically significant improvement in the average depression scores, only just over 50% reported an improvement in depression. Behavioural activation was found to be effective in other interventions (Papa et al., 2013) and it could be incorporated more explicitly into the content of the programme in an attempt to improve the symptoms of depression of participants. Again this would require either extending the time of the group or removing some of the current content.

6.1.17 It was striking that nearly half of the participants reported an *increase* in avoidance on the IES-E. If sufficient follow up questionnaires are returned it will be possible to see if this change is maintained; it is possible that it is related to the questionnaires being completed at the final session. However it is also possible that the programme content could be adapted to specifically reduce avoidant coping and avoidance. Despite the research finding that in the short-term regressive coping (including avoidance) was not predictive of longer term distress (Murphy et al., 2003) in traumatically bereaved adults, avoidance is generally considered as maintaining difficulties such as PTSD (e.g. Ehlers & Clark 2000), and reducing avoidant coping was specifically a part of the Complex Grief Therapy that is somewhat effective (Shear et al., 2005). However it would be important to keep in mind that Complex Grief Therapy consisted of 16 individual therapy sessions; so a great deal of thought would need to be given to how such an aspect of therapy could be adapted for use in a time limited group programme. It might ultimately be considered that a short focused group intervention is not the appropriate context in which to reduce avoidant coping.

6.1.18 Three participants commented that they would like something beyond the final group session. RoadPeace already provide bi-monthly meetings in the London area to enable people to continue to benefit from informal social support. Providing this in other areas might not be viable depending on numbers who would be interested. But as increasing numbers complete the programme in areas outside of London this might become more realistic. RoadPeace could specifically address ongoing support in the final session of the programme and both gauge participants' desire for an ongoing meeting facilitated by RoadPeace, but also encourage them to think how they might continue to support each other independently of RoadPeace.

6.2 Evaluation

6.2.1 There was quite a lot of incomplete data from the standardised questionnaires. This is such a rich source of information that any steps that could be taken to increase the complete sets of data would reap huge benefits. In the UK, Child and Adolescent Mental Health Services that are part of the Government's Child and Young Person's Improving Access to Psychological Therapies (CYP-IAPT) programme are expected to return data for 90% of referrals. RoadPeace may want to consider setting itself a similar target for data return.

6.2.2 Short anonymous evaluation forms could be completed at the end of each session. This would enable feedback to be much more specific to different parts of the program, and it would also enable participants to ask questions anonymously or ask for further explanation, which could be addressed at the following session.

6.2.3 The Life-style Questionnaire appears to not be sensitive enough to capture changes and consideration should be considered to modifying it or using an alternative.

6.2.4 There are more recent, more widely used, and more psychometrically robust measures of depression and anxiety which are still very brief, such as the 9-item PHQ-9 (Kroenke & Spitzer, 2002 and the 7-item GAD-7 (Spitzer et al., 2006) which are used as part of the NHS Improving Access to Psychological Therapies (IAPT) programme. Similarly a slightly different version of the Impact of Event Scale is used very widely in various programmes (Impact of Event

Scale – Revised; IES-R). If RoadPeace were to start using these three measures of symptoms of anxiety, depression and PTSD, it might assist in signposting to other services which might require such questionnaires to have been completed, and it would enable more meaningful analysis of the data. For example it would make it possible to calculate how many participants had "recovered" and how many showed "reliable improvement"; these figures could then be compared to other interventions such as the NHS IAPT. However changing questionnaires at this stage would make it much more complicated to include the current data in future analyses.

6.2.5 Understanding of complicated grief reactions has increased substantially over the last decade with complicated grief reactions being largely accepted as different to depression, anxiety and PTSD. It would therefore be worth considering if it were practicable to assess such reaction in participants that attend groups. This could be done using a robust tool such as the 17-item Revised Inventory of Complicated Grief (Prigerson et al., 1995). It might be that this would more accurately identify the difficulties with which participants are struggling and would therefore be more sensitive to the changes effected by the programme. Furthermore, if it did transpire that such complicated grief reactions were characteristic of the participants attending the programme, there is an increasing amount of research examining what helps, which could then influence future iterations of the course content making it more effective.

6.2.6 Follow up questionnaires are usually sent to participants 6 months after the programme, but return rates have been low. Many studies of interventions that do collect follow up data actually discover that significant improvements are made *after* the intervention. Emphasising to participants during the programme that the follow up questionnaires provide important information, and using electronic methods to distribute the questionnaires and collect answers might improve response rates. This might enable RoadPeace to examine whether improvements were maintained or even increased after the programme.

6.2.7 The time between the death and the programme could be routinely recorded and included in the dataset. As the numbers of participants increase it might be possible to analyse the data to see if there is an optimum time to attend the

group and whether there are any particular “risks” of attending before a certain time has elapsed.

6.3 Research

6.3.1 RoadPeace could be very well placed to conduct more research in this under-researched area, and it may be able to explore collaborations with universities, particular those that run training for clinical psychologists.

7 References

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders 5th edition. (DSM-5), Washington, DC: Author.

Boelen, P. A. (2006). Cognitive-behavioral therapy for complicated grief: Theoretical underpinnings and case descriptions. *Journal of Loss and Trauma*, *11*(1), 1-30.

Bonanno, G. A., Neria, Y., Mancini, A., Coifman, K. G., Litz, B., & Insel, B. (2007). Is there more to complicated grief than depression and posttraumatic stress disorder? A test of incremental validity. *Journal of Abnormal Psychology*, *116*(2), 342.

Breen, L. J., & O'Connor, M. (2009). Acts of resistance: breaking the silence of grief following traffic crash fatalities. *Death studies*, *34*(1), 30-53.

Brewin, C. R., Andrews, B., & Valentine, J. D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of consulting and clinical psychology*, *68*(5), 748.

Dyregrov, K., Nordanger, D., & Dyregrov, A. (2003). Predictors of psychosocial distress after suicide, SIDS and accidents. *Death studies*, *27*(2), 143-165.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour research and therapy*, *38*(4), 319-345.

Goldberg, D., Bridges, K., Duncan-Jones, P., & Grayson, D. (1988). Detecting anxiety and depression in general medical settings. *BMJ: British Medical Journal*, *297*(6653), 897.

Golden, A. M. J., & Dalgleish, T. (2010). Is prolonged grief distinct from bereavement-related posttraumatic stress?. *Psychiatry research*, *178*(2), 336-341.

Grantham, Budnik & Musham. Downloaded on 15th March 2014 from http://www.skillsdevelopment.co.uk/files/GroupSizeReportEdited.pdf

Kroenke, K., & Spitzer, R. L. (2002). The PHQ-9: a new depression diagnostic and severity measure. *Psychiatr Ann*, *32*(9), 1-7.

Lichtenthal, W. G., Cruess, D. G., & Prigerson, H. G. (2004). A case for establishing complicated grief as a distinct mental disorder in DSM-V *Clinical psychology review*, *24*(6), 637-662.

National Institute for Clinical Excellence (NICE). (2005). *Post-traumatic stress disorder; the management of PTSD in adults and children in primary and secondary care*. Gaskell and the British Psychological Society.

Murphy, S. A., Johnson, L. C., Chung, I. J., & Beaton, R. D. (2003). The prevalence of PTSD following the violent death of a child and predictors of change 5 years later. *Journal of traumatic stress*, *16*(1), 17-25.

Papa, A., Sewell, M. T., Garrison-Diehn, C., & Rummel, C. (2013). A randomized open trial assessing the feasibility of behavioral activation for pathological grief responding. *Behavior therapy*, *44*(4), 639-650.

Prigerson, H. G., Maciejewski, P. K., Reynolds III, C. F., Bierhals, A. J., Newsom, J. T., Fasiczka, A., ... & Miller, M. (1995). Inventory of Complicated Grief: a scale to measure maladaptive symptoms of loss. *Psychiatry research*, *59*(1), 65-79.

Shear, K., Frank, E., Houck, P. R., & Reynolds, C. F. (2005). Treatment of complicated grief: a randomized controlled trial. *JAMA*, *293*(21), 2601-2608.

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of internal medicine*, *166*(10), 1092-1097.

Stroebe, W., Schut, H., & Stroebe, M. S. (2005). Grief work, disclosure and counseling: Do they help the bereaved?. *Clinical psychology review*, *25*(4), 395-414.

Stroebe, M., Schut, H., & Stroebe, W. (2007). Health outcomes of bereavement. *The Lancet*, *370*(9603), 1960-1973.

Tehrani, N., Cox, S. J., & Cox, T. (2002). Assessing the impact of stressful incidents in organizations: The development of an extended impact of events scale. *Counselling Psychology Quarterly*, *15*(2), 191-200.

Umphrey, L. R., & Cacciatore, J. (2011). Coping with the ultimate deprivation: Narrative themes in a parental bereavement support group. *OMEGA--Journal of Death and Dying*, *63*(2), 141-160.

World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines* (Vol. 1). World Health Organization.

Yalom, I. D. (1995). *The theory and practice of group psychotherapy*. Basic Books.

8 Appendix: Interview Schedules

Participant Interview Schedule

Hello, my name is Alice, I'm calling from the team that is evaluating the RoadPeace Resilience Building Program.
Did you hear from the RoadPeace team that the Program is being evaluated for the benefit of other people potentially using the program?
I'm interested in your views and wondered if I could have a chat with you.
We want to try and look at what it does well and how it can be improved in the future.
I'd like to ask you a few questions, it'll probably take about 10 minutes, is now a convenient time?
We'd like to use your answers in a report for RoadPeace, a summary of which will be available publicly, but it will be anonymous so your name won't be mentioned. Is that ok?

If we get to any questions that you'd rather not answer, then please just let me know.

1) Firstly, how many of the sessions did you attend?

2) What was your reason for attending/not attending all 4 sessions?

3) Did you find the program to be helpful?

4) In what ways was/wasn't it helpful (symptom reduction)?
   Reducing problems
   Increasing coping
   Social support

5) Did you find any of the techniques learnt in the sessions to be helpful in everyday life? If so which ones? (e.g. deep breathing, tensing and relaxing, safe place visualization, positive thinking, imagery techniques, drawing, writing)

6) Did you or others notice any differences in yourself after the program?

7) Why do you think the program helped/didn't help?

8) Did you enjoy interacting with the other people in the group?

9) Do you continue to meet with any of the people that you met through the program?

10) Was there any part of the program that you think could be improved?

11) Would you recommend the program to a friend?

Do you remember the questionnaires that you completed as part of the program? We are hoping that people would be prepared to complete them once more to help us track how people are doing. Would that be ok? Would you prefer to have paper copies sent to you in the post, to answer them online (I'll send you a link), or to do them now over the phone?

Thank you for taking the time to speak with me today, your views and opinions are extremely helpful in improving the program. Should you need any further support, RoadPeace is always available for you to use, their helpline is 08454500355. There is also a list of other support trusts in the back of your journal, or via the RoadPeace website.

Facilitators Interview Schedule

Hello, my name is Alice, I'm calling from the team that is evaluating the RoadPeace Resilience Building Program.
I am interested in your views on the program and I wondered if I could have a chat with you.
We want to try and look at what it does well and how it can be improved in the future.
I'd like to ask you a few questions, it'll probably take about 10 minutes, is now a convenient time?
We'd like to use your answers in the report, but it will be anonymous so your name won't be mentioned. Is that ok?

If we get to any questions that you'd rather not answer, then please just let me know.

1) How many of the sessions did you facilitate?

2) Overall, how did you find people responded to the program?

3) Were there any areas/techniques that were particularly well received?

4) Were there any areas/techniques that were not received well?

5) Do you think the program was helpful for the participants?

6) Did you notice a change in any of the participants over the course of the program?

7) How do you think the group contributed to any differences noticed in the participants?

8) Why do you think the program was/wasn't helpful for the participants?

9) Did you find that participants enjoyed the social aspect of the program?

10) Are there any areas of the program that you think could be improved?

11) From what you have seen of the program, would you recommend it to a friend?

12) Do you have any thoughts about the way in which the programme has been evaluated (questionnaires, this survey)?

Thank you for taking the time to speak with me today, your views and opinions are extremely helpful in improving the program