THE UNIVERSITY
of EDINBURGH

Wound meets wound in the counselling room

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In fulfilment of the requirements for the degree of Doctor of Philosophy
The University of Edinburgh

2017

Declaration

I hereby declare that this thesis:

(a) has been composed by me

(b) contains my own original work

(c) has not been submitted for any other degree or professional qualification

Signed: [redacted] (Patricia M. Bond)

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Commonly used Abbreviations

CBT	Cognitive Behavioural Therapy
CPTSD	Complex Posttraumatic Stress Disorder
DID	Dissociative Identity Disorder
DSM	Diagnostic and Statistical Manual
EMDR	Eye Movement Desensitization and Reintegration
GP	General Practitioner
NHS	National Health Service
PTS	Posttraumatic Stress
PTSD	Posttraumatic Stress Disorder
VT	Vicarious Trauma

Acknowledgements

Over nearly seven decades I acknowledge with gratitude that in the generosity of the ultimate Wounded Healer my life has been enriched by many people. There are more than can be mentioned by name here, but some stand out.

Without the support of staff and fellow students in the School of Health in Social Science of Edinburgh University this work would have been impossible. Special thanks go to my supervisors, Drs Jonathan Wyatt and Ethel Quayle, and earlier Siobhan Canavan. Their knowledge patience and encouragement has never failed to astonish and humble me. I have learned much from their critiques without ever feeling criticised.

Looking further back, my mother Liusi, aunt Ailidh, and grandmother Mary raised me with love, and are largely responsible for my resilience in face of childhood adversity. Along the way there have been teachers, doctors, mentors, therapists, friends and colleagues who have all contributed to the measure of healing I enjoy today. Without diminishing the part any of these people have played, special thanks go to Jacqueline Quinn, artist and psychotherapist, Tony Wright, clinical supervisor, Colin Oxenforth, vicar, and Ruth Siddals, Linda Talbert and Diana Frost, supportive friends. Two people in the wider trauma therapy field have particularly inspired me. Web-based seminars led by Janina Fisher have greatly influenced my own practice. My thesis title arose from an idea in one of Michael Soth's memorable workshops. Clients and refugees have taught me so much, as have the participants who have so generously shared deeply of themselves in this project. To all I am immensely grateful.

Abstract

Wound meets wound in the counselling room

In this exploratory study I ask, 'what impact might a personal history of developmental trauma have on a counsellor's experience of, and work with, traumatised clients?' The principal aim of the study is to add to the knowledge already available in a way which can assist practice, especially in generic services where trauma is often an underlying, and sometimes unrecognised, issue. The study makes three claims concerning: the importance of recognising diversity of trauma experience; client-informed flexibility in trauma counselling practice; and the advantage of a research strategy which includes elements of bricolage. Such knowledge is presented with a view to informing strategic decision-making, both in the counselling room and in training.

To contextualise the study, I begin with a literature review on two underlying phenomenological questions - trauma and the therapeutic relationship - and on the concept of the wounded healer. Epistemological and ontological reflection on these questions leads to a methodology which I call practical (phronetic) interpretive phenomenology. Data is from semi-structured interviews with six counsellor participants who self-identified as having experienced developmental trauma. I present this data as brief 'ghost-written' stories followed by reconstructions of the transcripts in the form of imaginary post-interview conversations. I also include an autobiographical reflection in order to make my position in relation to the participants' data transparent. Analysis of the participants' stories and reflections reveals them as idiosyncratic, emerging from quite different life experiences. Similarly the ways in which their trauma has impacted on their practice is varied. The methodology focuses on experience-near 'thick' description, reflection, and phenomenological analysis, and aims to privilege narrative context over study of selected variables. The findings indicate that a relational approach based on the client's experiences, and informed by the counsellor's own reflexivity, can connect

with clients in deeper ways than some more detached models of trauma therapy. The implications for counsellor development and practice are discussed, and include encouragement for ongoing processing of earlier trauma by counsellors, self-care, attention to countertransference reactions and to risks of vicarious trauma, and high quality supervision. Appropriate specialist training and continual learning from their own, their clients' and colleagues' experience are also recommended. The data suggest that these 'wounded healers' can have insights which may be of benefit to other trauma counsellors and their clients.

Key Words: Wounded healer, trauma, countertransference, phenomenology, narrative, phronesis, reflexivity, bricolage.

Lay Summary

A client who has been through really difficult experiences, either recently or in childhood, might wonder if it would make a difference if their counsellor were to be someone who themselves had been psychologically damaged. Would they think such a counsellor who had had their own struggles would be a lame duck, or do they imagine they might be better able to understand them because of what they had been through? This study looks at seven counsellors who have survived a variety of damaging experiences in childhood and draws some insights which might help our imaginary client to answer these questions. Could some of these insights even help other counsellors who have less personal experience of trauma? The answer may well be 'yes'.

SECTION I: PREPARATION

Preface

The thesis is divided into three sections: Preparation (Chapters 1-4), Exploration (Chapters 5-11), and Reflection (Chapters 12-13). There are similarities and differences to the more traditional Introduction/Literature Review, Methodology, Results and Discussion. The main difference is to be found in the Exploration section which is a deliberate merger of data and co-constructive reflexive interpretation of the data provided by the individual participants. The Reflection section, by contrast, analyses the data in the round.

All analogies are inadequate, but I wish to suggest that the structure, if not the content, of this thesis be likened to Mussorgsky's suite "Pictures at an Exhibition". Can we imagine that Chapters 1-4 are the approach to the art gallery, through a gateway (Chapter 1) and then perhaps up a long and majestic stairway (Chapters 2 and 3 – Literature Review and Research Approach) to the entrance? We arrive in the foyer with its directional arrows (Method, Chapter 4), and then the tour itself (Chapters 5-11) begins. Before each of these interview data chapters I have, following Mussorgsky, inserted a short 'Promenade' which contextualises each interview. Finishing the tour of the narrative 'pictures' we attend a talk about the pictures by the curator (Chapter 12 – Discussion) and then make our way back to the foyer (Chapters 13, Claims, Implications and Final Reflections) and home, hopefully taking our experience with us.

Chapter 1. Introduction

1.1. Hitting the mark or missing the point

> My client (whom I will call Sophie) answered: She just asked me how I was getting on with my mum.
> My question had been: Tell me something about the counselling you have had before.
> Another client (whom I will call Diane) answered: He just gave me some pills.
> My question had been: What did your GP say to you when you told him how you were feeling?

Sophie, a lady in her 40s, had, I quickly discovered, a history of incestuous childhood sexual abuse which she had not disclosed at the time, and had accommodated it, probably by dissociating. In her 20s she had been a hostage in a life-threatening armed robbery. Not coping with the aftermath, she had sought counselling but it did not help. Many years later she presented for counselling at the voluntary agency where I worked, showing clear signs of somatised posttraumatic stress[1].

Diane, in her late 20s, had gone to her GP because of high levels of anxiety and depression and a turbulent inter-personal relationship. GAD7[2] and PHQ9[3] questionnaires had been administered there and the high scores had led to her medication but not to a referral for counselling. Like Sophie, prior trauma had been missed. She had grown up in a dysfunctional family in which from quite a young age she was frequently assaulted by a very disturbed younger brother. A life-threatening knife attack by him had led to her fleeing from the family home at age 15 and never returning. As well as her symptoms of depression and generalised anxiety, she showed many of the classic signs of Posttraumatic Stress Disorder (PTSD).

[1] Physical symptoms, of traumatic aetiology, being the primary presentation.
[2] General Anxiety Disorder 7 item questionnaire (Spitzer, Kroenke, Williams, & Löwe, 2006)
[3] Patient Health Questionnaire 9 item questionnaire for depression (Kroenke, Spitzer, & Williams, 2001)

I could add a third client – myself. I also have suffered trauma. This trauma has turned out to have affected my life more than I had realised, and has also impacted in a number of ways on my work as a counsellor. My own story is found in Chapter 5.

My research interest grew as I became more aware of the length of time it had taken to recognise the link between psychological distress in adulthood and my own early trauma, despite several lengthy periods of counselling (overtly for depression and relationship problems) prior to the most recent one. The latter was undertaken to work though the transition between retirement from my long employment as a scientist and development of my 'second career' as a counsellor. That transition was achieved, but the therapy was also a time of breakthrough into work on my own trauma and dissociation. I do not criticise my previous counsellors for failing to recognise the importance to me of my dissociative experiences because shame had caused me to hide them quite skilfully.

Before becoming more fully aware that my childhood had been traumatic rather than just somewhat difficult, I found myself drawn towards working with traumatised clients. Even before I was as aware as I now am of my own posttraumatic reactions, I can look back and see a number of examples of how my experiences have influenced my work – in both helpful and less helpful ways.

Clients Sophie and Diane, together with my own personal story in which historical trauma had not been fully recognised, were amongst the motivators to embark on research which could possibly shed light on why trauma might not be recognised or acknowledged by counsellors and other health workers, but also to question whether being a survivor of trauma might influence a counsellor's sensitivity to trauma symptoms and, if so, where on the continuum of dissociating their own experience on the one hand, or projecting it on to clients on the other, survivors might stand. In this exploratory study I ask, 'what impact might a personal history of developmental trauma have on a counsellor’s experience of, and work with, traumatised clients?' My aim is to add to the knowledge already available in the trauma counselling fields in a way which can assist practice, and strategic decision-making, in the counselling room and in training.

As will be noted in the literature review, there is relatively little written about the wounded healer in the context of developmental trauma[4]. This study attempts to add to what there is and to encourage further exploration.

1.2. The topic and its relevance

Because of the potential importance of the effect that woundedness in the counsellor could have on work with wounded clients, it would seem that research into this topic could be valuable both for counsellors and clients. Counsellors might hide, dissociate or feel vulnerably isolated in their experience. Clients could be helped, distanced, or confused by subliminal, unconscious, transferential processes in their relationship with the counsellor.

Anecdotal evidence for wounded counsellors is strong. In my experience, scratch the surface of any training group, and it is usual to find a number of people who have suffered (or are suffering) in one way or the other. This is recognised in training programmes by building in mandatory training therapy, and/or intense personal development group work throughout the course. While this is very effective as far as it goes, it will be only part of an ongoing growth process, and, in the case of those carrying deep wounds, may not have adequately foreseen the challenges specifically touching those wounds that the future counsellor may face in their client work.

Of first importance in all therapeutic work is the safety and benefit of those who come to us for help. Amongst the neediest of our clients are those who have suffered significant[5] trauma in their lives. Their woundedness comes into the counselling room, and I believe it is important to have an awareness of how the relationship with the counsellor, and its effect on the therapeutic work, might be influenced should the counsellor also bring their own significant woundedness into the room. Unlike the work on wounded healers in which Martin (2011), for example, focuses mainly on therapists who have experienced a specific trauma in adult life, my research focuses

[4] Used here to refer to trauma which interferes in some way with healthy psychological development.
[5] In this project 'significant' refers to trauma which has had clinically definable psychological consequences. A fuller definition of trauma is suggested below, and in Chapter 2.

on the influences of therapists' carrying, processing and possibly using, experiences of developmental trauma in childhood.

Wounded individuals will have developed their own array of defences, and if it proves possible to identify some of these, it could be of help to counsellors involved in trauma counselling to 'look out' more effectively for their own defensive reactions as well as those of their clients. This could give them help in crafting methods of self-care which are most appropriate to them as individuals.

A third benefit of research findings in this area could be its impact on basic and further counselling training, particularly in modules or courses on trauma counselling.

The project has trauma at its heart. However, trauma does not exist in isolation – it has consequences, and is likely to have influenced the choices that the survivor has made. The choices of particular interest here are the counsellor survivor's own therapy, their decisions around counsellor training and the work they have undertaken with clients. I will seek to reflect on each of these three in turn and see if there are any connections between them and the underlying trauma experiences of the participants and myself.

A working definition of trauma:

The literature will be reviewed in the next chapter, but here I will outline my own working definition of trauma, which has evolved both from teaching on various training courses on trauma and from work with clients. Regarding the latter, it has been influenced by my work with torture survivors and with those whose history involved sexual and physical abuse, neglect or bereavement in childhood, or traumatic experiences as adults, as well as my learning from my own trauma experience. It was with these in mind that I approached my research.

Trauma's etymological root is the Greek work for 'wound'. Wound implies damage to the integrity of a living being which results in some form of loss, temporary or permanent, of wholeness and health and ability to function fully. In the case of psychological trauma, the wound occurs in the psyche, although because of the

connectedness of mind and body, physical and chemical reactions also occur as responses to the wound and become part of it (Van der Kolk, 2015). The wound, or trauma, is often experienced as a threat to life itself, but is can also be a threatening assault on the person's sense of self (Turner, 2012), and on their safe constructions of what it means to be who they are in the world and in relationship to others (American Psychiatric Association, 2013).

What I call primary trauma can take the form of a single event (such as a natural disaster, road traffic accident, or being kidnapped), a series of physically threatening events (such as interrogations under torture), or a longer period of abuse (such as childhood sexual/ritual abuse, school bullying, or domestic violence).

Trauma can also occur indirectly (McCann & Perlman, 1990)[6]. Those who witness another's trauma, even if they have not been hurt themselves (such as seeing an assault or accident in which someone was killed or seriously injured) can suffer secondary trauma. This can lead to recognisable trauma responses too, even though the witness has not directly experienced threat to their own life or integrity. Another form of indirect trauma is often referred to as vicarious trauma. Merely hearing an account of the severe trauma of another person can be traumatising. Vicarious trauma can occur particularly in those whose work brings them into frequent contact with such material (e.g. counsellors, police liaison officers, lawyers, administrative staff typing reports) (Cieslak et al., 2014). Both these indirect forms of trauma are examples of the threat being to the person's sense of self on the one hand - "what kind of a person am I if I didn't run out into the road and snatch the child before he was run over?" - or an unravelling of a lifetime's construction of what life is about - "what kind of world do I live in if people can do THAT to another person?" It is a common aim of torture to so weaken the prisoner's sense of who they are that they will capitulate to the demands of the torturers (e.g. Graessner, Gurris, & Pross, 2001; Reyes, 2007). Also, the experience of rape, for example, can completely alter a woman's view of men in general (Brison, 2002, p96). Trauma which threatens the

[6] There is more discussion of this in Chapter12.

sense of self, and meaning, can occur both in those directly affected and in onlookers.

Trauma, whether primary, secondary or vicarious, can be seen as being something that is physiologically 'too stressful'. The body has natural abilities to cope with stress, and indeed benefits from it at moderate levels (Le Fevre, Matheny, & Kolt, 2003), but if it is subjected to an experience which overwhelms these abilities, there is likely to be a disruption of normal functioning. This is true of both physical and psychological trauma. Normally our bones support all the rest of our body, but hit a bone too hard and it will break and no longer be able to give that support. Psychological stress at a normal level will set off a number of neurochemical responses (Baumann & Turpin, 2010) which are fine-tuned to enable us not only to survive the stress, but even to benefit from it. However, if the stress is 'too stressful' the system becomes flooded and, as it were, short-circuits. A message from the eye to the brain which says 'this is dangerous', will activate an emergency response to enable us to run away or fight[7]. Another response will cause 'freezing' (Barlow, 2002)[8], in which the appropriate action messages do not get through. The fight, flight and freeze responses temporarily bypass normal cognitive processing, which is why they appear to be automatic. Under normal levels of stress, unimpaired cognitive processing returns fairly rapidly ("Oh, that wasn't a snake after all. It was just a snake-shaped twig"), but if "too much" the normal circuitry of the brain malfunctions, affecting memory, temporal awareness (flashbacks appear to be happening *now*), exaggerated startle reactions and so forth (American Psychiatric Association, 2013; Rothschild, 2000).

Trauma, in my definition, always has some adverse effect, even if it can later give rise to different aspects of posttraumatic growth (Tedeschi, Park, & Calhoun, 1998). Trauma reactions need not fulfil the criteria for PTSD, but posttraumatic stress reactions of varying degree are widespread in clients seeking counselling.

[7] The term 'fight or flight' first coined by Cannon (1929)
[8] In developmental trauma van der Hart (Van der Hart, Nijenhuis, & Steele, 2006, p37) adds 'attach' and 'submit' to these three classic trauma threat responses.

A qualification:

While stress responses considered here are connected with trauma, in counselling practice we see many clients whose stress has other causes. The key to distinguishing traumatic and other forms of stress, is context. Albeit some traumatic events have been disassociated, especially, though not exclusively, when they have occurred in early childhood, in practice much of the stress that presents in the counselling room cannot be traced to traumatic event(s). Stress can be associated with contexts which do not have the distinguishing features of trauma such as trying to hold down a job which is unsuited to one's gifts or inclinations, being in an unhappy relationship and so forth. Also, biological factors can link stress with development of recognised conditions other than PTSD as in the diathesis model of psychopathology (Belsky & Pluess, 2009; Ingram & Luxton, 2005; Monroe & Simons, 1991).

1.3. Wheels within wheels – the counsellor/researcher

There is something of a conundrum to explore in being both a working counsellor and a researcher. Can you take the counsellor out of the researcher or the researcher out of the counsellor? In terms of 'a way of being' (Rogers, 1980), the answer might be 'no', but in terms of purpose there is a need to make a distinction. My initial training as a person-centred counsellor had a strong emphasis on counsellor-client relationship. Rogers' 'core conditions', especially those of unconditional positive regard, empathy and genuineness (Rogers, 1957), have remained with me as foundational to my understanding of a therapeutic counselling relationship, but there are other aspects of relating therapeutically which place more emphasis on a working alliance in which therapist and client agree to work together in a certain way, and in which the technical aspects of therapy are privileged. The process may appear, whether in reality or perception, to be somewhat more objective. I will focus more on these differences between counselling and research in chapter 4 (section 4.2.), but in relation to approaching this project, it could be argued that alliance would be a better description than (therapeutic) relationship. Though some research participants can find some therapeutic value in the research process (Bondi, 2003a, p87), this

would be a bonus and not the primary purpose which is to search for answers to the research question. I maintain that even the most relational professional counsellor stance with clients is quite different from friendship, although warmth, empathy and genuineness are features of both. The difference is in where the priorities lie. In the therapeutic relationship my own interests as counsellor are subordinated to those of the client as far as possible. Even if I gain something, such as satisfaction, from being able to help a client, the focus is always on the interests of the client, not my own self-gratification or aggrandisement. It would be unfair to imply that this is not true of those who identify more with the concept of alliance, and that warmth and empathy are in any way absent from people working within that model. Similarly warmth and empathy have a place in the research interview. The art is for the counsellor/researcher to avoid slipping into a therapeutic mode in interviews with participants and losing site of the purpose of the agreed exercise.

This study is undertaken in the hope that people like clients Sophie and Diane, and so many others who 'fall through the net' of imperfect services and find it hard to find those who are sufficiently equipped to help them may, as the participants in this study have shown, find that there is a way forward from developmental trauma.

Following my image of the gallery (see Preface), I move on from the gateway up the staircase to the main entrance and foyer. In the next two chapters I review the work of other researchers and clinicians, and then explore the philosophical and methodological foundations of the research project.

Chapter 2. Literature review

'What impact might a personal history of developmental trauma have on a counsellor's experience of, and work, with traumatised clients?' This question has been in my mind for a number of years and until undertaking this research has been answered mainly through my learning in basic training, continuing professional development courses, and my own practice, reflection and supervision. Much of what I had learned was from secondary sources, helpful though they were, but they would have been inevitably influenced to a greater or lesser degree by the views of my teachers. The clients I have seen have taught me so much, but again from their own unique vantage points. A formal research project gives me the opportunity to pursue a much wider search of literature than had previously been possible, and I present some of my finding in this review.

There are a number of areas relevant to this project – trauma, therapeutic relationship[9], and the wounded healer. Some of these have extensive prior literature and some have less. In the spirit of the whole thesis, I present the trauma literature in a reflective manner, interspersing review with comments on how I believe it relates or could relate to the research question and what it can tell us phenomenologically about the experience of the aftermath of trauma. I review the literature on therapeutic relationship more formally although also with an awareness of its phenomenological aspects. Lastly, I go on to relate both to what has been researched in the area of wounded healers, again with reflective comment.

2.1. Trauma

Definitions and theories of trauma abound. While I have given my own working definition in 1.2. above, I turn now to consider published work which has to a greater or lesser degree informed it. The participants in this research will have encountered many of these views of trauma and, like myself, are likely to have been influenced by them, which is why it is important to lay them out in a review. As the researcher, I

[9] The research relationship, which is somewhat different, as indicated in 1.3 above is not included in this review, but is discussed later, particularly in chapter 4.

need to remain aware that each participant could, perhaps rooted in their own experience, put more or less weight on different theories of trauma, and that their understanding of their own, and their clients', experiences might only be deeply understood in that context.

Although many theories of trauma exist, the literature indicates that few people, whether practitioners or academics, are willing to espouse what might be called a straightforward, unitary trauma theory. Law's (2004) treatment of perspectivism might help to explain this.

He devotes a whole chapter to examining the multiple perspectives represented by the methods used to describe an object. He seeks to show how method can create a reality, but that the method will inevitably define that reality, and exclude the perspectives of other methods. He illustrates this by describing the different disciplines involved in diagnosing and treating a patient with atherosclerosis, but I can see this paralleled in my own interest, trauma. However, regarding perspectivism, I suggest that the area of trauma has been less prone to protectionism by proponents of different trauma theories than many areas of counselling. Even in the 1980s when there was considerable rivalry between different counselling models, those writing about trauma were showing the kind of willingness to integrate, or at least question, theoretical understandings (e.g. Figley, 1985 especially chaps 1-4) in a similar way to that which has so enriched counselling today. This trend towards integration has continued, so that it is difficult to find proponents of purist trauma models in the literature. Perry et al. (1995), and Schore (2001), were writing primarily about neurobiology but make connections with other theories such as attachment and cognition. Similarly Jacobs and Nadel (1985) link memory acquisition with neuroanatomy, and Hutterer and Liss (2006) discuss cognitive development against a background of psychoanalytic and behavioural concepts and neuroscience findings.

Let us return to Law's ideas for a moment. He would say that definitions arise from the perspective of the one who defines, so a single 'object' such as trauma can have multiple definitions "out-there" (*sic*, Law, 2004, pp13&14) creating a multiplicity

which, even when merged, continues to marginalise the 'in-hereness' reality of the object itself. While the 'out-thereness' in trauma counselling would tend to belong to the counsellor, and the 'in-hereness' to the client, my research area explores the effects of the meeting of the 'in-herenesses' of both counsellor and client, as well as, where appropriate, the 'out-therenesses' of each. I suspect that Law writes from a more extreme constructivist position than I would adopt, but this point is of particular interest, and is a topic on which there seems little specific research.

My research focuses on experiences of trauma and its sequelae, meaning-making associated with trauma and its consequences in the counselling room. These will inevitably be influenced by what we (I and participants) have learned, cognitively, about trauma, so having an understanding of the major areas of trauma theory research is appropriate.

2.1.1. Understandings of Trauma

2.1.1.1. Historical overview

Trauma has been written about in the past against the backgrounds of the experiences of the writers and I include a brief historical overview to illustrate this because in our age we are not exempt from the same discursive pressures. In psychotherapy, as in politics and philosophy, "those who cannot remember the past are condemned to repeat it" (Santayana, 1998, p82). In the context of this study, I wish to be at least aware of the wider influences bearing on even our most treasured assumptions.

Posttraumatic stress has been understood (or misunderstood) as arising from physiological, moral or psychological roots, in the context of scientific, philosophical, sociological and political viewpoints of the day. Although a discourse analysis is not the direction in which I am taking this research, I believe it is still important to have an awareness of past and current discourses of trauma, especially perhaps for those of us who work cross-culturally, where there is a particular need to be open to discourses that might be alien to us but familiar to our clients. As we

read, with fascination and sometimes shock, of what our predecessors thought about trauma, it can remind today's counsellors to have an awareness of the context in which they live, what assumptions their socio-political or intellectual settings might impose on them, however subtly, through the media, peer discussion, and whatever ontological and epistemological ideas are in the ascendancy at the time. In reviewing the intellectual struggles that even some of the giants of the psychotherapeutic world faced, it can also highlight, and even normalise, the struggles that we might experience in attempts to understand the complexity of trauma.

In recent centuries, among the first recognitions by health professionals of posttraumatic experiences were those described following railway accidents and war. The hypotheses here were strongly physiological. Many traumatologists such as Herman (1992) and Van der Kolk (2015) cite the seminal work of Janet (1889), whose collaboration with the neurologist Charcot, and with Freud, was perhaps the first to give rise to the foundations of cognitive behavioural theories of trauma, albeit from a psychoanalytic perspective. This in itself is of interest for therapists. Some (e.g. Patterson, 1989) have argued that cognitive behavioural and psychoanalytic practices are based on incompatible theories of the psyche[10]. Janet suggested that frightening and novel experiences could not be integrated into existing cognitive schemas and were 'split off' from conscious awareness and control (Weisæth, 2002). Freud and Breuer (2004) initially concurred, though not unreservedly, with Janet's ideas, and made association between hysteria and childhood sexual abuse. Later Freud abandoned this model, favouring instead the theory of active repression of sexual and aggressive fantasies of the Oedipal Complex – his "unacceptable impulse" theory (Freud, 1961a, 1961c, 1961d; Weisæth, 2002).

The issue of posttraumatic stress forced itself to attention in a particularly horrific way in the First World War. Military and political leaders had a vested interest in seeing it as a moral weakness, and attempts to exonerate soldiers 'shot at dawn' for

[10] As integration and eclecticism are widely accepted today, earlier views such as those expressed by Patterson (and by my own tutors in basic training) are less often heard, but still have merit. However, it could be argued in terms of paradox – both/and rather than either/or – where 'not knowing' why certain theory-based techniques are helpful for some but not other clients, independent of therapist's theoretical orientation, must be accepted.

cowardice 100 years ago are still in the news today. One can only imagine the pressure under which army doctors were put to agree with this 'diagnosis'. However some psychiatrists stood out against it and advanced the process of understanding the psychological effects of trauma. Of particular note was the work of Smith and Pear (1917), whose bold and compassionate view of shell shock flew in the face of accusations of malingering or cowardice. At this time, there were attempts in the psychiatric community to understand trauma in neurophysiological terms. Bury (1918), for example, expresses a strong conviction that war neuroses must have physical explanations, and begins to point to experimental evidence which link trauma symptoms to the sympathetic nervous system. Campbell (1918), also ahead of his time, makes a case for understanding physical symptoms in terms of emotional stress. The period up to the 1940s saw considerable interest in organic causes and effects of traumatic stress, leading to a variety of physical treatments (see below, section 2.1.1.3.) which were applied during World War 2 (WW2). With increasing interest in psychodynamic and cognitive behavioural theories, neurochemical research declined somewhat and was not significantly revived till the 1980s.

In his seminal work, an important contribution by Kardiner (1941) was to recognise acute, transitional, and stabilized forms of distress in soldiers. While writing from a more classical psychoanalytic perspective, he also investigated possible links between 'traumatic neurosis' and personality. His work is a forerunner of the now recognised classifications[11] of Acute Stress Disorder[12] and PTSD (both American Psychiatric Association, 2013; World Health Organization, 2010) and Complex PTSD (CPTSD) (Herman, 1992).

Posttraumatic Stress Disorder, as such, was first named in DSM-III as recently as 1980 (American Psychiatric Association, 1980), and even then it was a controversial diagnosis. Jones and Wessely (2007) identify this development as a paradigm shift from conceptualising posttraumatic symptoms as results of a trauma triggering a pre-existing mental weakness or illness to the effect of the trauma itself on otherwise

[11] Principally the DSM (Diagnostic and Statistical Manual of Mental Disorders) of the American Psychological Association, and the ICD (International Classification of Diseases) of the World Health Organization.
[12] Named Acute Stress Reaction in ICD10 (World Health Organization, 2010)

healthy individuals. Paradigm shifts do not take place overnight however, and whilst dating it from 1980, work was moving in that direction from the 1940s onwards. Trauma theories have further evolved since 1980. Ways in which this project's participants use some of the current trauma theories in their practice will be discussed more fully in the Discussion (chapter 12). The principal theories informing practice today are:

Attachment Theories. Building on Bowlby's work on attachment in children (Bowlby, 1969, 1988), Ainsworth, Main and Crittenden have contributed significantly to adult attachment (Ainsworth, Blehar, Waters, & Wall, 1978; Crittenden, 2006; George, Kaplan, & Main, 1985). Pearlman and Courtois (2005) stress the importance of nurturing relationships between the therapist and client in trauma therapy, as a route to repairing attachment disruptions through childhood trauma.

Psychodynamic Theories. Freud's ideas about hysteria (Freud & Breuer, 2004), apparent failure (in trauma patients) of his theory that the function of dreams is to relax repression (Freud, 1964a, pp28-30), and finally his connection of trauma to the Oedipal Complex (Freud, 1964b, pp72-80, 99) are important in subsequent psychodynamic trauma theories. While there is considerable overlap with Attachment Theory, as the latter has its roots in psychoanalytic theory (Crittenden, 2011), current psychodynamic understandings of trauma are principally based on Object Relations Theory (Cashden, 1988; Gomez, 1997).

Behavioural and Cognitive Theories. Classic conditioning (e.g. Skinner, 1938) explains post-traumatic reactions as responses to fear-inducing stimuli. The conceptualisation of PTSD resembles that of phobias and led logically to the recommendation to extend exposure therapy to PTSD (Rothbaum & Schwartz, 2002).

Neurobiological Theories. It is interesting that trauma studies, as we know them today, were initiated in the late 19th and early 20th centuries by neurologists such as Charcot and Freud, and after a lengthy gap in which psychiatrically-trained researchers led the field, some of the most interesting current work is again being

conducted by neurologists. Differences are being noted between traumatised and non-traumatised individuals in the brain's anatomical features, such as the size of the hippocampus (Luby et al., 2012), activity of the amygdala (Nutt & Malizia, 2004), and biochemical changes (Kasckow, Baker, & Geracioti, 2001). The mechanisms by which the brain processes memory are being increasingly elucidated, showing that traumatic experiences frequently by-pass 'normal' pathways and get 'stuck' in a time-independent vortex, rarely reaching the cortex where they would otherwise be rationalised and available for control. Counsellors have been made aware of some of these findings through the work of Babette Rothschild (2000) and Peter Levine (2010), who have been able to communicate their relevance to treatment approaches to less specialised practitioners.

Person-Centred Theory. Rogers (1951, p487) saw the actualising tendency as being fundamental to human development, and the thwarting of it to lie at the root of psychological distress. Where most other challenges to the organismic self are in the form of conditions of worth, and this will often be the case in an abused child (e.g. the little girl who grows up to believe that she will only be loved if she offers men her body), a single trauma in an adult is more likely to challenge their configuration of self (Turner, 2012, p35).

Returning to my observation that writers on trauma have been notably willing to integrate theories, perhaps more than in some other areas of counselling, I see these vignettes not as contradictory but as complementary. They perhaps look at trauma from different angles – something like the Indian parable of the blind men's descriptions of an elephant, limited as they were by their reliance only on their sense of touch.

2.1.1.2. Understanding trauma today

Against this background, I turn now to explore current understandings of trauma which are likely to be ones with which the participants in this study are familiar. The word 'trauma' has come into the public domain as never before and this has spawned

a multiplicity of definitions. First, and of less relevance to this study, is the physical medical understanding – injury to the body, broken bones etc. Then we move into the psychiatric medical understanding of psychological trauma, as defined by a variety of disorders, symptoms or syndromes in e.g. DSM5 (American Psychiatric Association, 2013) or ICD-10 (World Health Organization, 2010). Then we have the lay understandings in which trauma can relate to anything ranging from experiencing a natural disaster to having a bad day at the office. It is in this lay category that things begin to become more complicated. Physicians and psychiatrists have laboured to define trauma on the basis of signs and symptoms, adhering in the main to a positivist, objective, viewpoint. That this is by no means satisfying to many in clinical practice is evidenced by the admitted common difficulty in assigning patients to a diagnostic category. The practitioner, whether medical or not, encounters patients/clients who bring their *experiences* first. Not infrequently, especially if the underlying trauma had occurred many years earlier, a client will not associate their current experience with the traumatic event(s). It is here that the value of having some diagnostic pointers in the form of the clinical manuals mentioned above can be seen. The described symptoms in certain combinations can indicate specifically acknowledged trauma disorders like Posttraumatic Stress Disorder (PTSD), but can also provide clues to recognise certain client experiences as possibly linked to Posttraumatic Stress (PTS). Posttraumatic stress, rather than PTSD, is the term preferred by most counsellors in the absence of a formal medical diagnosis[13].

Counsellors' opinions of trauma vary probably as much as those of the lay community. Some counsellors will regard as a trauma anything unpleasant or outside someone's comfort zone which leaves an emotional legacy. In this they may be over-influenced by emotional appeals of distressed clients and the current sociological blame culture trends which are often encouraged by compensation lawyers. Summerfield's (2001) provocative BMJ article questioning the validity of PTSD diagnosis highlights such concerns. Freud's "unacceptable impulse" trauma theory (see above) may also be partly responsible for generalising trauma. Others

[13] In the UK, counsellors who are not also registered clinical psychologists or medical practitioners are not permitted to make diagnoses as such.

will favour a more restricted, and arguably more medicalised, definition in which only experiences resulting in PTS symptoms of various intensities are recognised as traumatic, and it is this position that is adopted in this project. However, even this has its complications. If wound and trauma are synonymous, are the post-traumatic reactions of hypervigilance, avoidance, anger and so on to be considered in the same bracket as some narcissistic personality features such as the rage engendered by perceived criticism which can be encountered in someone carrying a narcissistic wound (Klein, 1987; McDonald, 2011; Mollon, 1993)? There could be overlaps, when considering attachment issues, but is this a step too far?

The difficulties of defining trauma are evident from the counselling room to the offices of the great and the good. In an interview van der Kolk (Van der Kolk & Najavits, 2013) outlines some of the fundamental difficulties with DSM and there have been earlier struggles to agree on the latest version of DSM, DSM5 (American Psychiatric Association, 2013). Comparison of DSM5 with DSM-IV-TR (American Psychiatric Association, 2000) shows reclassification of Posttraumatic Stress Disorder (PTSD) from 'Anxiety Disorders' to a new group entitled 'Trauma- and Stressor-Related Disorders'. This group also includes sections which were formerly found under 'Dissociative Disorders' and even, in the case of Reactive Attachment Disorder, 'Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence'. Clinicians who accept Judith Herman's definition of Complex PTSD (Herman, 1992, p121)[14] have long campaigned for its inclusion in DSM. Bessel Van der Kolk (2005) argued persuasively for the similar 'Disorders of Extreme Stress Not Otherwise Specified' (DESNOS) and Developmental Trauma Disorder (DTD) to be recognized on treatment grounds (Van der Kolk et al., 2009). Complex PTSD (CPTSD) is the term that I will use most frequently in this thesis as being the nearest diagnostic category into which the experiences of the participants fall. In spite of the widespread acceptance of CPTSD by clinicians (Cloitre et al., 2011; Cloitre et al., 2009; Lanius, Bluhm, & Frewen, 2011; Litt, 2013; McLean & Gallop, 2003) DSM5

[14] Herman (1992, p119) contrasts standard PTSD diagnostic criteria, based on symptoms following circumscribed traumatic events, with the more complex presentation of survivors of prolonged abuse who show signs of distortions to personality, relatedness and identity, and who are often particularly vulnerable to re-traumatisation.

has not clearly embraced these ideas, but this version is closer than earlier ones to including a posttraumatic syndrome which affects large numbers of adults who live with a history of recurrent childhood trauma. However, whilst recognizing the occurrence of dissociative symptoms in posttraumatic stress, DSM5 has still failed, sadly in my opinion, to give adequate emphasis to the frequent traumatic aetiology of most of the Dissociative Disorders. The continuing nosological paradigm in such manuals, while having some strengths, also retains the weakness of tacitly implying that clients who seek counselling are not really traumatised unless they fit into one of these categories. When this is too rigidly accepted it has serious funding implications around access to statutory services for some very damaged people. This places many counsellors in the unenviable position of seeing clients for much shorter periods of therapy than would otherwise be indicated (Cloitre et al., 2011) and is an issue which we will see as the data unfolds.

The difficulties outlined above in defining trauma could be alternatively rather depressing, or rather awe-inspiring. There could be the temptation to say that this is all too complicated to make any sense of it, so just let us love our clients and hope for the best. Or, and this would be my position, to wonder at the amazing complexity of the human psyche and catch some of the excitement of discovering new things. Marine biologists tell us that only a tiny proportion of ocean species have been discovered (e.g. Appeltans et al., 2012; Fessenden, 2015) largely because of the difficulties of access to their environment. The parallel with the psyche gives me optimism that not only are new understandings possible, but can, like the weird and often very beautiful marine creatures, refresh our senses of wonder – and our hope of being able to be of more use to our traumatised clients.

Today, as already noted, many of the different theories of trauma have been integrated. That the integration of trauma theories seen today is apparent even in Janet's seminal work (1889) is perhaps an indication that an ideal theory is not really a possibility (Flyvbjerg, 2001, pp25ff&39), and that it is actually very much more helpful to survivors of trauma to draw insights from different perspectives. This seems very much in line with Law's (2004) arguments above. Alternatively, such early and continuing integration could simply indicate the difficulty in deciding just

what trauma is. Clinicians, such as Rothschild (2000, 2010) and Fisher (2017), writing on trauma, even if they demonstrate a preferred theoretical position, have a tendency to approach their clients/patients as individuals, with individual experiences, in individual contexts, and remain flexible as to their therapeutic approach. This is not, I believe, motivated by a conscious espousal of postmodernism, but rather from having found in practice that this is the approach which works best.

Because the core of my research is about what happens in the counselling room, where trauma has been involved in the lives of both parties, I am interested in both counsellors' and clients' perceptions of trauma. What is their experience, and how have they conceptualised it? How have counsellors who have been clients been influenced by their own therapy and training? Counsellors, and some clients, may well have some theoretical knowledge of the field. There may be, for example, some understanding of various suggested mechanisms. Examples might be 'short-circuiting' of cognitive processing which might explain irrational fear responses to triggers - blending elements from cognitive and neurobiological theories (Vermetten & Bremner, 2002a, 2002b), or amnesia as a way of protecting the psyche from overwhelming distress – as informed by psychodynamic theories (Elliott, 1997; Hutterer & Liss, 2006). However, while psychoeducation is gaining in popularity in trauma counselling and can often bring a measure of relief ("so I'm not going mad"), it does not necessarily bring about recovery. Perhaps it is natural for people to think that what has helped them in a situation is likely to help others in what they consider a comparable situation. So to what extent do counsellors who have survived trauma have a tendency to conceptualise their clients' traumas in the same ways that had satisfied them when working on their own difficulties? I will say some more about identification below (sections 2.2.5. and 2.3.), but meantime, as it relates to trauma, how does a counsellor (whether a survivor or not) reach an understanding of the client's experience and conceptualisation of their trauma? In the recent past there has been considerable controversy around what has been called false memory syndrome in which therapists have been accused of suggesting and implanting memories in their clients, often where 'forgotten' sexual abuse has been suspected (Dallam, 2001;

Mitchell, 1996)[15]. Where this might have happened, why did it happen? What is the nature of memory? Any counsellor who has supported trauma clients' pursuit of justice will have experienced the incomprehension of many in legal and civil services when faced with 'discrepancies' in testimony around the memory of traumatic events (Cohen, 2001; Herlihy, Jobson & Turner, 2012; Jones & Smith, 2004; Smith, 2004). Given that such discrepancies occur, counsellors do well to interrogate any easy assumption that they may have absorbed that 'unconditional positive regard' means that the client has to be believed at all times. This is not of course what Rogers (1957) meant, but whilst honouring the sincerity with which a client may recall a memory, it is wise to hold specific 'memories' in open hands. Having said that, there is empirical evidence that where children have been abused, unless the memories have been dissociated, the bias is towards quite accurate recall (Ogle et al., 2008). This may not be true of all trauma memories, especially if they have been contaminated by the circumstances of the first telling – a criticism which has been levelled at critical incident debriefing (Paterson, Whittle, & Kemp, 2015).

2.1.1.3. Therapies for trauma-related stress

Bearing in mind the caution in 2.1.1.1. above to remember history, some trauma treatments in the past are only indirectly relevant to the picture today, and for that reason an overview has been relegated to the appendix (Appendix E). The two main categories of treatment to consider here, however, are: a) medication and b) psychotherapeutic interventions.

Many, if not most, clients who come to our counselling rooms today, with what is clearly or covertly a history of developmental trauma, have been given some form of medication – usually an antidepressant or anxiolytic – by their GP to help with symptom alleviation. The findings in a recent retrospective study by Mawanda et al. (Mawanda, Wallace, Mccoy, & Abrams, 2017) suggest that medicating PTSD sufferers may increase the risk of later developing dementia. Although the results

[15] The debate has even featured in fiction (e.g. French, 1997).

are tentative, they may indicate the advisability of reducing routine prescribing of medication for PTSD sufferers where patients are not also experiencing major depression. The problem remains, however, that the traumatic aetiology of many of our clients' symptoms is not always easily recognised, and a caring GP may well be unaware of the possible relevance of this caution. This is especially true of the developmental trauma with which we are concerned in this study.

In spite of efforts to find appropriate medication (see Appendix E), major breakthroughs in pharmacological interventions continue to be elusive and today medication is normally used for proven cases of PTSD in conjunction with psychotherapeutic approaches (NICE, 2005), and only where indicated to reduce symptom severity. Reger et al. (2013) showed that soldiers preferred prolonged and virtual reality exposure therapies to medication, unless they also had major depressive disorder. Current NICE guidelines (NICE, 2005) say that medication should not be offered as a first line treatment for PTSD, including chronic forms, and come out strongly in favour of trauma-focussed cognitive behavioural therapies (TFCBT) or eye movement desensitization and reintegration (EMDR) treatment. They recommend *no* other therapies, a recommendation which appears to contradict the experience of a number of expert clinicians in the field of CPTSD (Cloitre et al., 2011), 84% of whom endorsed a stage-based modality of treatment, starting with a stabilization phase and only later progressing to a focus on the trauma itself. De Jongh et al. (2016) are critical of the hypothesis that trauma-focussed approaches, without prior stabilization, are too risky for people with complex morbidities, and that adherence to stage-based treatment is too conservative, depriving some patients of effective interventions or causing unnecessary prolongation of therapy. An earlier paper (Feeny, Hembree, & Zoellner, 2003) by members of the same research group addressed myths surrounding exposure therapy (a trauma-focussed approach) for PTSD. Taken together with a number of similar publications (e.g. Bisson et al., 2007) providing good evidence for trauma-focussed treatments, these papers appear to look at stage-based treatment only when it, like the trauma-focussed treatments studied, is manualised. Manualised treatments lend themselves to empirical quantitative studies in a way that non-manualised treatments do not, so that the latter

are generally excluded from meta-analyses like that of Ehring et al. (2014). The differences between clinicians of different schools (by which one might justifiably mean different epistemologies) bring to mind the 'science wars' (Flyvbjerg, 2001; Ross, 1996) in which postmodern research has struggled to gain respectability in some circles. In both the De Jongh et al. (2016) and Feeny et al. (2003) examples, it is noteworthy that they make comments which could throw a different light on their findings. De Jongh et al. (2016) criticised the diagnostic heterogeneity of patients in the Expert Consensus Treatment Guidelines (Cloitre et al., 2011), which begs the question about possible limitations of the lack of heterogeneity in many empirical studies' subjects. A different angle is given by Feeny et al. (2003) in their examination of myths around exposure therapy. Whilst defending its validity, they also soften the criticism of its apparent opponents by acknowledging that 'in the real world' therapists using exposure therapy do modify it according to the individual patient's needs. The defensiveness of those who are wary of the risks of exposure and other trauma-focussed therapies for PTSD, and especially CPTSD, is rather a defence against another myth – that proponents of these therapies are practising them in a mechanical 'one size fits all' way. Few therapists of any compassion would throw the baby out with the bath water and reject empirical evidence on principle, and eclectic approaches are widely used in which both stage-based (manualised or otherwise) and trauma-focussed therapies are combined (e.g. Courtois & Ford, 2009; Fisher, 2017; Rothschild, 2000; Van der Hart et al., 2006). Rothschild (2010), in a comment to professionals in the field, reminds us (p157) not to be overly influenced by the *evidence base* (her italics), and rather think of it as a guide rather than a law. In "The Body Remembers" (Rothschild, 2000), Rothschild does however emphasise that trauma therapy needs, whatever one's discipline or modality, to be both structured and directive in order to prevent clients being either avoidant of, or overwhelmed by, memories (p151).

In the statutory services, as recommended by NICE (2005), the current treatments for trauma in the UK are TFCBT and EMDR. In private and voluntary sectors, therapists are generally free to choose from a greater variety of approaches - Sensorimotor Psychotherapy (Ogden & Fisher, 2015), attachment-based

psychotherapy (Liotti, 2011; Richardson, 2008; Richardson & Bacon, 2003), Dialectical Behavioural Therapy (DBT) where a diagnosis of Borderline Personality Disorder has been made[16], especially where dissociative symptoms and suicidal ideation is marked (Linehan, 1987, 1993), NLP[17]-based therapies like Rewind (Bandler, 1985; Muss, 1991, 2013) and Energy therapies such as Emotional Freedom Technique (EFT, commonly known as 'tapping') (Church et al., 2013; Craig, 2008)[18]. All these treatments have been applied in some form in the treatment of CPTSD. Some, particularly TFCBT and DBT, are used by therapists working in group settings, and group therapy has been found to be beneficial to some clients in reducing stigma and isolation (Courtois, 1988; Dorrepaal et al., 2012). Less often encountered in counselling practice in the UK, but included in Courtois and Ford's (2009) overview of CPTSD treatment, are Contextual Therapy, Contextual Behavioural Trauma Therapy, Experiential and Emotion-Focused Therapy and Pharmacotherapy. They also include overviews of general treatment approaches such as Internal Family Systems Therapy, and Couple, Family Systems and Group therapies (Courtois & Ford, 2009, chapters 17-20). Internal Family Systems Therapy (Schwartz, 2001) is used to effect in the treatment of dissociative identity disorder (DID) and other dissociative disorders with individual clients too, especially in the context of Sensorimotor Psychotherapy.

This brief overview of treatments for PTSD is included to place current practice in context and to highlight the complexity of the problem of helping people living with the aftermath of trauma. Many of the approaches will be mentioned by the participants in the project data, and discussed.

[16] BPD has not infrequently been given as a diagnosis to people who might better fit the criteria for CPTSD (Cloitre, Garvert, Weiss, Carlson, & Bryant, 2014).
[17] Neuro-Linguistic Programming.
[18] However, the evidence base is elsewhere considered rather weak because EFT combines imagined exposure, cognitive restructuring and relaxation so it is unclear whether EFT or one of its elements is causing the effect (Boath, Stewart, & Carryer, 2012; Waite & Holder, 2003).

2.2. The therapeutic relationship

At the heart of this study is what goes on in the counselling room when both counsellor and client have a history of trauma. What goes on in any counselling room is to a greater or lesser extent to do with a meeting of two (or more) people, whether it is called alliance or relationship. The literature frequently names high quality therapeutic relationship or alliance as being the principal factor which consistently results in favourable outcomes in any counselling (Cooper, 2008, ch6; Lambert & Barley, 2001). Most, if not all, counselling training courses, and certainly the ones undertaken by participants in this study, put an understanding of the therapeutic relationship in pride of place. As well as theoretical knowledge, the courses provide exercises and placement experience in which students can learn in practice how that relationship is fostered, and what pitfalls might need to be avoided. Against this background, I review here how the therapeutic relationship has come to be understood. In the early 21st century, differences in understanding of the therapeutic relationship are less stark than they have been in the past, but what different emphases there are have historical precedents.

2.2.1. Classical psychoanalysis

Psychotherapy usually traces its modern roots to Freud. As can sometimes happen, the followers of a particular innovator can sometimes refine and redefine the ideas of a founder, and some of Freud's disciples became more 'Freudian' than Freud, especially in the way in which psychoanalysis was practised. Contrast, for example the length of analysis. Freud often completed analyses in less than a year, whereas many of his followers took much longer (Messer & Warren, 1998, p12).

Freud believed that the transference - a key concept in psychoanalysis and psychodynamic counselling - would be facilitated by the analyst becoming a 'blank screen' – out of the patient's line of vision. Freud and his followers believed that working with the transference was the 'royal road' to the unconscious, and held that

their own input into the analysis should be strictly limited to making interpretations. Thus the classical psychoanalytic stance of the completely detached observer came to be the norm.

2.2.2. Rogers and humanistic modalities

Basic psychoanalytic theory was the establishment position into which Carl Rogers stepped. Rogers is viewed by Khan (1997) as second in influence only to Freud in approaches to psychological distress. A psychologist, rather than a medical practitioner, Rogers did not see his distressed clients as ill, but as people who for whatever reason were out of touch with their true or 'organismic' selves (Rogers, 1951)[19]. Rather than adopting a distant, objective stance designed to evoke transference, he advocated a sea-change in the relationship with his clients. He believed that six conditions were necessary and sufficient for change (Rogers, 1957). He emphasised particularly the need for empathy, unconditional positive regard, and congruence (genuineness). This was to help his clients (a change of name from patients) to access their true/organismic selves so that they could grow. Originally a biologist, Rogers saw the human psyche as having an innate impulse towards growth (or actualisation), but this impulse is frequently thwarted by adverse environmental conditions. He believed that conditions of worth imposed in earlier life were introjected to a degree that clients truly believed themselves to be bad, unlovable, stupid and so forth. These beliefs had disabled their natural inclination to develop their potential as human beings. By being warm, accepting and empathetic, Rogers gave his clients, continuing the biological metaphor, a nurturing environment in which the stunted plant could be watered and resume its growth. Rogers' framing of the psyche in terms of a growing organism in need of nurture is of particular relevance to counsellors working with developmental trauma (whether they adopt a Person-Centred modality or not) given that this type of trauma is by definition disruptive of a child's psychological growth and development.

[19] The term 'organismic self' is not used here by Rogers himself, but the concept is present in his Propositions in Chapter 11 of that book, and in Rogers (1959)

Humanistic therapies are often bracketed together (e.g. Nelson-Jones, 1982), but not all are Rogerian. However, most have abandoned any idea that a coldly objective uninvolved stance on the part of the counsellor is therapeutic. Of all the humanistic therapies, Rogers' Person-Centred Approach is probably the most radical in promoting the use of the counsellor's own self in the therapeutic relationship, with training courses having a particularly strong emphasis on personal development through experiential exercises in the training group (Mearns, 1997). Other humanistic models also prize Person-Centred 'core conditions', but rather noticeably usually reduce them to the three mentioned above rather than Rogers' original six (Rogers, 1957)[20]. In attitudes towards implementing the core conditions, Rogers stands at one end of a spectrum, and Egan (1990) at the other. Egan describes their use in purely technical terms – posture, eye contact, types of reflection etc. – with little or no emphasis on the therapist's own self.

Other humanistic modalities such as Gestalt, transpersonal and existential therapies, and the cognitive behavioural school differ more in their theoretical underpinning than in the relationship issues which concern us here. However, as far as the relational aspects are concerned, they are all nearer to Rogers' approach than to that of classical psychoanalysis. In the current climate, influenced as it is by the frequent requirement of funders for evidence from empirical studies[21], often with a bias towards brief therapies (but see Lloyd's (2016) economic argument in which he refutes this bias in the treatment of Dissociative Identity Disorder), many of the humanistic therapies are 'priced out of the market' for significant numbers of clients. A major factor for sufferers of CPTSD and trauma-related dissociative disorders is that longer-term therapies are frequently more effective (Courtois, Ford & Cloitre, 2009, p96).

[20] The other three are that client and counsellor are in psychological contact, that the client is in a state of incongruence, and that the counsellor's empathic understanding is communicated to the client.
[21] See also Smith (2012), Smith & Joyce (2012) and Stewart & Smith (2015) for debates on evidence in policy making and their call for the use of complexity theories. Although beyond the scope of this project, there seem to be some parallels between the paradoxical epistemology for which I will argue and the practical recognition of complexity in policy making.

2.2.3. Post-Freudian developments in psychoanalysis

The extensive contributions of Heinz Kohut and Merton Gill and the significant part they played in the development of psychoanalysis are reviewed by Khan (1997, chs 4 & 5)[22]. Kohut and Gill, whilst influencing modern psychoanalysis in a direction away from the starkly neutral stance of classical psychoanalysis, have also created something of a fork in the ways. Kohut, writing mainly in the 1960s and 1970s, was so radical that although he remained firmly in the psychoanalytic community rather than jumping ship and joining the humanists, his insistence on a more empathic approach to patients, and an intense valuing of patients' experience (Kohut, 1984), caused much controversy and acrimony (see Gedo, 1980; Khan, 1997, p87). Gill, possibly partly in response to the controversy, proposed an expansion of classical psychoanalytic theory to justify a degree of departure from the neutral relationship to the patient. Gill, writing particularly in the 1980s (e.g. Gill, 1983; Gill, 1984) believed, unlike Freud, that it was not enough to remember repressed childhood material which lay at the root of their distress. The patient needed also to re-experience the emotional aspects of that material (Gill, 1982)[23]. He still believed that interpreting the transference was at the core of treatment. His new contribution was to emphasise that the patient would only be truly freed from their distress if they were helped to re-experience its origins in the transferential relationship with the analyst. Many approaches to trauma therapy today lay an emphasis on re-experiencing the trauma in trauma-focussed therapies (see section 2.1.1.3. above), and seem to reflect Gill's views. Others approach it cautiously because of the risk of exacerbation of symptoms[24] and/or early withdrawal from therapy (e.g. Cloitre, Koenen, Cohen, & Han, 2002; Kilpatrick & Best, 1984; Pitman et al., 1991).

[22] To give individual examples of their published papers could be misleading as the debate spans a number of years. Further information can be found by referring to Khan's (1997) review, to Gedo (1980) and to Leider (1983).
[23] Cited by Grant and Crawley (2002, p3)
[24] When assessed severe, on the ethical principle of non-maleficence (BACP, 2016)

2.2.4. Relationship vs alliance

It would be difficult to understand current thinking about the therapeutic relationship without this historical overview, because so many of these strands of thought are still present in different views today and emerge in the participants' data. In current literature, some write about "alliance" (e.g. Dryden & Feltham, 1992) and others "relationship" (e.g. Mearns, Thorne, & McLeod, 2013). The first question to ask is whether they are interchangeable terms or not. The second is to see if and how they have emerged from the different views discussed above.

Even if the terms are not interchangeable, it would be simplistic to suggest that there is a clear distinction between the two, although one might think of the former more in terms of an endpoint and the latter as a process. Hatcher and Barends (2006) make a strong case for a clearer distinction because, they suggest, confusion has devalued and discouraged researching measurement of the alliance. This reflects, of course, a modernist empirical epistemology. There is a sense in the literature that the more overarching term relationship tends to be favoured by therapists in the Rogerian tradition, where alliance is chosen more often by those in the psychodynamic, psychoanalytic and cognitive behavioural schools (see, for example, Safran & Muran, 1998). This may reflect the greater emphasis in the latter on honing the technical aspects of therapy in order to maximise effectiveness. This would be consistent with the more objective approach of Freud and the psychoanalysts to their interaction with patients. By contrast the Person-Centred tradition relies heavily on the client's actualising tendency (e.g. Rogers, 1978; Merry, 1995) to bring about growth, and on the effectiveness of the highly relational core conditions to liberate and facilitate that tendency. It is logical to see the relationship itself as key to that process. The therapeutic alliance, on the other hand, has more of a focus on the minima of agreement between client and therapist required to enable them to work together. This is not the same as general contracting (times, place, confidentiality, fees etc) but more about a common position on what the work is about - the client's goals, the tasks, and the nature of the bond between client and therapist - a conceptualisation spearheaded by Bordin (1979). The last of these, of course, brings

us into the realm of the therapeutic relationship, but for some therapists has been of less importance than the first two. It is likely that a positivist medical model of psychological therapies has influenced this. An argument might go something like, "provided you are prescribed the right medication it doesn't matter if you like your GP or not" or "your surgeon doesn't need to have a good bedside manner to carry out a successful operation". Such a stereotype of the 'technical' therapist is unfair, but one which is still heard amongst radical opponents to the roll-out in the NHS of cognitive behavioural therapies (CBT), especially when computerised, since Layard's report (Layard, Clark, Knapp, & Mayraz, 2007). However, many cognitive therapists are committed to challenging this somewhat tired stereotype and advocate a more relational approach to their clients (Friedberg & Gorman, 2007; Newman, 1998, p96; Waddington, 2002). Another reason for the current emphasis on goals and tasks is economic (Layard et al., 2007; Safran & Muran, 1998, p10). Brief therapies are generally embraced more wholeheartedly by health economists than by counsellors and psychotherapists, with a typically pragmatic comment coming from Khan, a psychologist in the psychoanalytic tradition. Of brief therapy he says "it won't be the same as years of therapy, but it will be a lot better than nothing" (Khan, 1997, p177).

2.2.5. Unconscious and conscious interactions in the counselling dyad.

As we will see below (section 2.3.) the interactions between wounded individuals is often particularly prone to unconscious complications in the relationship. Transference lies at the core of psychoanalytic and psychodynamic work (e.g. Jacobs, 1998, p1). The phenomenon of countertransference – in which the therapist has an emotional response of some kind to the client's transference – was recognised by Freud, but he believed that it usually hindered the analysis and would be eradicated if analysts had been sufficiently analysed themselves. In time, this attitude was modified (Heimann, 1950) to recognise that countertransference could actually be helpful to the analyst in understanding the form of the transference and be

thus better able to work with it. An example of transference in trauma work could be of the female survivor of her father's abuse perceiving her male counsellor as a sexual or physical threat. Unrecognised countertransference could be the counsellor's exaggerated desire to draw 'reassuringly' physically close to the client, unaware that this would actually increase rather than decrease the perceived threat level. Also relevant to counsellors of any modality working with developmental trauma, is the ability to recognise the unconscious processes of projection and projective identification (Grant & Crawley, 2002, chapter 2). An example of projection in trauma work could be a client's reluctance to disclose any pleasurable sensations experienced in incestuous abuse because they are unable to accept that they are disgusted with themselves and assume the counsellor will be disgusted with them. Projective identification (Klein, 1946) can occur if the counsellor, in this example, has unbidden judgements of the client as having been 'up for it' and rounds on the client in those terms.

Carl Rogers' conception of feelings arising in the counsellor's work with a client differed because he had largely rejected the psychoanalytic focus on unconscious processes, focussing instead on what was in the counsellor's awareness. However Person-centred theory recognises that the counsellor might have feelings which they could not immediately identify as arising from their own issues rather than the client's. If these feelings were particularly striking and persistent (Mearns et al., 2013, p116), and could not be otherwise explained, they could be usefully, if cautiously, disclosed to the client. Otherwise, while insisting on counsellor genuineness, or congruence, (the necessity of counsellors being aware of and accepting of their own feelings) he would discourage disclosing them. This was in contrast to the encounter movement, which was popular in the 1960s and 1970s (Howes, 1981) and which Rogers embraced, in which the sharing of all feelings by group members was encouraged in an attempt to reduce the power inequality in the more traditional therapeutic relationship. Even in the 1970s the encounter movement was seen by some as something of a passing 'fad' (Reinhold, 1974), but has gained acceptance now that it has developed into more evidence-based practices such as psychodrama and group psychotherapy (Treadwell, 2014).

Ehrenberg (1992) outlines both the positive and negative aspects of countertransference. Because the origins of countertransferential reactions are either unconscious, or on the edge of awareness, it is not difficult to understand the caution with which most writers refer to their use in the therapeutic relationship (e.g. Gelo, 2009; Halperin, 1991). Risking disclosure – and it is normally conceived as a risk, and one with which the therapist has wrestled – can often lead to a breakthrough in the therapy. Like any risk, it can also go badly wrong if misjudged. Ehrenberg recommends a careful assessment of whether the therapist's reactions have their origins in their own personal material or in that of the client (Ehrenberg, 1992, p.81)

In relation to traumatised counsellors, this is of particular interest in two ways. Firstly, because of the likelihood of traumatic past experiences having been dissociated to some degree, the counsellor may not be aware, in the moment, of their own trauma material's influence on them. This may be what Ehrenberg is referring to when she points out that therapist resistance to countertransference may actually be a form of countertransference itself (Ehrenberg, p81). The feelings of the counsellor, when working with a traumatised client, have the potential of being either useful or damaging. The key, I suggest, will be in the counsellor recognising the source of their responsive feelings, whether they choose to call them countertransference or not.

Kohut is regarded as having introduced the idea of intersubjectivity into psychoanalysis through his 'self psychology' (Kohut, 1977), and the concept has been refined by others, notably Stolorow (2004) and Benjamin (2004, 2006 2015). In some ways, intersubjectivity is similar to, but not the same as, countertransference. In intersubjectivity, the therapist's empathy with the client (and *vice versa*) leads to the kind of conversational patterns that are influenced by the expectation of how the other is likely to be thinking and feeling, or is likely to react. Agosta (1984) defines intersubjectivity as

> "our interrelated being together with one another in the interhuman world of regard for and sensitivity to the feelings of other persons" (p43).

An intervention will be crafted in a way deemed by the therapist to be appropriate for that particular client's way of thinking and experiencing. This, again, can be influenced by the therapist's identification, because of their own unique experiences, with the client's feelings, which may or may not be accurate. It is to the experiences of wounded healers that I now turn.

2.3. The Wounded Healer

The concept of the wounded healer is well known, and judging by the proportion of published literature, particularly so in Christian pastoral theology (e.g. Nouwen, 1979, and see below). The wounded healer motif actually dates back at least to the Greek myth of Chiron[25] and to Jewish prophetic writing in the portion of Isaiah known as the 'Servant Song' which is the forerunner of the New Testament portrayal of Jesus as the suffering servant "by his stripes [wounds] we are healed" (New International Version: Isaiah chapter 53 verse 5, and 1 Peter ch.2,v.24). The theme has been picked up by contemporary Christian writers as diverse as Williams (1965), Lyddon (1994), Manning (1994), Nouwen (1979) and Campbell (1986), as well as writers from some other spiritual traditions (e.g. Benziman, Kannai, & Ahmad, 2012).

In psychological circles, the term 'wounded healer' is most often associated with Carl Jung, even though its origins go back, as we have seen, much further. One of Jung's major contributions was to describe archetypes (Storr, 1983). These he saw as psychic structures which were analogous to mythologies, and were present in the 'collective unconscious' (Jung, 1991). As such they were present in all people. He said of archetypes that they appear in the mythologies of ancient peoples as well as in the dreams, visions and delusions of individuals today who have no knowledge of these myths (Jung, 1956). The occurrence of the wounded healer myth independently in different cultures, as well as in individuals' experiences today,

[25] A great centaur, famous as a teacher and for his knowledge of the healing arts, was struck accidentally by a poisoned arrow which caused him great pain. It could not kill him however, because he was immortal, but neither could he heal himself. In the end he gave his immortality to Prometheus.

supports the idea of the wounded healer as an archetype. Jung himself identified with the concept:

> "it is [the analyst's] own hurt that gives the measure of his power to heal. This, and nothing else, is the meaning of the Greek myth of the wounded physician" (Jung 1954, para 239).

While Jackson (2001) notes that both Freud and Jung had emerged from times of emotional turmoil with learning which influenced them in the later treatment of their patients, Jung's experience appears to have moulded his thinking profoundly and found its place in his theory of archetypes. Jung (2010) went through experiences which he considered might be described as psychotic, accompanied by suicidal ideation. Seeing himself as a 'wounded physician' to his patients he comes very close to the phenomenological question that I seek to address in this thesis, not only in the woundedness itself, but in how it impacted on his later work. Other researchers, including Guggenbühl-Craig (1971), Groesbeck (1975), and Viado (2015) have been strongly influenced by Jung's thinking, as have many working therapists. This project, although not a 'Jungian' study, relies on a belief that the wounded healer archetype has much of value to contribute to it. Although it has sometimes been suggested that counsellors and psychotherapists are the modern day replacements of the priest or minister for a secular world (Lines, 2006; Szatz, 1998; Thorne, 2002), there is relatively little published about wounded healers in the counselling community. This is not because it is not known, but it has seemingly been somewhat neglected as an area of research outside the academy[26]. Wounded therapists have mainly featured in the literature in the context of vicarious or secondary traumatisation (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Rothschild, 2006) and, usually regarding fitness to practice, in counselling supervision, and in ethics (BACP, 2010, 2016; Barden, 2005; Feltham & Dryden, 1994). Some of these will be mentioned in this part of the review, but the main focus will be on studies that have included reference to health workers who have some form of developmental trauma in their own history.

[26] Keyword searches of library databases indicate that there have recently been more theses written on the subject than publications in books or peer-reviewed journals.

Some have written about the value that experiences of wounding or difficulty can have in understanding clients in areas of medically diagnosed psychiatric illness (Cain, 2000; Fisher, 1994; MacCulloch & Shattell, 2009). Conchar's (2014) comprehensive review of the wounded healer paradigm within psychiatric health services points out that on published evidence we should be wary of assumptions that being healed of one's own wounds necessarily makes one a better healer of others. The present thesis is designed to explore both sides of this argument in the context of counselling practice.

2.3.1. Different research approaches

Wounded healer themes have generally appeared more often in qualitative than quantitative research projects. I give examples of qualitative studies below. Regarding therapists who have been exposed to trauma and included reference to their own early trauma history most of the quantitative research (e.g. Follette, Polusny, & Milbeck, 1994; Kassam-Adams, 1995; Levine, 2014; Rave, 2000; Rold, 2016) has focussed on measurable variables. Follett and et al. looked at vicarious trauma (VT) in mental health workers and law enforcement officers. Kassam-Adams similarly assessed secondary trauma in therapists who worked in the sexual trauma field. Rold was interested in posttraumatic growth, Rave in self-concept, affect and memory, and Levine in psychological mindedness and consciousness.

Most of the quantitative studies, focussing as they do on such variables, pay less overt attention to the relationship between therapist and client in the work that they do together. However, in my own study this is of primary interest. The therapeutic relationship is frequently more apparent in qualitative studies of wounded healer themes. Such qualitative projects, like the present one, have less emphasis on generalisation and have explored various themes in depth within small samples using a range of methodologies – phenomenological and heuristic (e.g. Martin, 2011; Rowe, 2010; Sandel, 1991; Siegel, 1999; Watts, 2014), Interpretive Phenomenological Analysis (IPA) (e.g. Barker, 2016; Jost, 2014; Penney, 2012;

Schonau, 2012), Grounded Theory (GT) (e.g. Baehr, 2004; Corney, 2016), autoethnography (e.g. Lemelin, 2006; Meekums, 2008) and narrative and case study research (e.g. Cvetovac & Adame, 2017; Etherington, 2009; Kern, 2014; Palmqvist, 2016; Viado, 2015). Of the methodologies themselves, however, my own chosen path owes most to those who have used the ones which take a phenomenological or narrative approach. Because I have not aimed to generate theory, grounded theory would have been unlikely to have addressed my specific research question. The research question itself is frequently pivotal in choice of methodology. Rowe (2010) and Watts (2014), for example, appropriately chose heuristic studies because their question focused on their personal experiences. Martin (2011) also chose Moustakas's heuristic method (1990), but adapted it in a way in which he could combine his own and his 17 co-researchers' experiences of how personal crises have affected the way they practise. I am in sympathy with his view that Moustakas's method is somewhat over-prescriptive, and this was my own reason for grappling with it, as he had, whilst also aiming to be phenomenological in my outlook. Although my own methodology does not claim to be heuristic, there are similarities between Martin's and my own eventual choice of approach in as much as I seek to draw knowledge from the experiences of a range of participants. Both GT and IPA were methodologies which, like Moustakas's (1990, 1994), have a tendency to require adherence to rather proscribed protocols, which did not seem to me to allow the flexibility that I sought and which will be argued later in the thesis. Where, as in Baehr's (2004) and Corney's (2016) studies, the aim was to generate theory, GT was an entirely appropriate methodology. In Barker's (2016) IPA study of the experiences of 4 therapists who work with traumatised clients the focus is on the interviewed therapists, rather than including her own, although this is mentioned briefly in the introduction. Her choice, again, of the more structured approach of IPA sits well with her research question on the participants' experiences of countertransference. Similarly, the aim of a piece of research is influential in the choice of a narrative methodology, as in Etherington's (2009) study on clients' experience of life story research interviews in comparison to therapy, in which she shows the relevance of a life story approach in counselling practice.

I have alluded to Martin's approach as one which is closest to one which would 'fit' my own research. Other studies also had elements which were of great interest to me, such as those on the potential importance of countertransference, but I was unable to find a study which combined all the elements that I hoped to address. Even Martin's paper, while seeking to co-construct meaning from both himself and his co-researchers, addressed adult trauma rather than developmental childhood trauma. Cvetovac and Adame (2017) give us a very different narrative approach than that of Etherington (2009). While both explore practice issues, Etherington does not include the counsellor's background, whereas Cvetovac and Adame focus on it, but work only from published biographical material rather than interviews. Some research focuses on specific client issues, such as Penney's (2012) study of therapists working with substance abusers who have a history of complex trauma. My study, however, sought to draw lessons from therapists' trauma in relation to a wider range of clients' traumas. Rowe's (2010) heuristic study, like Martin's (2011), interested me in involving the experiences of 10 other psychologists or therapists, as well as his own, and incorporating co-construction, but had a narrower focus on the impact of two major life transitions on practice. Again there were similarities to my own interests, but did not have the breadth that I sought. This, unsurprisingly perhaps, was true of many of the studies, given that projects are normally time-limited and attempts to include too many aspects runs the risk of being over-ambitious. Notwithstanding, one of the aspects of my topic that I was keen to explore was precisely the diversity of trauma experiences and people's reaction to them because, outside specialist services, therapists are likely to be confronted with such diversity in their client base. Casting a wider net, would, I hope, provide research findings which would be of value in generic counselling services in which diversity is 'normal'.

In the following sections I will relate the major findings of the studies mentioned above, and others, to my own research interest and aims.

2.3.2. Relatedness to clients: countertransference and other reactions

In qualitative research we enter the less easily measurable field of experience, and of the psychological dynamics of the relationship in the counselling room, and it is to these that we now turn. Countertransference, in particular, is of interest to many recent researchers in the wounded healer field (e.g. Watts 2014; Viado, 2015; Cain, 2000; Barker 2016), but the term is often used with a broad definition (as I have used it in section 2.2.5. above) to mean any affective response to the client or the client's material. Cain (2000), for example, includes identification with the patient in her discussion of countertransference. Most studies (e.g. Viado, 2015) highlight the potential usefulness of countertransference in therapy, drawing from the experiences of the interviewed therapists. Sedgwick (1994, 2001), a Jungian analyst, notes that particularly where sexual feelings arise it can be problematic, but nevertheless sees its importance in the relationship. Cain (2000), in her study of participant psychotherapists with a history of psychiatric illness, found that countertransference is shaped by their own experiences and that they saw both negative and positive effects in their practice. For example, loss of perspective though over-identification with their clients could have unhelpful consequences, but overall, countertransference was linked to enhancement of therapy through greater empathy and useful advocacy[27]. Viado (2015) found most of her participants reported that negative impacts of countertransference were reduced by awareness of their own wounds but also suggests that it is helpful for therapists to know that seeing clients with similar wounds to one's own makes therapists more vulnerable to countertransference. Watts (2014) talks of attunement to one's countertransference as having clear benefits for the therapy. Penney (2012, p92) reminds us of Najavits'

[27] On this last point most counsellors would agree that advocacy in the sense of 'speaking for' clients is not generally a part of counselling (COSCA, 2004) but when a counsellor has personal knowledge or experience of a system in which the client is involved, provided the countertransferential feelings are recognised and do not distort judgement, the line between education and enabling the client to be their own advocate can sometimes be difficult to draw. For example some counselling organisations such as Freedom from Torture involve counsellors in the writing of Medical Legal Reports for clients, and many counsellors are willing to contact GPs and others, with clients' consent, on their behalf.

(2000, p89) observation of "paradoxical countertransference" in which she can be both disgusted by her addict clients, and compassionate towards the woundedness that they carry. We see similar paradoxical countertransference in the Iraqi client's reactions to 9/11[28] described by Lemma and Levi (2004, p2) in which he was simultaneously pleased about a successful attack on the hated USA and uneasy about the ordinary people like himself who were suffering in the process. Earlier in the same chapter and on the same 9/11 theme Lemma and Levi (2004) also describe therapist identification with a distressed client. Both had relatives in New York and the therapist visibly reacted with her own material. The therapist was at one point "rather disoriented and at a loss" (p1), which the client noticed.

A component referred to by many writers (e.g. Grapp, 1992) is the responsibility of any counsellor or therapist to be aware of their emotional responses to clients and to understand their sources in their own trauma. Satir (1987, p19-20) pointed out that clients can be unintentionally damaged if therapists have unresolved issues of their own. Rold (2016) also refers to negative effects caused by lack of meaning-making and lack of ability to differentiate between the feelings of psychologists and others, and suggests the need for development of self-awareness and self-care if therapists are to see growth from their own and their clients' trauma experiences (Rold, 2016, p46).

Whether or not one sees therapist responses in terms of countertransference, there is frequent mention of the qualities that early trauma experience, if well integrated, can confer in therapists' practice. Heightened empathy and greater connectedness is suggested by Sandel (1991), compassion and humanness by Martin (2011), humility by Mander (2004), understanding of the neurological effects of trauma in clients by Watts (2014), and, by Grapp (1992), an ability to be confidently present with and able to witness the pain of clients. Grapp (1992) also reminded us that countertransference can be a two-way process:

> "I had not anticipated the notion of the mere presence of their [the therapist's] experiences as something which clients perceive and benefit from in an intuitive or unspoken way." (p100)

[28] Terrorist destruction of the Twin Towers in New York on September 11th 2001

Drawing lines between countertransference, empathic identification and projective identification is not always straightforward, and there is another aspect of counsellor response which is significant in work with traumatised clients. That is the risk of vicarious traumatisation (VT). The term was initially suggested by McCann and Pearlmann (1990) and has been described as "a special form of countertransference stimulated by exposure to the client's traumatic material" (Courtois, 1993, p1). A number of researchers have addressed this matter in relation to wounded healers. Their conclusions differ widely. Kassam-Adams (1995) concluded that therapists' personal history of trauma was positively correlated with VT when working with sexually abused clients. Other quantitative studies were either ambivalent (Follette, Polusny, & Milbeck, 1994) or found no relationship between VT and a therapist's history of childhood abuse (Van Deusen & Way, 2006). Follett et al. (1994) did find those with histories of abuse to score higher for trauma symptoms but indicated that other factors such as use of peer support, personal therapy and effective coping strategies were likely to be more significant. Van Deusen and Way's (2006) large national survey found that a history of childhood sexual abuse had no effect on the incidence of VT in therapists working in the trauma field. In an IPA study of four therapists with histories of traumatic childhoods Barker (2016) expressed surprise that none of the participants reported the vicarious trauma or burnout that she had expected. They attributed this to their own therapy. Rather, they sought to emphasise the positive aspects of their experiences in increasing empathy for their clients. In her qualitative study, Benatar (2000) found, like Van Deusen and Way, that there was no noteworthy difference in VT or burnout in therapists with or without childhood abuse histories.

Even from these studies we might conclude that the jury is still out on whether wounded healers are more or less prone to VT. It seems likely that the 'other factors' referred to by Follette et al. (1994) may hold the key to the variation seen from one therapist to another.

2.3.3. Sense of self.

Emotional reaction is one aspect of the self in therapy. In this section I will review another - the potential for wounded therapists to learn more about themselves as people and as practitioners.

That human beings can learn and grow from adverse circumstances has been known throughout history, but it has only been an active research interest and become known as posttraumatic growth since the 1990s (Tedeschi & Calhoun, 1996; Tedeschi et al., 1998). However, posttraumatic growth is not an inevitable consequence of trauma, and Rave (2000) found in her quantitative study of psychology students that the self-schemas of those who had been traumatised in childhood tended to give rise to more negative affect in adulthood, and that this was related to a greater level of negative autobiographical memory. Following Eisen and Goodman (1998), she noted the subtle difference between repression and dissociation, the former allowing retention of intact memories in the unconscious while in the latter the trauma is attended to but is never actually stored in the memory. She does not elaborate on this but the difference might well be illustrated in the 'body' memory associated with early childhood trauma (Rothschild, 2000).

However, although these findings need to be taken seriously, and could possibly indicate that in the general population (represented, Rave admits cautiously, by the psychology students) posttraumatic growth is not the norm, other studies paint a more optimistic picture for wounded therapists. In Rold's (2016) quantitative study 70% of her participant psychologists and forensic psychologists believed that their own (mainly adult) traumatic experiences had had a positive impact on their work. Zerubavel and Wright (2012, pp483,484) point to the growth benefit derived from a proper attention to woundedness and cite Briere's (1992, p162) belief that "sufficiently recovered wounded healers may make uniquely talented therapists". Briere's focus was on childhood trauma. Zerubavel and Wright do however note that there is insufficient discussion in the literature around the inhibitions to appropriate support (see section 2.3.5 below) to facilitate this posttraumatic growth in therapists. Schonau (2012) and Triplett et al. (Triplett, Tedeschi, Cann, Calhoun, & Reeve,

2012), in IPA and quantitative studies respectively, looked at respondents who had had recent traumatic events in their lives. Schonau's study was with experienced therapists and found that when they had engaged in meaning-making following their trauma they had been able to find new values and priorities and a more realistic self-appraisal. Triplett et al. (2012) found that deliberate rumination, rather than the uncontrolled rumination which is associated with PTSD, was beneficial for posttraumatic growth. Sandel (1991) in a phenomenological study explores the reasons why people choose to become therapists and found the resolution of early trauma through therapy and supervision to be of particular importance. A recurring theme in her participants' interviews was that of self-development. Sandel suggests therapist self-development is the polar opposite of narcissism. This is echoed in Schonau's participants' challenge to any omnipotent myths they might have held, and in Adams' (2014) "myth of the untroubled therapist". Orlans (1993) believes that her existential reappraisal through the breakup of her marriage helped make her a more patient and empathic therapist, albeit more alert to the risks of identification with clients in similar circumstances.

Drawing from these studies in relation to wounded healers one might conclude that, to expand Socrates' dictum, the unexamined life is not worth living if you are to be an effective counsellor. Our sense of self can be battered by trauma, but can also be transformed positively if our wounds are tended. Grapp (1992) in an epilogue to her thesis in which she had interviewed therapists who had suffered as children was moved by their resilience. While there is an expanding literature, beyond the scope of this review, on resilience in children in which the influencing factors are minutely explored, there is this other side to the coin – the potential for developing resilience by personal pursuit of meaning-making in adulthood following traumatic experiences. It is this aspect which is relevant to the present study.

2.3.4. Two-way interaction

Ideas around the counsellor's use of self in their work have been touched on in sections 2.2.2. and 2.2.5. above as well as, by implication, in 2.3.3. A rather different, and strongly Jungian angle on the self in therapy is presented by Miller and Baldwin (1987). Basing their ideas on those of Guggenbühl-Craig (1971) and Groesbeck (1975), they suggest that each individual has an inner patient and an inner healer. Where a sick person cannot activate his own inner healer he reaches out to an external healer, but in doing so may activate the inner wounded patient of that healer. This model, whose theoretical basis is also elegantly described by Samuels (2006), might subtly explain why some healers become helpful and other less so – the former who do not allow themselves to be hijacked by their inner woundedness, and the latter who do, and defensively succumb to the narcissistic myths mentioned by Sandel (1991) and Schonau (2012).

Other writers have also written of the two-way process of healing in therapy. While many are familiar with the idea of learning from the patient (Casement, 1985) some have applied this in trauma counselling. Some of Viado's (2015) research participants found themselves changed through their work as therapists, with some personal healing as a by-product. They saw the dyadic relationship as "mutually transformative" (pp iii & 115). Stephenson (in Stephenson and Loewenthal, 2006) acknowledges that conducting his research project

> "heightened my awareness of the extent to which my childhood experience of an absent father is always present in my work as a therapist" (p450,451).

For Martin (2011) returning to work as a wounded healer after a breakdown it was the observation of a client which enabled him to reframe his therapeutic work as "a mutual task of discovery" (p14).

Others, too, claim that their victimhood can be used in positive ways (Siegel, 1998). Having the memory of her own experience of loss, Siegel said of herself and her research participants

> "In helping those who hurt, we continue to help ourselves." (p328)

and that they

> "used their own experiences of loss to join with patients, giving and receiving simultaneously" (p328).

This two-way interaction is particularly relevant in the present study, and the ideas of Miller and Baldwin (1987) could be informative in the dilemma of why some wounded therapists have greater or lesser capacity to become wounded healers.

2.3.5. Societal context.

The wounded healer paradigm has social, political and professional aspects which are of relevance to this project. Trauma is frequently linked to shame and where there is shame there are secrecy, avoidance, blame, loss of confidence, stereotyping and trust issues.

2.3.5.1. Stigma

Shame's bedfellow is stigma, and people with any mental health issue in this society have had to run the gauntlet of stigmatisation. This, I suggest, is as true of those displaying the symptoms of posttraumatic stress, which are not infrequently unrecognised as co-morbidities or (mis)diagnosed as depression, Borderline Personality Disorder and so forth, as of other mental health conditions. In their study of addiction treatment, this societal attitude was recognised by Frese and Davis (1997). They noted that psychologists have not been immune to its influence. As recently as 2008, Overton and Medina (2008) lament the stigma that still inhibits the lives of people with mental illnesses which can even block their access to treatment (p146). They call for counselling training to address specifically the issue of stigma to "minimise the development of stigmatising beliefs" (p149).

Early in the professionalization of healing there was an increase in the stigmatising of people with any diagnosis of mental illness, which of course would include PTSD.

This was seen not only by Frese and Davis (1997) but also by a number of mental health professionals working in psychiatric services. Fisher (1994), a psychiatrist with a personal history of mental illness, says

> "the mental health profession is one of the most discriminating and stigmatizing towards consumer/survivors." (p68)

Stigma is now being challenged but still lurks covertly if not overtly.

Similarly, Cain (2000) found that stigmatization was the main reason why professional psychotherapists would not disclose a personal history of mental health issues, and some identified it as a hindrance to professional advancement.

White (2000) traces the increased involvement of recovered alcoholics in treating addictions in terms of their

> "filling a void within a stigmatized arena that attracted only a small number of professionals." (p15)

The tide however is turning, however slowly, and more optimistic views are expressed by mental health nurses MacClulloch and Shattell (2009), and Cain (2000) and Zerubavel and Wright (2012) see light at the end of the tunnel in the form of supportive supervision and managerial acceptance of the positive value of personal experience of wounded healers. Hankir and colleagues (2017; 2014, 2015, 2016; 2015), recognising the high incidence of mental health issues in medical students have developed a well-received educational programme to address stigmatization. Even Frese and Davis (1997) found hope in the Consumer-Survivor Movement.

2.3.5.2. Speaking out

It is interesting that in spite of the burgeoning literary market in stories reflecting what Douglas (2010) calls "a cultural preoccupation with trauma" (p6), there is relatively little written specifically by counsellors about their own trauma. Some exceptions are found particularly in the autoethnographic and autobiographic literature (e.g. contributors in Etherington, 2003; Orlans, 1993; Tamas, 2009). Lemelin (2006) writes movingly of his experience of being a wounded healer following childhood sexual abuse but focuses on his being a healer through his

writing and political action rather than experiences as a therapist. This is significant as 'telling' is a political action. Political action takes a certain kind of confidence and the stigma around trauma may be at least partially responsible for hesitancy to disclose in print. Some, such as Zerubavel and Wright (2012), suggest that an absence of dialogue around the subject contributes to the stigma and shame around disclosure of mental health issues amongst therapists. This not only deprives them of needed support, but may also inhibit their own posttraumatic growth, and of recognition for the unique contribution that they may make. Psychologist Stephen Andrew's (2017) exploration of the ethics of autoethnography gives many personal illustrations. The present study follows the example of these and others who have given deeply of themselves in sharing their own trauma for the benefit of others.

2.3.5.3. Transgenerational and cultural issues

Because context is so important in the conception of this project, it seems right to make at least a brief reference to transgenerational effects of trauma and to transcultural aspects that need to be borne in mind. Fossion et al. (2015) remind us that the mechanism of transgenerational transmission of trauma effects is unclear, but favour family structure and coping strategies. Burcherta, Stammel & Knaevelsrud (2017) noted gender specificity (mother to daughter) in the higher vulnerability of daughters to their own trauma exposure if their mothers had been traumatised, but say that further research is needed to explain this. Rozentsvit (2016) suggests epigenetic effects, and the work of Yehuda's group (Yehuda, Morris, Labinsky, Zemelman, & Schmeidler, 2007; Yehuda, Teicher, et al., 2007) on cortisol have demonstrated low cortisol levels in offspring of Holocaust survivors as well as in survivors themselves. So even if there is no agreement as to the mechanism, there appears to be diverse evidence that there is some kind of transgenerational transmission of posttraumatic symptoms, or vulnerability to them.

Cross-cultural counselling has a growing literature, and because of the upsurge of migration from war zones much of it has an emphasis on trauma. Although this is not within the scope of this project, in an interview with Roy Moodley (Moodley, 2010)

Vontress, who was a pioneer in cross-cultural counselling, made a contribution that is of relevance to any trauma study. This is because trauma always carries its own narrative, and transgenerational memory is highly dependent on the power of the stories that are passed down. Vontress says of his own family's trauma:

> "the Ku Klux Klan starting roaming the countryside, trying to restore the racial status quo. It was during this period that they killed my great-grandfather for cohabiting with a "mulatto girl." When I was a little boy, my grandfather told me and my siblings this story. It remains to this day etched in my mind." (Moodley, 2010, pp7,8).

The effectiveness of trauma counselling may well be reduced if counsellors pay little attention to such family or community memories held by their clients. Some participants in this study refer to such memories and how they have impacted on their own lives.

2.4. Conclusion

This review has sought to contextualise my research question i.e.what impact might a personal history of developmental trauma have on a counsellor's experience of, and work with, traumatised clients? First, I needed to find some understanding of what lies behind some of the many definitions of psychological trauma used in the literature. Second, as there have been major shifts and remaining divisions in understanding of what is and what is not helpful in the relationship between a therapist and their patient/client it was important to explore this topic. Lastly, I needed to see how these more general theories and practices related to my specific focus on wounded healers' work with traumatised clients. Having gleaned much from this review of work that has already been done in related fields I move on now to two chapters which outline my philosophical and practical approach to the present project.

Chapter 3. Research Approach

3.1. Finding a way to answer the research question.

> In my dream I saw people wandering in a forest. Most were alone, a few in small groups. All were searching for something. They would stop at a tree and look intently at it, and then move on, apparently disappointed in some way.

This imaginary dream could be the story of my search for an approach which would best address my research question, in which I explore the impact of a counsellor's own developmental trauma on their work with traumatised clients. I write this chapter against a background of my own research journey, which took me through many explorations – from phenomenology though narrative inquiry and back to phenomenology with several detours in between. I begin, though, with some basic philosophical considerations.

3.2. Philosophical considerations – ontology, epistemology and methodology

A focus on ontology

Trauma presents some interesting ontological and epistemological puzzles, making clear positioning problematic. The experience of psychological trauma is neither wholly subjective, nor wholly objective. At the time Van der Kolk trained as a psychiatrist, there were many new discoveries about the effectiveness of psychopharmacology in treating patients with different diagnoses (e.g. Van der Kolk, 2015). Van der Kolk describes this time as one in which the discourse was changing from the "wooly-headed theories of philosophers like Freud and Jung" (Van der Kolk, 2015, p27), to psychiatrists seeing themselves as "real scientists" who were dealing with chemical imbalances in the brain. Whilst this may be somewhat unfair to Freud, who considered himself scientific in his approach (Freud, 1954), it perhaps

illustrates a general trend towards a 'hard', strictly objective, view of reality, which still underlies much modern empirical scientific methodology. Before Modernism became the dominant philosophy, there was a greater acceptance of numinous realities, such as religious beliefs, which do not lend themselves to empirical, concrete, proof. Whilst Modernist thinking is still dominant in some disciplines, its deficiency in others has led to a re-evaluation by a range of philosophers, and the birth of Postmodernism.

Whilst excited by new physiological developments in psychiatry, Van der Kolk saw great value in listening to his patients' stories and seeing the connection between these and the more dramatic manifestations attributed experimentally to neural activity which we now associate with trauma.

> "But if the stories I heard in the wee hours were true, could it be that these 'hallucinations' were in fact the fragmented memories of real experiences?" (Van der Kolk, 2015, p25)

Since that time, great strides have been made in traumatology, and it is now commonplace to recognise both emotional and physical effects of trauma. If ontology asks the question "what is [real]?" (Crotty, 1998, p10), there can be two answers – the reality which is clearly demonstrable because it is perceivable by the physical senses, and the reality which is in some sense simply experienced, and could be deemed a construction of the mind. The former objective reality is more closely associated with Modern philosophy, in which empirical demonstrability is a requirement. The latter, more elusive, reality finds its home in Postmodern philosophy[29]. Trauma research can be rooted in either, or, as I propose, both. This may appear uncomfortably messy, but as Law (2004) argues

> "if we want to think about the messes of reality at all then we are going to have to teach ourselves to think, to practise, to relate and to know in new ways. We will need to teach ourselves to know some of the realities of the world using methods unusual to or unknown in social science." (p2)

[29] Postmodernism is "characterized by a rejection of ideology and theory in favour of a plurality of values and techniques" (Oxford English Dictionary, 2012). In other words, reality is not available only to the physiological senses so cannot fit neatly into modernist empirical methods.

One way that such a 'new way' could be framed is the holding of a paradox, a concept which empirical science strains to resolve, but which may in fact be liberating. We may find that a less reductionist approach to ontology, and indeed epistemology, yields a richer understanding of complex human science research questions such as the one I seek to address. Whilst holding awareness of the value of much empirical science in the trauma field, I approach this particular project from a postmodern position, but in my view all trauma counsellors, when practising, need to consider the paradox carefully. Ontologically there are aspects of trauma which are objectively/demonstrably real – brain structures, neurotransmitters, stress hormones, guns, fire, train crash, rape. There is a wealth of evidence from empirical positivist modern science, particularly in neuroscience, that cannot be ignored (e.g. Anda et al., 2006; Bryant et al., 2008; Etkin & Wager, 2007; Howe, Goodman, & Cicchetti, 2008). There is an objective reality 'out there'. However, many other aspects of trauma, including many of the ones with which counsellors will be involved, are subjectively real – fear, memories, anger, desire for revenge, confusion and so on. Such subjectivity is closely linked to context, whether personal, cultural or social. In that case, reality may be viewed as contextually constructed.

An example:

> It is a Halloween night. I am with a friend (she could have been a client) in a room at the front of an old terraced house which has no front garden or gate. There are frequent loud knocks on the front door – unsupervised children roaming the neighbourhood in search of treats. My reaction is to jump momentarily, then to be somewhat irritated but otherwise untroubled. My friend, however, becomes very agitated. She is an older Chinese lady who had lived through the Cultural Revolution where Red Guards had frequently banged on doors demanding entry and subsequently ransacking the houses of 'bourgeois' such as this lady, who was a doctor.

What is happening here? There are two objective realities in the mix. Neuroscience tells us that the initial startle reaction experienced by both myself and my friend is

due to demonstrable increased activity in the amygdala (Lanius et al., 2008; Etkin & Wager, 2007; Fisher, 2003; Lanius et al., 2011). In my friend, however, this activity is of sufficient magnitude to shut off access to the cortex where assessment of the meaning of the sound would normally be made. I, in this illustration, have 'normal' communication between the alarm centre (amygdala), the memory centre (hippocampus) and the cortex and can quickly understand that there is no real threat. However, there are subjective realities present too – my irritation, and my friend's fear. In a counselling context, if a counsellor fails to recognise the presence of both realities in the client, they are much less likely to respond appropriately to the client's physical signs.

A subjectivist ontology, which sits comfortably with postmodern thinking, where experiences are deemed 'real' but in ways which are not demonstrable empirically will be the one underlying my research, though references where appropriate may be made to positivist/realist neuroscience.

Putting it together

In this research, I am concerned not only with debates about what is real, but also about what it means to know about this reality, or put another way, what I think knowledge is. A number of writers on qualitative methods have stressed the necessity of the researcher having a clear understanding of their ontological, epistemological and methodological positions. Mason (2002) is particularly insistent on this as a prerequisite, and gives the impression that the research cannot really start until standing on this solid ground. Others agree with her to a degree but allow more flexibility in the process. Silverman (2005, 2011) allows a to and fro movement on the basis that "true learning is based upon doing" (2011, p4). Crotty's schema (Crotty, 1998) - although interestingly it does not include ontology explicitly[30] -

[30] Crotty's apparent omission of ontology is explained here: "Were we to introduce it [ontology] into our framework, it would sit alongside epistemology informing the theoretical perspective, for each theoretical perspective embodies a certain way of understanding *what is* (ontology) as well as a certain way of understanding *what it means to know* (epistemology). Ontological issues and epistemological issues tend to emerge together" (Crotty,1998, p10) [his italics]

suggests that as well as starting with an epistemology, one can start with methods, and work back to the epistemological underpinnings.

Rather than a linear paradigm starting with ontology and progressing to methodology, or even *vice versa*, I interpret Silverman's and Crotty's schemas in a more dynamic form and show this in Figure 1. Alternatively, more radically, incorporating ideas of Karan Barad (2007) which emphasise "a fundamental inseparability of epistemological, ontological, and ethical considerations" (2007, p26)

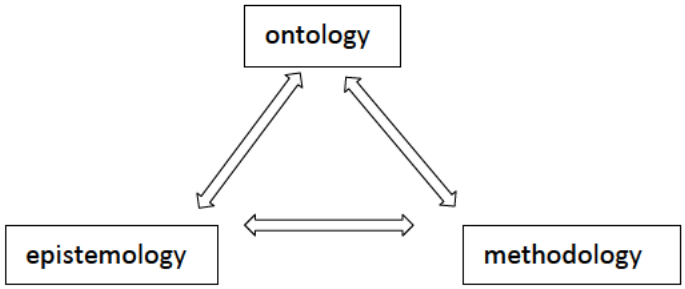

Figure 1: Interactions of ontology, epistemology and methodology

I show a different dynamic model in Figure 2. Barad's theory, which she calls 'agential realism', is one that she finds consistent with the latest scientific research, but importantly is transferrable to the human sciences. She aims to get away from

> "well-worn debates that pit constructivism against realism, agency against structure, and idealism against materialism" by "rethinking of fundamental concepts that support such binary thinking, including the notions of matter, discourse, causality, agency, power, identity, embodiment, objectivity, space, and time." (Barad, 2007, p26)

Diagrammatically, Barad's is not so much triangular as a rotating cylinder, in which one has a greater sense of movement and blurring:

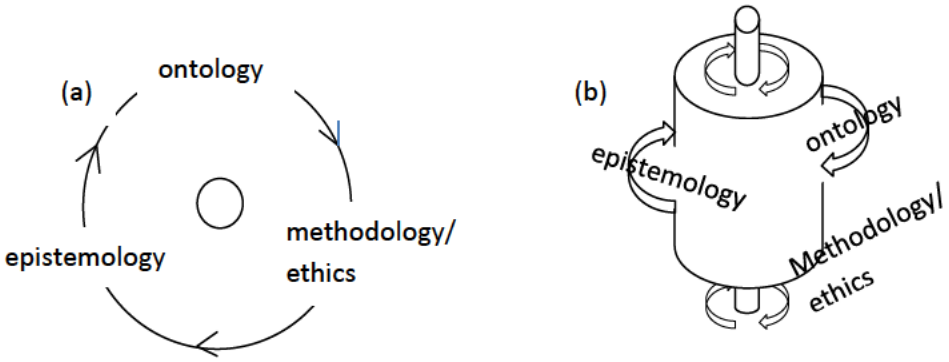

Figure 2: Dynamic relationship tending towards merging, from (a) above, (b) side

Unlike Barad, I have no substantial knowledge of quantum physics, but I am reminded here of my excitement as a teenager in first learning about calculus, in which the jagged crudeness of a histogram can be transformed into a curvaceous normal distribution. That gave me a glimpse of the 'beauty' of mathematics. Barad may well have something similar to reveal to us in philosophy.

Deleuze has much to say about both ontology and epistemology, but not in those categories as usually defined. One of his basic premises (ontologically) is that reality is rooted in difference (Deleuze, 1994) and that traditional views of thought (and one could infer, therefore, epistemology) are problematic because they are not problematic enough. Deleuze saw genuine thinking as a confrontation with reality, and a rupture of established categories. Such views do indeed challenge the above attempts to relate such categories.

While holding on to these uncertainties, thus heeding Deleuze's warnings against dogmatism in metaphysics, I return now to more traditional views of onto-epistemology. Three selected definitions of epistemology are

> "The theory or science of the method or grounds of knowledge" (Oxford English Dictionary, 2012).
>
> and
>
> "a certain way of understanding what it means to know" (Crotty, 1998, p10, and see footnote 30 above).
>
> and
>
> "what you would count as evidence or knowledge" (Mason, 2002, p16)

Beyond definition, different qualitative researchers adopt different epistemologies. Crotty, for example, says that knowledge can be objectivist, subjectivist or constructionist (Crotty,1998, pp8,9). We see here echoes of different ontological realities, showing how they are so often intimately connected. Others, such as Butler-Kisber (2010), consider objectivism an ontological rather than an

epistemological position (do we see something of Barad's blurring here?) Crotty prefers to minimise these distinctions by calling, for example, a realist epistemology a 'philosophical perspective' rather than an epistemology *per se*.

How do I know that this thing in my hand is a pen? It looks like a pen, it feels like a pen, and it functions like a pen by making marks on paper. This statement is made from an objectivist ontology and a realist epistemology (following Butler-Kisber) (see Fig. 3), but the interaction between a counsellor and a client with which my research is concerned 'looks' very different. Knowledge here is found through *interpreting* words, non-verbal communications, body language, and intuitive perceptions. Interpreting here is used in a less technical sense than in the interpretism proposed as an epistemology by Schwandt (2000), or as a theoretical perspective by Crotty. Some level of interpretation is inevitable in research and it is important to keep this in mind

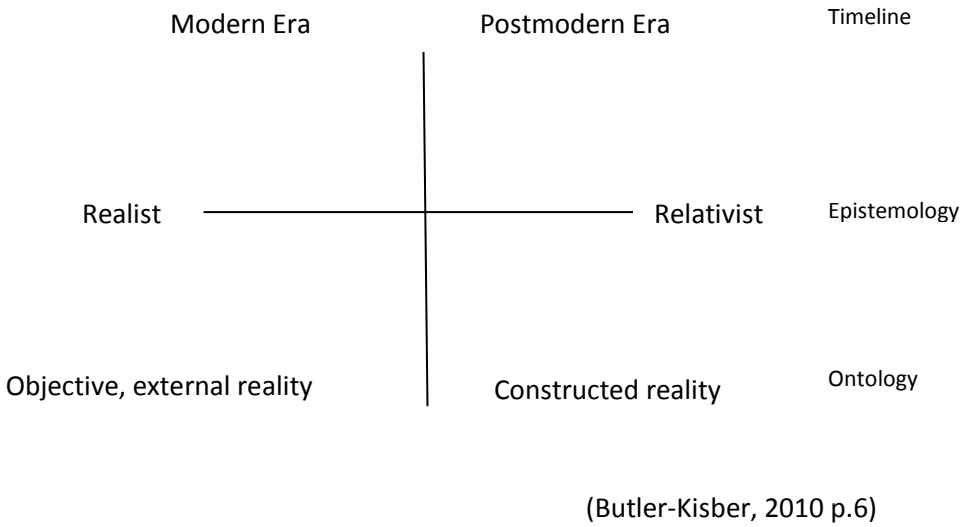

Figure 3: After Butler-Kisber's schema, positioning range of ontologies and epistemologies in relation to Modern and Postmodern philosophical eras.

In a postmodern world, such awareness of not necessarily having the 'correct' answer is much more acceptable than in empirical work, but at the same time not a licence to abandon the kind of rigour considered essential in post-positivist research or to promote an 'anything goes' platform for personal prejudice.

Denzin (1989) critiques different interpretive approaches and sheds light on some possible misunderstanding. Whilst proposing that all qualitative research involves interpretation, he contrasts (Denzin, 1989, pp49ff) the classical forms of interpretation (into which Schwandt's and Crotty's usage would fall), which rely on objective post-positivist assumptions and verifications, and later forms which fall into three categories which rely, respectively on 1) the subject's point of view presented by the researcher but without the latter's interpretation, 2) the subject's own unmediated autobiographical presentation, and 3) "strategies which weave the subject's life into and through the researcher's interpretations of that life." (p58). This last format describes most closely that which I have chosen to use, and is somewhat close to Schwandt's 'philosophical hermeneutics' epistemological stance which allows for an insider (researcher) contribution, though I have followed a phenomenological methodology in the sense of having immersed myself in the transcripts in a similar manner to phenomenological inquirers such as Moustakas (Moustakas, 1990, 1994) and Peter and Ann Ashworth (Ashworth & Ashworth, 2003; Ashworth, 1996; Ashworth & Greasley, 2009). In clinical practice this is an attitude I liken to Rogerian principles of inhabiting, as much as possible, the frame of reference of the participants (Merry, 1995; Rogers, 1951).

A brief digression, relating to practice

Schwandt expresses these misgivings in the 'final note' of his paper:

> "It seems to be a uniquely American tendency to categorise and label complicated theoretical perspectives as either this or that. Such labelling is dangerous, for it blinds us to enduring issues that each inquirer must come to terms with in developing an identity as a social inquirer ... . What we face is not a choice of which label – interpretivist, constructivist, hermeneuticist, or something else – best suits us. Rather, we are confronted with choices about how each of us wants to live the life of a social inquirer." (Schwandt, 2000, p205)

Categorisation and diagnosis are core features of most medical practices. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013) in the field of mental health, and the International Classification of Diseases (ICD10) (World Health Organization, 2010) in mental and

physical diseases are well known examples of this, and have undoubted value in signposting to appropriate treatments. However, they are far from free of controversy. Aspects of each edition of DSM have been argued over at great length by clinicians holding different views (e.g. Kriegler & Bester, 2014), and trauma is an area that has been particularly contentious (e.g. Hinton & Lewis-Fernandez, 2011; Spiegel et al., 2011). It seems highly likely that differing and strongly held opinions put forward for inclusion in DSM have originated in clinical practice, where patients and clients have defied clear diagnoses and tragically have too often fallen through the net of services as a result. Each revision of both DSM and ICD is more complex, sometimes to the despair of staff in clinical systems which require accurate coding.

This digression is not without purpose. Whether the exercise is to pin down one's epistemology in research in human sciences, or a client's diagnosis, the problems that arise are, in my view, down to the complexity of human beings – both physically and emotionally. It is because of this complexity that I propose the necessity of becoming more comfortable with the holding of paradoxes – in epistemology as well as ontology - in counselling practice and to a degree in this piece of research. This is not to say that knowledge-seeking is a doomed project. Rather it is a way of embracing complexity in the way that turning a well-cut diamond in the light will reveal different reflections and enhance its beauty.

Aristotle[31] saw three classes of knowledge – productive (*techne*), practical (*phronesis*), and theoretical (*episteme*) (Barnes, 2000, p40; Flyvbjerg, 2001, p55f). Aristotle's episteme, whilst giving us 'epistemology' in English is closer to the idea of modern scientific knowledge while *techne's* basic idea is the 'how' knowledge of production e.g. the skill bases of crafts. Of most interest in the current project is phronesis, which has been called 'practical common sense' and 'practical wisdom' (Flyvbjerg, 2001, pp56,57). Life as it is lived is a dominant focus, so social construction will play an important part, but the aim of such knowledge is active rather than passive, and as such can be said to have a political dimension. Flyvbjerg sees context as being central in phronesis (2001, p38ff). Flyvbjerg's discipline is

[31] Metaphysics, VI.1

economic geography, but his thesis is transferable to other realms of social sciences, including counselling (e.g. Bondi & Fewell, 2016; Dykes, 2012; Miller, 2009; O'Hara, 2012). O'Hara in particular argues for the place of practical knowledge, or phronesis, as having a relevance in counselling that cuts through the more traditional research epistemologies. This resonates with my argument about the need to hold these theories of reality and knowledge as paradoxes. One cannot escape paradox, which is inherent in the human condition, and a phronetic approach deals with the practicalities of life. This is in my mind an acceptance of Law's 'mess' (see above, p50) rather than the kind of conflation to which a respondent in MacIntosh's blog (MacIntosh, 2009) critically refers. Conflation implies merging, whilst paradox does not. Paradox retains the kind of clarity which Mason (2002, p13ff) sees as essential for robust research.

3.3. Methodological approaches

3.3.1. Phenomenology

After considerable deliberation I have chosen to approach my research question with a broadly interpretive phenomenological methodology, though one enriched by some cautious elements of bricolage. I will say more about bricolage below (section 3.3.2), but first explain my positioning within phenomenology.

Phenomenology is a broad church, ranging from Husserl's descriptive phenomenology with its strict avoidance through 'bracketing' of the researcher's assumptions, through Heidegger's interpretive phenomenology to Ricoeur's hermeneutics of suspicion (Josselson, 2004; Ricoeur, 1970) and willingness to import external theories into his inquiries (so in that sense quite different from Husserl's original project). My own approach owes more to Gadamer and Ricoeur than to other phenomenological philosophers. Both saw interpretation as being legitimate in the search for understanding the phenomena under investigation. Of particular relevance in this project is Gadamer's idea of the 'fusion of horizons' (Gadamer, 2004, p313) and Ricoeur's openness to other theorists and his acceptance

of narrative as being a vehicle for phenomenological understanding (Ricoeur, 1983). In order better to fulfil the aim of the project I added 'practical' (or 'phronetic') to the name of my methodology, having been influenced by Flyvbjerg's (2001) writing.

In Chapter 4 I explain the methods I have used in the project, but here I focus on the principles. There are many different approaches to phenomenology, including those of Husserl, Heidegger, Moustakas, Giorgi and the Duquesne School (Garza, 2007), Gadamer, Ricoeur and others[32]. Although not the approach I have chosen here, Interpretive Phenomenological Analysis (Smith, Flowers, & Larkin, 2009) has provided a bridge over which people challenged by the dominant modernist discourse in medical research have been able to introduce postmodern insights into human sciences research. Gadamer's and Ricoeur's hermeneutics and the ideographic phenomenological work of Ashworth and others (Ashworth & Ashworth, 2003; Ashworth, 2006; Ashworth & Greasley, 2009), have allowed me to pursue a more narrative-based phenomenological inquiry, asking of the participants what are their individual conceptions of both trauma and what goes on in the counselling room .

The principle of deep immersion in the data is a common thread in all phenomenological inquiry. Immersion, according to phenomenologists, is more than just paying close attention to something, but rather it resembles the experience sought by any Rogerian counsellor of accessing the feeling world of a client through entering their frame of reference, not only objectively, but subjectively. This immersion, and focus on 'experience-near' description (Bondi & Fewell, 2016) underlies the methods I outline in the next chapter.

3.3.2. Bricolage

I remain acutely aware that paradox, 'mess' and perspectivism have methodological implications. Denzin and Lincoln support the idea of researcher-as-bricoleur[33], a term which occurs repeatedly in the their seminal Handbooks of Qualitative Research (Denzin & Lincoln, 2000, 2005, 2011). Bricolage (e.g. Kincheloe, 2001, 2005 ;

[32] I am indebted particularly to Linda Finlay's summary of the field (Finlay, 2011).
[33] Which they base on ideas of Levi-Strauss (1966).

Rogers, 2012) accepts complexities of ontological and epistemological approaches in life as it is actually lived. It thus grants a greater degree of creativity in methodological choices. On the one hand Mason's arguments for cohesion can be accepted but not rigidly within the framework of some more traditional research approaches. Whilst I can agree with the bricolage project being too wide and complex for the time limitations of a doctoral study (Kincheloe, 2001, p681), requiring, as it does, in-depth familiarity with a large range of disciplines, Kincheloe goes on to say that in that context it can still be named as an aspirational direction for future work. So while I have not deliberately set out to be a bricoleur, I have wrestled with the demands of coherence (i.e. within one specific methodology) whilst being unable to escape from the complexity of the phenomenological questions surrounding both trauma and the therapeutic relationship and the centrality of narrative in life as it is lived by both therapists and clients, not least as they meet in the counselling room.

My description of my epistemological and ontological stance as 'paradoxical' could fall into Denzin and Lincoln's (2005, p4) category of 'theoretical bricolage'. This is just one of a number of types of bricolage they propose. Others are interpretive, narrative, political and methodological bricolage.

Methodological bricolage is sometimes equated with "mixed methods" approaches, but Denzin and Lincoln (2005, p5) point out that although it is multi-method in focus it is not used for triangulation in the way that 'mixed methods' normally are. They say that bricolage is an attempt to secure an in-depth understanding, and that objective reality can never be captured. This project uses many stories, and could have been taken in the direction of a narrative inquiry. I attempt to use the stories within the context of phenomenological meaning-making around being a wounded healer. I find support for this position in Ricoeur's later work on narrative and his understanding of phenomenological time (Langridge, 2007; Ricoeur, 1983).

In the context of interpretive phenomenology Denzin and Lincoln's (2005) interpretive bricolage needs a mention. When they say that the interpretive bricoleur

> "understands that research is an interactive process shaped by his or her own personal history, biography, gender, social class, race and ethnicity and by those of the people in the setting" (p6).

I hear echoes particularly of Gadamer who believed that we cannot but speak from a position dependent on our history and culture (Gadamer, 2004; Langridge, 2007, p42). Whilst the analysis of the data will largely follow a practical interpretive phenomenological methodology, my sense in Chapter 2 of the importance of outlining the historical roots from which today's theories of both trauma and the therapeutic relationship have grown come from interpretive bricolage[34] rather than from phenomenology.

One more word on bricolage before I continue. In my position as both a counsellor and a researcher I appreciate King's (2012) understanding of bricolage in clinical work. He argues that both analyst and client (but true too I believe of counsellors) "necessarily employ bricolage in the work they do together" (p 556). The data from participants in this project bears this out.

Relationship between epistemology and methodology

It is at this point that the relationship between epistemology and methodology can become a little clearer. Questions about what knowledge *is* lead on to questions about what knowledge is *for*. Where I place myself methodologically, connected as it must be with my ontological and epistemological positioning, is part of the route towards that goal. I seek knowledge about my research topic so that it can assist strategic decision-making and practice in the counselling room and in training. What I consider to be evidence strongly influences my choice of methodology. Clark (2011) addresses this issue in his critique of 'evidence-based practice' (EBP), particularly within social science. Lester and O'Reilly (2015) express similar disquiet about the current favoured status of EBP in qualitative research. Whilst acknowledging the strides made in biomedical science though positivist approaches, Clark says that even proponents like Dowie and Elstein (Dowie & Elstein, 1988) who argue strongly for quantitative positivist medical research accept "that clinical

[34] Kincheloe (2001, p681) names the historicity of different modes of knowledge production as one of the elements contributed by bricoleurs to a research project.

judgement is a complex, many-faceted activity that must centrally address dealing with uncertainty" (Clark, p52). Drawing on work by Glasby and Beresford (2006) Clark challenges EBP in the context of social care, saying that objectivity does not always make for validity, that evidence is not hierarchical as laid out by Davies et al. (Davies, Nutley, & Smith, 2000, p48) where experience is relegated to the lowest rank. So Randomised Controlled Trials – highly prized by medical decision-makers – are not always the best way to conduct valid research, and that the wisdom of experienced practitioners also holds practical knowledge[35]. This viewpoint is close to phronesis, and opens up the way to a range of qualitative methodologies for research in the human sciences.

It may seem to be a statement of the obvious to say that practical wisdom generally arises from practice. Practice, in any field, involves learning how best to do, make or achieve things. We learn both from watching others and from our own successes and failures – how they and we have done our work, created our artefacts or achieved our aims. So having asked what knowledge is, and what it is for, the next question is 'how do I get there?' It is to this question that I now turn.

[35] See also Dreyfus and Dreyfus (1980,1988)

Chapter 4. Method

My 'how?' question: How could I discover the impact that early personal trauma might have on counsellors' work with traumatised clients? One simple answer is 'ask them'. So from the start I expected to be selecting and interviewing counsellors who fitted certain criteria (see Appendix A) and who would agree to participate in the project. The developmental trauma criterion for participation in the project was deliberately broad because there have been many studies focussing on e.g. ritual abuse, physical cruelty, neglect and other specific traumas such as bullying and childhood bereavement. However, in its breadth it still excluded single incident traumas, or traumas occurring in adult years (whether single-incident or prolonged) which would have increased the diversity further. The breadth was chosen in order to avoid, if possible, some of the assumptions informed by good evidence of the efficacy of particular therapies for types of trauma fitting much narrower criteria.

I also saw a place for including my own experience alongside those of other participants. Initially my interest was not in the details of early traumas but rather the impact of generic developmental trauma on practice, and I expected to focus more on the current experience of the participants whilst minimal information about their trauma, their therapy and their training would enhance understanding of the former. My interview prompts (see appendix D) followed these lines. By the time I needed to start collecting data, I was still struggling with ontological, epistemological and methodological issues and found that when I interviewed participants, the majority wanted to focus primarily on their trauma story. Therapy, training, and to a lesser degree practice, came across also in story form. So, on the 'working backwards' principle (Crotty, 1998; Silverman, 2005, 2011) I realised that my methodology had to be sympathetic to narrative, even if not a formal narrative inquiry, and the underlying ontology and epistemology, and my final choice of methodology followed, as described above.

4.1. Ethics, recruitment and interviewing

Guided by BACP's ethical framework (BACP, 2016), their earlier counselling research guidelines (BACP, 2004), and the requirements of the University of Edinburgh, first I applied for ethical approval for the project. This was granted by the University's School of Health in Social Science Research Ethics Committee. Informed consent was to be carefully managed, with initial information about the project and call for participants, with inclusion criteria, first going to possible sources such as counselling organisations (see Appendix A), but contact and invitations for further information (Appendix B) being requested from individuals directly so that their organisations would not be aware of who might have approached me, and thus disclosing by implication that they had experienced early trauma. Other safeguards around participants' identities, confidential storage of raw data, and opt-out opportunities were included in a two-part consent form (Appendix C). The risk of triggering trauma symptoms was made clear by including advice about self-care in the information sheet.

A small number of participants (six were found) were recruited. Five of these volunteered following approach to the organisations where they worked, and a sixth following an appeal made at a conference which I attended. I also fitted the criteria so although I could not interview myself in the same way, I planned to present my own data as a parallel contribution to those of my participants. The recruited participants agreed to one semi-structured interview. A follow-up interview was offered[36] but none chose to take this up.

The interview would be structured only to the extent that certain topics which I wished to explore would be introduced by me only if they were not mentioned spontaneously by the participants. These topics are listed more fully in my interview guidance notes in Appendix D but, in brief, I would seek very basic information and reflection on the trauma each participant had survived, their experiences of therapy

[36] My rationale was the thought, which turned out to be unjustified for the participants who volunteered, that the interview itself might raise practice-related issues of which participants had not previously thought, and that they might subsequently make discoveries which they would wish to add to the project.

related to that trauma, their training as counsellors, and their own practice as counsellors.

Five of the six interviews were arranged at the participants' places of work. The other was in the participant's home. Interviews lasted from one to two hours, with an average time of one and a half hours. In all cases I started the interview with a review of the consent form (Appendix C) which had been sent (for information purposes at that stage) with the longer project outline. I asked participants at that point to sign part one which related to the interview itself. They signed Part 2, related to transcription, storage and uses at the end of the interview. No participant interviewed refused or later withdrew consent.

I started each interview by asking how the participant was feeling, in the moment, about taking part. This was designed to alert me to any perceptions which might have increased anxiety and to answer any questions which might have been troubling the participant about the process. My next question was a general prompt to share information about how the participant came to be a counsellor. I placed this open question here to give participants maximum choice about what they felt most comfortable sharing in relation to their trauma history. In most cases, the question prompted an extended account of their trauma.

The interview prompts were frequently not needed as participants often spontaneously included the sought for information in the telling of their story. Where an element was not mentioned, I introduced specific questions. This aided comparison of the participants' data.

I held recordings on an encrypted drive and transcribed them using verbatim transcription (Gibson & Brown, 2009)[37]. I used f4 transcription software (Dresing, Pehl, & Schmieder, 2012)[38] and ensured that transcriptions were also encrypted. I

[37] Analysis used these focused transcriptions but for ease of reading, quotations in this text are of unfocused transcription, with addition of comments on non-verbal or para-verbal inclusions where needed.

[38] This software enables the use of a foot pedal to stop, start and recapitulate the audio recording whilst transcribing, and to reduce the speed of speech without changing tone or pitch.

kept any hard copies in a locked cabinet. Only two participants opted to read the transcription.

While these basic ethical issues were anticipated and allowed for, material was occasionally introduced by participants in the interviews which occasioned ethical reflection and I will mention these later in context.

4.2. Positioning as researcher/interviewer

I come to this research as a practising counsellor, and that brings with it issues which have been addressed at length in the counselling/psychotherapy research community as well as those from other disciplines who have interrogated the psychological dimensions of research interviewing. Some of the relationship processes such as identification and projection have already been addressed in chapter 2, but there are others of which I needed to be aware in choosing to interview participants.

Interviewing, as a research tool, is not without its critics. Silverman (2007), for example, argues strongly against interviewing on the basis of the interviewee's power to withhold data, leading interviews to be less reliable than observation. However, in the present study, interviewing is, at the very least, the most pragmatic approach, and the *kind* of data obtained is unlikely to have been available by other routes. However, even if interviewing is acceptable, there remain arguments about how the interview is conducted. Brinkman and Kvale (2005) are concerned about idealising "intimate and caring interviews" (p158) and suggest a more confronting Socratic style in order to uncover underlying assumptions. In a later paper Kvale (2006) presents a wide-ranging critique of the manipulative potential of warm caring interviewing where inadequate account is taken of power differentials. He notes that many, including himself, have written of the virtues of the caring interview (Kvale, 1996), but seeks here to redress the balance which he sees as having swung towards an uncritical acceptance of legitimate feminist arguments around power imbalance.

While Kvale and others are writing about research interviewing in general, there are specific challenges facing the counsellor-researcher. A warm and empathic style of communication is usually one which has been long fostered by practising counsellors

and we are therefore at particular risk of the very issues highlighted by Kvale. A number of writers have alerted us to the danger of an interview becoming confused with a counselling session (e.g. Birch & Miller, 2000; Bondi, 2003a), especially when researching sensitive topics (e.g. Goodrum & Keys, 2007). Developmental trauma is one such topic and required me to avoid a bias to therapy in my interviewing, especially where participants chose to talk about their trauma experiences.

Another, and perhaps the defining difference between therapy and research, is the framing of meaning-making (Bondi, 2003b, 2013). In therapy meaning is created in the therapy session and is private and is of benefit to the client only if that meaning is made by him/her. In research interviews meaning may or may not be co-constructed, but interpretation is not primarily the task of the participant but of the researcher, and normally later during analysis of the data. It is not for the private benefit of the participant but for wider dissemination.

Returning for a moment to Silverman's arguments (Silverman, 2007) for the inferiority of interviewing data, which he considers manufactured (as opposed to naturally occurring) data, he does concede that no data is of itself 'bad' or 'good'. In relation to this project I have already suggested, as he does, that sometimes interviewing is the pragmatic course, but there are two more cogent arguments he makes to counter his opposition to its use. One is that of data collection being beholden to the research question, and the other that the way the data is analysed is, at the end of the day, what determines the quality of the research. My argument on the first point is that to answer my research question by gathering naturally occurring data, I would have to have had access to observations made by researchers covering a lifetime, including the intimate family lives of those who had suffered developmental trauma. Such a longitudinal study is outwith the time-frame of most researchers but, in addition, addressing this question would require access to the intimate lives of those who had suffered in childhood. Such access would be not only unlikely, but unethical. Data would be incomplete without 24-hour surveillance – a nightmarish "Big Brother" scenario (Orwell, 1989). Even if such access were possible or ethical, there would be no guarantee that the subjects would at some point in their future go

on to become counsellors, let alone allow similar access to their counselling sessions. Perhaps I have laboured this point, but only to demonstrate the inappropriateness of observational data for this research question. Silverman's second counter-argument addresses the quality of data analysis. In the following sections (4.3 and 4.4 below) I outline my analytical methods, with their reasoning. A key element is transparency – making my own position clear so that where it affects the analysis (as it inevitably will to some degree) it should be apparent. Another is the use of as much of the transcript material as possible to minimise selectivity bias.

4.2.1. Researcher reflexivity

As well as having an identity as a counsellor, I concurrently inhabit another position – that of being a trauma survivor myself. Without going into details I did inform the participants of this. Then there are the inevitable positions of equality and difference – demographic details shared or not shared with participants – I being female, single, Scottish with an English father, Christian, over 60, childless, scientist, and a host of other similarities and differences that are impossible, or arguably undesirable to ignore or 'bracket' (Fischer, 2009; Husserl, 1970). Bracketing, originally understood as a core principle in Husserl's phenomenology, is understood by Heidegger and others as being, in practice, impossible, but where researcher and participant understandings of the phenomena differ transparency about what is not or cannot be bracketed allows the reader to come to their own conclusions.

4.2.2. Autobiography

My own material was a reflective exercise, using mainly memory and current experience and perceptions, but aided by diaries, journals, art work and old family photographs. As most of the significant family members and other players are deceased the account could not now be confirmed (Golafshani, 2003; Mason, 2002) by obtaining data from them. For consistency's sake, I abandoned early ideas about

consulting with previous therapists, so what is written here of my own story is from a uniquely personal perspective.

The rationale for including my own material is that it would give not only another trauma survivor's narrative, but that it should help to make my own relationship to the research question, my relationship with the other participants, and my handling of the data they shared with me as transparent as possible.

4.3. Data Analysis 1. Organising the material

Coding:

Influenced by phenomenological 'bracketing' (Fischer, 2009; Husserl, 1970) initial coding of the raw data was based objectively on topics raised in the data with every attempt being made to keep any latent personal hypotheses at bay. Although I would later go on to use a less objective form of phenomenological inquiry, I believed it was important to start with this exercise to enable me to 'see' the data from an observer position, giving me a minimally interpreted view of what meaning that data might go on to construct. I liken this to the process that a builder would go through when first on a new site, laying foundations and erecting supportive girders before adding all the refinements that would make the building functional.

I made use of Dedoose software (Dedoose, 2016) in coding the transcripts. Before having a settled decision on the methodology that I would use, I was collecting large amounts of data from the transcripts and sought a way, initially, to manage them. Using this software allows the user to highlight and colour code portions of text in a transcript, and link them to codes, which I chose (Corbin & Strauss, 2008; Saldana, 2016) and modified as I read through the transcripts. The software also allows for creation of sub-codes. Retrieving code-specific data becomes more efficient than manual methods, and, where appropriate, leaves an audit trail. My initial purpose in

choosing codes and sub-codes was to include as many topics raised by the participants as possible. In this first cycle, the codes I identified were:

- Feelings about taking part, both about volunteering, and about the interview itself. Issues such as the participant's preoccupations, the context – time, place etc, and the need for self-care.

- Participant's own trauma. Included nature of the trauma(s) if disclosed, principal effects, impact on self in training, resolution of the trauma, understanding of the trauma and factors identified as meaningful to participant, associated mental health issues, influence on practice.

- Participant's recognition of their trauma. How/when experience(s) recognised as Posttraumatic Stress.

- Dissociation. Any specific mention of dissociative issues.

- Family. Including historical/geographical context, mental health issues in other family members, influences on participant, family scripts, assumptions and secrets.

- Medical professionals. References to experiences of non-counsellor professionals, for self or others, includes clinical psychologists and psychiatric nurses.

- Participant's therapy. Including prompts to seeking therapy, age(s), no(s) of episodes, medical treatment, perceptions of therapist(s) and feelings about, modality(ies) of therapy if known, influence on sense of self, influence on own practice.

- Becoming a counsellor. What led to decision to train, route to training.

- Basic Training. How course(s) chosen, prior knowledge of modalities, Experience, perceptions and influence of, how much trauma training included in, influence on practice.

- Post-qualification training. Courses taken, and impact of.
- Practice. Descriptions of work experience.
- Working with Trauma. Type of trauma work undertaken, impact on participant – as trainee or qualified counsellor, attitude to clients, support (by employers, supervisors, personal therapy, personal resources, friends), impact of organisational management, effect on self, personal responsibility and relations with other staff.
- Understanding of trauma. Including workplace theoretical orientation.
- Wounded Healer motif. Comments on.
- Perception of self. Including perceived personal resources and cultural scripts.

Refining Coding:

Although I would be looking at the ideographic aspects of the data (Ashworth & Greasley, 2009) rather than focussing on generalisations, it seemed to be useful to order the data of each participant into larger categories in order to create a structure which would allow a measure of comparison should this be appropriate. These second cycle codes, which were generally chronological in the participants' stories, were

- Trauma
- Therapy
- Training
- Practice
- Definitions of trauma
- Wounded healer reflections

I then divided the first four codes of participants' transcripts into 'facts' (the story), 'feelings' and 'reflections' (the participants' reflexivity). My own material was less clearly partitioned and was more reflexive in character and its aim is both to add data from another trauma survivor, and also to make transparent any latent biases in later interpretation of the other participants' data.

4.4. Data Analysis 2. Writing as Research

4.4.1. Introduction

Even though coming from a background of ethnography rather than phenomenology Laurel Richardson's work on writing as a method of inquiry (Richardson, 2000) has resonated strongly with me. Her creativity, humour[39] and passion to communicate to a world beyond the academy, whilst still carrying out rigorous research, have been motivational. Other writers, mainly autoethnographers or narrative researchers (e.g. Etherington, 2003; Speedy, 2005a, 2005b, 2008; Speedy & Wyatt, 2014; Tamas, 2009; Tamas & Wyatt, 2013) have similarly used creative writing methods to evoke fresh understanding in their readers. In the chapters which follow I have experimented with my own writing in what I hope is a similar spirit. Such experiments in writing are in themselves a way of doing research (Richardson, 2000; Speedy, 2005b).

Richardson (2000) considers writing to be

> "*a method of enquiry* [her italics], a way of finding out about yourself and your topic. ... Writing is not just a mopping up activity at the end of a research project. Writing is also a way of 'knowing' – a method of discovery and analysis. ... Form and content are inseparable." (p923)

She goes on to say that when writing is used as a method we "reword the world". This, no more than conventional 'writing up', she says,

> "never accurately, precisely, completely captures the studied world but we persist in trying. Writing as a method of inquiry honors and

[39] "in a spirit of affectionate irreverence toward qualitative research" (Richardson, 2000, p923)

> encourages the trying, recognising it as embryonic to the full-fledged attention to the significance of language." (pp923-4)

She sees writing as a research practice suited particularly to investigating how we construct the world. I have adopted this position in relation to both the participants' and my own accounts and how together they make a new and hopefully richer construction. I agree with Richardson's lament that much qualitative research suffers from "acute and chronic passivity", and is underread because it is "boring" (Richardson, 2000, p924). One of my motivations in embarking on this research is a desire to communicate its findings to other 'jobbing' counsellors who have perhaps not had the opportunities for professional development that have come my way. A book I recommend quite often to supervisees is Marie Adams' "Myth of the Untroubled Therapist" (2014), a product of her own research, which has that eminent readability of which Richardson would no doubt approve. That book's communication style too has been motivational in my own research.

4.4.2. Exploring the phenomenon through writing

Following a phenomenological methodology, I immersed myself in the transcript data (Moustakas, 1994), both as I was coding, and thereafter. Interpretive phenomenologists all rely to a greater or lesser extent on language, believing that this is the medium that is normally, even if imperfectly, used to communicate a person's conceptualisation of any phenomenon under investigation. For this reason I chose a method which made maximum use of the actual words spoken by the participants.

Ghost-written vignettes

First I took the bare bones of the stories the participants chose to tell me and wrote them, using their words where possible, as 'ghost-written' vignettes. It has been pointed out by a variety of researchers (e.g. Bignold & Su, 2013; Bulpitt & Martin, 2010; Kvale, 2006; Roulston, 2010, Ch6), as well as by later interpretive phenomenologists like Ricoeur (e.g. Ricoeur, 1974, Geanellos, 2000), that the researcher will inevitably influence the way they obtain data and write about participants, and a choice of ghostwriting whilst not removing the writer's influence can hopefully minimise it, especially, as here, when the ghostwritten sections were

participant-checked[40]. Rhodes (2000) writes about his own ghostwriting of an interviewee's data:

> "I purposefully took on the role of a ghostwriter by attempting to develop an account of another person's experience that is sanctioned by that person yet that still acknowledged and incorporated my own writing practice into my methodological position even though I am explicitly absent." (p519)

Although minimising my voice in the ghostwritten sections, I did so only to prioritise the participant's voice more clearly before moving on to construct 'conversations' in the form of re-formed dialogues based on the transcript data.

'Conversations'

Next, with Gadamer's recognition of the importance of conversation (Gadamer, 2004; Langridge, 2007, p42; Regan, 2012, p295) I created imaginary post-interview 'conversations' with the participants. In these, I identified the actual words they had used while being diligent in remaining within their frame of reference which immersion in the data had helped me to ascertain. Again, influenced by Gadamer's thinking regarding the importance of historical and cultural context and Ricoeur's category of 'phenomenological time' (see Langridge, 2007, p52), I re-ordered the transcript data along approximately temporal lines focussing in turn on trauma, therapy, training and practice, at first identifying feelings, and then recounting the participants' reflections. Because I was focussing on developmental trauma, it made sense to start the temporal ordering with the trauma experience of the participants. Therapy and training were less likely to be consecutive, with both frequently being ongoing processes, though in most cases I would have expected the participants' first experience of therapy to pre-date their basic training. Similarly, experience and learning from practice would be ongoing through both basic and later training, supervision and quite possibly further therapy. Although aware of Etherington's (2004, p84) problematising of linearity in narratives, saying that they are essentially 'messy' and multi-layered, I have chosen to set out the participants' data in this way partly for ease of reading but mainly to provide a structure from which to attempt to

[40] With one exception, Fran, who did not respond.

make and co-construct meaning. I think of this structure as more akin to scaffolding than its being a fixed entity, and like scaffolding it can be dispensed with when it has served its purpose. Braun and Clarke 's (2006) thematic analysis seemed useful for this stage, not least because they present this method as theory neutral, which I believed to be consistent with a phenomenological approach.

The main division of the conversations into 'feelings' and 'reflections' is an attempt to explore the 'then' and 'now' experiences of the participants. Again Ricoeur's "Time and Narrative" work is instructive, in his recognition of the different perceptions of time. The division also makes some distinction between the emotional and cognitive processing in which the participants engaged in their recovery from trauma. Whilst dividing the data in this way there are inevitable overlaps – part of the wonderful 'messiness' of life – and I attempt in Section 3 (chapters 12-13) to bring the two together.

In these conversations, although not participant checked, I strenuously attempted to continue to maintain a position of keeping as far as possible within the participants' frames of reference. Rather than following a template provided by other researchers I wrote these experimental conversations as a way of re-constructing the participant data whilst taking care to represent as faithfully as I was able the experiences and reflections that they had shared in the interviews. *Re*-constructing was the technical part – ordering the data following coding - but it was also an exercise in *co*-construction, recognising my part as interviewer as having some inevitable impact on the telling (Speedy, 2000, p365).

Richardson (2000) suspects that the diminution of the researcher's sense of self in their writing contributes to a risk of its being boring (p925). In these conversations I take an active part in the dialogue. As in the ghostwritten sections, in the dialogues I used many of the participants' actual words, marking them with faint underlining, and omitting non-verbals and repeated words for ease of reading. The result is the creation of six 'new' transcripts, which include few of the actual words I used myself in the raw transcript data, but in which the original words of the participants are prioritised.

Speedy comments:

> "Writing as inquiry is an attempt to capture the readers' attention and engage them in conversation. It assumes and articulates a reflexive, situated researcher stance, but does not necessarily dwell there." (Speedy, 2005b, p63)

She goes on to say that experimental forms of writing counselling research

> "provides descriptive, evocative evidence of the particularities of conversational practice. It illustrates and suggests but it does not explain or evaluate." (p64)

A relevant word for my own approach here is 'evocative'. In the 'conversations' I am in effect inviting the reader into the interview room to observe wound meeting wound in that context to see if there are any parallels which might be drawn to such a meeting between counsellor and client. I acknowledge that the research interview and the client session have a different purpose, but in this case there are some common features – the self of the researcher for one, and the shared experience of developmental trauma as another. Any practising counsellor is dealing daily with conversations and stories, and being drawn into the clients' lived experiences. Much of our learning takes place in these genres. As conveyers of knowledge stories - true, fictional, or 'factional' - have been used from ancient times in Greek myths, the Bible, The Canterbury Tales, Freud, Yalom and many others. In the academy "case study research" (McLeod, 2010; Stake, 2000; Yin, 2003) is one accepted form of writing, as is "lifeworld" research (Ashworth & Ashworth, 2003; Finlay, 2011; Van Manen, 1997). I warm particularly to Bondi and Fewell's preferred descriptive terms "experience-near" and "power of example" (Bondi & Fewell, 2016) for what I have tried to do rather than to tie myself too strongly to the pre-conceptions of these other named research strategies. The very words "experience-near" highlight the importance of context, which is the strength of case studies and in line with Flyvbjerg's reasoning (Flyvbjerg, 2001, 2006). My choice of experience-near methods (rather than 'case study' which is a term which has a more objective sense to it, and one which is sometimes used to generate theory, which is not my purpose here) is based on my belief that they are the best way to provide 'thick' descriptive studies. Dunne (2005; 2011) frames these in terms of context-dependence as

opposed to 'technical' rationality, and sees them as a necessary complement to much generalised empirical research. Interpretive phenomenology developed from descriptive phenomenology rather than replacing it, so using such experience-near descriptive methods is not in my view incompatible with the methodology I have chosen. The 'conversations' seek to demonstrate the phenomenological aspects of the topics we discuss, and in an interpretive way. The reflections, in particular, draw us into the participants' interpretations of their experiences. The practical, or phronetic, aspect of the data analysis will be clearer in Chapters 12 and 13, where I will be able to view the data as a whole, and see which identified impacts of wounded healers' developmental trauma on practice can be valuable in professional development of any counsellors who work with traumatised clients.

The participants' stories and the conversations are the basis for some further discussion, but their evocative nature is designed to convey to the reader many of the meanings that the participants, and I as researcher, have made from what they have told me. Some were more aware of the impact of their trauma on their own practice than others, but all had contributed something towards an answer to my research question. In choosing the medium of imaginary conversation in chapters 6-11 I must acknowledge with gratitude the influence of Kenneth Bailey, an Arabist, ethnographer and Biblical scholar who has used dialogue to re-tell the story of the Prodigal Son in the form of a one-act play (Bailey, 1973) which enlightens readers much more, I suggest, than many of the theological tomes on the same subject.

Autobiographical material

Preceding the 'conversations' chapters, I set the scene by including one in which I present my own reflexive material. The format could not be the same as that of the conversations, for the reason that the source of data was different – personal memory and reflection, written over time rather than spoken spontaneously in interview. I chose instead to alternate memories (including feeling memories) and reflective writing after an initial factual vignette. This I found to be the nearest equivalent to the 'conversations'.

Although writing autobiographically, I make no claims for writing autoethnographically although some influences of autoethnographic writers such as Tamas (2009), Ellis (2004), Adams (2012), Wyatt (2005) and others may be detected. In Adams's paper he sees autoethnography, autobiography and communication as essentially linked. In my understanding it comes down to a question of where the emphasis lies – in my writing here the focus is more on communication, and evocation, than in the political layering that is a feature of ethnographic work, although my hope is that some political issues will be implicit. Richardson, coined the term "creative analytic practice ethnography" (2000, p929). Her belief is that it

> "displays the writing process and the writing product as deeply intertwined; both are privileged. The product cannot be separated from the producer or the mode of production or the method of knowing. ... How does the author position the Self as knower and teller? These questions engage intertwined problems of subjectivity, authority, authorship, reflexivity, and process on the one hand and representational form on the other." (p930)

Discovery through writing based on both interview transcripts and my own reflexive account is an aim of this project. I come from an academic background in science, so this has been an adventure in learning. Since the 17th Century there has been a movement to divide writing into 'literature' and 'science', in which the former is allowed subjectivity, fiction and rhetoric, and the latter only objectivity and unambiguous fact. Gradually the pendulum swung in favour of 'science', but is now swinging back again, hopefully to a point in which the best of both will give a nearer approximation to truth that we can live by and which embraces the glorious complexity of the human condition. The form of this thesis aspires to approach such a point.

SECTION II: EXPLORATION

(contemplating the pictures in the gallery)

Promenade to Chapter 5

Moving from the gateway up the staircase and entrance foyer I arrive at my imagined gallery of pictures. The first picture raises some conflict in me – it is a self-portrait. I question myself. Do I really want to foreground my own material by putting it first, especially as it is painted on quite a large canvas? Not really, but on the other hand in order to give you, the reader, enough information to detect my voice in these data chapters and discussion, I think it only fair to unwrap at least some of the packaging of what it is like to be me so that you can make a judgement about where (for all I cringe at this hackneyed phrase) I am coming from.

Writing and rewriting this piece was interesting. This version is in the first person, but an earlier one in the third person, observing myself from a position outside myself was very different. The one I present here is more analytical, even self-critical. The third person version was more tolerant, gentler. That interested me and may have an impact on my treatment of the participant data in later chapters. The transcripts were delivered from first person perspectives but received by me from an outsider position. A double hermeneutic (Giddens, 1984) would inevitably be involved.

What I disclose here is inevitably selective. The elements of my story and reflections have been chosen for their possible bearing on the research question. I do not include, for example, memories of having fun in the Brownies, playing in orchestras, hating rice pudding (although that might actually be a trauma-trigger), and enjoying Sudoku puzzles and whodunits.

Chapter 5. Pat

5.1. Vignette

Pat: Let me start by giving you an outline of my story.

Mum and Dad, an unsuitable match, met during the War and married in 1947. I was a cherished child. Dad remained in the Air Force throughout his career and was seldom at home.

At the age of 2 years I fell ill with tuberculosis of the spine and was hospitalised in what was a Dickensian-style sanatorium where visitors were only permitted for two half hours a week. After six months my mother, appalled by the conditions, discharged me against medical advice and I was nursed at home by my aunt.

In those days treatment for orthopaedic TB was immobilisation. The 'new' drugs were reserved for those with life-threatening varieties, one of which (meningitis) I developed when I was 4 years old. Back to hospital – a better one – for a year, with daily injections, foul-tasting medicine and other unpleasant procedures.

At 5 I was discharged, learned to walk again and started school when I was 7. Life returned to 'normal' until aged 14 when major surgery on my spine was needed and I lost five months of schooling. More surgery at 18, after which I developed agoraphobia, or so it was thought, after more months of being housebound in convalescence.

My 'agoraphobia' was, I now know, something of a misdiagnosis. Treatment with tranquilizers and antidepressants somehow enabled me to hold down a job in a laboratory and eventually to resume a 'normal' life without their help, go to university to study science and move on to several interesting jobs, including three years teaching in a Saudi Arabian women's medical school at a time when female education there was in its infancy.

But from the age of 19 till a few years ago, I was plagued by transient but very frightening dissociative experiences, best described as 'derealisation' (Simeon & Abugel, 2006). Although I had sought counselling for depression and relationship problems in my 30s and later, those symptoms were never overtly recognised as being post-traumatic until in therapy with my most recent counsellor. By that time I was a counsellor myself, having trained in Person-Centred counselling part-time before retirement, and had worked with some clients with classical PTSD. My own dissociative symptoms seemed trivial and unrelated. Until helped by this counsellor to see the connection with trauma I had not joined those dots, but when I did it was as if a vital part of the jigsaw had been found and put in place, and my symptoms all but disappeared.

My counselling work, since retiring from my last job in science, where I was a molecular geneticist working for the NHS, has been in general counselling, but with an emphasis on longer-term trauma work. As well as with developmental trauma I have also worked both formally and informally with more acutely traumatised asylum seekers, some of whom are survivors of torture.

5.2. Dialogue between Pat's remembering and reflecting selves

(Reflections indented and italicised)

Those are facts. But what of my feelings? I see myself as someone whose trauma has left her with something of an affect deficit. Far from being a 'cold fish' – I am capable of intense feelings – those feeling memories, for much of the time, seem somehow locked up.

Perhaps Levine's SIBAM[41] *model of trauma processing (Levine, 2010, chap 7) might explain this. He proposes that some areas of memory ("channels") are strong while others are weak or non-existent, the latter being the ones that are protectively dissociated – in my case the A of SIBAM – Affect. For some people sensation may be dissociated, as in physical trauma involving acute pain. Yet others will dissociate every aspect of their trauma, for a longer or shorter time. This is well known in childhood sexual abuse (e.g. Briere & Conte, 1993; Chu, Frey, Ganzel, & Matthews, 1999) where the memory, whilst residing in the body is out of conscious awareness but ready to be reactivated by later triggers.*

Figure 4: "Locked up"

One would not expect explicit episodic memories to extend back to early infancy, but if Rothschild (Rothschild, 2000) and others (e.g. Ogden & Fisher, 2015; Van der Kolk, 2015) are right, as I believe them to be, that 'the body remembers', there will be sensory and emotional feeling memories laid down in the body. One way in which clues to such memories might be obtained is through art (Gantt & Tinnin, 2009; Talwar, 2007).

In middle age I joined an 'art therapy' evening class run by two art therapists who believed that their profession had applications for the general community, not solely in mental health organizations. The class lasted for two terms but spawned a small group of ex-students who met regularly in each other's houses to make and discuss

[41] Sensation, Image, Behaviour, Affect, Meaning (Levine, 2010, p139)

images. Over more than 10 years I have produced many hundreds of pictures, some of which give clues to forgotten or hidden experiencing.

Figure 5: I was a much cherished baby, bringing delight to my family

Something I notice about this image is that I, the baby here, am disproportionately small compared to the adults. This theme recurs in other images and is significant in the way I have come to perceive myself in many circumstances. I am of short stature because of the curvature of my spine, and this may be one factor, but not I believe the fundamental one. The smallness is more to do with perceived vulnerability. When I feel unthreatened I am unaware of my physical height and 'walk tall'.

I have some explicit but few 'feeling' memories of my illness.

> *It is inconceivable that as a small child I would not have experienced some quite dramatic emotions given my circumstances – suddenly separated from mother, treated 'badly' by strangers in a hospital which nowadays would certainly be put in special measures if not be closed down completely, and subjected to procedures which were painful or unpleasant.*

Other than my own memories most of what I know I learned from my family, information which supplied sufficient evidence of my distress. There were the times when I would be inconsolable at the end of visiting hour – so much so that my mother took to lying - 'I'm just popping out for a moment to speak to the nurse'- and not returning because she could not bear to witness my tears when the visit ended. Then there was the time when I was transferred to another hospital and refused,

absolutely, to eat for almost three weeks so that I was sent home in order to save my life.

> *I assume, though impossible now to verify, that this was when I was removed from the sanatorium aged about 3, before the decision was made for my aunt to quit her nursing job to look after me at home whilst my mother became the breadwinner. For a child to go on 'hunger strike' at this age is surely more than just a tantrum, but rather is indicative of such despair that physical needs had become less vital than security needs (Maslow, 1943). In adults this is not unusual after trauma. Those familiar with the asylum-seeking community know people whose appeals have failed who prefer destitution in the UK to returning to their own country, such is their fear of death or torture (Bloch, 2014; Burnett & Whyte, 2010).*

My first sensory or emotional memory is of a skull-splitting headache – quite likely when I developed meningitis - made worse by staring into a very bright overhead light bulb. I also remember being fearful of the sight of 'the blood man' (a phlebotomist) on his ward round in hospital when I was 4, and of anger and fear around one particular nurse, whose name I still remember, whose hand was never steady when giving

Figure 6: "Crushed"

> *I am almost invisible as a tiny patient in the tiny bed at the bottom of the picture. A*

huge weight of medical staff, equipment, and 'spikey' feelings of threat bear down on me.

injections, making them more painful than necessary. I also remember the taste of the medicine, para-aminosalicylic acid (PAS), which had to be dissolved in water because the rice-paper capsules in which this compound was normally delivered were too large for a young child to swallow. The taste seemed to come straight out of some demonic chemical factory. I remember the small patients always singing, inappropriately, "Ye're no awa' tae bide awa'" [42] when any one of us was discharged from the ward, and of being ungratefully uninterested in seeing a television for the first time when one was specially brought into the ward for the Coronation.

All through my illness, eating had been a problem for me and I frequently refused the food that was so necessary to my recovery. I became a fussy eater. One emotional memory was the shock I experienced on seeing my mother, only once, dissolve in tears on one of these occasions.

Refusal of food has some echoes of the 3-year old's rebellion. Perhaps I had learned that this was a strategy I could use to get my own way. In the first instance it was a survival strategy, but morphed into manipulative behaviour to give me back some sense of power. Seeing my mother cry was my first remembered lesson in recognising that my power could hurt as well as satisfy.

That memory probably belongs in the two years between hospital and starting school but is the only memory I have of that period. The next memory, age 7, was of the feel of the cold wooden seat against my bare bottom the day that I had started dressing myself for school and had forgotten to put on my knickers! And then the days when mum would take me after school for a treat to a nearby milk bar and I luxuriated in a milkshake or ice cream soda.

It is interesting that my physical memories outnumber emotional ones, but perhaps the two cannot be so easily separated if "the body remembers" (Rothschild, 2000). Again, art may confirm this link. As well as this sense of

[42] Trans: 'You're not away to stay away'

being crushed (Fig.6) another image indicates a felt sense of being unavailable for reassuring or loving touch:

Figure 7: "On View"

I am in a glass box. The observers are the family members (grandmother, aunt and mother) with whom I lived as a small recovering child, with my father as a separate distant individual, facing away from me - or maybe not.

Most of the rest of my childhood was unremarkable. I did well in school, had friends, and knew myself loved and safe with my mother in a small village.

Figure 8: "Stand-off"

But darker clouds rolled in when I was admitted, at the age of 11, to a school in Edinburgh where my mother and aunt had been pupils. This involved more separation. I lived with my grandmother and aunt during the week and returned to my mother's home, some 40 miles away, at weekends.

I would stand up defiantly to our terrifying headmistress, who had a reputation for her ability to reduce girls to tears. I never cried.

Although loved and cared for in my Edinburgh home, I remember a kind of weariness in my passive acceptance of getting on the bus to return on Sunday nights to the capital. I did not like the new school. I was no longer near the top of my class in this high-achieving establishment, and whilst avoiding the 'teacher's pet' accusations of some less able pupils in my primary school, I missed the reassurance of high marks for relatively little work. Now hard work was demanded, in spades. Discipline was strict.

> *Anger, and wiliness, helped me to overcome my fear of authority, already fed by 'the doctor' and 'the minister' (to a lesser extent) and one primary school teacher who made liberal use of 'the belt' (on others in my class, but not, as I remember, on me). I teamed up with another 'rebel' in the class who became a useful ally.*

I didn't question adult motivation. My family wanted the best for me – both physically and educationally. The best was achieved in that I recovered from TB, and I have done reasonably well academically.

> *But there lingered the sense that pain was being inflicted 'for my own good' and this has been a perception that has been hard to shake off, leaving an inner child (Berne, 1966; Missildine, 1963)*[43] *who was easily angered and not entirely convinced of her own autonomy. There was another assault on that autonomy when I was 14 and had to have surgery.*

That time the family arranged for me to convalesce at home, which I remember as embarrassing and humiliating. People were kind, but I was as helpless as a baby, immobilised in plaster, and subjected to the indignities of having relatives, not nurses, dealing with bedpans, washing and the like. It is the only time in my life when I have ached to be out in the rain.

[43] "Inner child" is a frequently used concept, but I actually prefer to think in terms of "child parts" (e.g. Van der Hart et al., 2006) as an idea of a unitary "child" does not make sense to me.

I remember being depressed, but I must have been quite resilient because when I was able to return to school I picked up the threads of my life there fairly seemlessly and worked hard enough to pass the exams I needed.

I had a joyful religious conversion experience and became a little obsessed with it. Music was my other obsession. Both of these obsessions fuelled my rebellion against the head teacher, who disliked the first and considered the second to be an inappropriate subject for pupils in the 'A' stream.

> *My rebellion did not end when I left school. Rather than stay on to sixth form I opted to go downmarket to the local Technical College and sit some A levels. I already had enough qualifications for university entrance so this year was more of an education in life, and fun. But another year of surgery and convalescence after that happy interlude led to what I now recognise as retraumatisation and reactivation of dissociated affect.*

My memory of that time was of being scared a lot of the time. I remember it as a fear of fear, because fear is how I experienced the derealisation episodes which I suffered whenever I left the house. I never had a panic attack, and no connection was ever made with my childhood traumas. Pills got me though, somehow, though didn't entirely 'cure' me.

After a couple of years things improved, and normal life resumed. Work, university and other jobs and training that followed were all envigorating. My happiest time was in Arabia, where I felt more free to be me, and to be a woman, than I ever felt in Britain – you can get away with anything by being a foreigner!

I returned to the UK – to Liverpool - in the middle of the unrest of the '80s, and dived into life in Toxteth. Jung dreamed of Liverpool as the "Pool of Life" (Jung, 2010) and that was certainly my experience of the city. I loved it, but still depression crept up on me there while a research assistant and led to my first experience of counselling.

I guess I could call myself 'an experienced client'. My first counsellor was a follower of Frank Lake (Lake, 1966). I hated this counsellor some of the time. I hated the way I so often felt small, stupid and embarrassed. My ego was bruised and my defences breached. It was easier to blame him than me for how I felt in sessions, but he was good for me because I couldn't manipulate him. What I learned then was that I didn't like owning my anger, and had habitually reframed it as 'hurt'. I had to laugh when I came across an old school photograph after he had once pointed out my body language – head tilted slighly to one side with a pleading expression – and in the photograph I had adopted an identical pose. Some time later, having begun to make friends with my angry self, I went to another counsellor. I discovered that she couldn't 'do' anger so I walked away to lick my wounds.

> *Perhaps because of my obstinate streak, but more likely because in my very early years I had been loved enough to become more resilient than many child trauma survivors, I didn't give up on counselling after that latter rather bruising experience (and the times I hated my first counsellor I can now see were the times when he would not allow me to manipulate him), but it was several years later before I became a client again.*

A dead-end job and no other prospects in my beloved Liverpool led to my move to Newcastle, where I felt unwelcome, alienated and professionally and socially miserable. Back to counselling. That kept me going and helped me towards greater acceptance but much as I appreciated the two counsellors I saw at different times, it was not till much later – when retired from my job, and by then a counsellor myself – that I went for a 'top-up' (or so I thought) to another therapist to help me with that life transition. A good decision. This very gifted psychosynthesis counsellor was able to help me uncover my underlying trauma in a way that no-one else had been able to do.

My job in the NHS involved close collaboration with medical staff and one of my colleagues, a nurse-counsellor, encouraged me to apply for a genetic counsellor training post, because she perceived me as being more patient-focussed than some of

the other scientists. Preference was to be given to candidates who had done Certificate-level counselling training, and I applied for a local course, launching into it with enthusiasm.

Although short-listed for the post, I was actually relieved not to receive an offer because by then I realised that genetic counselling was too narrow, and would not qualify me for work after retirement from the NHS, so instead I continued to Diploma-level counselling training and qualified two years before retiring.

> *Long before finding the confidence to train as a counsellor, I had engaged in listening skills and Myers-Briggs (Briggs Myers, 1993; Briggs Myers & McCaulley, 1985) faciliator courses. Both had given me a range of insights into counselling and personality, but had not given me insight into different models of counselling so when it came to choosing a training course my decision was made on pragmatic grounds.*

I loved the training, which was rather purist Person-Centred, although it brought challenges aplenty. In fact there are few subsequent CPD[44] or other training courses that I have not enjoyed.

> *Even as a small child I have had an insatiable curiosity, from dismantling the household's barometer to see how it worked (a failed teenage experiment), to a doggedness in teasing out genetic defects in cancer patients. Widening my understanding from body to mind of how the amazing human organism (including my own) seems to work has been for me a natural progression.*

Whilst enjoying the learning I was not uncritical. In one module in a couple counselling course I felt the tutor was emotionally abusive. I remember her laying into one student who had shared with me a crisis that was going on in her own life at the time, and the tutor's assault could not have been less appropriate. My response was to distance myself in a passive aggressive way from any groups that this tutor was facilitating.

[44] Continuing Professional Development

That response is one that I recognise as being part of my pattern of rebellion. When the odds seem to be stacked against me, withdrawal seems a better option than attack. But it is an anger-fuelled withdrawal, not an accepting stance. An ability to find appropiate ways of standing up to authority is still one of my development needs. Fear still lurks, and often wins.

My first ever counselling clients were when on placement in NHS primary care. I remember being scared. In an attempt to make my clients comfortable I remember trying to exude a confidence that I certainly didn't feel.

But even at this early stage of training I was not a shrinking violet in face of authority. In-house supervision was inappropriate to my training modality and again I rebelled by asking for a change of supervisor, and was delighted that my assertiveness in this instance 'worked'.

Although I now have many hours under my belt, I still suffer to a degree from a lack of confidence in my skills as a counsellor. Out of fear of inflicting pain when working with some very damaged people I have a tendency to hold back from challenge where challenge might be indicated.

That is a strange mixture of genuine compassion, a protective 'rescuer' Drama Triangle position (Karpman, 1968), and fear of rejection, probably in that order. Unlike one of my supervisees whose basic fear seems to be of 'getting it wrong' and getting into trouble with her professional body, that has been a minor issue with me. Perhaps I had plenty of practice at staying just on the right side of the law at school!

I sometimes wonder if my rather antinomian take on counselling, albeit ethical in my view, might be reducing my effectiveness at times. I am someone who has always felt more comfortable with guidelines than rules and this could well be influenced by my ingrained dislike of 'being done to' 'for my own good'. For the same reason I am not attracted to manualised therapies like CBT and where I believe one of these would benefit a client I will refer them on rather than try to engage in a modality where I would feel incongruent.

I am probably driven by the 'do as you would be done to' golden rule. While I believe that recognising difference is very important, I also believe that being myself is vital in any relationship, including those in the counselling room. To me 'being myself' does not mean inappropriate self-disclosure, but it does mean modelling for clients the possibility of being comfortable in one's own skin. Most of my clients, especially those with early trauma history, have ingrained conditions of worth (Rogers, 1959). But with trauma clients, whilst bearing this in mind, I am more inclined now to help clients identify the survival strategies they adopted in childhood. This approach, learned mainly from Janina Fisher (e.g. Fisher, 1999; Ogden & Fisher, 2015), has the great advantage of encouraging clients to see their inherent will to survive and the resilience that they were able to show even as small children. I believe that if they can make connections between those learned strategies and the current behaviours which no longer work for them they are more likely to be able to change.

In retrospect, I can see that my attraction to this way of working has a great deal to do with the way that I found healing. Reflection on my own trauma history, understanding its biological, psychological and behavioural effects leads me to believe that clients who are open to curiosity and have a capacity for reflection can find this approach as helpful as I did. But as Judith Herman (1992) emphasises, the first therapeutic need is for the client to feel safe.

This need for clients' perceived safety has its pitfalls for me. One is my ambivalence about challenge (see above – my power to 'hurt' my mother) and another is when faced with clients or friends who cannot feel safe, because they are NOT safe. The small, vulnerable 'me' in so many of my paintings reflects my personal yearning for safety, and that part of me still exists. This may be a common element of the human condition, but is probably enhanced in trauma survivors.

Safety is a major issue in work with asylum seekers. Even if they have suffered terribly prior to escape to this country, the asylum process can not only be

retraumatising in itself, but until/unless it concludes with a grant of leave to remain in the UK, the fear of return is a constant threat. This is well recognised by Freedom from Torture (FfT) whose counsellors work on a 'triple trauma' model (Michultka, 2009; Orley, 1994) – torture, flight and loss, and the asylum process. In my experience, the insecure feelings invoked by the third usually dominates counselling in those who have not yet been granted asylum.

My early practice was inevitably influenced greatly by my Person-Centred training, and to date, when 'stuck' I will review my work and return to Rogerian basics.

However, even when training, I was not wholly convinced that Rogers had the last word. To my mind he had too positive a view of human nature, and did not have a satisfactory answer to evil.

When clients bring experiences into the room which should never have happened – ranging from abuse of children to atrocities of war – I cannot just nod and reflect 'you feel sad when you remember .....' and not express my own anger at the injustice they have suffered.

Far from running ahead of the client's headlights I believe in the therapeutic value of being a witness to the injustice of suffering. There is always a risk of projection here. I may feel angry, but the client may not. However it should be possible to honour the client's current feelings without hiding my own. To me, if my congruence remains internal, I take a greater risk than projection – collusion. As collusion is a frequently used survival strategy under severe threat, clients will probably at some point need clearly to hear an alternative discourse to that held by their abusers. I have benefitted from being challenged in that way. Although they genuinely loved me, my family was in a number of ways dysfunctional. So many children who suffer some kind of developmental trauma survive by believing that their experience is 'normal'. In my case, illness and an absent father were 'normal', in others abuse or neglect within the family is 'normal'. I remember a counsellor remarking, almost as an aside, that my family was dysfunctional, and this was quite a revelation to me,

but something that was very helpful. Truth, spoken with love and care as suggested by St Paul (Ephesians 4:15) tends to be helpful I believe.

It would be disingenuous of me to pretend that my counseling practice is not influenced by my spirituality as well as my trauma experience. It would also be disingenuous to assume that the two are not connected. Christians see in Jesus the ultimate 'wounded healer' and this motive has been much addressed in theological work (e.g. Nouwen, 1979).

I share a belief held by many Christians that God is our creator and the source of all human wisdom. Though less so now than in the past, perhaps because of the church's reaction to Marx's "opium of the people" critique of religion (Marx, 1844) and later of Freud's explanations of religious experience in psychopathological terms (e.g. Freud, 1961b; Freud, 1964a), counselling has been viewed with suspicion in some Christian circles. Other faiths too may see psychological insight as inferior to their teaching. Christian faith being of great importance in my own life I have reflected much on where I place myself in this debate.

In the counselling room, I am comfortable when clients refer to their spiritual beliefs, but always wait for them to initiate conversation. In spite of my belief that ultimate healing comes from God, I do not feel that it is my place as counsellor to make that belief explicit.

My approach relates again to safety. Although I see little direct connection between my own trauma and coming to faith, some trauma clients have found a measure of safety and reassurance in religious faith and it makes complete sense to me that such clients would find it unsafe to relate to someone who is unable to speak that language sincerely. They might even fear that this 'expert' might try to minimise their experience and, with Freud, explain away their faith. I would not, all those years ago, have gone to my first counsellor had I not been told that he was sympathetic to Christianity.

There are days when I don't seem to feel the energy to see clients – although I rarely feel that about supervisees. But when clients make connections and show increase in confidence my energy returns. I did have one very long term client who sapped my energy so much that I sometimes found it difficult to stay awake – even when I had no such problem in sessions before and after that lady.

> *That was an older lady who defined herself by her genuinely difficult issues (arising from childhood trauma) and had little capacity to reflect and as little courage to change. But my colleagues in the project, who knew her - she could be 'difficult' - used to commend my patience with her. I am curious about my ability to be patient, because I recognise in myself an easy irritability. I have been known as someone who "doesn't suffer fools gladly" and can be quite bad tempered or even ascerbic. But with anyone I perceive as suffering I can have the patience of Job. I have to wonder, yet again, if this is connected with my fear of hurting the vulnerable, a projection of my own experiences of vulnerablity.*

Patience and long-term work seem to go together, and I sometimes find time-limited work frustrating, though I see both long and short-term clients. It really depends, as ever, on what the client brings. On assessment it is usually fairly clear to me if they have issues that include childhood trauma of some kind, and how I approach the counselling often has to depend on whether the contract is time-limited.

Where I am only allowed six or eight sessions with a traumatised client and onward referral is unlikely to be an option for them, I normally ask them to choose a focus for the work, and I make no attempt to probe for deeper, more historical issues. One time-limited client chose to tell me many abuse issues from his childhood, but his focus was more on seeking a way of sharing some of this material safely with his partner, and of recognising trigger factors which had led to an unexpected breakdown so that he could be forewarned should this threaten again. By contrast, a client I was free to see in an open-ended contract, came with a warning for me of an experience many years ago of having been encouraged 'to work on her trauma' (childhood sexual abuse) before she was ready. The warning alerted me to a need to be even more

careful than usual about pacing the therapy, and not to damage her further by running ahead of the headlights.

> *On a training course, and in my subsequent study, I have taken on board the advice not to take on clients at the the more extreme end of the dissociative spectrum unless I am prepared to commit to long-term work (Ringrose, 2012). This would be particularly true of clients with a diagnosis of Dissociative Identity Disorder (DID) who may need uninterrupted therapy over many years. But those with related milder forms, as was the case of the second client mentioned above, also need the patient commitment of a gentle counsellor so that their dissociated 'parts' can feel safe enough to contribute to the work. The length of time I spent as a counselling client, including three years with my last therapist, has left me very tolerant of the fact that this can be a slow process for a client. Whilst I sometimes feel that I am not 'good enough' as a therapist (as in Winnicott's (1953) well-known idea of the 'good enough mother') I take heart from my experience of being a client who, I am convinced, would not have responded to quick fix solutions. That is not to say that all survivors of developmental trauma are the same, and I periodically review with long-term clients to find out where they see themselves on their path to healing. I remind myself that counselling is not about me. Clients are the focus. Not infrequently they blame themselves for slow progress, or feel guilty about wasting my time or being 'self-centred'. I can meet them there, because I have expressed similar feelings in my own therapy. The focus shifts then to addressing those feelings so that progress can be resumed.*

Although I had seen a number of traumatised clients in my training years, after qualifying my first concentrated exposure to severe trauma issues was with survivors of torture. Applying to be a volunteer with FfT when they opened a centre in Newcastle seemed at the time the natural thing to do, even given my relative lack of experience.

> *My rationale was threefold. I had a personal interest in trauma, albeit of a different magnitude. I had done two years full-time training in cross-cultural*

communication before working in Arabia. And more than three years living in Arabia and the Emirates had given me a first-hand experience of living in Islamic countries – and many FfT clients are Muslim.

With my dissociative experience I find it relatively easy to pick up clues when working with a client who uses language which seems to describe similar episodes, and often find that the client is relieved by my understanding. It had taken me a very long time to admit to derealisation episodes. The longer I delayed the harder it was because I always feared that it was a sign of mental illness and that I would be deemed unfit to practise as a counsellor. And add shame into the mix.

The experience of relief when I did disclose and my counsellor took it in her stride, has given me the confidence to offer such uncritical reassurance to clients who find the courage to risk exposing what they may also consider shameful. I now understand dissociative experiences – which can be unpleasant as well as soothingly protective 'normal' reactions to trauma – so together with other trauma symptoms need carry with them no shame.

It would be both misleading and ungrateful to write about my practice without mentioning my positive experiences of supervision. The more I learn about trauma, my own and that of others, the more I value the supervisors I have had, and have, who have in-depth experience in the field. If I owe much to my past therapists in my own journey to healing, I now owe much to the wisdom and care of past and present supervisors in my development as a counsellor.

Promenade to Chapter 6

I remember a conversation I once had with an artist about hanging pictures. I had noticed that a picture of his that had looked wonderful in one room had looked quite different and had seemingly lost something in another. He nodded sagely. Approaching each of these interview data chapters issues of context which have already been noted (see chapters 2 and 3) come again to the fore so I will preface each with a 'promenade' which will hopefully allow each 'picture' to be seen in its best light.

Of the format, before imaginary post-interview conversations, I present each participant's story in a ghost-written vignette in which I use as many of their own words or phrases as possible. Some of these occur again in the 'conversations'. In the conversations, I divide the data, in conjunction with co-constructed contextual interpretation, into two major sections – feelings expressed in the interview, and reflections made by the participant. I have done this to allow some distinction between the emotional and cognitive facets of the related experiences. I have identified words taken verbatim from the transcripts by faint underlining. I have not presented the participants' data in the order in which the interviews took place. This is simply to enhance readability through maximising variety.

The 'Promenades' are to bring you, the reader, into the room with me as I remember the interviews. And as in an art gallery, where the viewer must leave the picture before it has told all that it has to tell, each of these chapters ends, sometimes rather abruptly, without a satisfying 'ending'. Further reflection must wait till Chapter 12.

Helen's interview

I was unfamiliar with the location of Helen's building and that added a frisson of nervousness as I had initially enquired at the wrong door. But my welcome was warm, and Helen cannot be faulted in her attempts to put me at ease, though I was aware of being on the weaker side of a power imbalance in the presence of a therapist of such seniority and experience. Overawed is probably the best word. I

was also tired that day, which reduced my confidence, and towards the end of the interview I was flagging, as I suspect Helen might have been too.

Chapter 6. Helen

6.1. Vignette

Helen: My decision to take part in this research was thought through at some length and was prompted by the recent death of my mother. I knew that that would be closing a particular lifelong chapter for me, potentially liberating, and also I thought that it might be quite helpful for *me* in fact to hear myself talk it through within this kind of context. It would be interesting to do and it would be safe enough because, you know, I'm going to be in control.

I was born in the '50s, the younger of two girls, and both my parents in different ways suffered from ill health. My dad was ill and disabled really all my life. I must have been 2 or 3 years old when he was diagnosed with Parkinson's Disease even though he had probably had it undiagnosed since his 20s. I think when I was 3 and then again when I was 5 he went through two different neurosurgical operations – in those days very basic. Apparently he did get a bit better after that and he was able to do things like lift us up and his mobility improved, but after his second operation he had a cerebral haemorrhage which left him with complete loss of speech and completely paralysed down his left side. He was in his 40s then and he died at the age of 66 when I was in my late 20s. So over that time I have this rather strange experience of having this parent around till I was that age and never able to have a proper conversation with him or know him as the person he'd been.

The same year, in the early 1960s, that my father had his stroke my aunt died of a brain tumour and both my paternal grandparents also died. My mother had suffered severe bouts of depression since her 20s, but remained undiagnosed till the mid-1970s. She was then diagnosed as bipolar and had ECT[45] as an outpatient. Then 8 years later she attempted suicide and was in hospital for 4 months. It was when she was hospitalised that my dad was admitted into a geriatric unit where he died the following year. She had another two months in hospital after he died.

[45] Electroconvulsive Therapy

The focus was always on my mum. It had all happened to her and it took me *years* to realise, when I was in therapy, that it had also happened to me – that I'd been traumatised. I've got very patchy memories of the rest of my childhood. I think what I was left with was being almost in a *permanent* state of fear - somebody would either die or become ill. And various other incidents fed into that – men exposing themselves to me in the street, and discovering a burglar in our house. I developed a stammer for a few years.

Changing from primary to secondary school was difficult. I think I became depressed. I was frightened about being on the bus, frightened of getting to and from school. Never *occurred* to me to let anybody know this.

Living with mum's instability and dad's declining health is how it went on really until I left home at 17 to do nursing training. Then my mum became severely ill. That was when she was diagnosed and had ECT. I remember at this tender age not having a clue. My sister was abroad at the time and I was dealing with consultant psychiatrists, petrified. Yes, I took on really the role of parent. She just stopped taking any responsibility for herself and remained emotionally dependent on me till her death 9 months ago. Really, from the age of about 11 I'd become her counsellor.

The first time I sought out counselling was probably in my early 20s when I'd met my husband. We were living together and I thought at the time that I wasn't quite right in the head. It was almost as if I couldn't enjoy this adult life and being in a relationship because I was so convinced that either one of us would die or become unwell and disabled. I recognised that this was not normal thinking. I naively took myself off to my GP who referred me to the local psychiatric hospital where two psychiatrists asked me all sorts of questions. I remember lying. They quite rightly said there wasn't anything actually wrong with me. But I could see this isn't how other people think. They don't go around waiting for something terrible to happen or expecting death, disease and pestilence, which is essentially how I viewed the world so that's when I took myself off to counselling for the first time.

I didn't have children till I was in my early 30s because it wasn't until then that I knew I could risk having children – for fear they might be ill or disabled.

But making the connection with trauma didn't happen until about ten years ago when I had an extreme reaction to the serious injury of a friend's son and I suffered some of the classic trauma symptoms, including flashbacks to my 6-year old experiences.

Although I trained as a nurse I realised quite early on that I didn't actually want to work with ill people. And I didn't like the system. As soon as I finished training I went into occupational health – and have been in that field since, first in industry and latterly in healthcare. Counselling was one branch of occupational health open to me and I chose to train because I enjoyed the one-to-one work with people and was interested in what made people tick.

Having looked into it, my preference would have been to train in Person-Centred counselling, but that option was not available in the city where I lived so the course I did was an Integrative one. Much of my CPD was on Person-Centred courses though, although I've also recently done a training in EMDR as well as some other courses focussing on trauma. My work in occupational health quite often involves both discrete trauma and childhood trauma – often sexual, although it is basically a generic counselling service offering short term work to a large client group of people working in a huge variety of jobs and at different levels.

6.2. The Conversation

Pat: When I met each participant in this project I did so with awareness that it could be a sensitive topic, and each could have their own unique response to it. I remember you laughed when you said that it would be "safe enough" because you were "going to be in control" and that relaxed me quite a bit too!

Helen: You'll remember that it took quite a long time for me to respond to your initial email, partly because of my mother dying, but I also thought that it might be quite helpful for me to hear myself talk it through within this kind of context.

Pat: You said something about using the time to "join dots" of many of the things you'd gone over in therapy.

Helen: There was something about the timing that felt right. That would be closing a lifelong chapter for me, potentially liberation.

Feelings

Pat: You started your story with your father's diagnosis of early-onset Parkinson's Disease, quite primitive surgeries and his subsequent stroke.

Helen: There was never really a time when I knew him when he wasn't ill. I was only 2 or 3 when he was diagnosed. It was just kind of the norm.

Pat: That norm for you was "around the themes of illness and loss, disability, death, illness and loss within the family"

Helen: The background was my father's illness, but there were other things too that reinforced those themes. The main feeling I associate with my childhood is being frightened, and being frightened that something was going to happen, never feeling that sense of safety of continuity and that somebody would either die or become ill that to a lesser or greater degree continued.

Pat: You spoke about never knowing what was going to happen.

Helen: And it seemed that bad things did keep happening. I twice had men exposing themselves in the street, and once I discovered a burglar in our house – that kind of thing.

Pat: The world seemed a very unsafe place

Helen: Yes, but I felt that was how the world was. I do remember specially that the move from primary to secondary school was particularly difficult. I really struggled with the travelling. I remember really struggling with my mood at that time and again a lot of fear. Frightened about being on the bus, frightened of getting to and from school. Never occurred to me to let anybody know this.

Pat: I had the impression of a pretty isolated little girl. You had an older sister, but you didn't mention anything about any support from her, and your mother seemed totally pre-occupied with your father and with her own problems with depression.

Helen: She was dealing with bringing up two girls, with a severely disabled husband, and behind closed doors she was also struggling with her own mental illness and I was intuitive enough and empathic enough to pick up on that.

Pat: Putting it a bit harshly I guess you just know instinctively that you wouldn't get the support *you* needed.

Helen: Very occasionally she would be a bit out of control - once a bit violent towards us, my sister and I ..... It was never predictable. She wasn't steady. Things could be happening and either she would be fine and on top form or else she could be not coping at all and in the kitchen in floods of tears and not be able to prepare a meal.

Pat: And at the time you wouldn't know anything about Bipolar, so this was just how mum was I guess. Hardly surprising that you felt fearful and insecure.

Helen: As a teenager another memory around my dad is of there being a mixture of being mortified at having this disabled father and at the same time being very very angry at how he was treated. People would laugh at him or assume that he was stupid and I became a bit of an advocate towards disability and got involved in things and was very sensitive and aware of disability and how people were treated differently.

Pat: You also used the word "heartbroken".

Helen: I do remember being heartbroken about my dad and not being able to express that or know what it was but just looking back and grieving, grieving for the loss of him, even though he was still there. But there's a cruelty about that. At least if someone is dead you know where you are. It's final and it's awful but it's clear.

Pat: You spoke very tenderly about him. About his deterioration you said "I found it very hard witnessing my father's decline because he ended up you know, well, just

.... poor soul ....". And your mother's condition worsened, with a psychiatric assessment at home followed by ECT as an outpatient.

Helen: My sister had left home by then and I was left kind of 'in loco parentis', not having a clue, dealing with consultant psychiatrists, petrified, absolutely petrified.

Pat: But it wasn't till some eight years later that she was so ill that she had to be hospitalised.

Helen: It was only after she'd tried to kill herself and arrangements were made for my father to go into a geriatric unit that she was admitted to hospital. She really should have been hospitalised sooner.

Pat: And he died only nine months later.

Helen: Looking back it's rather extraordinary that I didn't recognise that I'd been traumatised by all this. There was a kind of family script that all the difficult things had happened to my mother – we kids weren't seen in it all.

Pat: But as you now know, trauma will out.

Helen: Yes indeed. When I left home and met my husband my view of the world as being full of death, disease and pestilence was so ingrained that I realised that I wasn't like normal people and sought help. I worried a lot.

Pat: And nursing training wasn't that easy for you either.

Helen: I think I was pretty traumatised through a lot of my training I really struggled with how people were treated. I didn't like the system. Suffered terribly when I was on night duty. Always took on a sense of responsibility. But again frightened, looking back I was frightened a lot of the time.

Pat: Fast forward to about ten years ago you had an extreme reaction, typically post-traumatic, to a friend's son's serious brain injury.

Helen: Yes. If anyone is in doubt about the possible severity of secondary trauma – tell them to ask me about it! It was awful. My reaction was just so *extreme* what I

was experiencing and feeling, even compared to his mother. I was absolutely distraught. The nightmares, the imaginings, the flashbacks....

Pat: That took you back to therapy. Earlier experiences of counselling had encouraged you to think that this could be helpful.

Helen: Yes some earlier counselling had helped me understand myself a bit more – especially in relation to my coping with mum and dad's dependence on me. But some was less helpful too. I remember the first one I saw, and maybe it was me but how I heard her, when I was saying some of the things that I needed to say about how I felt about my mum I almost got the feeling that she didn't approve of what I was saying. For the first time I was risking expressing negative feelings and it was almost 'yes, but your mother's doing the best that she can' kind of thing.

Pat: Ouch.

Helen: But when my trauma was triggered ten years ago I returned to one of the counsellors that I'd seen before, and very quickly that helped me make the connections between this young man's trauma and my own trauma when I was a young child.

Pat: The more so, maybe, because his injury required neurosurgery – just like your dad.

Helen: Therapy has sometimes been hard. And something that I experienced in therapy, I experienced also in training. I found it very hard to be in the moment in the unknown. I struggled to know what to say next. In these big groups I would sit and wait and wait and stay in my head and then wait for my moment and then say it. I was so schooled in being emotionally self-sufficient.

Pat: You hadn't had much practice at being a free child (Stewart & Joines, 1987).

Helen: not at all!

Pat: The basic training you did was an integrative one, not entirely by choice.

Helen: I'd much rather have done a person-centred one, but it wasn't practical to travel. I did struggle with it a bit at the time. I used to struggle with the psychodynamic theory. I was one of these people that read Rogers and it just made sense to me.

Pat: You said that in hindsight you're glad you did it though, and you really enjoyed doing more focussed person-centred CPD courses, especially your supervision course.

Helen: If only all the CPD I'd done was like that. When I was really in need of help with difficult trauma work, I went on one course where I felt like an absolute dinosaur amongst a group of newly-qualified counsellors. It was as if I was in a different world to some of them, and I came away feeling very angry, pissed off because at that time I was in in the depths of this kind of horror and working at a very deep level. The course was so basic and the freshness and optimism and openness and undamagedness around me on the day highlighted for me how dark and heavy work was for me at the time.

Pat: Fortunately you went on to describe a much better trauma course.

Helen: and guess what – it was a person-centred one! I came away from that one feeling much more heard, acknowledged and reassured that it is normal to be depleted and horrified by some of what we hear.

Pat: Moving on to practice you commented that a large number of your clients in occupational health come to the service with trauma issues.

Helen: Indeed, and, you know, I think I'm good at working with people who have been traumatised. I have a deeply held belief that people have the capacity to recover.

Pat: Most of your work is very fulfilling, but you did speak about that one very difficult experience with a client quite recently, where you had to stop working with them.

Helen: Yes, I learned the hard way that some of my vulnerabilities are still there. My resources became quite depleted. But I have learned from that, and I have recovered my optimism.

Reflections

Pat: When you sought counselling you didn't think, as you did later, that you had a form of PTSD.

Helen: I suppose because on my mother's side of the family there had been quite a complex history of mental health issues - suicide, depression, and so I had always assumed that what I was battling was depression - I was going to be ill like my mother.

Pat: It seems that it was only many years later, when earlier trauma was triggered, that you began to see your depression and anxiety as symptoms rather than primary issues.

Helen: The effect of my friend's son's injury was so extreme, yes, and my counsellor at that time helped me to join the dots. Later too, when I was working with the strongly dissociated traumatised client I mentioned, I came to recognise that while I thought I, the adult, would be able to deal with it I think in fact it was too much for my 6-year old self to do that work.

Pat: Yes, I remember that you must have been about 6 when your father had his stroke following surgery.

Helen: That's when he lost his speech. So I have this rather strange experience of having this parent around till I was 27 and I never was able to have a proper conversation with him or know him as the person he'd been. Before that he'd been able to lift me up, so I guess I had some kind of 'normal' relationship with him which was shockingly ruptured by his stroke.

Pat: And there were three significant deaths in the family that same year, so it's likely that your mother was quite unable to give you the support that such a small child would need in the drastic change in her father. That was really the start of the family script about everything having happened to your mother – not to you.

Helen: It took me years to realise that it also happened to me. It's had long-lasting effects. So that's what I base it on actually. That is the time I was I think I was traumatised.

Pat: You said too that memories of your childhood were very patchy. And I have to say that the ones you did share were mostly negative.

Helen: Maybe that's the nature of the topic – I'm sure there were good things too – but whether it was to do with what was going on at home or not, I had developed into a child who must just have had one of those kind of open and vulnerable faces because incidents like being followed, men exposing themselves and so on just seemed to happen to me, not to my sister. Nothing with serious consequences but just fed that fear.

Pat: I have the impression of a little girl who largely had to fend for herself – at least emotionally.

Helen: I think that's true, and involved something of a role reversal too. Looking back I think I became my mother's counsellor. On a practical level, keeping house, she kept going even after her bipolar diagnosis, but not emotionally.

Pat: When I asked when she had been hospitalised, you were about to say something from her point of view before saying, from your point of view, "as soon as she could". Then you caught yourself and laughed "I don't have to say it from her point of view any more".

Helen: Empathy can become quite a habit!

Pat: But after you left home to start your nursing training you said

> "She just kind of stopped taking all responsibility for herself and her life, and ... I would say that that probably continued her emotional dependence on me until she died last October - a long time."

Quite a burden to bear.

Helen: Of course for many of those years I had my own family life too, and counselling has definitely helped a lot, but although I control it well through awareness, my deep-seated legacy of believing that the world is a somewhat dangerous place still lingers.

Pat: That's rather typified in your saying

> "through having children and meeting other women and realising other people don't think like me, they don't see the world in the same way that I do which is 'well if you're lucky you'll be healthy, you'll be OK' "

Helen: Yes I just thought that was how you lived. Feeling like that was just part of it, being human.

Pat: It's just how life was?

Helen: Yes, and I'm sure that was why it took me years to recognise that what had happened to my mother, had also happened to me, and that they were unusually bad things.

Pat: It was when you became anxious that there was something wrong with you that you sought help – initially through our GP.

Helen: Even though the appointment in psychiatry was anything but helpful, I didn't give up, and sought out counselling instead. In hindsight I was trying to be proactive.

Pat: Which is something I always consider a good sign in new clients.

Helen: Looking back, although counselling was very helpful in some ways I realised for myself is that it's taken me a long time to use therapy – to make use of what it could offer me. Because I think I've carried on that 'I've got to sort everything out for myself' so I would kind of work things out in my head, work everything out, go

through my process and then go and tell my counsellor, so it was being heard, being acknowledged but actually I had done a lot of the work.

Pat: I wonder if that all comes back to the self-sufficiency thing you mentioned earlier, or even to the assumption, born of experience, that other people weren't really there for you.

Pat: Some people I've spoken to – and this would be my own experience – investigated counselling training because they had had good experiences as a client and had been drawn into that 'world'.

Helen: It wasn't really like that for me. Having realised that hospital nursing wasn't for me, but occupational health was, I settled into a long-term career in that field. As with many careers, there are various specialisms you can focus on. In occupational health counselling was one option, going down the health and safety route and become a health and safety advisor could have been another, and moving into management would have been the other. I asked myself 'what are the bits of my job that I really like best?' and I realised it was sitting with people on a one-to-one basis and I was interested and curious as to what made them tick and so counselling seemed the way to go. I don't know if I realised it at the time but I would actually have more autonomy and more freedom working as a counsellor than I would in either of these other specialisms even those within the construct of a very bureaucratic system.

Pat: Going back to training – in hindsight you didn't regret doing the integrative course, even though it was your second choice.

Helen: No. Perversely maybe it gave me kind of something to stand against. Where I think if I'd done a person-centred training and it had only been person-centred and there was nothing for you to question it would just have been kind of accepted. It reinforced my theoretical position, although I found it hard at the time because it was early days and you want to be basking in the theory of it and then practising it.

Pat: For someone so dedicated to the Person-centred approach it rather surprised me that you had considered EMDR as an option in trauma counselling.

Helen: It might seem contradictory to being person-centred but the philosophy of this organisation is somewhat unsympathetic to Rogers, and the service we can offer is only short-term.

Pat: It's always a tension isn't it? Organisations are either constrained by funding, or by an ethos that achieving functionality is their remit more than facilitating more holistic healing (Totton, 2004).

Helen: Yes, true, but we can't ignore some of the very positive outcomes of EMDR in some cases, and I can't turn my back on the evidence and become wholly entrenched in my own preferred modality.

Pat: You'd also become more interested in how trauma affects the body.

Helen: I began to become curious about other ways of working with trauma and this idea that so much of it is held in the body and experienced in the body. We can talk about it and talk about it but if a person hears that sound or smells that smell or whatever the body goes into this response. Talking alone doesn't stop the traumatic responses.

Pat: Although I haven't trained in EMDR myself I share your interest in bodily reactions to trauma, and recognise the importance of those much more often now. We're talking in terms of your basic training having been some time ago now, but when I asked you about elements of trauma training within it you said that there wasn't much.

Helen: Certainly nothing about the idea of the difference between a simple discrete trauma and complex trauma. But judging by my negative experience, however coloured by my own secondary trauma at the time, of the course where most of the participants were recently qualified, I'm left wondering if much has changed.

Pat: You drew a comparison between counselling CPD trauma training and NHS CPD training – you'd attended a 3-day course on complex trauma run by the NHS.

Helen: Yes, the emphasis was very different. It was very much, you know, sitting down and slides and being lectured. It wasn't experiential in the way that you and I

would be used to. Most of the people there were psychologists and I think they were quite shocked at the idea of being congruent or listening to yourself. They seemed to be so focussed on 'If a client's presenting with this thing - then what do you bring out here to deal with that?' I think it's limited, the medical model.

Pat: Even though your work is theoretically generic, you said you have a lot of clients who are traumatised.

Helen: Many suffer what would be called a 'discrete' trauma through the nature of their work though there are a significant number who have developmental trauma of some sort – sexual abuse, neglect etc. I think there are a lot. But then I'm not going to get a balanced view on that because I'm not seeing people here who do their work in the organisation without its causing them any problems at all – and we have a very large staff in a huge variety of jobs and levels.

Pat: With trauma having affected you the way it has you made an interesting comment about still being surprised "that other people can go through life not planning and preparing at some level for the death or the illness or the disability of their loved ones." I wonder if that's because if they are carrying an old trauma it has affected them in different ways, or if you're thinking more about clients who haven't had significant earlier trauma.

Helen: Probably both, but I do work a great deal with trauma and my expectations of having to anticipate bad things happening is something I still have to work at. That's something that I still live with it and I think that's quite an interesting contradiction because of course I'm very aware that choosing to do what I do and work with people that have been traumatised in a way keeps feeding that beast so to speak because I'm surrounding myself with stories and people that bad things happen to them. Yes, it's strange, because a major attraction of occupational health for me was working with healthy people.

Pat: So that was more of a conscious motivation than a move towards trauma counselling.

Helen: Yes.

Pat: As I read through the transcript I've become more and more aware that your traumatised clients roughly fall into one of two camps – developmental or discrete.

Helen: A lot of the latter are essentially healthy, emotionally robust who have experienced a discrete trauma, whether it's work-related or not, and therefore they are very good candidates for EMDR. And I am in the process now of practising that when I get the opportunity and finding ways of integrating that into my practice - absolutely fascinating - this idea of processing trauma but without having to tell the story again and again.

Pat: What about those you suspect of much deeper-seated trauma?

Helen: I think the challenges of that are: what do you do short-term? How do you support people to perhaps find what they're looking for longer term. In our short-term work I do quite a lot of normalising, reassuring, focussing on the here and now supporting people or trying to help them to see how much they are achieving, what they are overcoming.

Pat: You have a few long-term clients too.

Helen: I have worked with clients long-term in various ways, sometimes here, also in a small private practice.

Pat: I picked up that it was this kind of work which exposed you more to the risk of secondary trauma.

Helen: It kind of creeps up on you. I have to confess that my expectation of myself has been that I was trained to deal with anything because that's what I do.

Pat: Can be quite seductive, can't it?! I've sometimes felt that too.

Helen: That's made some of that work particularly hard, and I've had to learn to recognise my vulnerabilities and to look after myself.

Pat: Ditto.

Helen: But above all I still retain my belief in the capacity of the human being and spirit to heal and recover. And that includes me.

Pat: And me.

Helen: But I paid a bit of a price in that one experience of working with what I think was beyond my capacity. That's where supervision really comes into its own – I had lots over work with that client, and to some extent that is ongoing.

Pat: And even though that experience was quite bruising you said that you are now good at identifying the warning signs.

Helen: That client's experience was unusually horrifying. I think it took me a while to realise that actually I didn't have to do this and I think in the future I would certainly be able to recognise my limitations and realise I had a choice and that I didn't have to do that work if I didn't want to.

Pat: Like many such clients you recognised her dissociative process.

Helen: Yes and I worked with that. I became the person that she was able to be safe with in her dissociation, and there was a lot of healing work that came out of that of which she probably doesn't have quite a lot of memory because she was dissociated and protected. What took its toll on me was being alongside her beyond what I could ever have imagined that human beings could do to one another.

Pat: You mentioned that there were blanks in your childhood memory. But you said that it was particularly in your EMDR training that you came to realise that we all dissociate – that "it's a natural, healthy thing to do – at a neurobiological level to have a bit of a shut down and give ourselves a breather". Does that elicit any thoughts about dissociation in your clients?

Helen: From my own experience I can only imagine that it's one of the reasons that I have these blanks from childhood. My sister remembers more things than I do. Of course I don't consciously remember so that's really all I can say about that in terms of myself. With clients it seems to me that it's actually quite a positive protective post-trauma response, and part of the process. It's like it's a coping mechanism, and I

suppose depending on the degree and the severity of the circumstances that can work with them and for them, or can land them in trouble and make them vulnerable.

Pat: With this particularly challenging client you were aware of that positive side.

Helen: But from the therapeutic angle I believe that it's only because I was able to go to that place with that person that they have been able to get as far as they can in their healing. Unfortunately I think that's not recognised within the medical model or in a psychiatric hospital. But it's a hard place to go and not everyone has got the capacity.

Pat: And you wondered that although you'd learned about your own limitations you weren't sure if you would choose to go there again.

Helen: Yes, because it has changed my world view again, but in a way that isn't healthy for me.

Pat: I was struck by a phrase you used "I am on the alert for something happening" . That is in contrast to being surprised when it doesn't seem to occur to clients that their parents would die or something bad could happen.

Helen: I am genuinely, within myself, saying 'How could you not imagine?' But this kind of alertness doesn't dog me now as it used to. Like a lot of people what I do is I manage it. An example would be that at one time when my son went out and I thought 'It might be the last time I see him.' But now I just think it. I don't lie awake any more. You think 'Well, yes, that's how you think and these are the reasons why you didn't get on with your life'.

Pat: The image I have is of a scar rather than an open wound, as it once was.

Helen: Absolutely. And I'm aware that what I do involves sometimes irritating that, yes. It reinforces it because people come in and I hear stories about dreadful things happening to young people. But regardless of my own issues I'm increasingly optimistic about the human capacity to heal and recover. And also I've become more and more aware that because of my experiences I do what I do and also that I'm good at what I do.

Pat: I was wondering if your own history of dealing with dependent relatives might affect the work you do with clients who are struggling with similar issues. And you laughed!

Helen: Yes! I think I'm really good with those people! I have such a heightened sense of empathy and a well-developed internal supervisor so I'm absolutely in their frame of reference, whilst listening to myself and encouraging them usually to focus on themselves. They're there, what's that like for them, what does it mean for them, and how to keep a sense of their own individuality....

Pat: You said you were also aware that people who have long-standing illnesses – physical or mental – can become emotionally manipulative and self-centred.

Helen: Yes indeed, and it's quite insidious for the carer. So when clients are struggling with that I just try to help people to feel that they've got choices, they're not actually responsible for this other person. But a lot of healthcare workers have a very heightened sense of responsibility. I've got the T-shirt!

Pat: Maybe that's a danger for many of us as counsellors.

Helen: This is an area where supervision is so important, isn't it? Quite a lot of my clients here are in a similar age-bracket to myself, so as well as their caring roles at work they are often dealing with elderly parents. It's a regular theme for me to go to supervision aware that I'm seeing such and such a client and there are so many parallels with what I've been dealing with in my own life.

Pat: You said that in terms of working with trauma you expect a lot of your supervisor.

Helen: I do. I expect my supervisor to be able to meet me and to be able to hold that and work with me. But I enjoy separate group supervision for EMDR too, which is much more case-based. Others in the group are working with more extreme pathologies than me, and that's a learning experience. Peer events with my colleagues here too are good.

Pat: I'm fascinated by how as a person-centred therapist you interact so comfortably with people who are tied into the medical model.

Helen: I think there is room for diversity. It seems to me that they look for evidence within such a limited framework- it's only if it's RCTs[46] that the research is valid. So yes, that's frustrating, but I'm sufficiently sure of my own ground to be able to hold that diversity, make use of other insights, but without abandoning my own.

Pat: Your work setting allows only short-term contracts and you said there were limited options for onward referral.

Helen: That's getting harder, because everywhere the waiting lists are going up. There are fewer and fewer places offering free counselling. And the service we offer is only for our own staff of course. For the general public it's much harder even to get short-term counselling. There aren't many GP surgeries in this city that offer it, and where they do it's likely to be with a CPN[47] who's trained in CBT. Five years ago I wouldn't have been having talks with clients so much about the idea of paying for therapy but now I am increasingly doing that. In principle I wouldn't have done that before but I think very often it's the reality.

Pat: And specialist trauma therapy in the NHS in your city you said was offered only within very strict criteria.

Helen: Yes, and the developmental trauma that we've been talking about is rarely catered for.

Pat: There are the text-book definitions of trauma that criteria are usually based on, but I've been asking all the participants what their own personal definition is. This is what you said:

> "Unexpected ... and extraordinary event ... that either you don't have the resources and few means to deal with or, yes, ... so an unexpected or extraordinary event that takes us beyond our capacity and resources to deal

[46] Randomized Controlled Trials
[47] Community Psychiatric Nurse

with it, and to integrate it. And can often be threatening, life-threatening, literally or at least introduces us to fear and uncertainty"

Pat: We've also touched from time to time on the theme of 'wounded healer' and it seems that you are very conscious of it both in yourself and in many of your colleagues.

Helen: I remember saying that I don't think I've come across many counsellors who *aren't* wounded healers. It may be because wounded healers seem to be attracted to working in the care sector.

Pat: And for yourself, you said that you felt there was something of a strange contradiction in your optimism about clients' capacity to heal, and your being good at working with traumatised people.

Helen: The kind of contradiction comes in because I know, I've known, I've witnessed it in myself but also in others and that that is a very privileged position to be in and a journey to take with them and it's as if the same part of me that's damaged, and traumatised also needs to know that and to be part of that for myself and for other people.

Promenade to Chapter 7

In spite of the depth of suffering that Helen had experienced, I walked away from this picture remembering its pastel shades, which seemed to speak of a calmness created by reflection. From there I see the next picture beckoning with its strong and sometimes discordant colours. I am moving on to my experience of my meeting with Jane.

I remembered the interview. I was to go to her home for it. I reached the building and climbed several flights of stairs only to find that there were two unmarked flat doors on her floor. One was closed, the other open. Which was hers? No response from the closed door. From the open door, noises of voices and activity emanated. Unexpected. But yes, this was Jane's flat. Workmen were fitting a new kitchen, and she was in the midst of taking leave of a friend. Because of the renovations, I thought, the living room into which I was cheerfully ushered was very cramped and cluttered and while Jane waved me towards a chair, I looked hopelessly around for a suitable place to put my recording equipment (it ended up on the floor). Not the most auspicious of starts – Jane's was my first 'real' interview. But Jane could not have been friendlier and was more than willing to talk.

Jane presented me with the first of only a few unanticipated ethical queries. Her rejection of the invitation to choose a pseudonym was less an issue in itself, other than it could have aided the identification of her living mother. We discussed this in some detail, with its various implications, but she retained her choice to use her own name.

Chapter 7. Jane

7.1. Vignette

I probably came into counselling on a bit of a wounded healer route like a lot of us go[48]. In mid- to late-20s I had about four years of person-centred counselling which I went into because from my late teens I was quite anxious. I suspect I had generalised anxiety disorder that was never diagnosed. I was taken to the doctor once but it was never diagnosed and I never got any help with it. I just kind of got on with it as best I could. I was quite highly functional but was being a bit chased round the bed at night by various things I hadn't dealt with.

Going back a bit – family stuff - I became aware, probably not until my early teens, that my family were Jewish because my mother never talked about it. Nobody talked about it.

I was told initially by my sister that mum had been in a concentration camp and most of my relatives had been killed in Dachau so that was the first time I got to hear about it. I learned later that my mum's story wasn't quite like that. It turned out that she wasn't in fact in a concentration camp. She left Austria in 1938 on a Kinder train. Both her parents made a suicide pact. The plan was to get her out on a Kinder train and then kill themselves. They were both Jewish intellectuals and high up on the hit list. So she came to Britain aged five as a German-speaking small child with a lot of prejudice against anyone who was remotely German, regardless of whether they were Jewish or anything else. Went off to boarding school aged five speaking no English, and then she just had a catalogue of kind of most traumatic circumstances you can probably ever go through and yet (I'm going to get cross at this point) she's *never* had that suggested in any way in her psychiatric treatment whatsoever. It's *never* been addressed. She's never been offered any proper therapy for it. You know, she's probably got PTSD. Why wouldn't she have it? I'm sure

[48] "go", rather than "do" taken directly from the transcript.

she's got it. Having seen the effects on her though I developed my pet theory that my mum's mental illness is I believe caused by trauma.

When I was eight my mother had had a complete breakdown, became extremely unwell and was quite terrifying really. She was eventually diagnosed as being bipolar but it's my belief it was trauma-related. When I was eight she'd sort of lost touch with reality and did really odd things like picking my sister and I up from the cinema wearing a wig and things that really quite freaked us out but that she thought were very funny at the time. She was obviously having a bit of a manic episode, as I now know, but things felt very scary and she was sectioned after going round to my neighbours and saying the Nazis were coming. I just remember being *very* frightened of her and she was very angry and quite terrifying really. So she was hospitalised for a month. I did go and visit her there, at one point. She kept trying to run away. And so that was a very distressing episode. She came out after a month. I do remember feeling I don't even know if I want her to come back. She'd just been so sort of awful really and scary. My dad had done his best to cope but wasn't coping very well with two children and, you know, looking after everything. That obviously was a major source of anxiety for me and then things changed in the household after that. I didn't know this at the time but my dad apparently tried to commit suicide when my mum came out of hospital. Everything was very shoved under the carpet.

When my mum came out she was very, very medicated. That obviously helped to keep her level but she wasn't the warm empathetic sort of vivacious person she'd been before because she was on that very heavy dose of drug. I didn't really know that but I knew that she'd changed. She wasn't scary any more but she was also very subdued and her attention was mostly on my dad so, it's a bit of a dramatic thing to say, but my sister and I effectively brought ourselves up after that.

By the time I left home, home was a very volatile place, not knowing really what was going on. I did very well academically and just took myself off, but it left quite a legacy of anxiety which I suppose in a way was trauma-related because, my mum

would be very volatile and my dad didn't intervene even when she was out of control. He probably did his best but it was very unstable at home.

My dad also suffered from depression that wasn't necessarily trauma-related and I was fairly neglected actually. Anyway that's my background in a nutshell.

All this went on behind closed doors. I went to private school. I grew up in a very big house. My mum was a social worker. We didn't have any help whatsoever as a family. I suppose my anxiety surfaced when I was seventeen and studying for A levels. I did very well but I kind of overdid it. I think I was just so anxious to get out of the house and do well and get to university, sail off and have my own life and leave it all behind. I was pretty desperate to do that.

So in my 20s I found a really good counsellor who I trusted who worked on my family issues, bringing more out into light. I found that quite a transformative experience and I thought, well, when I'm a bit older - I was a bit young at that point - when I'm a little bit older it's something I'd be really interested in doing myself. My mum's a counsellor as well so I guess it sort of runs in the family a little bit. But it's primarily my experience of having personal therapy myself and the lasting effects it has on me. So I did a little bit of voluntary work at a telephone counselling service just to check out how interested I was and whether I thought I could do it and then went on from there. I suppose it took me about five years between doing a bit of voluntary work through to qualifying.

I was living in London at that point. I did a Gestalt sort of basic introductory certificate which was quite experientially-based. Didn't enjoy it very much but it gave me a bit of a flavour of what it might be like so I signed up for a post-graduate integrative counselling diploma at 30. I wasn't really sure about all the different approaches but integrative sounded like a good idea - it seemed like quite a broad approach. And it was a well-regarded course and fortunately I got on to it. I felt that I'd been accepted by the skin of my teeth - I think they thought I was too extravert to go into counselling training actually. I really enjoyed the course, and did that alongside work over the space of two years and another six months to complete my 100 hour client work which I did in a clinic attached to the University. Most of my

clients there were non-British, and some of the work quite complex, some with quite severe trauma issues – kind of scary. But when I look back at my basic training I don't remember trauma being actually touched on directly at all. That came later, after I'd qualified.

I moved from London and started work for an employee assistance programme (EAP) initially just one day a week as a bank worker. I was fundamentally a fund-raiser at that point but did bank work as one of their telephone counsellors. I really loved the counselling and sort of switched to doing that as my main focus. The work was solution focussed brief therapy, and most of it was trauma-related. In all I did that for 11 years.

I am now living with my young daughter in another town where my mother is now living in retirement. I am doing some general counselling work, but have no particular desire to specialise further in trauma counselling.

7.2. The Conversation

Pat: Good to see you again, Jane. I've been looking over the transcript of our interview and wonder if we can have a conversation about it. My idea is to look first at some of the feelings you expressed, and then at the reflections you offered.

Jane: That sounds OK, but I'm sure I missed a lot out. We only had just over an hour after all, to talk about my whole life!

Pat: True, but perhaps we can still work out some of the things that are particularly important to you as we talk….

Feelings

Pat: One of the things I noticed is that you speak about your childhood experiences – your trauma story – with a lot of passion. The bare facts don't really do it justice,

which is why I've tried to reflect some of the emotion of your telling in the 'ghostwritten' section I sent you to look at.

You start by recalling your mother's "complete breakdown" when you were only eight and how she had been diagnosed as suffering from bipolar disorder. I wonder if you remember some of the words you used to describe your own feelings at that time.

Jane: I think I can, especially feeling anxious, but remind me.

Pat: Yes "anxious" and "anxiety" were words you used 14 times in the course of our conversation. But recalling your childhood and teen years you used even stronger language:

> "quite terrifying" (twice) and "scary" (twice) – of your mum's behaviour
>
> "freaked us out" – of your reaction to her bizarre actions
>
> "very frightened", "distressing", "awful" and "desperate".

Jane: Oh yes. Home was a volatile, unstable place and mum's time in hospital almost seemed preferable to her being at home. Dad did his best but being so depressed himself seemed to make him incapable of giving me and my sister the support we needed. I remember her shouting her head off in a really sort of out of control kind of way. My dad didn't intervene. I don't think he was up to it really. And after she got back from hospital my sister and I effectively brought ourselves up.

Even though our mother's frightening manic behaviour was suppressed by medication and she was subdued and wasn't scary any more I was very aware that she had changed. Now mum focussed most of her attention on dad, not on us children. I felt fairly neglected. I guess my family was very dysfunctional. You know, I laugh when I say that, but there's something inside which felt very unprotected too. Home was a place where I was not knowing really what was going on.

Pat: I sense the desperation of a child who has no adult carer to turn to, putting a brave face on it, 'coping', but beneath it confused and hypervigilant, her laughter an attempt to conceal this.

Jane: mm. I guess. But I enjoyed schoolwork, even though I kind of overdid it when it got to A levels. For me studying was something of a refuge. It was a gateway to escape from home and make a life of my own.

Pat: I get the impression that you were a bright child, got to university and did well. But also that you carried with you some of the anxiety you'd experienced at home when you 'escaped'. It must have been troubling you a lot by your mid- to late-20s. You had a friend who recommended a counsellor he'd seen and trusted and suggested you go and see him.

Jane: Yes I remember being so anxious going for my first session. But my friend's confidence in the therapist helped, and there was also a part of me – the more risk-taking part – that was saying 'give it a go'. I guess I was bothered enough about the insomnia – maybe not just the insomnia but also needing some kind of answers. One question I often asked myself was 'am I really highly strung?' Looking back on it, yes, I think that it was just part of my make-up to want explanations. And it was the time I had with this therapist that helped a lot in disentangling some of the family issues and allowing me to see how all that had happened had affected me.

Pat: I can believe that. I sometimes wonder if one of the down sides of having a high IQ is that it makes it particularly annoying to be unable to use reasoning to explain feelings that we don't like.

Jane: Anyway, I never imagined that I'd be four years with that counsellor!

Pat: I remember your laughing when you said that. I also noted that as you laughed you said "It's quite a long time, isn't it?" – almost as if you were uncertain of my reaction and were looking for some reassurance?

Jane: Oh! Ouch!

Pat: No offence meant. Maybe I'm projecting a bit there because I've had a whole lot of therapy too – more than 4 years – and I remember going through times feeling, yes, almost ashamed about its taking so long, that there was something either seriously deficient in me, or that I was being self-indulgent. Certainly not something I told many people about. So even if you did want some reassurance, I'd have understood. We might talk about this later, but shame is something I've become interested in in the context of trauma counselling. I've come across it so often, as I expect you have.
As with your therapy, you recounted little in the way of your feelings during training. You said your move from therapy to counselling training had been cautious, trying out some voluntary work first to see "whether I thought I could do it". Would your interest be enough?

Jane: If I showed ambivalence about continuing with training it might have had something to do with the certificate course I did as a 'taster'. I didn't enjoy it very much. But I was interested enough to apply for the integrative Diploma course – maybe, when I think about it, just a little bit like the 'give it a go' attitude that helped me overcome my fears of going to see a counsellor – and I did enjoy that.

Pat: Like I said, I noticed that you had little to say about your feelings during training – at least the classroom-based work - but you said a lot more about them when it came to your counselling practice. This was your first real experience of sitting in the counsellor's chair of course.

Jane: And talk about challenging! My 100 training hours were in the University clinic and most of my clients were cross-cultural, some of them with seriously traumatised backgrounds. I found it really interesting but I felt I'd been thrown right in the deep end and it was kind of scary.

Pat: I noticed that you said "kind of scary". I'd have been terrified! My training clients had been reasonably well triaged.

Jane: We'd only had a little about trauma when taught about CBT, but otherwise nothing that really prepared me for full-on torture or domestic abuse situations.

Pat: Here's one you told me about - a Kurdish lady who had been tortured before coming to Britain. You said:

> "had about five or six sessions with me where she just sat and wept, wasn't really able to talk about it. I was a bit freaked [*laugh*] by the whole thing. I was thinking 'Gosh I'll end up thinking about torture and sort of I haven't really been trauma trained'"

and

> "I … just sort of felt completely out of my depth and just thought I have got no idea what to do with this."

You know it really impressed me that you were able, as a student counsellor, to sit with someone for 6 sessions, even when feeling "freaked" whilst being unable to 'do' anything. I wondered if there might be a connection with your childhood learned behaviour of just getting on with it, with the expectation that you would have to find your own resources and deal with whatever was thrown at you rather than addressing the difficulties by seeking help.

Pat: Your first job in counselling was with an EAP company which had a particular focus on first response to traumatic incidents. As your counselling work increased there you gave a number of illustrations of the emotional effect that work had on you.

You said you "loved it" and stayed in that job for eleven years, but some incidents stood out for you because of their intense emotional effects. Like this passage:

> "I was involved in debriefing people who'd witnessed, who were part of the London bombing 7/7, you know, I mean those are probably the most dramatic ones that I can focus on but, people literally coming, calling up in the middle, you know, having just been on the bus that was bombed, you know, screaming about bodies, and blood, bawling…"

What struck me particularly was that you felt that your familiarity with London allowed visual images to come particularly easily to you. You used some words which are easily recognisable as classic trauma symptoms in describing your reactions to these calls:

> "hypervigilant"

"raised anxiety levels"

"overly responsible"

"incredibly sort of angry"

"difficult to forget"

"intrusive imagery"

Jane: and that was some six years ago, and the memories are still very vivid.

Pat: and there was another "dramatic" incident – a client who had suffered a serious knife attack –

> "the sort of feeling like 'I wish I didn't have to listen to this' [*laugh*] and there's no space to withdraw especially on the phone with somebody. They're right inside your head."

You described the experience as "incredibly intrusive" and the session as one which "stuck with" you.

You know, when you were talking about insight into the enhanced intrusiveness of telephone communication a very recent incident came back to me. A client was describing abusive phone calls from a relative over many years and the way they affected her. Without the assistance of non-verbal communication from any body part other than voice my client, like you, felt that there was indeed no space to withdraw.

I'd had to clarify this with you, but as I understand it you had a mixture of telephone work at the EAP. Most of it was "one-off" in which clients were still "in the thick of things" but you also had some clients who were contracted for up to six sessions.

Jane: Yes, and although these contracted clients were often very vulnerable, I found that work much less intense than the one-off calls from people who had, for example, just found a body. In that type of crisis telephone work you get the full force of the blast of what's happened, with no time for reflection and one in which you're caught up a little bit in the sort of horror and the helplessness of the situation in a way.

Pat: Near the end of your time working for this company, you had a co-ordinating role in assigning counsellors and liaising with managers in a large multinational

company during a very major hostage crisis in a plant overseas. You said you had found the work, as you had hinted before, very interesting, but the price you paid was high. Some of the phrases that you used were:

"the stress levels were just sort of through the roof"

"time pressure around it"

"level of responsibility"

"at one point I ended up shouting at my poor daughter."

"I thought 'God I really needed a bit of a safety valve' "

"and I ended up sobbing" (all through a show you went to one evening)

What a vivid picture of your state of mind through this crisis. I felt I was right there with you.

Reflections

Pat: Looking back reflectively on your childhood and teen years, you believe you were suffering from chronic anxiety caused by your mother's volatility and your father's inability to support you and your sister because of his own depression.

Jane: Yes, but I believe he probably did his best but in the face of mum's illness it wasn't enough.

Pat: You were graphic in describing the confused emotions in your childhood, but you understood more as you grew older. You were convinced, having heard more of your family history, that your mother's symptoms were trauma-related, for all her clinical diagnosis was bipolar disorder. And that is something that clearly made you angry.

Jane: Yes she *never* had that suggested in any way in her psychiatric treatment whatsoever. It's *never* been addressed. She's never been offered any, offered proper therapy for it. You know, she's probably got PTSD. Why wouldn't she have it? I'm sure she's got it. Never, you know what I mean? She's had no diagnosis and *no* help

I just can't believe that none of the medics even asked questions about what she'd been through as a child or apparently thought it relevant. *So* frustrating!

Pat: Something else that stood out for me was one that you referred to at least three times – that was the 'secret' of your mother's Jewish origin and the links you make with her symptoms and trauma. You said:

> "the fact that it is a secret I think that ties in with the trauma doesn't it really?"

You first heard this secret when you were 13 or 14 "only really because [your] sister blurted it out". Having been brought up as Christians this was a complete surprise to you. I wonder if this secrecy might have extended to other things like aspects of your mother's (and maybe your father's) illnesses. Here are some of the phrases you used:

> "Everything was very shoved under the carpet"
>
> "It was all behind closed doors."
>
> "Nobody talked about it."

I imagine the confusion of a thoughtful child who "just kind of got on with it as best [she] could" while at the same time, your parents were desperately trying to shield their daughters from truths that they could neither fully understand or bear themselves. Even if it proved damaging to you in the long run it is not hard to imagine that your mother's strategy, conscious or unconscious, of coping with her own trauma at the age of 5 would be denial.

Jane: mmm … I guess that could make sense.

Pat: I also wondered if there might have been echoes of secret-keeping in your own life in comments like:

> "in a way it's [my mother's diagnosis] none of my business" and

> "I'd sort of tried to put my family stuff in a box and kind of — [49] that's not me and I'm going to do something different"

In conversations with your parents in adult life "trying to work out what happened" it seems that some of the secrecy had been relaxed, and by the time we met you felt very strongly that none of your story should be hidden. You even chose not to use a pseudonym, and said that

> "[trauma is] very under-diagnosed. It's not talked about. So actually I'm kind of— my perspective on it is 'let's bring everything out into the open'. It depends on how people feel about being brought out into the open if you like, but I think it's helpful to be really aware of it."

Jane: Yes. Too many secrets. But to be fair my childhood wasn't all bad. I developed my own ways of coping even though we kids had effectively brought ourselves up. We didn't have any help whatsoever as a family but I had some good friends and I had friends whose parents whom I kind of adopted a bit. I was asked to go on holiday with other people and I was also quite good at finding parents even at that sort of age so those sorts of things helped. And studying was also a bit of a refuge ..... it gave me something of my own.

Pat: When we spoke about your experiences of seeing a counsellor you said this:

> "I guess I completely lacked a dad really when I was growing up although he lived in the same house as me. So it sort of was that classic dad-like figure"

That really touched me – the bit about dad living in the same house but not really being a dad. Something very poignant about that. So no wonder finding someone who fulfilled some of those very normal child needs, even once you were an adult, felt good. Here was someone you trusted because of your developing relationship with him and not now just because your friend had trusted him and had found him helpful.

[49] In this and other direct quotations from transcripts I use ellipses (...) to indicate missing text, and em dashes (—) for running speech in which the speaker has markedly chosen not to finish sentences or phrases before switching to another thought. These em dashes are used to highlight instances where such interruptions are particularly marked to distinguish from normal short pauses where commas are used.

Jane: Yes I guess that was what enabled me to talk at depth with him about my family issues – thing I hadn't really been able to work through with friends, and certainly not with relatives. I think I'd recognised already that my family was dysfunctional but hadn't really made many connections between that and the anxiety which I'd been experiencing over the years.

Pat: We'll talk about your training in a moment, but I wonder how much influence your therapy had on your decision to train as a counsellor.

Jane: Lots! I would still say that my positive experience as a client was my primary reason for taking it further.

Pat: Some people learn a lot about themselves during training, but you indicated that you hadn't had many surprises in your counselling training. You said you thought you had "kind of got most of the skeletons out of the closet when … doing [your] own therapy." I can relate to that – I learned a huge amount in training, but it was more about personal development in the present moment than about understanding the confusing feelings and reactions emerging from my personal story. In fact I don't believe I'd ever have thought of counselling training if I hadn't been a client beforehand and worked through so much stuff.
I admired the fact that you weren't put off by your first rather negative experience of your certificate course.

Jane: No, I hadn't liked it much, but maybe it was because I'd had such a good experience as a client that I knew that there would be something better out there.

Pat: You told me a funny story about your interview for the Diploma course – how the fire alarm went off in the middle and also how you were convinced that the interviewers must think you were far too much of an extravert to be counsellor.

Jane: Yes I felt very lucky to get in and I thought that what had done it was telling them that I liked lurking in the garden thinking. They must have realised that I had some potential for reflection. I still feel I got in by the skin of my teeth!

Pat: More seriously though I imagined you at your college interview with that old anxiety threatening to take over. I'd imagined that you were maybe suppressing anxiety by talking too much, embarrassing yourself and projecting that disapproval on to your interviewers. Being honest, not knowing you, I had wondered if your talkativeness in our interview (welcome I may say – there's nothing worse than a respondent who gives monosyllabic answers!) was an echo of your college interview. So that rather than the extraversion you expected to be seen as inappropriate in a counsellor your presentation might have had more to do with anxiety.

Jane: mmm. Maybe, but I still consider myself an extravert.

Pat: I'm not disputing that – and many parts of your story would back that up. Indeed I doubt if a classic introvert like me would have either survived or even contemplated doing some of the things you have – you won't catch me swimming with crocodiles as you did on your trip to Australia! But even introverts can talk a lot. My friends would agree! I love a quote from Kierkegaard where he says something along the lines of 'silence hidden in a decided talent for conversation is silence indeed' (Dru, 1958, p245).
Most of your reflections on your training are around your clearly quite challenging client work. You had little memory of trauma having been covered explicitly in your course.

Jane: Yes, I think that was quite strange in itself. And when faced with traumatised clients I suppose I felt quite ill-prepared really apart from having general counselling skills - listen, and support, accept and do what you're trained to do.

Pat: But looking back you still seemed to feel that your quite difficult client work was "great learning", even if trauma had not been explicitly integrated in your basic training.

Jane: True. It was in my later employment that I was given specific trauma training, initially in psychological first aid, which was a large part of the work my agency did. We were also trained there in Mitchell's critical incident debriefing (Mitchell, 1983) though I believe it has been discredited (McNally, Bryant, & Ehlers, 2003; Paterson

et al., 2015) and is no longer used, and I did various refresher courses. My own reading has also been an important part of learning about trauma.

Pat: It seems that your exposure to the extremes of immediate critical incident trauma work almost eclipsed some of your other experiences of trauma counselling. In spite of having described some very challenging client work when a student you said:

> "the first hint I had really of trauma was dealing with traumatised clients on the phone at [the EAP company]"

And it took a reminding prompt from me for you to make a link with your earlier face-to-face work.

Jane: I guess it's maybe a time thing. My student placement seems such a long time ago and my EAP work has so dominated my life for the past 11 years that the trauma counselling I did there was foremost in my mind. There's maybe a sense in which I see those experiences as being so very different from each other just in the way we worked too. Looking back the transition from long term face-to-face to telephone counselling was strange. And now I've maybe been going through the reverse process, having left the telephone work less than a year ago. So maybe that's strange too, and has taken more processing than I might have realised.

Pat: But to go back to your critical trauma work – you reflected on its effects on you at the time in some detail. Here's one of the things you said:

> "it is quite anxiety-provoking work and I think my levels were probably higher than some people's"

You noticed your "rescuer" side being activated, and with it becoming "a bit overly responsible". You recognised vicarious trauma symptoms of hypervigilance and anger too. Interestingly your anger was directed against the organisation for giving the staff inadequate support whilst they were expected to engage in very intense work. But you made a connection there with your own trauma experience:

> "It was probably a bit of a throwback to dealing with the trauma of my family getting absolutely no support or help with that."

You were holding quite some tension though, because you also said that you were "able to work perfectly professionally". You didn't comment on the contrast here, but I had to wonder at the stress generated by the splitting necessary to maintain your professionalism whilst suffering from some level of vicarious trauma on top of a degree of re-traumatisation.

Jane: Something I remember talking about is counselling folk caught up in the London 7/7 bombing.

Pat: Yes, and what really stood out so clearly for me about that are your descriptions of how you are very sensitive to sensory stimuli. You could easily visualise the scenes described to you, and many were horrific. Your visualisation was enhanced in that case because you actually knew the geographical context:

> "The London ones for me particularly bad - buses I'd been on. Places I know. I've friends who live there. I lived there a long time myself so it was very close to home."

Jane: Yes, that's so true. Sometimes I wished I didn't have to hear what was being said to me but I know that it can be an important part of their healing for clients to offload the awfulness of what they have just experienced and pass it on to a listener.

Pat: Much of your work was offering psychological first aid in 'one-off' calls. Sometimes these were quite stressful, but you also said you had some more routine work where you gave holding support over more than one call to clients who had recently gone through a trauma such as rape or an accident. Of these you said they were

> "less traumatic for me in a sense. I mean they maybe concerned me more than other clients because they were particularly vulnerable but it was probably—but less intense than dealing with the one-offs which were very much sort of in the thick of things - 'I've just found the body', or, you know, or whatever."

Jane: Yes much of my telephone work was either 'one-off' or a few contracted sessions. But very near the end of my time with the EAP I was given a rather different and incredibly stressful assignment – and I wasn't even directly involved in counselling. I was tasked with co-ordinating a response to a very major incident,

arrange for some 200 on-site debriefings, liaise with employers of the people directly involved – who were in shock themselves, but trying to do the right thing whilst completely outside their comfort zone – and field my own managers' anxiety about whether or not they were doing a good enough job. This tripled my team's workload. My stress levels were just sort of through the roof for the 3 weeks of the crisis.

Pat: I wonder if you remember how you put it:

> "Oh God I must have been bottling up an awful lot of— I know you shouldn't do it but when you're in the middle of it and you've got no time off. And then we were doing overtime and stuff to try to deal with the volume of it. But what are you meant to do? You can't just like push a button and go and hide in the toilets always."

Pretty graphic! And this was the time that you lost it one day with your daughter over something trivial, and when you did take some time out to go to a show you sobbed all the way through it.

Jane: All in all my experience at the EAP left me wondering if I had as good defences against working with trauma as some counsellors might have.

Pat: But I asked you too how you did cope – what resources you drew on to see you though. You said you are by nature a very optimistic person. And you have a sense of humour, albeit graveyard type humour. And you connect well with other counsellors and friends so that within confidentiality limits you're able to offload, over a cup of coffee, chat and laugh. You said another important thing too is your awareness of your own reactions to trauma. You said:

> "The fact that I … hopefully to a greater extent to have dealt with my own earlier traumas, if you like, means I suppose … if I get really angry or freaked out by something I'm kind of usually aware of 'well that's what's likely to happen' if you know what I mean so I'm quite prepared I think which doesn't make it any easier but at least you have a bit of insight which is helpful because I've been like OK. I'm not going crazy sort of, you know, basically understanding a bit about trauma, I suppose, you had yourself, is useful."

Jane: Yes, and my training in trauma debriefing gave me insight into how acute trauma affects people. Much of my work involved "holding" people and checking to

make sure that they were looking after themselves, but I have learned to recognise that different traumas may affect people differently.

Pat: I guess that helps you in two ways – one that you are less likely to be phased by some of the unexpected responses folk have to traumatic events, and another that you won't project your own past reactions on to clients.

Jane: I've also found some client issues that come up are ones I don't know much about and that's spurred me to read up about it. I find that not only interesting but also helpful in my work with these clients, like one for example who was a victim of stalking.

Pat: And on the subject of the different effects of trauma, you said that had been the most helpful aspects of a number of courses you'd been on, more, I think, than what they offered in the way of specific skills.
We talked a bit about your reflections on the difference between your short- and long-term work. Of your long-term work – and of course that's really mostly in the context of your student placement work, and perhaps very recent work since you left the EAP – you said:

> "I suppose you get bits of the searing trauma in there but you also perhaps have feelings and thoughts and experiences that have perhaps been a bit more worked over and then you have hopefully the time and the space over a number of sessions to be able to work with that person on them amongst other experiences that they've brought, in a more sort of thoughtful, less time-pressured kind of way. Doesn't make it easy, but it does mean that, you know, between sessions hopefully having supervision to ….. take what you're experiencing to."

Jane: Yes, and the contrast is with fielding the full force of the blast of what's happened in my crisis work, and the lack of opportunity for follow up which leaves the 'what happened to that person?' question hanging in the air.

Pat: I have a sense that until you left the EAP company you were, in your words, "so caught up … in the horror and helplessness of the situation" of your clients that you had not really had much opportunity or emotional energy to reflect as you now have. Now you speak of being more aware of the feelings of loss of the many clients you

had to refer on, and the contractual limitations to your real desire to sit with clients and work through more buried traumatic material which might be affecting their current reactions. And I noticed that as soon as you'd made these comparisons you recalled your encounter with the torture survivor during your training. Then you had felt completely out of your depth. You described the client's life, and attendance, as "chaotic" and recognised that the you were quite chaotic yourself – listening and empathising, but otherwise not knowing what you could do, not knowing if you were being helpful at all.

Jane: Oh, yes, I remember those feelings so well and I was convinced at the time that ten years wouldn't have been enough time to sort of deal with it properly" .

Pat: When you said that I sensed some conflict between your much more experienced counsellor self, and your student counsellor self. Memories of the profound discomfort of working with your earliest trauma client are still very vivid.

Jane: You know, trauma work is not what I would have deliberately chosen.

Pat: Yes, you actually said that twice during our interview.

Jane: In a sense I didn't have a choice really with the job I did, and I wouldn't choose to work with trauma as a specialist and I think because of my, you know, experiences.

Pat: In context, the experiences you referred to are of your reactions to your most recent highly stressful incident management role. It was after remembering that that you said you'd wondered about the possibility of having comparatively lower defences due to your own trauma history.
Traumatic dissociation is something of which you appear to have more theoretical that experiential knowledge. You had no recollection of dissociating as a child, though you supposed that you probably did, and could only think of one incident in adulthood that you attribute to dissociation.

Jane: Oh yes – the crocodiles! My reaction was so bizarre.

Pat: You were a strong swimmer and had rescued a friend from a crocodile-infested river when on holiday in Australia. On reaching dry land you had become hysterical.

Jane: Yes, it was so bizarre, so inappropriate. I couldn't stop laughing. I felt absolutely numb. I felt completely dissociated.

Pat: Yet when you relate this to your experiences with trauma clients you said you don't remember encountering anything similar in your face-to-face work, but that you had seen unexpected reactions in your telephone work. I was thinking of dissociated affect when you said:

> "inappropriate reactions to a situation or somebody speaking about something in a way that is so flat and so sort of like dismissive and you just think 'God, you know, you — yes they've obviously really cut off from … the force of what it is that's happened to them. … It's really obvious when it's happening. It's just that strange disjunction between what someone's saying to you and the complete casualness or, or blaseness in the way that they're talking about it."

Near the end of the interview, in a way to return to our starting point, I asked you for your reflections on the term 'wounded healer'. You said that your initial attraction to the project was the theme of wounded healer and described your own route into counselling training in those terms:

> "I suppose having experienced a lot as a child (and I don't suppose my adult experience hasn't been completely trauma-free either) I kind of entered into counselling. I was partly attracted to it probably because, you know, I'd been hurt myself, as it were, which heightened my interest and empathy towards other people who maybe hadn't had the same kind of wounds but other kinds of woundedness. … It's something about vulnerability, I guess."

Jane: Yes, having experienced vulnerability myself I have a sense with other traumatised people of all being in it together. (Goodness, that sounds like a politician speaking!). That's when I'm sitting in the counsellor's chair, but I had a bit of an experience of the value of that when I went for occasional top-ups to a therapist when I was working. Although she had not shared much of her story because she was there as my therapist rather than something else she had said enough for me to

know that she had a similar Jewish family background of war-time flight. Even knowing that much helped me in a way.

Promenade to Chapter 8

The strong colours of Jane's picture were striking but also disturbing. Some of them clashed, like words tumbling out so fast that they included unintended double negatives, as in the last quotation. I walk away with a sense that Jane still carries quite a bit of raw pain, for all it is bravely born.

I move on to a very different picture. Like Helen, Morag was the head of her service, and a very experienced counsellor. Once again I felt on the weaker end of a power balance – but again this was, as counselling jargon likes to say, 'my stuff'. Morag's organisation had taken part in other research projects and she told me that she had a commitment to research and was glad to help. When I arrived, also like my appointment with Helen, I had a little difficulty finding the building, and when I did I wondered what I was coming to. The entrance was down a dismal narrow pathway to a back door. But inside was bright and welcoming, as was the room where we met. Morag too was welcoming, but I sensed a guardedness in her disclosures, albeit some were of a very personal and sensitive nature. In particular, although she reflected in some depth on her work with clients she gave no examples. While I had to respect that, on the assumption that she took a very cautious line on confidentiality, I left the interview feeling that something was missing. Perhaps it was the matter of context, which by that time was becoming clearer as a focus for my research.

Chapter 8. Morag

8.1. Vignette

Morag: It seems useful to give you a few facts before we talk. About 30 years ago, I was on my way home one evening and I was jumped and raped by three men. I couldn't bring myself to mention it to anybody or even to think about it for myself. When I reflect on it now I can see *all* the hallmarks of trauma, but didn't then. I started to have very bizarre perceptual experiences which didn't even seem to have anything to do with the rape itself and bit by bit I became I suppose more and more psychologically isolated - I was having flashbacks, freezing up in the street for no reason. I wasn't even feeling panicky or anything like that - it was just lots of stuff that was very strange to me. Eventually I was taken into hospital and was there for 4 months. What I came out with was a very jumbled frightening set of memories I suppose from way way way back and a big uncertainty at times about how much of these could be real, how much of them might be the product of the rape, how much was just kind of *fear*-based and produced by being fearful.

I was in and out and in and out of hospital for about a year and a half, mostly in, and I ended up in a long-term ward for about 5 months. It was kind of like in the space of six months my life just completely changed. It was a bit of a sort of dead zone - they didn't really do anything and most of us were drugged up to the eyeballs anyway. I think it was the lack of what I would call interference - I think it would probably be classed as intervention - that allowed me to *very slowly* start to realise that my life *was* different now from what it had been a year or so ago and what was I going to do about it? My section had come to an end so I refused to take the medication any more and I signed up for quite a sort of low level student training course at a local college and later to do some voluntary work. I just needed to see whether I could get out there and be around people other than psychiatric patients. I could, and after a while I applied to train as a psychiatric nurse. The training hospital was *highly* traditional in terms of hierarchy and attitudes to patients and this didn't sit very well with me and a couple of years in I started to do a counselling skills course

because I thought it would improve my communication and of course it really highlighted for me that there's a whole different way of responding therapeutically and the hospital wasn't for me but this was. I didn't actually finish my nursing training.

I had a *huge* amount of therapy before my counselling training, while I was nursing, and during training and afterwards - about 7 or 8 years. Some therapists stand out in my memory because they were exceptional in my experience and that's excellent. There were quite a few of them who I felt embarrassed on their behalf. That sounds a little bit patronising but that's how it was. What was particularly important to me was that a therapist believed, even if I didn't, in the equality of the relationship, and that the therapy was relevant.

I've been really lucky as I went through my training and afterwards in terms of jobs kind of opening up. My personal experiences have probably had something to do with why I've ended up in my current job working with people who have experienced trauma, but I've previously had posts in workplace counselling, in addictions and in mental health and I've loved doing all of them. I didn't purposely choose trauma work – it just happened. Even in my private practice I would say the *majority* of people who come to me have quite a lot of severe problems from complex PTSD but I don't think I'd miss it if I were working in a completely different type of job, even though I like what I do.

8.2. The Conversation

Feelings

Pat: Thanks Morag for being willing to discuss our interview now that I've transcribed it.

Morag: that's fine

Pat: If I may, I'd like to look first at the feelings you expressed, and then at the reflections you had. The first thing you spoke about wasn't your childhood trauma but the awful rape experience you had as a young adult which seemed to trigger locked-up issues from the past.

Morag: The actual events of the rape were terrifying, and extremely painful, and disgusting and left me feeling very fragile but my reactions were pretty weird. First of all I couldn't bring myself to mention it to anybody or even to kind of think about it for myself. I could have – there were people I could have spoken to but I just didn't. Talking about it just wasn't on the radar. I didn't even feel stunned, I think I just felt a little bit hazy.

Pat: It was at that point that you were admitted to hospital

Morag: I was there for about four months. I came out with confusing memories that seemed to be from a long long time ago. At times I was uncertain if they were real, or were just kind of fear-based and maybe the product of the rape.

Pat: You said you were in and out of hospital altogether for about a year and a half, though you said you were "hazy" about the time scale. You thought that you were finally in a long-stay ward, sectioned, for about six months.

Morag: Yes. It just seemed like I'd been parked there.

Pat: You said you objected when people wanted your attention, and that you were "embarrassed on their behalf" and that "human interaction was just too much".

Morag: Yes, difficult to put into words really.

Pat: I get a sense that you were in your own world – later on you talked about the importance of relevance to you – and that the staff in the hospital were in a way intruding into that world in a way that was both mildly irritating and just irrelevant. Maybe your embarrassment was to do with their inability to recognise that. I asked you at that point how you felt then as a person.

Morag: I don't think I did feel like a person at all. *All* my emotions and perceptions in relation to the outside world were very blunted.

Pat: That would tie up with a split between your inner and outer world, wouldn't it?

Morag: I think the medication had a big part to play in that.

Pat: You made an interesting comment about the difference between the hazy and confusing memories of early trauma and the rape which triggered them. You said that while the events of the rape left you "feeling very fragile":

> "They didn't have that awful power that the childhood memories had ... They had less power to define me as a person even though it kind of seemed to emphasise certain things. ... I kind of thought that what had happened ... seemed to have a beginning and an end ... whereas the other stuff it just seemed like it was marking out my life."

Morag: It seemed almost like a spiritual contest.

Pat: I was fascinated that with your pretty negative experiences in hospital that not only did you choose to train in psychiatric nursing, but to do so in the same place. I said then that I perceived you as brave.

Morag: but it didn't feel like that. I think I do have a big thread in my life, that's about escape. That obviously goes back to childhood stuff. So I'm not sure that there was a lot of courage involved. I think it was just sort of 'I got out, I have escaped' and so I can now do it.

Pat: I'm still musing about whether that's about escape enabling you to get on with life as if the bad stuff hadn't happened, or about escape bringing with it a gutsy kind of "I'll show them ...."

Morag: I'll leave you to your musing!

Pat: I've been talking about your times in hospital in the context of trauma rather than therapy but in another sense it maybe should be considered as therapy, whether helpful or not. Before discussing your own therapy beyond that, so I'll just mention the things in your hospital experience that had some impact on you.

Morag: Overall, "impact" is *not* a word I'd use!

Pat: Well, OK, point taken. The thing you said was most helpful was "just being left in peace".

Morag: Yes, particularly in the last long-term ward I was in. You asked me if I had thought then that there were any other form of therapy which might have helped and frankly it didn't cross my mind.

Pat: You weren't even sure what the staff were trying to do.

Morag: I knew that sometimes some of the nursing staff and occupational therapists were trying to do something but I didn't even know what it was they were trying to do because, without wishing to kind of sound condemning of them, whatever it was they were attempting was just so short of the mark. It was like watching a child try to build a bridge over a large estuary.

Pat: Irrelevant again? So maybe not even worth trying to puzzle it out. When you were discharged (or more accurately when your section ended, you said) you were a lot more ready to face the outside world.

Morag: Yes, I did test the waters though by doing that college course, and some voluntary work. I just needed to kind of see whether I could actually get out there and be around people other than psychiatric patients and get up in the morning and do my stuff.

Pat: And it was after you'd gained some confidence that that you took up your nurse training. I gather that you first became a counselling client during your training.

Morag: Yes, and for years after that too. In my second year of nursing training I wasn't really impressed with it at all. That was when I started to do a counselling skills course because I thought it would improve my communication.

Pat: The course was a bit of an eye-opener for you.

Morag: Yes, this seemed to be for me in the way that the hospital's way of responding to patients wasn't.

Pat: After hospital, over quite a long time you went to several therapists.

Morag: Often they were people that other folk recommended. Choosing one for myself was a big kind of task for me. That was not something that I managed to do. There were a few in my mind who obviously stand out because they were exceptional in my experience and that's excellent. There was quite a few of them (oh this sounds patronising) I felt embarrassed on their behalf. Their approach just didn't help.

Pat: You described yourself as "such a disaster" in your nursing training, and when you went into counselling as a client that your life "in many aspects was just a bit of a bombsite at that time".

Morag: I absolutely wanted to see if it was possible to have even a bit more than that so it was terribly important to me that they could kind of grasp something in what I was doing rather than just go through the motions. I was questioning myself while I was with these counsellors like I question myself about everything. I had a sense that this was very serious for them and even though I didn't think that my life merited that kind of attention I think still it seemed like if they took it really seriously then they must have an idea that this could go somewhere.

Pat: You portrayed yourself as quite wary in your counselling sessions.

Morag: I was actually so withdrawn. I could appear to be quite receptive but within myself I was so extremely hesitant even to think things rather than to voice them, because I was terrified of thinking the wrong thing. It seemed like the road to hell - if you start thinking the wrong thing you're done for, so even to kind of allow myself to start to register certain things seemed to require a an immense seriousness of relating.

Pat: You mentioned "presence" too.

Morag: Yes. Communicating and presence I suppose on the part of the counsellor, somebody who kind of embodied the thing. That helped so that it isn't going to be a

bit of a battle of wits. But it's all a long time ago and it's so difficult to look back into that experience.

Pat: Looking carefully through the transcript I became aware that your own counselling training hardly featured at all. Perhaps I could have pressed you on that more than I did, but it's interesting to me that you didn't choose to make direct reference to your own training.

Morag: I don't remember your asking so I thought it was probably irrelevant.

Pat: Touchée! You did say a bit about your nursing training, which you didn't complete. You were clearly unhappy there. You found the hospital very traditional and hierarchical and found yourself "constantly in conflict of one kind or another".

Morag: I just couldn't not think what I thought.

Pat: In contrast, you spoke warmly of more recent training in EMDR.

Morag: Yes, I like it, but I use it with caution. I confess that sometimes I have used it out of utter desperation, even though my heart has almost been in my mouth and the results have been phenomenal.

Pat: While nervous in using EMDR, you have been encouraged by the joy of witnessing "the most wonderful results for clients".

Morag: Still, I use it sparingly – and it's always based on what I believe to be the depth of the relationship that we have and the trust that is there. It wasn't easy the first time. But I've either been extremely fortunate or it's in some way been the right thing to do.

Pat: Another place where you mentioned joy was in relation to your intense experience of joy in escape and I wondered if this influenced your practice.

Morag: No. The joy of escape is a deeply personal one for me. I'm not sure it really translates very much into the work. It's probably actually verging on euphoria and a sense of invincibility and everything, so it probably is a good thing that it doesn't

feature very highly in my practice. It's a very intense experience, long-lasting, but still probably far too intense to have a legitimate place in therapy.

Pat: Your laughter when you said that suggests to me something of your ability to avoid merging your own and your clients' experiences.

Morag: Yes, I think it comes back again to relevance. My therapy *has* to be relevant to the client. But even though my own joy in escape, specifically, is separate from my practice I do take a lot of pleasure in clients experiencing very positive outcomes, even like the slightly smaller scale ones along the way.

Pat: On the subject of outcomes, or at least ongoing movement in clients, you have some strong feelings. You said, for example

> "even the thought of trying to conduct even one session if I'm not seeing noticeable things happening, noticeable benefits and kind of positive developments - that gives me the shudders. I'm not sure how somebody would actually manage that. I take my hat off to somebody who can do it. That would feel very arid to me."

Morag: To me the idea that it's enough as a counsellor to wait for a client to express emotion because the reason they're not doing it is because they're not ready in the work that they're doing or the relationship that we have, that makes me want to blaspheme to be honest. There's got to be more to inform you than just sitting and waiting and leaving it down to the person who may not have the wherewithal because of what has taken place in their lives. I'm deeply passionate about that.

Pat: What came across so strongly to me is that you *are* really passionate about your work.

Morag: I really like the work. I like the fact that it requires something of me. I do mostly feel that I've got quite a lot to offer.

Pat: I'd asked you about whether you'd chosen to do trauma counselling, and you said not, even though you are so involved in it now, both in your organization and in your private work. You have worked in a number of different fields – EAP, addictions,

mental health and so on - but you said you wouldn't miss trauma work if it weren't available.

Morag: I have been so lucky. After my training different jobs just seemed to open up and I liked all of them.

Reflections

Pat: I had the impression that the things that you experienced in the days following the rape were strange, but not at that time frightening.

Morag: Obviously when I reflect on it now I can see all the hallmarks of trauma.

Pat: If I had been an onlooker at the time I guess I'd have marked it down to quite extreme dissociation.

Morag: That's true. I became more and more psychologically isolated, freezing up in the street for no apparent reason. And flashbacks.

Pat: Even with all that going on you said you weren't panicky, which rather reinforces my perception that you were pretty dissociated.

Morag: Others may well have been more aware of it all than I was, and that was how I ended up in hospital. In some kind of a way it was during the time in hospital that early memories, hazy though they were, surfaced to a degree. I didn't tell you any details of that but the theme of escape, which has been a big thread in my life obviously goes back to childhood stuff.

Pat: It is very interesting just how shaping our childhood experiences can be, isn't it? For you it was escape, for me it was trying to make sure people are treated better than I was in similar circumstances.

Morag: You know, however awful the rape was, it didn't have that awful power that the childhood memories had. It had less power to define me as a person even though it kind of seemed to emphasise certain things. I know I said that I didn't specially

choose to be working in trauma, but I guess it's a possible reason why I've ended up in this job rather than something else.

Pat: Do you think that in its own way, your experience of being a psychiatric patient could have been traumatising too?

Morag: Hard to say, putting it like that, but one thing I would say is that I'm *now* grateful for it because I believe that the experience, quite apart from the fact that it allowed me to see and experience things that I obviously needed to, I think that has given me a huge insight into all sorts of aspects of what, what clients were dealing with.

Pat: The only things you said about your own therapy were two aspects which were helpful for you. One is the therapist's "belief in the equality of the relationship" and the other was that it had to be "relevant".

Morag: Yes. It was my sense that if my therapists believed in equality, even though I didn't experience that way, but I knew that they did, and that was meaningful to me. However much I felt unequal, I know that as soon as someone else started behaving or relating in a way that suggested that they didn't see it as equal something very kind of stale and dead kind of happened and it wasn't going to go anywhere. So I kind of realised that I needed their belief in the equality of both of us.

Pat: And relevance?

Morag: I think this might be possibly accidental but the experience that I had of two person-centred therapists was that they were better at being relevant than some of the others who used to maybe speculate a bit or introduce stuff that was completely over my head. So the irrelevant stuff was sort of like a bit of a black mark against them in terms of me engaging. It might be just that the two person-centred ones were particularly good but, whatever, they were able to kind of keep their responses relevant to where I was and what was going on for me and that engaged me.

Pat: Were you aware of the counselling modalities of your therapists at the time?

Morag: I think most of them told me, you know and because I'd also started to become interested in it and read a bit and everything, it didn't necessarily mean very much but I knew the names.

Pat: Unsurprisingly you said you didn't know anything about the possible trauma background of any of your therapists, so you couldn't make any connections between that and any empathy they showed towards you.

Morag: No, that would just be speculating.

Pat: When you spoke about being very withdrawn as a client, you thought that the depth of relating was what made the most difference.

Morag: I think maybe quite a lot of it was actually sensory as much as anything. This is interesting. I wonder whether I also had a sense of the kind of extension of those more helpful counsellors to me, and with the other ones maybe not. But it really is difficult to see it back through those eyes because they don't really exist any more.

Pat: OK, I get that, and that seems to be the same in regard to your own counselling training too. You have many thoughts about training now, but they don't seem to relate to either positives or negatives in your own.

Morag: I guess I've done so much since my basic training, learned from so many people – clients and counsellors alike, that like my therapy, it seems a long time ago.

Pat: As we like to say "I've moved on"!

Morag: But you're right, I have thought long and hard about how to train others, because we have a training programme for anyone who works here.

Pat: You said your vision was to provide a training to equip people to work with your client group whatever their training background.

Morag: I produced a 4-day training here because it was becoming more and more apparent to me that people just didn't have what they needed and they were trying *really hard* to work in the way with all the information that they had and it wasn't

enough. I don't mean that counsellors who are working in a context that is generic rather than in this kind of context aren't any good at working with our client group. I don't mean that at all. But I, I've yet to come across a diploma level course that actually looks at the effects of trauma. I hope I'm not doing them a disservice, but I have the impression that they've missed the point by looking at client issues which to my mind are very very likely to be effects of trauma and yet not making that connection.

Pat: You described the course as being appropriate to counsellors who'd trained in all different approaches and at different levels.

Morag: Yes, a tall order maybe, and I'm still a little bit surprised but just *deeply* grateful that it has actually worked out like that because I wouldn't want to be in the job that I'm in here managing the service if people didn't have that training. It's now compulsory for anybody before they start.

Pat: That takes me on to look more specifically at how your experiences might have impacted on your practice. What stood out for me was your understanding of the effects of psychoactive medication.

Morag: Yes, two things. One is that I've made it my business to know a little about it. It's a huge field and I only know a kind of smattering but I know a little about it and a little about interactions and side effects and am absolutely not afraid of it.

Pat: And you have an insider view of how some of these meds can affect people.

Morag: Yes. I know to kind of anticipate a different style of communication when somebody's on medication and maybe that's quite helpful for me.

Pat: You admitted that this "seems a fairly ordinary kind of thing", and I guess that most of us are aware of clients whose responses in counselling are influenced in some ways by their medication. Maybe though because you've 'been there' you are more acutely aware of it, particularly the blunting of emotions – all of them, you said.

Morag: Maybe that's an asset, but to be honest, most of the clients I see are pretty desperate to be here. Even if they don't have much hope, the alternatives for them are very distasteful. That's just some of them, though many really try to come and deal with their stuff and sometimes it does work, sometimes it becomes valuable to them.

Pat: I found that part of our conversation intriguing because while you said that most of your clients come actually *wanting* some kind of helpful interaction, one of the things that you found most helpful in hospital was being "left in peace".

Morag: Ah, yes, but the difference again is *relevance*. I think it *did* certainly teach me that if I believe I have something to offer it *has to be* relevant to the person I'm offering it to. In the hospital, the interventions people had tried were just irrelevant to me.

Pat: I asked you for ways in which you discern what is relevant to a client.

Morag: An obvious one is to keep asking. I also use what I consider to be empathic material. I'm quite a sensory-based person so it's often to do with body sensation and if I think that I'm experiencing something I'll check out with the client whether that has relevance for them. Also the lack of any sensation at all is obviously a big one, kind of cognitive shutting down, so I use a lot of my kind of moment-by-moment experiencing where I check out with people if that makes sense.

Pat: I was interested to know if the skills you have developed in this way were due to your training or not.

Morag: No. I had obviously had a huge amount of therapy but as I became more, well, present - I realise that there is a lot of value in the stuff that I experienced and that it wasn't just stuff happening, it actually related to what was going on around me just as much as some of the kind of nightmarish stuff related to what had been going on in my past. And then I learned to use it. And that was the hard bit I think. Probably the task for many counsellors is discovering something that you have and then learning how to use it.

Pat: Given that your own formal training doesn't seem to feature much in your current practice, I'm interested that you should set so much store on training the staff and volunteers in your organisation.

Morag: I think it's mainly because I've become frustrated with some of the assumptions I've heard expressed by many counsellors. I've already ranted about the kind of passive 'wait till the client is ready' approach. While not being ready might be one element of what's going on, to focus on that and to ignore the rest is akin to your child not crawling and you say 'Oh well they'll do it when they're ready.' There's something *wrong*. You can't just wait.

Pat: We went on to talk about how clients may not even know that what they are experiencing is the result of trauma, so this might be one of reasons for their not disclosing, rather than their not being 'ready'. That was certainly the case with me. It's relatively recently that I had a counsellor who spelled out that my symptoms, particularly dissociation, were post-traumatic.

Morag: Yes, given how prevalent trauma is it sounds like it's terribly important to at least know what the consequences can be – and that is something our course aims to familiarise all our counsellors with.

Pat: You include many things in the training –

> "different aspects of experience and when experiencing is synthesised"
>
> "behaviour and thinking and emotion and affect" as "part of the way we just move through life"
>
> "different emotion states, and when trauma is experienced that gets blocked and ruptured and splintered off" while "some bits are kind of like on high function all the time"

Morag: All this so that as counsellors if we train ourselves to *notice* that. But some of it is just re-iterating it and helping people to remember that there are things that are really really big big clues and really helpful to respond to that might not be kind of made very much of on their training course.

Pat: It's clear to me that your training includes a focus on dissociative processes.

Morag: Yes, my impression is that it's rarely covered adequately in diploma-level courses.

Pat: When I asked you why you thought this was so you were rather reluctant to speculate.

Morag: Generally I don't like speculating. But when you pressed me I made a few very tentative suggestions.

Pat: Let me just list those:

- Trainers "might not see themselves as equipping students to work directly at that kind of level", so as not to "produce false ideas about what [students are] competent in".
- "The people who are delivering the training have kind of stumbled through their own learning development in that area" and basically lack awareness of it.
- Trainers are following such "kind of pure principles of their approach that they believe that that is actually all that's necessary".

Morag: I really want to underline that these were *just* speculation. I have no evidence.

Pat: OK.

Morag: What I say to folk who are starting training here is it's not like what you do is likely to be wrong and damaging. It might not always be terribly useful and sometimes it might be that it just takes a long time to be useful. But why would we want that?

Pat: I can sense again your passion for counselling to be relevant, and your dislike of the philosophy of waiting till the client is "ready".

Morag: That's a bit stark. I believe the client *can* really benefit from just waiting and things will happen that then sparks stuff off anyway, but why would we want that to happen? Why would you want to rely on your child getting milk from next door if you could give it to them every single day yourself? To my mind the idea that somebody has to kind of move more slowly through this stuff than might otherwise

be necessary is just awful. It's not so bad as a counsellor - you do your hour and that's it - but if you're a client you're living it 24/7 and not a break, so it just seemed unethical to me that we didn't have a lot more to put in.

Pat: You're referring to client's need to be informed about trauma.

Morag: Yes, there's maybe not *enough* evidence to say how clients can benefit massively from responses that are *very* informed about trauma but with all the EMDR stuff and everything like that that's going on I think there would be a bit more excitement about how to inform ourselves.

Pat: That kind of underlines how good it is to keep up with research findings, perhaps especially for trainers. The title for my research is "Wound meets Wound in the counselling room", along the "Wounded Healer" lines. I was struck by your indifference to that term.

Morag: I'm not against it – it's just that I don't tend to think in terms of metaphors and pictures and stuff like that, so the words are very *literal* to me. To me it sounds sort of like a native American kind of thing.

Pat: Well leaving aside the metaphor, my interest is in how prior trauma might affect the interaction between counsellor and client. You thought that it was very likely to have some effect. But you seem to draw particularly on somatic experiencing.

Morag: I think so.

Pat: What about counsellors who *don't* have prior trauma?

Morag: I imagine it might be harder for them to make sense of stuff as well. Maybe not, maybe there's just another way in but like when I actually get the *sense,* the actual body sense, of certain things it's recognisable to me and that is helpful. I think it might take a lot longer if I had to try to make sense of that and wondering and all that sort of thing but it, it's to me, it's probably more direct and useful information than you get verbally.

Pat: I asked you for a definition of trauma.

Morag: A real little favourite of mind actually.

Pat: This is what you said: "a traumatic experience is one which splinters our ability to experience ourselves as whole beings".

Morag: What I try to kind of impress on the training is that an experience might be utterly unnoticeable to many people if it's happening to an infant and yet it can produce significant changes in what is possible for that little person at that point and as it moves through life and if an adult hasn't had those kinds of unnoticeable traumatic experiences or even more noticeable ones (I don't want to *really* commit myself too much to this one) but I think broadly speaking it might take something a lot more noticeable to produce that splintering effect.

Pat: I sense thinking about resilience here?

Morag: Yes, definitely. I mean if you've if had *enough* security building and building though life you get a lot of resilience, or you get enough to use. I'm not *aware* of anything that can make somebody invulnerable to trauma. I don't think that could be the case, but the kinds of things that that produce that effect can vary immensely even though they're invisible.

Promenade to Chapter 9

Morag's picture was so different from Jane's. There were many clean lines with well-boundaried blocks of colour – a sense of control having been taken on what might otherwise have been chaotic. Many of the colour blocks drew me into their depth.

As I walk towards Paul's picture I reflect on the day of his interview. When I made my way over ice-covered pavements to his place of work I thought I had arrived at an airport, not a hospital. The main concourse, if it did not have duty free, did have enough shops to supply anyone's immediate needs. In something of a daze I followed Paul's excellent directions to an upper floor and his office. After a brief chat with a friendly receptionist (such a good person for a counselling service, I thought) Paul appeared. He had a client booked in after our interview and it was a case of getting down to work straight away to make best use of the time. At first, given experience of others who had given long accounts of their trauma, I wondered how having a time limit would impact on the quality of the data, but I need not have worried. Paul chose not to elaborate on his childhood, as you will see, but gave deep reflections on his later experiences and his practice. I left feeling I had hit a gold seam.

Chapter 9. Paul

9.1. Preamble

One of the striking things in analysing Paul's transcript was my difficulty in separating 'feeling' and 'reflective' themes. Initially, because of the lack of a 'trauma story' it seemed that the whole interview was reflective and there was little emotional content, but on deeper engagement with the text this was not at all the case. The connections between experience, life and practice were so deeply made by Paul that he came across as someone whose trauma and the surviving of it had evolved into an integrated whole. In particular, it was of note that in his many thoughts on his counselling practice he emphasised the likely needs of traumatised clients in terms of those of his own when he was in the client's chair. At the same time he is very aware of the dangers of projection, but more of this later.

Paul said that the interview had "been a good experience" because it had taken him to reflective places that were unexpected to him especially as he admitted to spending much time in conversations with himself. The interview had reawakened some dormant assumptions that he worked from. Like Paul, I too had found the interview stimulating. Whilst very aware of the paucity of narrative detail of his trauma, I felt privileged to have been given such a window into his reflective process

9.2. Vignette

Paul: I was quite young at the time - I was only in my mid-20s when I started my training. I had been seeing a counsellor for a number of years. I feel I have a fairly negative experience of being a client and I think probably came at the end to trying to find some way to be healed that wasn't coming through being a counselling client but rather to gravitating towards studying it. I started to read books about it which got very interesting and this prompted me to think maybe I should make this learning more formal. I was just getting pretty keen to try and soak up more and more

information hoping that eventually that that would make me feel a bit better - the more I learned the more I understood, the more I'd be able to help myself.

When it came to training, I chose to train in psychodynamic. I think it was lack of choice as much as choosing that modality because I came from a community where no-one went to counselling, no-one spoke about counselling, never heard of counselling, so even in those early days trying to find someone to talk to was very difficult. To find a course the options were few and far between and I think at the time it was the only course that I actually knew was running so there weren't a great deal of options there available and I never knew anyone I could ask advice from or bounce ideas off of or anything like that.

The negative experiences I had of counselling were I think more about the people that I met than about their model of counselling. The first counsellor - I felt a need not to contaminate this young lady with anything negative that was inside me. The second seemed bored.

I enjoyed my training. I remember feeling very, very alive, very excited just suddenly finding language, concepts, that were allowing me to try to make sense of being me. But while intellectually I could now understand it and could explain it to myself and other people the feelings within me just stayed pretty much as they were. I suppose it's been 20 years of practice and self-acceptance, trying to change the conversations in my head. It's been about meeting someone, getting married, having children, finding the things that reassure and comfort me and not being too intimidated by the things that scared me. Seriously I think what change in feelings have taken place have been outwith therapy.

Reflecting on practice one of the things that's particularly hard in the key development stage has been pre-3, and that's the thing that really upsets me the most, that trips me up. My own trauma experience was primarily pre-verbal. I think other things that came along after that maybe helped to reinforce that damage or confirm that damage too.

I work in short-term primary care general counselling, meeting much trauma, but not specifically employed to see clients with trauma issues.

9.3. The Conversation

Feelings

Pat: Like one of the other participants you chose not to focus on your childhood trauma.

Paul: Yes, I guess there were two reasons for that. One was that much of my significant trauma was when I was under three, so personal episodic memory is lacking, for all I know details though others' accounts. The other is that I was aware that I was a bit more apprehensive than I was when I first thought about arranging the meeting.

Pat: You said that discussing it recently with your supervisor you'd "forgotten every time you tell your story, you reflect on your story, just how difficult that can be again."

Paul: Yes, so I was a bit relieved that you were happy to focus on its effects rather than its details. Something I do remember though about the time after my trauma and before I knew any of the details was that my feelings were confusing, scary and infuriating.

Pat: I was interested in what was going on at the time you first sought therapy.

Paul: It was through my GP. I'd been bouncing along the bottom for quite a long time. I think I would have gone along with … whatever my GP had suggested.

Pat: But that didn't work out very well.

Paul: No. The first person that I met was very young, female, attractive, and that to me was everything that I didn't want to be around because I felt that what I carried inside was so black, so damaged, and wouldn't think that sitting in the company of somebody who'd had a positive experience of being a human being, someone who'd done well at school, gone to university from school ... so I didn't want to contaminate this person with anything negative that was inside me.

Pat: I have this picture of a teenage boy from a community where education was not highly prized - you said that you didn't know such a thing as a university existed till three years after leaving school - sitting in a room with someone he felt so far out of his league that it would be impossible for them to find enough common ground for meaningful rapport. He would be tongue-tied, maybe giving mono-syllabic answers or 'don't know' responses to questions put to him.

Paul*:* I guess I was also confused because I think she was interested in a cognitive approach and here was me having difficulty knowing how I felt, let alone what I thought!

Pat: It seems to me that this woman symbolised for you everything pure and beautiful that you were not, arousing in you a belief that you would "contaminate" her.

Paul: So that was the first one. Another one was probably bored, or burnt out or just going through the motions of bringing people in, taking £35 off them and doing their best just to listen.

Pat: That reminds me of a client who was also a student counsellor, who was being supervised 'in house' in an NHS service. She was distressed by this supervisor's negative and dismissive attitude to clients and was determined that if she ever felt like that she would give up counselling. My guess is that that supervisor was burnt out and came across as bored.

Paul: So I was pretty disappointed, because I'd hoped to get help. It was worse because here's someone who's specifically trained, specialised to understand other people and even they couldn't understand.

Pat: You said

> "it wouldn't even have occurred to me that there was a range of therapists, you had to try and get the right person that could get you, so I left that thinking that well that was it, the world of therapy was no longer an option."

Paul: And I took it as evidence of just how damaged that I must actually be. It all just became extra fuel for my feelings of self-loathing. But there was still some part of me that didn't quite give up, some part that refused to assume it was me.

Pat: That was a part of the interview where I had a sense of paradox. One minute you were talking of the self-loathing – which sounds like rather classic feelings of worthlessness, but the next you're saying that you weren't assuming it was you that were the problem. I've come across this in traumatised clients, whether you talk in psychodynamic terms of splitting, or more humanistic alternative 'configurations of self'. Almost as if there are two conflicting feelings going on, one shouting at you 'It's all your fault, you're just a rubbish person!' and the other 'No it isn't, and I'm not!'

Paul: Maybe, but it was repeatedly hitting rock bottom that kept bringing me back to therapy.

Pat: But in the end you more or less gave up on therapy.

Paul: I was feeling at some level that there wasn't going to be another person that was going to be able to understand me or bear me or, or even kind of connect to me, and probably feeling that process had to be done alone by myself in some way. It started with reading but led in the end to training, which I enjoyed.

Pat: You said that you remember "feeling very, very alive, very excited just suddenly finding a language ...."

Paul: Yes, concepts that were allowing me to try to make sense of being me.

Pat: It sound that you were excited about finding at last something that made sense to you in a world of non-sense, a world where feelings had no explanation, in which

you felt isolated from other human beings and in which even 'experts' could not connect with you. But you did admit to its limitations.

Paul: Yes. Intellectually I could now understand it, I could now explain it to myself, to other people, but the feelings within me just stayed pretty much as they were, albeit with some relief of now being able to have something that, that understood.

Pat: Perhaps more of a doorway to hope than an all-round solution.

Paul: I guess that's true. Interesting that you suggested 'hope' because something I know about myself is that I'm quite pessimistic.

Pat: You actually mentioned that three times in the course of the interview - once in direct relation to your own past experience of searching for help, once in a general comment about your work with traumatised clients regarding outcomes (in the context of your short-term contracts) though you believe that's just being realistic, and once when describing your empathy with traumatised clients – feeling their pessimism.

Paul: When I'm with a client I often feel the sense that maybe … this [counselling] is like a last hope, a kind of moment of thinking 'nothing, nothing is really kind of going to help, nothing has helped. I'm lost with this. I now need to turn to another human being.' And I often find that experience of maybe slight pessimism that 'will I find someone that gets this?' 'what will happen when I try to describe this?' So I feel that when I stand in other people's shoes I don't feel this great sense of hope and expectation. But over 20 years I have found a more optimistic way of being. I put that down mainly to processes outside therapy, particularly family life and practising meditation. But this pessimism I sometimes feel in the counselling room is something of a double-edged sword. It tends to make me work much harder, more determined that every person that comes in that door I will find a way to connect to them, no matter what that takes. On the optimism side I hold on to the belief that if I can get the basics right something good will come out of that.

Pat: You admitted several times to feelings of frustration. Lack of connection – whether in the counselling room or in life in general - seems to be the main source.

Paul: And there are others too: frustration at being understood theoretically rather than heard as a human being; frustration with, and envy of, counsellors who speak of the magic that takes place in counselling (I'm very anti-magic); and frustration, though becoming more tolerable with the years, in knowing that I can only offer significantly traumatised clients six weeks of counselling in my work context.

Pat: on this last point I have come across this same frustration both in myself and in supervisees. And sometimes onward referrals don't reduce this frustration.

Paul: My worry for people is that I don't know who they're going to get. If they're not here telling that story I'm always worried for that person if they don't get someone who will understand it or listen to it or be able to bear it. They may well get someone who's fantastic and who absolutely gets that story, but I think I always carry that little bit of anxiety that they may not get that. And that anxiety is sometimes about the fact that some specialist services may be working to a model that doesn't prioritise connection as I do.

Pat: I picked up that your way of handling your frustrations has been to comfort yourself with the belief that the six weeks you see a client are six weeks in which the client is alive and able to tell their story and be heard rather than have that story trapped inside their own head. Even though you are not able to see the process through to completion, adjustment of expectations is key. Accepting the inadequacies of what you can offer allows you to work more effectively in the short time you have with clients.

Reflections

Pat: You chose to say very little about your childhood trauma and that's fine, but you did indicate that it had taken place mostly before the age of 3.

Paul: In developmental terms I recognise that dissociation was important for me. I don't necessarily look at it as a negative, or as pathological. I'm thinking of my own

experiences of disassociating or fugue where it was actually the only comforting thing that was available where … your mind had some capacity to slip out of itself, to step away from itself, and I've often looked back and thought 'What would I have done if I hadn't had that capacity?'

Pat: And you illustrated that by talking about your grandfather's experience of fighting in the jungle during the war. This is what you said:

> "a bit like troops fighting in the first or the second world wars. If you completely and utterly tuned into reality you would have gone mad or you would have shot yourself because the reality, if you'd actually stepped back and looked at what you were doing, to me would have been intolerable"
>
> and
>
> "If [grandfather] knew, if he actually in his mind stepped back and kind of was able to fully recognise the reality of what he was doing I'm sure you [*sic*] would have shot yourself. So actually having that ability to kind of step out of yourself, and that could be a godsend at times."

Paul: My trauma was primarily pre-verbal, but I think other things that came along after that maybe helped to reinforce that damage or confirm that damage. I often think if I had a brain scan done there would be some black hole that's still there that's never kind of quite managed to re-wire fully.

Pat: You thought though that you were "in quite an unusual situation" in knowing your story. You have, "quite a lot of facts about pre-three" so you could write down a coherent narrative, but you are aware that for many clients this is not the case and that they may still be thoroughly confused, by their feeling, as you were before you had this information.

When you reflected on your initial counselling experiences as a client you were more philosophical than you were at the time.

Paul: I went to my GP - tried his best ... I don't think he necessarily understood but I think what he did understand was that I was going to need someone with a bit of time to try to help me make some sense of this, just unfortunate I don't think that that person was available at that time.

Pat: It's only with the knowledge you now have that you can have some ideas about the therapists that you saw.

Paul: I had two experiences when I was in my late teens, early 20s. Looking back I think one has been a very early pioneer of cognitive therapy so probably not trained in it, but probably someone who's read up a bit on some of the reports coming from America, and I think the other one was person-centred.

Pat: You wondered in hindsight if these experiences might have influenced you against the value of these modalities, but you'd concluded that it was less about the modalities than those particular counsellors and the way they worked.

Paul: Looking back there was not any real skill or any real strategy being employed. So these are things that I've always tried to guard myself against.

Pat: Given your negative experience of therapy it's maybe a bit surprising that you chose to train.

Paul: It was less out of wanting to be a therapist as a continuation of my reading – I just wanted to know more, in the hope that it might make me feel better.

Pat: and your choice of the psychodynamic model wasn't as much influenced by your negative experiences of others as a practical one. It was the only course you knew about in your local area. And I wonder how many counsellors have a similar experience. I know that my own basic training in person-centred was chosen without any knowledge of different modalities.

Paul: And who would I have asked? I came from a community where no-one went to counselling, no-one spoke about counselling, never heard of counselling, so even in those early days trying to find someone to talk to was very difficult.

Pat: I asked you about your memories of trauma training on your course.

Paul: We did quite a lot of work on attachment theory, so we weren't really being taught about direct interventions specific to trauma. We were being introduced to concepts, theoretical models ... that for me were helping to explain the process that I

was going through, the process inside me, and I suppose to begin to try and fit together some kind of coherent story that I could use for myself because up until that point I had no story, no way of understanding the language.

Pat: I had the impression that it was a stimulating intellectual experience but tinged with disappointment too.

Paul: I think I thought this was going to be it. I think that I assumed they'd found all the pieces of the jigsaw. I just needed to fit them together. And of course that never happened. But I do believe that I was becoming much stronger, at least intellectually.

Pat: You said that theory was giving you some control over feelings that were otherwise chaotic, though later meditation was an important way of doing that.

Paul: Training was only a start in that sense. For me I found that I have had to spend a long number of years practising meditation just to try and find ways to feel that I can I can slip out of my mind but I can probably connect back in to feeling so it feels a bit more under control rather than just some random automatic process that has its own life.

Pat: I've certainly found that one of the most distressing things for traumatised clients is a feeling of being out of control of feelings, and although psychoeducation is something that some find very useful, I do find that making the connection between thoughts and feelings is what really helps most.
And connection, but this time between client and counsellor, is one of the three major elements that stood out for me in your reflections on practice. The others were realistic expectations, and the use of skill and strategy.

Paul: They are all linked. Part of the skill I believe is to find a language or a model, a way of being that will …. at least guarantee that we will get connected. …..That's the one thing I've got to do when they come in no matter what their story is and help them get back on their feet.

Pat: I imagine that strategy is particularly important when you are restricted to short contracts and realistic expectations will come in there too.

Paul: First, I pay a lot of attention to how they initially present their story. I tend to listen out for conversations that appear to be conversations that the person has with themselves. So I'm always listening out for signs of people's imaginary conversations... that they had with me before they've even met me. Or conversations from the past or on the bus that morning. I think I'm always listening out for different parts of that person. They might present as very rational, logical and mature, but I'm looking out for fleeting snippets of another voice that's inside someone's head that's more irrational or more controlling or more critical. ..... Different voices coming from that person, some of them not necessarily verbal, but I've always been conscious that there's likely to be at least two versions of the person that's sitting in front of me.

Pat: I'm guessing that that has been learned from your own experience as a client – you indicated that you were always aware that there was something else about you that you were not able to articulate. And you said you pay a lot of attention to what clients did or didn't say about their past.

Paul: When you've got someone tell their story and there's either a great many references to the past or there are zero references to the past I'm always intrigued by why the past is getting brought into this room so much or why the past isn't getting brought into this room at all. And sometimes I'll just make that observation to people … And then it'll be gauging people's reactions to that.

Pat: And those reactions could either be to tell you more, or to be dismissive or even angry.

Paul: If they are angry, I take it as a big early warning sign to back off - I'm not the person that they're choosing to do that with, or this isn't the setting, or this isn't the time for that conversation to take place. So I tend not to pursue it, but I always figure that I have to trust people that if past trauma is ultimately the reason that they

came in that door that they'll find a way of telling me that. And if that's not the case they'll find a way of telling me that as well. …

Pat: ... and yet you didn't find a way of telling that to your own therapists.

Paul: True, but that's where the importance of connection comes in. They had not made that connection with me. To be fair I think at that time I had no language and wasn't even aware of having needs. But in my own practice I try to tune in to how things have been said, what's been said. And I don't have a rule about it, but when someone mentions something once in the first session I might make reference to it but I'll not pursue it because you maybe don't have the impression that they necessarily want to talk about. Is it a trust question? They tell you some horrific thing, not necessarily because they want to pursue it but it's just that they want to see if they can trust you, that you can bear that bit of information about them. I sometimes bring that to people's attention. Sometimes I don't. An intuitive decision.

Pat: You mentioned "bearing" four times in the course of the interview.

Paul: Did I? Well that's revealing, isn't it? Goes right back to my own early experiences of being unable to bear my own feelings about myself and projecting that on to others.

Pat: You said something too about approaching clients' stories in the context of six-session counselling.

Paul: I don't believe that many clients have an awareness of what a series of six sessions looks like, so I often go with the approach that this might be the only time that they feel safe enough tell their story. I don't think they are likely to choose *not* to tell their story because they think there would be insufficient time to deal with it.

Pat: Perhaps that's true of first session disclosures, but I always remember an experience I had, when in training, of a short-term client who had multiple trauma issues from childhood, which she had disclosed early but soon withdrew from counselling. I was convinced that she knew, and she knew that I knew, that her allotted number of sessions were insufficient for her needs. Now, I would be more

likely to make those intuitions explicit and fully explore onward referral options, few though they sadly sometimes are.

Paul: In that situation I'm just very honest with people in saying there might be some relief and some hope that comes from telling their story and perhaps together being able to try and understand and bear that story but there might be more work that needs to take place that it won't necessarily happen in here. And make sure that they know where the options are about how they could do that instead.

Pat: You linked that to your own experience of needing help in finding a language and a framework to begin to understand it...

Paul: ....and they'll not necessarily get the year or two that it may take of being with another understanding human being.

Pat: You said your frustration with time-limited therapy for trauma has lessened over the years and that you take a more pragmatic approach now.

Paul: I used to be the world's worst at extending sessions. Early on I remember wanting to help bring healing to everyone and make sure that clients were in a completely different place by the time that they left. But now I see that an extra few sessions isn't the answer – it's more about helping people to accept the limitations and to find a context in which they can get the length of time and level of safety that they need.

Pat: You quite strongly disagreed with the common discourse in counselling circles about people choosing to come for counselling 'at the right time'.

Paul: Yes. Not my experience. Folk very often come because they've hit rock bottom, as I did, and have been sent by someone else – often a GP. They're often desperate but don't have a lot of hope – more a case of 'I can't really see how another human being is going to be able to help me, but I'll give it a try'

Pat: You said you often feel that clients "have tried everything by themselves to feel different about themselves, to feel safer in the world or less angry with the world or

feel less persecuted". It seemed to me at the time that you were saying those words of yourself as a young man.

Paul: Yes.

Pat: On a more positive note you also guess that clients are usually aware that allocation of a counsellor is a "hit or miss" process, and that allows them to search further if it's not helpful.

Paul: ...which is what I did.

Pat: We talked a bit about different counselling models.

Paul: Yes. Although I trained in psychodynamic, and I've returned to that model now, I have studied different ones. There were two reasons I think. I trained at a time when counselling world was quite polarised with each model claiming that it was right, and putting energy into proving that other models were wrong.

Pat: I remember my own trainers telling us about other models but only to criticise them!

Paul: Only one was right, according to everyone, and you were worried that you were on the wrong one, and you were worried why you were seeing benefits from all of them and then being kind of confused.

Pat: I wonder if your exploring of other models was linked to your experience of being intellectually but not greatly emotionally helped by the psychodynamic model in those early days.

Paul: I went through a bit of a crisis, asking myself if psychodynamic was just, you know, intellectualise, rationalise without actually healing. But I've come to the point of seeing that if you can get the intellectual bit right you want the relationship then you've got a chance of effecting a bit of a change.

Pat: I'd agree with you there. I've personally found that a better intellectual understanding of the connection between trauma and dissociation has helped a lot. I was interested that between us we had experienced two different aspects of

dissociation. You found it to be a positive survival mechanism, but I was more focussed on very unpleasant derealisation experiences later in life.

Paul: Yes, you asked me if I'd ever encountered that in clients. Yes, some have been quite scared and that's the thing that's brought them in – maybe thinking they were going mad. One colleague at university described a more out of control experience 'as if my mind has a mind of its own that I need to be engaged at this moment in time but my mind has other ideas and it's off, it's not here.' But when I encounter that in the counselling room I try to separate function and story. If you can begin to understand its function and look at the actual experience of disassociating rather than the arms and legs of the story that might get added to that experience of self as 'not normal' I think when you start to kind of cut through some of these story lines that maybe go with the experience the actual experience is not necessarily so terrifying.

Pat: I remember the first time I really disclosed my experience of derealisation to a therapist that her response was very healing.

Paul: I think sometimes just the mere fact of the other person totally gets it is so comforting and so reassuring - that can be quite a positive experience in itself because you're aware you know, you put yourself in their shoes - how long it's been for them to have to admit this process, that it feels quite healing in itself just to be allowed to kind of talk about that side of yourself and you begin to understand it and not feel it's quite so strange.

Pat: I'm interested that you used the word "comforting" in this context when previously you'd used it of your ability to dissociate – both in childhood to survive your trauma, and later in a controlled way in meditation.

Paul: One of life's paradoxes? But going back to the client in the room, when people get to the point that they tell me about such experiences I often think that's very far down the road of a therapeutic process.

Pat: Maybe that brings us back to relationship again – if they feel confident enough in that, it can overcome the shame associated with dissociation.

Paul: and fear – some really believe they'll be sent immediately to a psychiatric ward. One of the difficulties is that dissociation is a hidden thing. They've never heard anyone talking about this at school or in the family, and none of your friends seem to get this. I think that it takes great courage to come in to a professional and tell them that.

Pat: I'm guessing that was your experience.

Paul: Maybe that's why I set such store on the value of 'getting' a client.

Pat: You said that you'd not come across clients who dissociated but did not have some history of trauma.

Paul: No. In a high proportion of my clients something traumatic has generally happened at some part of their life process. They would be people who are able to detail sexual trauma, emotional neglect, physical neglect, early bereavements.

Pat: You said that the clients who have not been traumatised at an earlier stage in life but have only recently been through a traumatic event are very much more focussed on processing the experience of that event.

Paul: I do believe that the stage at which someone's been traumatised makes a big difference. I like a lot of Winnicott's ideas – those very primitive fears, you know, that sense of falling for ever and so in my mind I use that from my own experiences of remembering what that's like. I use probably that Winnicott language to explain it to myself. It's probably part of the human condition. I feel that a lot of people get experiences at the right time that can calm and reassure these kind of primitive fears so that they're not such a big issue in adulthood. But while everyone has those fears to some extent there are those who have experiences that really compounded and encouraged those fears, that can take way or never give the ability to self-soothe or comfort or in some ways have something internal that would allow you to get past some of those experiences.

Pat: And you felt that six weeks of therapy were very unlikely to be enough. Their resilience is low. When you suspect that a client has early trauma, because of your

own experience you were aware that if they didn't talk about it it could well be because they don't have the memory to draw on.

Paul: It's quite strange that the bit that's most needing attention might be pre-three but all that they've really got to work on is how it feels today, at this moment to be in this room with me. And I often think that that even if the actual memory is not there or if the story isn't there, I think that it can help just knowing what that has done by being able to trace lines of that early damage to who they were at primary[50] or what their experience of high school was, and then their present day experiences.

Pat: You said you've found that people are often focussed on the 'Why?' question. It can go on for years, and if it isn't answered makes it very difficult to do anything else.

Paul: If no-one's available to fill in the blanks, as they were for me, I reckon that some people will just maybe get to a point where they can just sort of live with the fact that there's something that's not available to them but that what we can do as adults is maybe look at the consequences of all of that and how we live being this type of human being.

Pat: We laughed when you mused about how good it would be if we could get a print-out from Social Services that says 'this is your first three years'. Maybe that's an echo of your perception of a black hole in your own wiring.

Paul: Quite likely!

Pat: I've asked participants for their off-the-cuff definition of trauma, because it seems actually quite difficult to pin one down. This is what you said:

> " I tend to assume with trauma that there's been some experience at any stage of life that you weren't able to understand but that stopped our innermost basic needs being met in a way that you found — we found distressing, but also in that the distress was never soothed or allowed to be expressed and understood or heard by anyone else, and the consequences were that people felt trapped with that personal experience and never allowed to, you know, repeatedly then in different ways tripped

[50] i.e. primary or junior school (up to age 11 years)

> us up as we've fallen through life, so I often think of it as just being an experience, usually an abusive experience, but not always, where you feel the most basic needs, in an attachment perspective, are not being met, you need to feel safe, secure, connected to, comforted, reassured that in actual fact that not only are those needs getting met but the actual opposite may be taking place - that you're … feeling threatened or intimidated or ashamed or any of the other of things that trigger different crippling emotions that can come."

Paul: And I liked the question. It made me think because there will be a working definition lurking somewhere at the back of the mind that you don't ever pay attention to, that you don't actually pull out and invoke because a lot of that definition will be based on assumptions, and to actually pull it out is quite a good process and to look at it and think 'Do I agree with this assumption that I hold somewhere at the back of my mind without even knowing it's there?'

Pat: The concept of wounded healer is one I find compelling and I was interested to hear your thoughts on it.

Paul: When I saw your proposal that was my main reason for agreeing to participate. If I'm being completely honest, I think that I wish I'd met a wounded healer when I was 17 and when I was 19 and when I was 21, and I think if I'd met a wounded healer I would have had a different experience and I think I met people who were working as healers but they didn't have the wounds that would have allowed them to understand me and to offer the thing that I need.

Pat: You mused that if you were now able to see video-tapes of those early sessions that a wounded healer would have been able to pick up clues like 'Oh that boy is trying to say this', or 'This boy's unable to say that'

Paul: I've a strong hunch that that would be true.

Pat: I was interested too in your comment that when you were on CPD courses you sometimes look at the other participants and imagine which ones you might choose to go to for therapy and you're not surprised that those you select tend to have wounds themselves.

Paul: If I find one or two it's been a good event.

Pat: But you thought that the 'wounded healer' theme could also be a "double-edged sword".

Paul: It can be the best ally sometimes in the room - your own experiences. It can give you much more intuitive understanding but I think it has to be a carefully managed process. Sometimes if the practitioner isn't in a great place with their own wounds that's going to have such a detrimental effect and I often thought 'Does that explain some of the bad cases that you hear from our clients, some terrible things that have been said to clients?' And I'm thinking 'Whose wounds were you responding to, because it wasn't this client's?' So it's a scary area and I can understand why a lot of professional bodies would maybe want to back away from it because it carries with it dangers. But if you can get it right I think it can carry immense benefits really.

9.4. Postscript

After the interview Paul sent an email which said:

> "There was one point I found myself reflecting on quite a bit after our interview. This was around the physical impact of trauma stories on practitioners who have past trauma
> "While I've nothing to compare it against, I have recognised that I have to really focus on looking after myself - especially physically. I find that trauma stories have a very physical reaction in me which I now see as being related to my own early experiences. Unfortunately it's taken me numerous experiences of feeling unwell - sickness, stomach problems, disorientation, pain, etc before I began to accept that I will typically process the experiences of others in a very physical way. Our interview helped me pay attention to this process and let me focus more on having a strategy that helps me manage my body as part of my work."

Promenade to Chapter 10

Paul's picture drew me right in – the kind of canvas that has a depth to it that leaves the observer wanting to return to it again and again. But I leave it for now with the realisation that there are still two more pictures to see.

The interview with Lizzie was my second meeting with her. She was in fact the only participant I had met prior to interview. At a training day at which we were both present, the organiser had given me permission to speak for a minute or two about my project and make flyers available. Lizzie was one of two who approached me later to express interest (the other withdrew because of a family bereavement). The day was organised by a national Christian network of counsellors to which I belong and Lizzie and I had that extra bond of knowing that spirituality was a vital part of both our lives. Meeting for the interview involved a journey to a beautiful, but rather remote, part of the country and Lizzie had offered to meet my train and take me to her consulting room which was in her house. I was unprepared for the story she shared with me. I have listened to clients speaking of physical torture, but seldom to an account of such harrowing emotional abuse on top of serious childhood emotional neglect. The depth of psychological work Lizzie had done to overcome her past had a profound effect on me as I listened, and her generosity in sharing her story and her long experience as a psychotherapist will remain with me as part of my own learning.

Lizzie, like Jane, presented me with an ethical challenge, but of a different nature. The malpractice of her first 'counsellor' is something of which she is now highly critical, but it does not appear that she had reported this to any professional body. In the context of the interview, rightly or wrongly, I chose not to pursue this point, trusting that as she had impressed me as someone who did have high ethical standards now she would have done the right thing for the protection of any other people who might consult him. She might, for example, have known that he was no longer practising so not posing a current risk, or that he had already been sanctioned. Had our interview been in a context of a counselling or supervision session I would however have felt it my duty to explore this issue robustly.

Chapter 10. Lizzie

10.1. Vignette

Lizzie: Historically, starting at the beginning, my parents were missionaries in Africa. I'm the middle one of three girls, very close together in age because my mother was going forty at the time she had my oldest sister. When I was four and my older sister was six my older sister was ready to go to school and she was sent to a boarding school run by my aunt in the UK. My parents had no income other than given by individual churches and every five years or so they'd come back to the UK and they would do preaching tours. They didn't want to trawl three kids round with them so my sister went to this boarding school and I went too even though there were no classes for me and no playmates of my age. My parents didn't even take us away at half term so we'd rattle about this school on our own in half term. Everybody had cleared off home and my aunt, who ran the school, was always so busy she had little time for us. All told I had ten years boarding in three different places. We all returned to Africa and when I was six I was again sent with my older sister to boarding school in an adjacent African country. We only had two holidays a year, totalling seven weeks when we would see our parents. In time my younger sister joined us at that school. But although all three of us were there we saw very little of each other except when we had to share a letter that came from our parents. Letters took six weeks to arrive, and they never wrote to us individually. When my older sister reached fourteen, the upper age limit of that primary school, I was again sent with her to the next school, which was in yet another African country hundreds of miles further away, and not one that anyone we knew went to. My younger sister stayed at the primary school. I was at this third school, which I hated, for two and a half years and only got home once in that time because civil wars in intervening countries made travelling impossible. Instead we were sent for holidays to a country to which we could travel to stay with an uncle we'd never met before. This school experience, and living in a hostel with a pretty unkind warden, was awful. Rescue

came when an uncle from the UK had reason to be in Africa and came to visit us. He visited our parents too and said "you must get these girls back to England. You cannot leave them there any more". Some months later, we did all return to the UK.

We actually started living as a family. Nobody knew how to do this family thing. It was *chaos.* I went to the local day school but my dad said "You can't stay at school for ever. You've got to leave school and start earning some money for yourself". I went into nursing. I began to build a new life for myself. Then I got married and we started a family. Going back to a nursing post didn't work out with childcare so I became a full-time mother. My husband was training at a Bible college and we eventually settled in another part of the country, where my second child was born. He had serious medical problems and it was difficult. Though unaware of it initially, I was actually suffering from postnatal depression, really ever since my first child was born, but acutely so after the second. It never occurred to me to go to my GP. At the time we were involved in a type of Christian thinking that emphasised spiritual healing and at a conference which was very intense and completely unboundaried I sought help, but the 'help' pushed me over the edge into a psychotic episode. For some two and a half years after that I went, on the recommendation of someone at the conference, to a counsellor in my area, who worked in the same way. I discovered later that he had virtually no training and wasn't in supervision and he just about did for me. He was *so* abusive.

We moved again, for my husband's further training, and I joined a counselling class that was open to spouses of the students at the college. I did well, and once I had completed the training even became involved for some years in teaching counselling myself on an extension programme they had. And I got appointed as community lay chaplain to the mental health unit in the city, working mainly with the staff.

During that time a Gestalt training course started locally and I did that 3 year training and followed that with integrative training there and in another city. However I later had another psychotic breakdown and had to give up my practice for 3 years. I had

excellent support from a psychotherapist and a psychiatrist during that time and was eventually able slowly to resume my practice.

More recently I did the training in sensorimotor psychotherapy.

I have a private practice as a psychotherapist and supervisor, and see many clients with a history of developmental trauma.

10.2. The Conversation

Pat: Good of you to agree to meet again to discuss the transcript of our interview, Lizzie.

Lizzie: I'm a little apprehensive, to be honest. Although the interview didn't trigger me I know from my own experience that I might feel quite unsettled in a few hours' time. This normally happens for me. I'm OK now but maybe later on this evening I might feel kind of uneasy or sad or a bit depressed. I know myself well enough. I'm still a bit wary of how going over the same material again might affect me.

Pat: Thanks for making me aware of that, and we can stop at any time. What meeting again will help me with is to share some of the thoughts I've had as well and to check out if they mean anything to you. Hopefully together we will begin to make some meaning that might help other counsellors in their practice.

Feelings

Pat: What you told me of your upbringing, and of things that happened to you subsequently, frankly horrified me for all you told it so calmly.

Lizzie: I guess the calmness was because I've told it so often in therapy, and have done so much work on it, that it no longer has the immediate emotional impact on me that it once had. But from time to time I do get 'triggered', although that didn't

happen in the interview, much to my relief. I'm also very aware of self-care and, yes, I'm cautious.

Pat: Of course – and I'm glad you are – this wasn't a therapy session after all, but a research interview, and I am so grateful to you for addressing so many of the practice issues that I'm particularly interested in as well as telling me something of your trauma experiences. We'll come on to those reflections later, but perhaps we could start with an overview of some of the feelings you did tell me about.

Lizzie: OK

Pat: As your story unfolded my own inner reaction was quite painful, especially when you described your feelings of abandonment. Here was a little girl, not only being the 'middle' one of three, but with parents who were more interested in their missionary work than they were in their family.

Lizzie: They wouldn't have put it that way. They would have said that God's work comes first.

Pat: I'm familiar with that kind of thinking, and disagree with it quite profoundly even though I am a Christian. I think it is a narrow interpretation of the Bible, missing out lots of teaching about family values, responsibility, and the meaning of love. When you spoke about that, I felt ashamed by the damage that was done to you in the name of the faith that we both hold dear.

Lizzie: Yes it's quite painful.

Pat: Could talk about this at length, but let's get back to what you said about your childhood. One of the things that stands out for me was that you were shuffled about, moved from one place to another without a lot of thought about the effect it would likely have on you. Not being the baby of the family, your parents thought it better to send you away with your older sister, even though you were too young for the schools she went to.

Lizzie: Yes, it left me with a persistent feeling that I'm not important, I'm not cared about, others are more important. And from that grew a kind of nomadic "I don't

belong at home and I don't belong at school but I belong at school and I belong at home" so it's like "So where do I belong?"

Pat: Your first school was in the UK when your parents were busy raising money for their missionary work. You were only four and there wasn't really a place for you there.

Lizzie: There were no classes for me, there were no playmates for me because they were all six year old and upwards. So that was my first experience really of abandonment and of boarding school. The school was run by an aunt – looking back I don't think she knew how to cope with me because she was very busy, but at the time I just felt unwanted. And I remember that even in half terms my parents didn't used to come and pick us up so we'd rattle about this school on our own.

Pat: That sounds so bleak.

Lizzie: Time came for us to return to Africa with mum and dad. When I was six I was sent to boarding school in a nearby country with my older sister, and when my younger sister was six she came too but we were all in different classes. There was a sense in which I had sisters in the school but we had — used to never relate to each other except for when our parents' letters came.

Pat: You told me that your parents used to send you one joint letter which used to take six weeks to arrive.

Lizzie: That's right. My parents never wrote to us each individually, it was always the shared letter. Apart from that I had little recollection of, of hardly ever seeing my sisters because we'd all sleep in different dormitories.

Pat: Again I found that all very bleak, and it rather surprised me that you told it in such an unemotional way. Perhaps you had to block out some of the feelings that would be expected in a child of that age in that situation.

Lizzie: Maybe. But I was there for a few years and of the three boarding schools I attended it was the one I was really quite happy in on the whole. I had to leave there

when my older sister got to fourteen - too old to stay there. And - guess what – Lizzie had to go too. The next school was an altogether different story.

Pat: I want to read back to you what you said about this:

> "my older sister got to fourteen and same scenario, [she] had to go to somewhere else. She couldn't go on her own. Lizzie's got to go with her even though Lizzie's not old enough yet. So all our friends used to go down to [another place] but for some funny reason my parents had had a conversation with somebody who said that [another place in another country] was much much better, much more Christian, we should go there. And it was hundreds of miles further away. So…my sister and I were shipped off…. leaving my younger sister … at the primary school"

I remember the way you said that, even though you didn't verbalise it. I sensed a mixture of weariness, impotence, anger, and resentment. I wanted to scream 'THAT'S NOT FAIR!' Here were adults, parents indeed, who could not or would not listen to their children.

Lizzie: But remember, by then I was convinced that I was not important, that I'm a nuisance and that parents can just dispose of me when they saw fit.

Pat: And to make matters worse you said of the city where the school was

> "I didn't like it. I didn't feel safe there. I was unhappy there. I didn't feel like I belonged and ... we lived in a hostel but went to a day school to a secondary mod and the woman in the hostel, whether she took a disliking to me or what it was about that she was pretty unkind em and would do things which I knew were wrong, but had not grounds, no grounds, it was nastily subtle. It wasn't overt, but it was ... it was cruel.

Lizzie: and we were stuck there for two and a half years – only getting back home once in that time because of several civil wars in the region. We were farmed out to an uncle we'd never met for the holidays. The long and short of it is that I became very rebellious and as stroppy as could be.

Pat: I've known many missionaries, and am aware of issues 'mish kids'[51] can have but this is one of the worst stories I have ever heard. Usually the boarding schools and hostels are run by very caring people, and many of the kids are very happy there,

[51] Commonly used term in missionary circles for "missionary children"

though some have difficulty re-adjusting to their 'home' countries when they return for higher education.

Lizzie: Not just the ones that had a good school experience – our eventual return to the UK was just awful! What happened was that another uncle was visiting Africa and when he was in the country he came to visit us. He was clearly shocked by how unhappy we were, and later also visited our parents and told them we had to be taken away from there. And, at last, my parents listened. My mum was already back in the UK because her sister was dying and wanted to see her before she died ….

Pat: Interesting that she was willing to drop everything for her sister, but not for you.

Lizzie: …. and we were put on a flight [as] unaccompanied children which was quite rare in those days. Later my dad sold up everything and returned too. But it was all culture shock plus, plus, plus, plus, plus……Nobody knew how to do this family thing. It was chaos, and I was in a mega rebellious place and completely confused.

Pat: What comes to mind is 'too little too late' as far as family life was concerned. And in the middle of all that you said your father was putting pressure on you to get a job. This was the way you said he put it: "You can't stay at school for ever. You've got to leave school and start earning some money for yourself". You said that when you were back in Africa he had had the same bluntness in the face of your tears when you had to return to the school you hated so much. I want to quote what you said about that too:

> "I can remember crying and crying and crying the night before we had to go back to school and my dad said 'Stop that. You're making your mother upset. You're going to school. God's work comes first. You're going back to school so stop it.' So it's like there is no point in protesting."

Lizzie: and crying wasn't allowed. He had a view of God that I don't now share.

Pat: It rather surprises me that you didn't turn your back on God. Your father sounds like such a dominant inflexible force in your life and most people take their image of God in some way from their experience of fathering.

Lizzie: So of course I did dad's bidding and got a job. I got a place at a hospital to train as a nurse – even though I really wanted to do horticulture (just didn't have the science subjects needed) – and surprised myself by enjoying it. It was like I built a new life for myself. All the same, even though there were bits I really liked, like night duty when I had opportunities to listen to some of the patients who couldn't sleep and they really affirmed me in that (although the staff didn't!). After I got married and had my first child I really didn't want to be a nurse any more. I didn't want the uniform. I didn't want to be told what to do. I wanted to be a mother.

Pat: Ahh – some echoes there – "didn't want to be told what to do!"?

Lizzie: I guess! But that was a strange time – after my daughter was born. I now think I must have had some measure of post-natal depression even then, although after my second child was born I went into a huge post-natal depression. That was a very bleak time. I was severely depressed and I didn't realise it. It never occurred to me to go to my GP.

Pat: That was a time when you got really mad with your mother when she visited.

Lizzie: Yes, she said to me 'You're quite depressed you know'. I was so angry with her. 'You cheeky bugger. You don't really know? What's it got to do with you? Of course I'm not depressed. I'd know if I was depressed.'

Pat: You know I felt quite relieved when you said that. There was much emotional neglect and marginalising by your parents when you were a child and yet you'd told those stories with very little emotion, but I sensed you were very much in touch with feelings just then. Like a lot of the anger which you hinted at when you spoke about being "ultra-rebellious" at school was finding its real focus.
But it was after that that you had your first experience of being a counselling client.

Lizzie: I have a chequered history of therapy. My first experience was truly awful.

Pat: Absolutely. I've seldom heard of such abusive treatment by a so-called 'counsellor'.

Lizzie: It has had a profound experience on my attitude to abuse in therapy – it's something I'm very sharp on when supervising.

Pat: I'm not surprised. Without going over the details again, which are so shocking, the primary features that you identified were its "unboundaried" nature, your counsellor's "grandiosity", and his lack of training or supervision.

Lizzie: You'll remember that I got into it through attending a conference where they engaged in a type of prayer ministry.

Pat: Y….es…

Lizzie: I went … believing that whatever was wrong with me - and I knew there was something badly wrong with me but didn't know what it was - would get healed because this was all to do with prayer.

Pat: So really, being so depressed already you were very vulnerable and very suggestible.

Lizzie: Yes. And I had a psychotic episode at that conference, but no-one knew what to do with it. There was somebody who actually happened to be a psychiatrist at this conference. I remember saying to him on the last morning 'What am I supposed to do now? I feel dreadful. I feel awful.' And I, I remember him dreamingly looking at me and said 'Oh well you need to go and see this counsellor [name]' who happened to live in the same town as me. 'He'll be able to help you.'

Pat: [groan]

Lizzie: So, desperate as I was, I did so. He was so abusive. I would I would emerge from sessions – some of which he would arrange for other 'helpers' ….

Pat: ahh [groan]

Lizzie: ….and I felt like done over by three different people, two of whom I'd never met before. That went on for two and a half years, by which time somehow or other I got a bit better, I don't know how. Then we moved because my husband went to college to train for ministry.

Pat: My reaction is to say "thank goodness!" You might have carried on with the guy for who knows how long otherwise.

Lizzie: Anyway, I was really interested in counselling by then and there was an opportunity to do some counselling training through my husband's college. I did all the modules and even became a trainer myself in the end. But there was a more difficult side for me too. During that time there was a therapy group I attended. I used to get really frightened with what used to come up for me in these group sessions and I got the feeling sometimes that the facilitating therapist didn't know what to do with me.

Pat: Sounds like an unsafe place for you.

Lizzie: Yes, but I weathered it and became more and more involved in the college's programme.

Pat: That wasn't your last experience of being in therapy though, was it?

Lizzie: No indeed. After a lot of other training elsewhere, and having established a practice I had a major psychotic breakdown, which was just awful. I was very suicidal, terrible terrible nightmares and dreams. For 3 years I couldn't practise.

Pat: You told me that you had managed to find a "very gentle, very sensitive and caring" therapist at that time. You continued with her, but she had recommended a psychiatric assessment.

Lizzie: Yes, and I was so fortunate there too, because I couldn't bear the thought that I might be admitted to hospital because it would be the same unit where I had previously worked as a lay chaplain. I begged not to be admitted to hospital. He was wonderful – he agreed, on the condition that I saw him weekly.

Pat: That was as well as your psychotherapist, wasn't it?

Lizzie: Yes. And he prescribed hefty doses of antidepressants, confident that they would work for me.

Pat: Although it was a long haul, you seem to have made a remarkable recovery given everything that had happened to you and that was lying dormant ready to explode as it did.
Other than your discomfort with the group therapy sessions you said very little about your initial training. But you went on to do other training after that.

Lizzie: Yes – the first course was Christian-based. The others were standard gestalt and integrative courses, and more recently sensorimotor.

Pat: Something struck me about an exchange you had on your gestalt course. One of your colleagues had said "You had — you were so traumatised as a kid". And you said "What? Not me! We had fun as kids."

Lizzie: Yes, it was only then that I first began to realise that I might have had a little bit of trauma when someone in the group said that. I think it began to open a door and I began to see that actually they were right. That was in my second year, and in my third year of Gestalt I got madly interested in PTSD…… I got really excited and interested in it.

Pat: I'd like to move on to look at some of the feelings that came, and come, up for you in your practice that might be relevant.

Lizzie: OK

Pat: There were two things that particularly stood out for me. One was the empathy you now feel for clients who have had mental health breakdowns. And the other, you've already mentioned, is your anger when you suspect abuse in therapy.

Lizzie: When I was still doing some Christian-based group work – at a retreat centre - I found myself co-facilitating groups with my previous counsellor, now as his colleague, not his client.

Pat: You didn't elaborate on that and I was rather bemused at the mildness of your reaction. You simply said "I was unhappy at the way I saw him treating other people because I knew it was what I had been through, and decided not to do it any more." This was such a contrast to your current "sharpness" in confronting client abuse

when you talked about your supervision practice. It makes me wonder if at that time, which must have pre-dated your recognition of your own trauma history, you were still very enmeshed with what I would call the *pseudo*-Christian teaching espoused by the 'counsellor'. I had to ask myself if you were harking back to the 'survival' mechanisms of your childhood when any dispute with your parents was pointless. So passive acceptance, then, or simply walking away, now, was your default.

Lizzie: It also pre-dated having any really effective therapy myself. Another thing too though about client abuse – I have to watch myself as well. Recently I had a client who left me feeling very angry and punitive and I said to my supervisor that I just felt like swiping him. My supervisor was very affirming and said 'You absolutely must listen to what's happening in your core self and stop working with this person. You do not have to be traumatised by him.'

Pat: When you were a mental health chaplain you said that you were afraid of mental illness, and did most of your work with the staff rather than the patients. But that that changed after your own major breakdown. You said

> "now, I'm not afraid of — when I worked in the mental health unit I used to be terrified of mental health issues. So I'm not afraid of people who've shown signs of psychosis or severe depression or anxiety depression."
>
> and
>
> "I feel that I have a real empathy to understand what it feels like for them to be in a place like that, em which I think is is significant"

Lizzie: But I have to watch out too. Sometimes I get, my own stuff gets triggered. You know, I, I find myself self, sort of seeing flashbacks of what I used to be.

Pat: I asked you how you felt about working with traumatised clients. You were very clear about that, and in an interesting way, distinguishing between clients who were very cognitive - with whom you felt colder and more distant - and those that are not. Of the latter you said "I feel warm, feel pleased, I feel, I feel a kind of a 'yes' inside"

Lizzie: Yes.

Pat: Here's an example you gave:

> "a new client phoned me this morning. He said 'I've lost my emotions' crying on the phone, um 'I don't know who I am any more. I don't know where my personality's gone to.' And what, what clicked in for me was a kind of 'yes, I think I can help you. I'd be willing to see you. I'd like to work with you. Let's arrange for an assessment session.'"

Lizzie: I'm much slower to take very cognitive people on. Hard work.

Reflections

Pat: I was particularly impressed by your reflectiveness in the interview. Perhaps we could move on from feelings to some of the ways in which you have processed your story.

Lizzie: OK, where do you want to start?

Pat: Let's take it in the same general order – from your childhood trauma onwards. You actually only used the word "abandonment" a couple of times, but in context this was clearly something that you had considered a great deal. You said, about half-term holidays in the school where you were sent to board at the age of four:

> "Everybody cleared off home and my aunt was always so busy she had little time for us, so it was, it was a lot of my early abandonment stuff comes from there."

You said that was your first experience of abandonment, but in the same sentence said you'd been 10 year at boarding school in 3 different places.

Lizzie: Yes, it had become an expected pattern. I see it now in terms of introjects – I'm not important, not cared about, a nuisance, parents can just dispose of me. These introjects had a very profound effect on me. I guess nursing was really the first thing I ever chose for myself.

Pat: While you gave me a pretty linear account of your story initially, as our conversation developed there were a number of occasions on which you referred back to your childhood and the way that it had affected you. Looking back on your

first traumatic therapy experience you now make a number of links to your earlier life. In so many ways it could be seen as classic re-traumatisation.

Lizzie: Yes. It was.

Pat: You made several references to boundaries – or lack of them. That maybe links in with the lack of respect of your personal boundaries as a child.

Lizzie: Yes, I'd learned very well that there was no point in saying 'Stop it. I don't want this.' There's no point saying 'Could we negotiate? Could we have something else here please?' And the way my therapist brought in strangers to help with the therapy sessions (confidentiality was nowhere)….. And I was so vulnerable that I had developed a very unhealthy dependency on him.

Pat: That comes out clearly here:

> "one of the times I went to him and I had the courage to say to him 'I feel like you're trampling all over me' and it took so much courage to say that because I thought 'he's just going to dismiss me and say 'OK you can get lost" and I felt my life depended on seeing him. And he got up out of his chair. He laid down on the floor and he said 'all right then. I want you to tramp all over me'. And I can remember just going into freeze"

Lizzie: And of course "freeze" is a classic trauma symptom.

Pat: Picturing that scene I actually felt quite sick. And very angry. You went on to say

> " I can remember this tiny little girl voice coming out saying 'I don't want to.' [in a tiny little voice] Where did that come from? So I must have completely dissociated."

Lizzie: Of course at the time I couldn't see it as I see it now. And the courage it had taken me to show any resistance to him was huge. From experiences like my father's insistence that I return to school I had leaned another lesson. The sense I make of it is that as a child it was absolutely not OK to protest. Another introject.

Pat: When I see people who have been traumatised as children I confess I think less in terms of introjects - although that's what they are – as in terms of survival strategies. We learn how to survive. Children are brilliant at that. But the

techniques that worked for them then kind of get embedded and carried into adult life. Your relationship with your abusive counsellor brought out this "little girl voice", hugely courageous to "protest" at all, but done in such a passive way.

Lizzie: An 'adult' response, had I been capable of it then, would have been to march out in high dudgeon and never return.

Pat: There were a couple of times in our interview when you did indicate that you had been "rebellious" and "stroppy" though.

Lizzie: Yes – once was when I was talking about my last school. You know before our uncle rescued us, as I learned later, plans were being hatched to send me to a psychiatrist. My behaviour must have been very challenging, but it was largely in response to the cruelty of the hostel warden and the perpetual feeling of being unsafe. I guess that it was OK to use the 'fight' trauma response with people who didn't matter to me – but not with parents – at least not then.

Pat: Also you were a teenager by then. The other time when you described yourself as rebellious was when you returned to the UK. And that was in the family context.

Lizzie: It had become pretty unbearable, and nursing was actually a way out.

Pat: [laugh] The 'flight' response this time?

Lizzie: Ha!

Pat: I wonder, if the 'survival' model[52] is correct, if you were by then realising, at least subconsciously, that you were not going to get the parental care and nurture that any young child needs and that it was up to you to get on with your life on your own.

Lizzie: Yes I'm definitely at the top end of the sensitive-withdrawn scale and self-reliant scale. It's one of my biggest difficulties to allow people to help me. Um, I'm much much much better than I used to be, way at the far end of that that self-reliant independent scale.

[52] Not called by this name, but descriptive of much of the underlying formulations made by sensorimotor psychotherapists like Janina Fisher. The basic premise is that the survival strategies learned by abused children are carried into adult life, where they are unlikely to work so well.

Pat: But of course it's seldom a linear process, and you later reverted in desperation and allowed yourself to be 'helped' by that counsellor. But eventually, years later when you had such a serious breakdown, you again sought help, but this time from the right people. Perhaps both your life experience and your own counselling training had enabled you to do that.

Lizzie: I'm sure that's true, and there had been a lot of water under the bridge since then. We have a good and happy marriage, and yes, by then I had had *lots* of training. My first training was Christian-based and humanistic. In those days, to be fair, most counselling training was Rogerian, and it was good in its own way, but I found myself shifting into a much more psychodynamic methodology which is why in the end I opted for an integrative training, and latterly sensorimotor. So you could say that I've been round the houses in the counselling world.

Pat: I'm a tad envious. Coming late into counselling I don't have nearly such a broad training experience. I wonder sometimes if it's only possible to be truly integrative if you have gone into several modalities in depth as you have. I asked you how much trauma counselling had featured in your general training.

Lizzie: Yes, and I think I said that I didn't think the word trauma was ever mentioned in my first training and only implicitly in my next, gestalt, training. But mind you the word trauma has become much more fashionable to use now than it was then, when a phrase like hurts from the past were more likely and maybe didn't sound as bad as trauma. I think in the counselling/therapy movement as a whole trauma has become, like stress, as the big thing. Trauma was the big word to use and all the associations with it and it was about that time that all the neuroscience was coming out…. that showed how actually trauma affects the body and the brain.

Pat: I guess that our profession, like others, has 'trends', and I suppose I have to agree that 'trauma' is quite 'popular' just now, but I'm not sorry about that. We have learned so much, as you say, from neuroscience recently. I do take issue though with people who minimise trauma by calling anything upsetting 'traumatic'. And I hear that from some counsellors as well as the general public.

Lizzie: It was really in my sensorimotor training that everything began to fall into place for me. At level 2 you do trauma training first, and then you do developmental then as we began to unpack developmental trauma ,,, it all began to make sense that whereas I thought for a long time 'I haven't been traumatised, I haven't been raped, I haven't been in car crashes, I haven't been in plane crashes. My life's been very ordinary'. When we began to look at the effects of developmental trauma then it was it was 'Ah-ha! Now I get it. Now I understand it.'

Pat: Janina Fisher is very hot on the value of psychoeducation in trauma counselling. I agree with her – and it looks as if that was significant for you. I liked what you said here:

> "The whole neurological strata gets damaged and changed and the whole biological stuff that the brain gets altered and changed."

Lizzie: Yes, psychoeducation is important but still you have to have that relationship with the client right first – you have to judge what is that right approach for them as individuals.

Pat: Yes. Just one more thing about training. You had some quite strong views about how counsellors should be trained, though without reference to your own.

Lizzie: That's mainly come from my experience as a supervisor, especially of PhD students[53].

Pat: Mine is more through supervising people who have done only foundation degrees and it sometimes seems to be a bit of a hit and miss process rather than based on a good understanding of what they are actually doing.

Lizzie: Maybe, but above all I believe it's doing your own work that is the most important thing. I think it's irresponsible to be attempting to work with people unless you've done your own work. Quite a few of the people I've supervised have been PhD students so driven for an academic qualification that their image is so narrowed down to their particular topic. I'm not happy with them practising because they

[53] My understanding is that Lizzie was not employed as an academic supervisor, but as a clinical one.

haven't got the spread and they are so left brain attaching to the work that they miss the clients empathically and don't even know how to go there.

Pat: You feel strongly about that, I can tell.

Lizzie: … particularly nowadays with, with training saying you don't have to be in your own counselling or therapy it's like — I'm not at all happy about that.

Pat: I agree with you up to a point, but I'm actually quite glad that the training I did recommended, but didn't insist on, concurrent therapy. I'd had years of therapy before I started training – and since – but I know I would have resented being forced into therapy. I know of a training course where not only do they insist on concurrent therapy, but they insist on students having therapy 'in house'. I've known a few casualties from that course. There's an incestuousness about it which I don't think is healthy.

Lizzie: I think it is different for different students. Some may feel safe to know that their counsellor is a tutor on this course though it may not be their tutor. For others it's really important to have that boundary where they can take their stuff right away. I think that would depend on the personality of the student but if they are told you have to go to somebody in the system, either they do that or they protest and have to go to somewhere else to train.

Pat: You said that the sensitive and withdrawn, self-reliant group might prefer to do their work outside the training environment. I was interested that you had used that description for yourself, so I guess that is maybe what you did. If so, I can identify with that!

I'd like to move on to focus more specifically on practice. The themes that emerged from our earlier discussion seemed to be

- Levels of empathy and appropriate approach to individuals
- The impact client material has on you
- Your competencies as a therapist.

Lizzie: We covered quite a lot didn't we?

Pat: You've already said you "don't have to put on empathy", that you "really know what it feels like". In context you were talking about clients who had mental health breakdowns. Because of your own experience you are no longer afraid of them, as you once had been. And also you have no difficulty in recommending psychiatric assessment, as your psychotherapist had done for you, and supporting psychiatric treatments.

Lizzie: I am so very grateful for the positive experience I had where a combination of an excellent therapist, a sympathetic psychiatrist and appropriate medication proved a life-saver.

Pat: I sensed though that empathy is not confined to such clients.

Lizzie: No, and it's strange but I believe it's no coincidence that virtually every client that comes my way has got developmental trauma. They just find their way to me.

Pat: And you feel warm towards many of them, though you struggle more if they are highly cognitive.

Lizzie: yes that's true. That maybe leads on to another theme you mentioned – the impact clients can have on me. I mentioned a man who was so defended that he challenged every single attempt I made to help him and I've reflected on that. I think it harks back to not being listened to as a child. I remember wanting to say to him 'You won't listen to me. You won't look at me. You won't do what I want you to do. I'm trying to help you and you won't accept my help.' And I thought it was a countertransference coming up from my past.

Pat: This was the guy you wanted to swipe, wasn't it?

Lizzie: Yes [laugh]. But seriously I do pay attention to what's going on in me. It's like, my countertransference response, and I sometimes have to say "Hang on a minute, Lizzie, hang on. Is this is my history coming up to collide? Is this in the room coming from the client - this need to get sarcastic, to be swipey, to become a bully myself, um, to feel that "where is this coming from?" And in a sense it doesn't

matter where it's coming from. It's professionally how do I hold myself in this aggressive space where I'm feeling aggressive. And so I'm often — take quite a long time — I can disengage but I'm kind of thinking, not entirely about my past but what might I be bringing forwards from that because I don't want to, you know, I don't want to injure somebody when they're already hurting badly.

Pat: In another place you said something else about cognitive clients which sounded more like an empathic awareness too though. You said:

> "A very cognitive person has lost their ability to stabilise through being cognitive for some reason therefore there's a trauma issue around somewhere, although the defensive or the, the supportive structure is to be very, very cognitive and to avoid going anywhere near emotion. Nevertheless they wouldn't be coming to me unless that system had got disrupted somewhere."

Lizzie: There should be both shouldn't there – empathy, and a congruent self-awareness that takes note of countertransference?

Pat: Can't disagree with that.

Lizzie: At the end of the day, I feel it's my responsibility to check myself because sometimes my own stuff gets triggered. I was a little wary that this interview might trigger me – I'm glad it hasn't, but if it had I would later, by way of self-care, acknowledge it and spend some time in meditative prayer or just in quiet mindfulness or something. I believe self-care is important in this kind of work.

Pat: Indeed. I'm also interested in the actual way you work with trauma clients. Overall, I had the impression that you were quite strongly influenced by your sensorimotor training, but that you use other modalities where you believe they are indicated.

Lizzie: Yes, sensorimotor doesn't work for everyone. But I think a lot of the time our clients' bodies tell us what they need, rather than their words, and we can train ourselves to 'read' and 'listen' to that. I can think of one very traumatised client I saw who became much more settled after consistent sensorimotor work over weeks – very effective – but sensorimotor debriefing of another client didn't work at all so I

went on to use the Rewind NLP technique with him because while he was very cognitive he was very good at imagery and that was very helpful. I use Rewind with quite a number of clients. I don't believe in, in just coming from one stable all the time. There are other approaches to trauma out there too - Gestalt, EFT, EMDR and so on, but principally I would use sensorimotor or, when more appropriate, Rewind. So it's like if something doesn't work, try something else. So I don't stick rigidly. I sense what is going to be best for this? What have I got in the toolkit? I mean at the end of the day it's about being therapeutic rather than stick to a modality. So I have some degree of flexibility around that.

Pat: You'll remember that I expressed some interest in traumatic dissociation. Knowing what I do of sensorimotor psychotherapy I imagined that you would be very familiar with working with it, and that seems to be the case.

Lizzie: Yes, but I can only remember working with two DID clients. But I've recently been working with one lady with DDNOS[54]. She just freezes and goes dumb and can't talk, and I have to talk for her and that brings her back.

Pat: Yes, you talked about the spectrum of dissociation – 'highway hypnosis' (or what we Brits are more likely to call 'motorway amnesia') right through to the full-blown switching seen in DID.

Lizzie: I guess where I work is somewhere, somewhere around the middle … I mean I've got one client I often see switching but not in a mega way, but her eyes kind of go like that and I know she's switched, or the tone of voice will suddenly move, change. So … I see it as a spectrum. If a client is within their window of tolerance ...

Pat: You mean the safe zone between hyper- and hypo-arousal?

Lizzie: Yes. But if they are hyper- and hypo-aroused nothing's fixed. It's like being able to intuit and notice and be with not so much the words but what's happening right in the room right in front of you or picking it up in myself thinking 'that doesn't make sense', or suddenly feeling cold or something like that. And then taking it back

54 DID – Dissociative Identity Disorder; DDNOS – Dissociative Disorder Not Otherwise Specified.

to the clients and saying "What's going on here?" and then whatever's going on working it from there.

Pat: And you said you liked Lana Epstein's[55] gentle way of simultaneously affirming a client's thinking part and encouraging them to side-line it so as to access their emotional part: "could we just ask it to step aside so that the emotional part come forward?"

Lizzie: It works, quite often. One point I'd like to make though – normally in the very first session or two I'll say 'If I use the word parts' I'll say 'it doesn't for a minute mean you're schizophrenic ….or there's anything mentally wrong with you'. I'll say 'When I'm talking to myself, there's one part talking to another part, and I'm perfectly healthy'

Pat: I shared with you that I had suffered from one of the negative manifestations of dissociation and said that I had never experienced it in a session. And you rather pounced on that, saying that I wouldn't know if I'd dissociated and if the therapist didn't pick it up it was their issue not mine.

Lizzie: Absolutely.

Pat: I can't actually agree with you on that, although I appreciate that you are maybe defending me against blaming myself rather than my therapists, but the derealisation experience is one I am always aware of – it is so unpleasant. So I guess we might be using a rather different definition of dissociation. It seems you are thinking more specifically of splitting, and of course I'd agree with you that clients are unlikely to know that they are doing that, while I am using it in a broader sense.
That brings me on to thinking about other definitions. I asked you for an 'off-the-cuff' definition of trauma. This is what you said:

> "off the top of my head: it would be a violent disruption of relationship with the self or with others, um, that leaves the individual, um, distressed, considerably distressed and disorientated. I guess that would be it. And then overall a subtext would be that being, um, distressed, being dysregulated, um, of all of that flight fight freeze attack responses kind of

[55] Tutor, Sensorimotor Institute

> banging all over the place. But I think basically it's a disruption to the self and disruption to relationships, disruption of the environment."

I found that really interesting, and wondered if it emerged from you own personal experience of trauma.

Lizzie: Perhaps it couldn't be otherwise. I come back again to my wariness of people who are only interested in the academic side of counselling without a willingness to do their own work.

Pat: There's another angle to that too – the insistence of some organisations (and I guess I'm thinking particularly of the NHS) – on using only one or two modalities in trauma therapy. That again looks to me like being based more on sticking to quantitative empirical evidence – though nothing wrong with that – to the exclusion of the more nuanced experiential evidence which might be provided by individual therapists.

Lizzie: Yes, I come back to my point about the need to be flexible if one is to be truly therapeutic.

Pat: You shared some lovely things about what you'd learned from your own therapist's work with you, and how you incorporate them into your own practice.

Lizzie: The one that comes mostly to mind as you say that straight away is that when a person is very very distressed and they're just weeping and weeping and weeping is something that I learned from that therapist …was just to say nothing and just to go 'Mm, oh, .. oh that hurts' [very quietly] - minimal but keep the contact going, saying nothing until they, till they come back into the contact. I now understand it's a social engagement system. I keep the social engagement system linked by just 'ooh, yes, yes, it hurts, oh this is sad, oh yes' [very quietly] so little little things like that. … The other my therapist was really good at is what I came to call burbling, and she'd go on talking like this in a very quiet voice 'It was so hard for you when you were little, wasn't it? There was just nobody there for you at all.' And she'd go on like this for minutes at a time, and it was like, it was like soothing oil being poured on.

I do that sometimes, particularly if a client looks like they've gone a long way off…. like on the edge of dissociating. I'll start this almost semi-hypnotic burbling, like you're speaking to a 2-year old or a baby, and just keep it going, keep it going, with hardly any pauses in it, and that seems to reach a lot of people and it really settles them. Their whole limbic system goes down. You can see it happening, settling, and I think it's to do with the contact. It's that very primary level of contact. This is what animals do. Birds go 'cheep, cheep, cheep, cheep, cheep' to little embryo birds in the eggs, and I learned that from her.

Pat: You linked that back to your time at boarding school when "there was nobody there".

Lizzie: So to have somebody staying with me and let me know they were there because I could hear the voice. I could hear actually the breathing change or I could hear the 'ahh' - little things like that, really kind of made a big difference.

Pat: You warmed to the term 'wounded healer'

Lizzie: I almost want to say it's like your badge of approval if you've been through your own developmental or trauma healing. It's like you've, you've kind of earned the right to walk with somebody else though theirs.

Promenade to Chapter 11

Lizzie's was one of those pictures by which you are both fascinated and repelled. Something like one of those grand battle scenes full of blood and gore, but bringing to the viewer one special combatant's heroism and the message of ultimate victory. I walked away therefore with both relief and hope, wondering what the next, the last, picture would say to me.

Fran and I hit it off immediately. We laughed a lot. We had a similar quirky way of looking at life and counselling. This was the longest of the interviews but seemed to go in a flash. There was so much energy in the room. Fran was very enthusiastic about the project, and there was a meeting of minds on the importance of research and addressing this particular research topic.

Only when I came to transcribe the interview did I notice how Fran very frequently did not complete sentences, and broke off mid-word when she thought of something new to say. Yet in spite of this I had no difficulty in following her meaning at the time. The more absorbed I became in analysing the transcript the more extraordinary this seemed. Most counsellors still manage to get the general drift of what is being conveyed when they work with clients who are far from articulate or consistent in their verbal communication, but this was different. It did seem that Fran and I shared, unconsciously maybe, a common language which did not rely on words.

One explanation for the broken flow of language could simply be that Fran is a very quick thinker, and new thoughts were arriving quicker than her articulation of the current one. There is some evidence from her story – such as her 'next day' phone call to Scotland Yard after 'discovering' psychology – that she has an impetuous trait. But I am left with the impression that, even if this is true, it does not explain my own ease in mentally finishing her sentences for her. I am left with the question of whether there was some kind of transpersonal mechanism operating between us, facilitated by our shared experiences of developmental trauma.

Given this marked connection, and her enthusiasm for the project, it is still surprising to me that Fran was the only participant who did not respond to any further

communication from me by way of follow-up to the interview. I found this ethically challenging, leaving me with a conflict between simply trusting that as she had not withdrawn consent, thus allowing me to use her material, and a respectful desire not only to have her 'participant check' her story and choose a pseudonym ('Fran' was my choice for her) but some guidance as to which unique disclosures could lead to her identification. Having discussed this in supervision, and having made several attempts to contact Fran by different means, I decided to use her material on the basis of her initial consent, but I did alter some details to strengthen protection of her identity. These alterations, however, are very unlikely to influence the analysis.

Chapter 11. Fran

11.1. Vignette

Fran: How did I become a therapist? I'm trying to plump for whether to give you the kind of politically correct, the kind of *cleansed* version of my story, or a more brutally honest version. Well, it started years ago when I was in my 20s and *very* angry. I was working in a pub at the time. A whodunit film was shown on the telly about how the murderer was found by profiling. It blew me away because - I know it sounds naïve - but I'd never even heard of psychology and suddenly I saw this film. My reaction was " What? Woah. People get *paid* to study this thing called *psychology?"* and it really grabbed my interest. I managed to embarrass myself, because the next day I phoned Scotland Yard from here in the Midlands saying I'd seen this film and asking how one would become a profiler! After the man stopped laughing at me he explained that I'd have to have a psychology degree and lots more experience besides.

It was from that point that I started looking at what psychology was and I think that was my way of trying to make sense of all my pain. Before that I'd tried different types of therapy - person-centred, CBT, psychodynamic - and *none* of them had worked. To be fair, I had once found a hypnotherapist who I related to better but at that particular time I wasn't well supported outside therapy and it was all a bit too much and I went down some less legal ways of coping. By the time I discovered psychology I had lost touch with him and wasn't really in a place where I wanted to have more therapy. Instead, I was thinking "if other people can't help me then I'll have to get myself in a position that I can help myself" so I updated my qualifications and off I went to uni' to do psychology.

I ended up taking the clinical psychology route and got a job working in the prisons. I loved working with the prisoners, but I was frustrated too, because I wanted to work therapeutically but most of my time was spent doing assessments. What I most

enjoyed was making that connection with people. At that time counselling psychology wasn't really an option, not locally anyway, and so I signed up for a counselling diploma. I found that a culture shock, and at the time I didn't enjoy it. But in retrospect, because I later processed some of the stuff that it triggered, I do see that it was helpful. So no regrets. Almost as soon as I'd finished the Diploma a Counselling Psychology Doctorate started at a university within travelling distance and I went on to do that. Personal therapy was part of my training but it wasn't all trauma-related.

Behind all that were my childhood experiences. I'd been sent off to boarding school, where I'd been abused by the doctor there and not believed when I reported it to a teacher – told I was "a vile child making up stuff" and was punished for it. But even before that I had been growing up in a very patriarchal violent male-dominated world where my mum would get beatings regularly, dad haranguing her for having a daughter instead of a son. There was also a lot of implicit stuff going on – dad telling me as a child all the time "Don't cry! It's a weakness"; and even after I married his choice was to talk to my husband rather than me on any important matter. Even from a very young age I became a very angry child, even though I did not dare to express it at home – not around my father anyway – but it caused lots of trouble at school.

My specialism in forensic clinical psychology had been sexual abuse of children and my prison work was largely with male perpetrators. In contrast my counselling training placement was in an organisation working with mainly female survivors of sexual abuse. I continue to work there, now principally with teenagers, as well as having a private practice.

11.2. The Conversation

Feelings

Pat: When we introduced ourselves and I said what form this interview would take, you showed no concerns, as some other participants did, about sharing your story, even though I gave you a clear let-out.

Fran: No, I love research and having been sitting where you are I know what it's like to find participants. And I almost feel a little bit indulgent somehow to have a space to talk about me! I'm always aware of recording, but I felt fine about being probed and didn't have any concerns or worries. It's an area I'm really interested in too.

Pat: To summarise, I picked up that you had two different childhood traumas to contend with. One was your growing up in a family where your father was, in your words, "a complete bastard I mean total horrible violent horrible husband" and the second was being sexually abused by the school doctor.

Fran: And not believed.

Pat: And not believed. At one point you referred to "violent alcoholic parents" which made me wonder if your mother was addicted too. But most of the time you focussed on your father's abusiveness.

Fran: He was also deeply sexist – misogynist indeed. Mum would get beatings regularly because she 'couldn't even have a son' and would disparagingly sneer that she 'had to have a daughter'.

Pat: Hardly a context that would help you feel good about yourself. It didn't surprise me when you described yourself as being "very angry".

Fran: I later came to realise in my early 20s that I was not only angry but was actually in pain. I was very sad but I was an angry person. That's what folk saw.

Pat: I asked you when you first became aware of being angry and you said you'd always been angry.

Fran: Even as a little tiny tiny girl I remember feeling angry. But the family didn't like it so I learned to avoid trouble at home. You daren't be angry at home. But dad didn't like crying either!

Pat: You described your dad as "terrifying" – I can believe it – and that sometimes you vented your anger on your mum instead.

Fran: Yes, and whenever I feel any shame about those days it's usually been about me taking my anger out on my mum.

Pat: School was different though.

Fran: Yes. It was an expensive boarding school where you had to find sneaky ways to be a rebel. But I succeeded and got into lots of trouble. Again that was all cultural and shame. Causing trouble there is not the same as causing say trouble if I'd gone to my local state school.

Pat: I went to a day school which may have been a bit like that. Shame was used as a powerful weapon to get us to conform, so you learned to be angry in different ways.

Fran: Yes I think if I'd been to the local comp I'd have been into drugs and sported tattoos but I was in an environment that being bad meant having your socks down and talking back and having an attitude. I smoked. That was the ultimate. And we had these political debates with the Headmistress. Once I said 'I want to be a Communist' - I mean just to piss her off'.

Pat: Believe it or not I said something rather similar to our headmistress once! If we'd been at school together I bet we'd have paired up and caused havoc!

Fran: That pattern continued after school too. I deliberately picked very very wrong relationships 'cos I wanted angry men to be with so I could be angry back to them. I was never allowed to be angry back to my dad. My anger was of the kind that was saying 'nobody listened to me so I'm going to make the world pay'.

Pat: I'm wondering if 'nobody listened' referred back not only to your family but also to that awful time that you were not only disbelieved when you disclosed the doctor's sexual abuse but were yourself punished for lying.

Fran: Undoubtedly one fed into the other.

Pat: I was struck by the fact that you mentioned twice, at different times, that you held no residual anger against your abuser, but that it was the school you wanted punished, not him.

Fran: I guess that resolution came with my quest to understand perpetrators. Now I can have empathy for him and would want him to seek help – if he's still alive (I don't know and don't care). But what I can't forgive is the school's response to me. I want the school punished. I genuinely do not carry any anger or pain any more towards my abuser.

Pat: You had some therapy before you thought of training in psychology, didn't you?

Fran: Yes, and most of it was pretty awful. Although I wouldn't have put the label on myself as 'traumatised' at that time I knew that it wasn't right to grow up in that much fear and shame. And I was aware of loneliness and isolation. But the various therapists I tried, bar one, didn't suit me at all. I'd tried person-centred and that was awful. It was just this nodding woman just, you know "so you're angry". I've just told you I'm angry. I don't need you to tell me, repeat back what — found that very frustrating. I tried CBT which was horrible. The girl didn't — it was just so cold. I tried psychodynamic, which was the theory that appealed to me in terms of any reading that I'd done it was one that had most resonance with me in terms of the theory but in practice I hadn't found it that helpful, because I think she was trying to be too interpretive and too clever. In the end I just said 'Bugger this, I'll do it myself!' So I did.

Pat: So while you'd been having these various therapies you'd also been reading about them?

Fran: Yes – so it's maybe all the more surprising that the idea of psychology seems to have passed me by. I hadn't seen the connection before seeing that film. It was only then, by which time I'd pretty well given up on the idea of therapy and was thinking that I'd have to sort my own problems out.

Pat: It rather seemed that the psychodynamic counsellor was the one who had the most negative impact on you. At one point you said to me when you picked up a very supercilious tone in her voice "It just made me go 'Arrrgh'" and you made a sound of sheer frustration and exasperation.

Fran: The only help I got at that time was from a hypnotherapist I'd found in Yellow Pages. He was brilliant. He was also brutal. But that really suited me!

Pat: I'd like to come back to that later. But you didn't stick with it then, did you?

Fran: No. The only reason why I didn't stick with the hypnotherapy was that it was too difficult. It really brought up a lot of stuff about — I wasn't really in a good place. I had no-one holding me. It opened Pandora's box but I didn't have good friends or good family or anything around me at the time so yes, so it wasn't a good time. I was also exhausted. It seemed easier to try other less legal ways of coping, shall we say.

Pat: You said that when you were in a better place you did try to find him again but couldn't.

Fran: Yes. In spite of having given up on that therapy, I remembered that there had been a significant shift in me then, so I was disappointed that I couldn't even remember his name.

Pat: When you 'discovered' psychology you threw yourself into studying in a big way, updating your qualifications to enable you to study it at university.

Fran: Yes. My experiences of therapy had been so negative that I had come to the conclusion that if other people can't help me then I'll have to get myself in a position that I can help myself. Desperation maybe! I did my degree, and specialised in forensic psychology.

Pat: I found it fascinating that the job you took after that was in the prison service working with sex offenders. But although you said that there was something in you that needed to understand these guys, having been a victim yourself, the job wasn't entirely satisfactory. You became frustrated. You said

> "I loved the work, well I loved the prisoners and I loved ... making that connection with people" but "it then became very clear in the prisons that it was all about risk assessment, parole reports and that's not what I signed up for".

Fran: No, I know this sounds like a soap box, but I signed up to make a difference. The only route towards doing more of that at the time seemed to be to train as a counsellor, and I signed up for a post-graduate diploma.

Pat: That didn't quite live up to expectations, did it?

Fran: I actually found the diploma very abusive. I didn't enjoy it.

Pat: From what you said, you sensed abusiveness in what you saw as poor boundary-keeping by the staff, especially in group work.

Fran: I don't think the groups were held safely. It brought back a lot of shame issues? I felt under attack quite a lot. At the time it felt horrible. It just didn't feel safe, and I felt very exposed.

Pat: I challenged you at the time about this seeming to fly against your preference for a combative style when you were a counselling client. I wonder if the difference could be explained by your maybe not feeling confident in the ability of those around you to 'hold' you. You had said there was a lot of "fragility" in the group, so I guess that would make sense.

Fran: I was pretty fragile too in as much as I found myself in a very different environment to psychology. Experiential learning and supervision were new to me. I've quite a critical stance of learning and that didn't go down well, so I didn't feel very heard and that that was very triggering for me. Combativeness needs to be in a safe environment for me.

Pat: You gave an example. When in an exercise you and your partner had tried out a different way of arranging the chairs to see if either of you would find it made it easier for you to talk – and it did – but you felt the staff jumped to the conclusion that you were being defensive without hearing you out.

Fran: Yes. And it was so different when I went on to do the Counselling Psychology Doctorate – they positively embraced that kind of experimentation, like 'Yes, this is good, keep it up'. Since the Doctorate I've learned to love groups, and enjoy challenging groups. It's when I've not been heard, or I've been misunderstood that I get triggered.

Pat: It seemed to me that you enjoyed your doctoral training a lot. You became very animated describing some of the seminars and – yes – groups that you'd been in, and the reading had clearly energised you. You particularly liked Van Scoyoc and Orlans' (2009, p19) view that counselling psychologists are the mavericks, and the rebellious.

Fran: As soon as I read that sentence I thought 'that's me!'

Pat: Your earliest private work was with men who were sexually attracted to children. You said you were "passionate" about the subject.

Fran: Yes I was. I was still too close to my own pain as a victim to be attracted to working with survivors. And even when I was considering counselling training I was still wanting to use those skills towards the forensic population.

Pat: And you told me about the stir you'd caused when in counselling training you'd had a discussion about what kinds of clients you would not want to work with and you'd said "the worried well" when most of the class were saying things like paedophiles and religious fundamentalists.

Fran: I just couldn't imagine myself patiently listening to someone complaining about her husband cutting her allowance and that she'd have to sell the Audi and buy a Skoda. That just seemed really trivial to me and I couldn't empathise with that at all.

Pat: There's a speculative part of me that wonders if that particular illustration might have something to do with a reaction against your own upbringing where clearly money wasn't short. I'm just thinking aloud. More recently in a similar vein you said you'd become aware of being irritated by some of the trivial complaints of your children when you'd come back from a day at work with teenagers who had faced major traumas in their lives.

Fran: Yes, it took discussion with my therapist to realise that this was normal!

Pat: Talking about reactions to clients you said you'd felt awful about taking a dislike to a client when you were on placement. Your supervisor was reassuring in pointing out that the lady was showing borderline processes and some of her attitude could be attributed to that, but what was even more interesting to you was that you realised then that you'd never worked with a woman before.

Fran: Yes, that's true, and later on the gender thing came up again. I have difficulty working with highly defended women, but love working with a defended man! I realised that I was getting excited about the idea of working with that kind of presentation, but only if it's a man.

Pat: But angry women draw out your empathy too.

Fran: Yes, I think I can truly say 'You're so full of rage and I know' (because I've been there myself).

Pat: I was interested in the way your own anger has changed. You were full of a kind of destructive rage in your 20s, but when we talked you said:

> "Anger now really fuels my motivation and fuels my passion and it's sort of half anger",

and that in your work

> "Instead of getting angry I used the energy kind of — trust my instincts about what's right for my client and me."

Fran: Especially in working with young people, I would find it very easy for me to get drawn into a kind of anti-establishment anti-authority place, so I have to be aware of that and keep a check in supervision that it's not shaping how I'm working.

Pat: Just one last point about the feelings you expressed during the interview. You work in an organisation which has an emphasis on sexual abuse, and I thought it was interesting that your own relationship with sex might be summed up as 'take it or leave it'.

Fran: That's true. Maybe I don't rate sex. If I never have sex again that wouldn't really bother me. But what would bother me is if I didn't have the closeness with my husband that is always there after sex or the laughs or the shared looks or the kind of sensitive touches or the kind of intimacy.

Pat: You said you "couldn't live without that". But I guess the issues you're dealing with in counselling are in a different ball park.

Fran: You could say that.

Reflections

Pat: We've talked about the feeling you expressed in the interview, but let's look now a bit more at the sense you made of them. As far as your trauma is concerned may I summarise some of your reflections?

a) You have an awareness that you still cannot forgive the response of your school about your abuse and that you risk colluding with your young clients' anti-authority feelings.

b) Your abuse experience has also resulted in your awareness that "there's something driving me about people who need to be able to speak the unspeakable" and this is what has given you a passion for working with people who might normally be "disenfranchised from therapy". This is one of the things that attracted you initially to work with abusers.

c) While you were terrified of your father, you also loved him and this has given you an understanding that it was possible to both love and hate at the same time.

d) You reflected that "growing up in a very kind of patriarchal violent male-dominated world" that was also violent had resulted in your being a very angry young woman.

Fran: yes that's right. I came to understand that anger lay behind most of the feelings that had taken me into therapy.

Pat: You'd had pretty unhappy experiences of therapy.

Fran: Yes, at the time it drove me into trying to find ways of helping myself instead, but later on I came to realise it was probably more to do with the therapists themselves than the modalities they were following. For example, I know now that CBT's come a long way since then and I've even experienced people who do CBT in a very person-centred way but when I tried it back in the '80s there was no personal connection there at all.

Pat: I surmised that your relationship with personal therapy had changed by the time you had to have therapy as part of your training.

Fran: Yes, but I think I'd realised somewhere along the line that I, personally, had needed the combative style that I'd found in the first hypnotherapist. I don't know whether or not he was actually very good but he was good for me. That's what I needed and that's what I responded really well to. I did try hypnotherapy again years later but it wasn't the same because I thought maybe it's hypnotherapy that worked but it wasn't. He must have done it in a safe enough way. There aren't many who can be combative in a Fritz Perls kind of way. I certainly can't. Most therapists are trying to be nice.

Pat: You said you believe you'll always be in therapy, even if just intermittently.

Fran: Yes. My supervisor doesn't have that professional-personal cut-off. She's very aware of how each flows into one another and I think that's why it's important to

always be in therapy. I like that. Supervision helps to prompt me about things I need to take to therapy. I know there will be unconscious stuff going on.

Pat: Having "discovered" psychology you took a psychology degree in which your forensic specialisation was in sexual offences against children.

Fran: Yes, I was still on that quest to understand what had happened to me.

Pat: And you went on to work for some time in the prison service but increasingly found the work unsatisfying because you were restricted in the time you could spend getting to know the men in depth.

Fran: Yes, I wanted to work therapeutically and I had previously thought that was what clinical psychology was about and I became quite aware that actually it wasn't so that's the background to my moving sideways into counselling training.

Pat: You may have thought it was just a sideways move, but you found yourself in "a different world".

Fran: Yes suddenly people start talking about supervision, like 'What? What are you talking about?' and your own process. 'Woah, what are you talking about?' It was a real struggle to adapt to such a different way of thinking. I can see this now but I couldn't see it at the time. I can see this now because after that I did my doctorate elsewhere, and no offence to my counselling trainers, but these guys really know what they're doing and it all made sense then. It was like one talked the talk but the other did it.

Pat: You said the effect that this counselling training had on you was that you "put up old patterns of responding - shutting down and disconnecting with the group".

Fran: Yes, it's like that's little Fran again, nobody's hearing. And then I'd started to do this kind of true/false self. I started to take on a persona in the group. It wasn't really me, and then that resonated a lot with the way I behaved at home as a child. You put on a public face. That felt very familiar, so I could do that. It was easy.

Pat: Patterns being repeated.

Fran: At the time I couldn't see how any of it was helpful, but later when I did the doctorate I was able to then process that and make sense of it and looking back I now see that the experience *was* helpful.

Pat: You said that the practice hours and the psychodynamic input in your diploma were particularly useful. I guess that was something you hadn't had a lot of in your psychology degree and was in the end a useful bridge into counselling psychology.

Fran: Maybe that's right. I got asked in my doctorate viva 'Did I regret?' and I don't, absolutely not.

Pat: You particularly singled out group work. That was something you had found hard in the diploma, but in the doctorate you had a very different experience.

Fran: Now that I've experienced actually the power of groups and when they're done well and done safely, they're amazing. I don't honestly know whether I'd been put off in the diploma but I'd been convinced that groups weren't for me. Perhaps it was just because they had been poorly facilitated or maybe it was a combination of lots of different things but I've certainly changed my ideas about them since.

Pat: Going on to specific trauma training, you were hazy about how much it had been covered in your counselling diploma. You said you remembered input on Margaret Warner's work[56] but not much else. But your main trauma training was in the organisation you now work for.

Fran: Yes, and it's terrific. I can say if I'm honest I think most of it came from here. In the doctorate in counselling psychology as well, you know, we had two days on sexual abuse and trauma, but to be fair the expectation on a doctorate is that you would then go and read more. That was in the formal taught stuff but [trauma] did come up a lot more in the experiential side in the workshops and things like that.

Pat: You said that your clients have taught you too.

Fran: I remember the first time I had a client who had a dissociative seizure. That was a learning curve. So every day you're learning more.

[56] On fragile process (e.g. Warner, 1998, 2000)

Pat: Talking of dissociation I also asked if you thought counsellors generally were well-equipped to recognise it ...

Fran: ... and I said unfortunately not. I don't think many of them are unless they have perhaps trained at somewhere like Rape Crisis or they've had specialist kind of input.

Pat: I've often wondered if counsellors who have been traumatised themselves are more likely to recognise trauma symptoms like dissociation. One of the reasons I'm doing this research is the experience of seeing clients whose trauma hasn't been recognised by previous counsellors.

Fran: The students we had on the doctorate - it was half and half. There was a lot of people that I think were very clued up but some who weren't.

Pat: That's interesting. When you were doing the doctorate, you had to be on some placements with clinical psychology students and you came over as quite critical of them.

Fran: Oh dear!

Pat: No, sorry, I'm thinking of the remarks you made, for example, about the time when you were comparing what the clinical training was like compared to the counselling psychology training and you were enthusing about a bereavement workshop run by someone. A clinical psychologist had said that they had had the same workshop and they'd put in a complaint about it. She'd said 'The theory was very good but all that emotional stuff - it should have been optional because a lot of us were dealing with our own grief and we weren't given warning.'

Fran: I was amazed. You know we'll go to the dark places with the client whereas they were horrified, absolutely horrified that this woman would dare to use experiential teaching. They'd put in a complaint because it had triggered their own processes of grief and loss whereas we were all like 'yes that was brilliant!' ..There's something about the training and the expectation that the clinical psychologists just feel that they weren't expected, nor did they want, to go with their own personal stuff.

Pat: As you said that, I can't help wondering if there are counselling courses out there that shy away a little from doing that too. I'm thinking of courses where personal therapy is not a requirement, or some in which it might be recommended but done so in a rather half-hearted way. I suppose some of my misgivings about CBT might be coming out here – at least CBT as it's taught to nurses and others working at a basic level in the IAPT system in England. All pretty manualised. Their training, like much of the clinical psychologists' training will borrow heavily from a medical model, which is itself based in a positivist philosophy.

Fran: I don't think it's CBT *per se*. I went on a CBT workshop run by Christine Padesky who trained under both Rogers and Beck.

Pat: An interesting combination!

Fran: In role plays she seemed to do it in such a Rogerian way, if there is such a thing! I'm not a big CBT person - that's why I went on the conference because I wanted to build on my knowledge. And it's a shame because I think CBT then gets a lot of the blame when actually I think it's less to do with CBT and more to do with the ethos of the person using it. I suppose it's like the Dangerous Dog Act isn't it? It's less to do with the dog, it's more to do with the owners. So I think it's the same with CBT.

Pat: Loved that! And surely that might be true of any modality? In my own basic person-centred training our tutor used to say that so many courses were person-centred because it was the easiest model to teach badly!

Fran: Yes, and probably one of the ones that's the most easily misunderstood. Because of the language of person-centred, people think they've got it. But with some other models like psychodynamic the concepts takes some wrestling with. A lot of the terminology terrifies me! You're just beginning to think you understand a bit of it, then you read Melanie Klein and say 'Now I'm really confused'!

Pat: So now we come on the central question as to how all these experiences and reflections have impacted on the way you practise.

Fran: The first prompt to decide to move from forensic psychology to counselling was the conversation with my seniors in the prison who noted that I took twice as long to do risk assessments - 'cos I actually engaged with prisoners and asked them about their life and things. Their attitude was 'why do we care?' and it made me realise just how much I *did* care.

Pat: And your caring stemmed from some of your own experiences? I'm thinking particularly of your saying that "not being heard" was a particularly painful memory. And you had this passion for enabling people to "speak the unspeakable".

Fran: Yes, here were these guys who were shunned by society and, I felt (and feel) needed some other human being to hear them, and let them speak.

Pat: when I asked you about the work you do now you said "there's something about people being disenfranchised from therapy for a start and there's something about people that normally don't get heard being heard. I'm absolutely passionate about it."

Fran: I know it comes from that that place of everyone deserves to be heard no matter how painful or how abhorrent.

Pat: You started working with sex offenders, but now you work mainly with survivors.

Fran: And I think it mirrors my move from clinical to counselling and counselling psychology. When I realised that I wanted to work within the area of sexual abuse just like I had done in theory I went to the offenders' side first, again because I think it was like because I wanted to understand for myself from their point of view and then once I was able to do that and had some sort of understanding and empathy with that it was only then that I was able to move on to work with survivors. There was something about victims being too close for me at that stage in my life because I hadn't processed the pain.

Pat: And you said you knew that you had work of your own to do before working with survivors.

Fran: Did you notice though that I used the term victims, not survivors, deliberately? In this centre we use the word survivor but where you work with men they use the word survivor to minimise so I don't like the word survivor because they will say "oh but people survive it all the time" so when I'm working with men I always use the word victim.

Pat: You said that you know many people don't like the term victim, and indeed you don't yourself, but I understand what you're saying about the context, and how it's important to you that perpetrators aren't given an opportunity to minimise the effect of their behaviour.

Fran: So I came into work with survivors much later. But yes in terms of my own trauma shaping what I'm trying to say is that there is another kind of global thing that definitely drives that need to let me empower people to speak. At the time of choosing what areas to work in it was more to do with what interested me, rather than it being well thought through. It's only in hindsight that I understand the process.

Pat: Your thing about reluctance to work with the "worried well"? You admitted to finding empathy difficult.

Fran: I'm much better but there was definitely something about my trauma even then shaping my empathy and that's a lesson that I've had to learn again with my own children when working with young people here. I've had to take some irritation with my children's petty quarrels to my own therapy because after a day dealing with very traumatised young people, I just got annoyed with them for not recognising how lucky they were. And actually they are not lucky they are normal. I'm not there yet though. Something that always comes up for me is this idea of 'you don't know how bad it can be' so it's still around so I've obviously not fully processed it.

Pat: I find that that's the beauty of good supervision, or periodic therapy – this way that you can continually voice your own struggles as they might be affecting both your life and your practice.

Fran: Yes, it's an ongoing process, isn't it?

Pat: We went on to look at your current work with young people, and you had some interesting things to say when I asked about dissociative processes.

Fran: Yes, I notice a difference in process in adults and young people there. I find that young people seem to be more able to talk about ... it's so strange ... I don't know whether it's just they're more willing to accept that that they do these things and that's OK there no real shock about it, or .... I don't know what's going on but certainly I know that with adult survivors working with any kind of means of dissociation or whatever you find that quite difficult to kind of grasp whereas the young people kind of like "mmm yes I do do that".

Pat: You said you weren't sure if this was a cultural thing, or that having more frank open discussions was a result of your own increasing competence but you're just sure that there is a difference. Adults are much more likely to edge around any strangeness.

Fran: I think back to when I was 15 or 17 and I suppose I [hadn't] learned to be so defended - that wall I talked about - my wall wasn't as thick then. Maybe the right person would have helped then but then I hardened up and put the defences up.

Pat: So now you want to be that right person in order to help these troubled young people?

Fran: I guess so.

Pat: You also made an interesting link between the model of learning where you go from incompetent to competent[57] and wondered if there might be a similar process of moving from defences to dissociation. You said

> "Maybe you get to the point where there's a prime time to do work on it and actually it becomes so ingrained that it becomes an unconscious way of dealing with things whereas with young people it's still more of a conscious thing. I don't know."

And we talked quite a lot about anger as being one of your principal defences.

[57] After Dreyfus (1980)

Fran: And how!

Pat: And that you had a kind of instinctual awareness of clients' anger and you empathised with it. And you drew out another really interesting parallel with your offending clients' ability to "smell" vulnerable children.

Fran: Yes, that's something I came across often, and it's also well documented by others in the field. I wondered if my empathy for angry clients is a similar kind of 'smell', simply because I've been there myself. I've got no proof but I really do think that when they speak to me I think they know I've been there ... when I'm talking about their rage and how it feels I think that they can sense that, like that Neitchze quote, I've looked into the same abyss as them. That's what makes me sometimes self-disclose.

Pat: You had come to recognise that your anger as a young person had actually helped you "hugely" with your resilience. In fact you said too of your anger that you needed it and wouldn't have survived without it.

Fran: Yes, and I've wondered if that is true of my young angry clients too. I admit that I don't know if it's to do with my own prejudices or blind spots but there's something about the rawness of the anger in young people that I don't see so much in adult female clients.

Pat: Regarding your anger and resilience you said "it helped me preserve my self-concept....although it was probably making life very difficult for lots of people around me."

Fran: Looking back it's really quite egocentric when you think you're going to make the world pay but that was the attitude I had then.

Pat: And therefore one that you can tolerate in your young clients?

Fran: Yes I think so – back to the thing about having been there myself. But while I can tolerate that anger in my clients, I'm now able to use my own anger in a much more constructive way – it energises me to bring about change, challenge unhelpful norms and find creative solutions to problems.

Pat: The 'maverick' again – I like it! When you were talking about your having to keep an eye on your anti-authoritarian tendencies we got into a short discussion about subliminal knowing and you had a sense that your clients knew where you were at without its being verbalised.

Fran: Yes, I think they can pick up as well when they're with me. They've never said but I think I think they know that I've not had this like 'Yeah I think she had this lovely life. You know at school did really well and got straight As'.

Pat: You said that you thought that counsellors are sometimes uneasy talking about subliminal knowing because it's too near to something "spiritual". I was fascinated that you thought though that "because of [my] science background" I would be able to see it. What I usually get is that "how can you as a scientist believe in things that you can't explain?"

Fran: Perhaps there's some subliminal knowing going on between us!

Pat: Perhaps!

Fran: I guess we're both of one mind in believing that it's far messier than the belief of those who would say 'I don't understand it so it can't be happening'.

Pat: I wonder if you've read Law's book on " Mess in Social Science" (2004). That's kind of what he's saying. Long live postmodernism!

Fran: Talking of avoiding things, you cornered me a bit about what I might avoid talking about with clients, and I realised that although I won't avoid it if they introduce the topic, it's probably sex.

Pat: You've already said that you're not personally very enamoured by sex.

Fran: Because my trauma affected my own personal relationship with sex and my own views on sex and therefore it's kind of filtered through. But perhaps that's worth pondering because we all know that sexually abused children can go in the other direction and become obsessed in an unhealthy and risky way with sex, but there are other possible responses too – complete avoidance, frigidity etc, but my own

response seems to be to have found a rather disinterested bodily stance. And I realise that when I'm doing risk assessments and asking folk about their resilience factors 'Have you got good friends?' 'Oh and you walk the dogs' and so on, I rarely ask if they have a good sex life. But for a lot of people it's actually part of that resilience, part of their coping strategy.

Pat: I'd asked you, given the way you feel, how this might affect the way you feel about the potential for sexually abused clients to be able to work through their trauma. You talked in term of "hope".

Fran: Yes I remember that. And I mused about whether talking of hope was me trying to cover the fact that I'm lying to the client. I remember a young client who thought after her experience that she'd never have a good sex life, and although we explored every aspect I did wonder if I'd sold her hope. But did I sell her a lie? But maybe it was my hope too. But even though as a married woman with children, sex is still very much part of my life, it's not the sex itself that I enjoy, it's the intimacy. So that's not a lie.

Pat: What I hear you saying is that you see sex in much broader terms – not just the act, but the whole experience, part of which you can live without and parts of which you said you "couldn't live without".

Fran: Yes, I think that's it. No, I can't lie to clients. I couldn't turn round and say 'I love sex' because I don't.

Pat: So the hope you are giving them comes from the experience of intimacy which you value so much.

Fran: I often believe that it can be as important to work with anger as with sex. And of course anger was at the heart of my own experience at home. I'm aware of how much I over-identify with my father. Although that wasn't sexual abuse. That was kind of violence and alcoholism. I'm very quick to help clients to be able to see and explore that anger towards the non-abusive parent.

Pat: Yes I remember your saying how you directed a lot of your anger towards your mother - the 'safer' target.

Fran: Sometimes if the client brings it up I go down that route of helping to give them permission to accept that, because everyone presumes that the person you should be most angry with is the person that abused you and actually they have to have the courage to say 'well actually I hate my mum more because she loved him and she could have protected me.' What I'm saying is I sometimes use my own experience to help encourage or create opportunities for them to talk about these things. You know it wasn't till I was in my late 20s that I realised I can love and hate the same person, it's actually not one or the other. I think perhaps I use that awareness to shape opportunities to be able to acknowledge that whilst their father might have abused them my God they still adore him and love him.

Pat: You said you thought probably many people would disagree with your creating these opportunities but you still hold that your "trauma has been very helpful" in this respect.

Fran: Yes, I'm going on the feedback. I've had clients say to me 'God, you're the first person I've admitted to that I still love him' and they have found that helpful. I don't think there's any way I would have moved to go there or moved to allow that if I hadn't been through it.

Pat: From talking about counsellor avoidance in practice we moved on to thinking about forgetfulness...

Fran: ... and I said, 'sure I forget things that clients tell me', but I believe it is normal forgetfulness. I tend to not forget significant things about them, like things that they felt about something or the pain.

Pat: You said you tend to keep minimal notes because of a bad experience you had in your forensic work when your notes were used against what you believed to be in the interests of one of the prisoners.

Fran: Yes, but I find that if I'm honest with clients and tell them I don't take many notes, and that the down side is that I might forget their aunty's names for the dogs. I think it's just common sense. I think as long as you're honest and open with people they're so forgiving - they know I'm another human being.

Pat: When we talked about being a bit anti-authority you talked too about loyalty.

Fran: I've noticed that some of my anger and energy kind of gets transferred into a kind of loyalty and I have sometimes fallen into being over-protective. I have to watch that. My supervisor's aware of that too and keeps a check on it.

Pat: You recognise its origins.

Fran: When I was growing up I didn't have anyone fighting in my corner I didn't have a close connection. I didn't have a sense of belonging anywhere.

Pat: So I guess you feel some of your clients' lack of loyal support quite acutely and feel drawn to fulfil that need.

Fran: An Achilles' heel?

Pat: We discussed boundaries with respect to loyalty to clients and you made some interesting comments about the differences between adult and young clients.

Fran: Maybe this is why I'm so attracted to working with young people because the boundaries are much more fluid with young people, but we still manage them very carefully here. For example, texting is second nature to young people, so texting between sessions to remind them of an appointment is something we do. And we look at what the research is showing young people want and are looking much more into how to use social media. The research seems to be stretching the traditional boundaries and we're paying attention to that.

Pat: And you wanted to accompany a client to court once, and discussed it with your manager who believed that was the right thing to do, when the young person had no family support and it was really an issue of child protection. You pointed out that

with an adult you would have helped them explore other possibilities of support rather than going yourself.

Fran: I'm really glad to work in an organisation which is open to doing things which some might think a bit 'risky' if it's really in the therapeutic interest of the client.

Pat: Always a difficult call, isn't it? Some don't like to mix counselling with advocacy, but I've also been in an organisation where most of our clients were very isolated and vulnerable and we did take on a role outside the counselling room.

Fran: I suppose it does appeal to that rebellious side of me which says 'I don't want you to tell me what I can and cannot do and I don't like people telling me what my clients can and cannot do'. I think it was because as a child I would have fought against it whereas now I fight against it in a different way – using creative, ethical, collaborative ways of doing new things. But good supervision and a great organization keeps my maverick tendencies in check!

Pat: You gave a great example of that. You have had some young clients who get triggered and dissociated in a closed room and asked if they could go out for a walk with you instead. And the organization did the risk assessments, extended the insurance and got clients to sign forms and so on so that you could do that.

Fran: You know the quality of work shot up when they weren't trapped. Some of my best therapy sessions have been sitting on a set of swings.

Pat: When I asked you about the concept of wounded healer you said that it had been very much a theme running through both your counselling diploma and your doctorate.

Fran: It's something that I've always been aware of since getting involved in the therapeutic world I think.

Pat: But you said that in your doctoral class there were some who might not have fitted into that category.

Fran: I don't like making sweeping statements but when I think about it it may have been that the people who have been through some kind of trauma themselves are more likely to recognise it I think, because certainly when I think about the people on my course that were not, that wouldn't even have understood this conversation, they are the ones that didn't experience the same level of trauma.

Pat: Having talked so much about trauma, I was interested in your own definition of trauma.

Fran: I remember that my immediate thought was not of one-off events but of a series of events, and on-going experience.

Pat: You almost visibly struggled to put it into words at the time, but then came up with this:

> "Trauma for me is something that totally ruptures emotional processing or psychological processing and it's not just a clear cut ... you know - it's a kind of poisonous cup .... a bit vitriolic, and I think it can lead you into so many avenues.... there's something very, yes, poisonous about trauma for me, that it ruptures right through lots of different ..... long-lasting, pervasive ..... rupturing I think. Gosh ... the number one word for trauma – rupture".

Promenade to the final chapters

The data tour comes to an end. I have looked intently at each 'picture', become absorbed respectively in my own, Helen's, Jane's, Morag's, Paul's, Lizzie's and Fran's contributions to the project. Each 'picture' in its own way has left a deep impression. Now I turn to reflecting on the whole experience.

SECTION III: REFLECTION

Chapter 12. Discussion

12.1. Preamble

Thoughts swirl. Slithers of memory ebb and flow. The critical voice objects. What's mine, what's theirs?

My counselling training:
"the client is the expert on the client"
"people won't tell you more than they want to"
"rapport can be lost in a moment but take months to rebuild – if you're given the opportunity"

My research training:
"Research and therapy are not the same"
"Research can be therapeutic"
"Your research topic should be something you are passionate about"
"Keep the focus on your question"

Chapters 1 to 4 do, I hope, make it clear that I tackle this research in the conviction that human lives are gloriously complex and frequently paradoxical. Whilst a focus on a particular question is needed, in this case 'what impact might a personal history of developmental trauma have on a counsellor's experience of, and work, with traumatised clients?', I do not believe that an answer to this question can be straightforward. Because my aim is to present evidence that will help counsellors in their day to day work with clients who present with signs of posttraumatic stress I have a particular interest in encouraging attention to context. The client's story, the motivation for seeking help, the counsellor's own background and many other factors all make up the context. The context, so vital in phronesis, will adeptly throw spanners in the work and cry out for a holistic view. In creating a methodology

which I call practical (or phronetic) interpretive phenomenology, not only do I explore some of the contextual complexities, but do so with the aim of the study being of practical benefit to counsellors who work with traumatised clients. In the course of the project I found it necessary to borrow from methodological insights beyond phenomenology, and below, (pp236, 276, and in chap 3, section 3.3.2) I make a case for a limited use of bricolage. The original contribution I believe this thesis makes is to draw specifically on the contextual experiences of the participants and glean insights across a wider idiographic base than much of the currently published work on 'wounded healers'. I also believe that too strict an adherence to the specific methodologies demonstrated in most of the literature (see section 2.3.1), while giving valuable new knowledge, also tends to limit the potential for moving on to new ground. In the scope of this project it has not been possible to move on very much further, but I hope that in what I have done I have opened the door to some new avenues that could be explored.

Those who use writing as research often find that learning arises from the evocative nature of what they write and part of me believes that chapters 5 to 11 go some way towards speaking for themselves. They are written with an interpretive phenomenological[58] hat on, my having immersed myself in the transcripts, and I have sought to lay out the data in a way which gives as holistic a sense as possible of the participants' experience of bringing their wounded selves into the room.

However, part of me also recognises that although my research method and epistemic stance allow me to make few general truth claims, this discussion chapter gives me the opportunity to reflect on some of the themes (applying a little methodological bricolage in borrowing from Thematic Analysis) which seem to me to have particular relevance to the research question about the impact a counsellor's own developmental trauma might be having in the room when 'wound meets wound'.

Having taken a methodological position at the far end of the interpretive phenomenological spectrum, and therefore feeling able to make maximum use of reflexivity, this chapter is more openly subjective than in the 'conversations' where

[58] Though not following an Interpretive Phenomenological Analysis (IPA) method.

intersubjectivity was quietly present. At times, I move into the 'third position' (Aron, 2006; Bondi, 2013), which has similarities to a phenomenological mind set, in which it becomes possible to observe both the participants' and my own subjectivities from positions other than the simple binary subjectivity which can give rise to incongruent attempts to be empathic, as Aron (2006) describes in his supervisee. In the counselling room, empathy is prized but if followed uncritically can give rise to stuckness. This ability to 'think outside the box' of one's own subjectivity often leads to a breakthrough. In research, it can lead to developing knowledge.

As a counsellor I have tended to leave externalising either my subjectivity or the 'third position' a little late in the process out of fear of losing rapport with my clients. I may be falsely assuming that clients are more fragile than they are, and my research participant Morag may well frown at my tendency to 'wait till the client is ready' (p157). When a client myself, I have been quite robust in the face of counsellors' challenges to my own subjectivity, defensively perhaps, but such experiences have usually led to growth rather than disintegration. Still, my tendency is to be cautious because I have come to recognise that elements of my own story have given me a measure of resilience that some clients do not have. Embarking on research, I bring much of my 'counsellor self', with its weaknesses as well as its strengths, and I will return to this briefly when considering the limitations of this study in the next chapter.

As with my clients, I sense some reluctance to externalise my subjectivity in this chapter but I do so less now for fear of damaging rapport and a premature withdrawal from therapy, as for fear of participants perhaps reading what I have written and disagreeing with me, feeling misrepresented and even objectified and 'used'. I am emboldened, however, by Rizq's (2008) experience of her participant therapists' responses to her analysis. One wrote:

> "Thank you for sending me this analysis, which I feel is a 'good enough' interpretation; it does not have to be the same as mine, but I can comfortably agree with it." (p48)

Rizq took this "not without some relief" as

> "an example of some participants' capacity to sustain rather than evade ambivalence and difference without feeling rejected and excluded" (p48).

My participants are all experienced counsellors or therapists and I trust that should they read my conclusions, they would do so with a similar openness and, where necessary, forgiveness.

I have been aware for some years of the increasing pressure to manualise therapy on the basis of 'evidence', where evidence is too often embedded in positivist thinking. By attempting to gain some phenomenological insights into what is actually experienced by this group of therapists, I hope to find a different kind of evidence – insights which might broaden perceptions and make way for greater flexibility in approach to trauma therapy if this is justified.

As I turn to some of my own suggested interpretations of the participant data, I am once again aware of my yearning to be a bricoleur. This lay behind my sense of the importance of outlining in Chapter 2 the historical roots from which today's theories of both trauma and the therapeutic relationship have grown. I have learned too from narrative researchers and use some insights from that methodology, albeit within Ricoeur's frame of reference (Ricoeur, 1983).

Reiterating my point on p74 above, in the 'conversations' (Chapters 5 – 11), while I take note of Etherington's (2004, p84) problematising of linearity in narratives which are essentially 'messy' and multi-layered, I have chosen to set out the participants' life narratives in an approximately temporal way, as explained in section 4.4.2. Some of the 'conversations' material speaks, I believe, for itself and will be discussed only selectively in this chapter, but as I embark on analysing it here, I am reminded of an illustration I often use with clients who complain about having 'looked at all that stuff already' and thought they 'had it sorted' and seem to be going over old ground. In Edinburgh there is a famous tall monument to Sir Walter Scott. Inside the monument is a 287 step spiral staircase, and at each turn of the spiral is a window from which it is possible to look out over the city in the same direction, but crucially from a slightly different elevation. So the view is the same, but different. The viewing angle of this chapter is more overtly interpretive than any contribution I

made in the 'conversations'. My focus in this chapter is rather on furthering understanding how the participants' 'messy' stories (which are indeed not linear) impact on them and their traumatised clients in the counselling room, and to see if there are insights here which can be usefully used by other counsellors who are engaged in trauma therapy. Both the stories and conversations present "experience-near" (Bondi & Fewell, 2016) themes from which the participants and I reflect on our meaning-making and how this can influence counselling practice.

Etherington (2004, p81), in her study of reflexive research, makes a point which I believe to be true of phenomenological research as well as the narrative research of which she is writing:

> "The analysis does not seek to find similarities across stories, and is not interested in conceptual themes, but instead values the messiness, depth and texture of lived experience" (p81).

Similarly this resonates with Bondi and Fewell's belief in the value of 'experience near' research in qualitative inquiry.

The context of the telling is significant too. In a 'one-off' research interview the relationship between the researcher and the interviewee, knowledge of the purpose of the research, the way the interview is started (particularly) and how that is interpreted, the ongoing interventions of the interviewer, things that have been going on for either interviewee or researcher on the same day, and many other factors will influence what is said on that particular occasion. This became clear to me in an unexpected way when, after the interview, I read a published reflexive piece[59] which had been written by one of the participants not long before we had met, in which they focused on quite different issues in their life story than they had done in the interview. Although not contradictory, the article added a layer of complexity which the participant did not highlight in the interview, where other matters had been privileged by them in that context.

In short, the data presented here are the constructions of that day and place, and whilst providing a window into each participant's reality at that moment, it is useful

[59] Not cited here to protect anonymity.

to recognise that the realities are the ones that are being constructed in those contexts. This takes me back to the discussions in Chapter 3 on ontology, where I argued that even the ontological position can be paradoxical. I believe that at the heart of much of the work of counsellors and psychotherapists is an attempt to help our clients find a place where they can be at peace with the paradoxes in their lives.

12.2. Discussion of the data

In the following sections I select aspects, drawn from the data, which I believe to be particularly relevant to the question of how our woundedness impacts on our work in trauma counselling.

12.2.1. What is trauma?

The introductory chapters (pp6-9, and section 2.1) have explored a variety of meaning for trauma. There are differences between acute, single incident, and the complex trauma which normally (but not always) originates in childhood. It is on the latter that I have focussed in the participants. However, I have deliberately lowered the inclusion criterion barrier regarding the participants' work with traumatised clients. I have done this because in spite of the differences there are more similarities, and arguably the experiential learning of a person who has spent many years living with, and working through, their own trauma will be relevant to those who have more recently been traumatised.

Near the end of the interviews I asked the participants for their 'off the cuff' definition of trauma. As participant Paul said, we all carry assumptions with us of which we are not always aware. These can influence us when working with our clients, and I noticed relationships between the definitions given and the way the different participants understood their own experiences, which again fed into their approach to trauma counselling. Helen spoke of trauma being an unexpected or extraordinary event which gives rise to fear and uncertainty. Fear had been a feature of her own story, and her gentle passion for the person-centred approach is consistent with a desire to reduce that fear in clients. Lizzie's definition spoke of violent

disruption of relationships with self and others. Her experiences had resulted in mental illness, and her understanding of the effects of trauma in her own relationship with self can be linked to her desire for clients to integrate their fractured self-understanding. Morag spoke of "splintering" (p160), and of the hiddenness of the effects of trauma that has occurred in early childhood. Resilience is a key to survival and recovery, and much of her counselling practice aims to enhance that. Paul understands trauma very much from an attachment perspective as something that stops our innermost basic needs being met. Distress is not soothed, leaving the person trapped in the story. A key element of his counselling is to allow clients' stories to be heard. Fran's defining word for trauma is "rupture" (p232). She also spoke of its being poisonous, long-lasting, and pervasive. Her imagery evokes in me the idea of an on-going fight with no holds barred. How consistent this is with her story of her own anger and its transformation, and her empathy with that same anger in her young clients. My own definition of trauma focuses on the wound to a person's sense of self, and of its creation of "too much" (p8) inner stress and conflict. A desire to reduce that conflict has probably been a major influence in my frequent use of psychoeducation and of the structural dissociation model (Van der Hart et al., 2006) in my work. While there are both lay and academic differences in defining trauma, this variety of 'core' understandings of the word might alert us to personal historical influences on the way we look at a phenomenon and what effects that might have on how we think and act.

12.2.2. Choosing what to tell

As a starter question I asked each participant how they came to be a counsellor. Four of the six answered with a more or less detailed account of their trauma history. Two – Morag and Paul – did not recount their early trauma experience. In both cases, their early trauma was not remembered, other than either in the sense that it had occurred, or from information gained from the report of third parties. Morag only alluded to it in recounting "bizarre perceptual experiences" and "confusing memories" (pp144, 146) during her adult hospitalization. Paul had information from

others about what had happened to him in infancy, but no clear memories of his own. He did not choose to talk about the details of his trauma, preferring to focus instead of the ongoing perceptions and feelings that had, he believed, emanated from that time.

Because Paul's and Morag's choice to remain largely silent about their childhood experiences was so different from the other participants, I will look in a little more detail about what meaning they derived from their different beliefs about what had happened to them as small children. Morag only alludes to her early trauma, focussing instead on the traumatic effects she has experienced as an adult. She does not make an explicit link between the two. I would argue that it is however implicit. Morag was one of the two[60] participants who were most openly enthusiastic and knowledgeable about the research process in general, and it is safe to assume that she would not have volunteered to take part without considering the criteria for inclusion carefully. Those criteria, of which the participants were reminded in the contracting process, clearly stated that participants would have experienced early trauma which had had consequences later in life. Secondly, while Morag's extreme response to her rape could have several causes which were not explored in this study, if she had experienced severe trauma as a child her resilience in the face of the assault is likely to be weaker than if she had had a problem-free childhood. Beutel et al.'s (2017) findings in a large German study confirms earlier data (e.g. Gündoğar, Kesebir, Demirkan, & Yaylacı, 2014; Simeon et al., 2007) of a positive correlation between childhood adversity and scores for distress and somatic symptoms later in life. They also demonstrated that resilience in people with a history of childhood adversity varied but was always lower than in controls. Beutel et al.'s (2017) finding is also consistent with these earlier studies, especially that of Simeon et al. (2007). Although these negative effects on adult health were mitigated somewhat in those whose resilience was higher, low resilience was associated with a risk twice as high as that of adults with no history of childhood adversity. Thirdly, though less convincingly, it might be relevant that there is also quantitative evidence of a positive correlation between childhood trauma and later onset of psychotic episodes

[60] The other being Fran

(Alemany et al., 2013; Bendall et al., 2013; Janssen et al., 2004; Şahin et al., 2013). These studies are based on confirmed clinical evidence which is not available in Morag's case, although her description of her breakdown rather suggests that the hospital could have considered her psychotic. However, given Morag's description of her dissociative state immediately following the rape, Scane's (2016, p52) finding that childhood trauma is a predictor of both dissociation tendencies and hallucination-proneness could be relevant. It might be consistent with a connection between early trauma, dissociation and Morag's "bizarre thoughts".

Although Morag related these past experiences with little obvious emotion – something that is typical of some clients, like myself, who have told their story so often that it has taken on the nature of rehearsed material – one element stood out clearly. That was her relief at being "left in peace" (p148) in her last months in hospital. This seems to relate to her way of counselling clients in a rather unexpected way. In the light of the helpfulness of being left alone in a period of "non-interference" (allied to the importance of "escape" for her) it surprised me that she is passionate, really passionate, about *not* waiting for the client to be "ready" (p151) to find things out for themselves (from which I infer an implicit criticism of some simplistic interpretations of Rogerian counselling). To understand this it is perhaps necessary to look into what happened before her period of "being left in peace" in hospital. The picture she paints was of being pestered to do things she did not want to do, without any explanation or perception that there was any therapeutic strategy behind it. While there undoubtedly would have been a strategy, it was clearly not one that connected at all with Morag's needs at the time. She referred many times to the need for relevance in therapy, and this is the hallmark of her own work today. That is something about which she is also passionate. She carries that same passion into her training work, believing that while counsellors have much to offer clients, what they do choose to offer *must* be relevant.

Paul, on the other hand, spoke so eloquently of the effect his traumatised childhood had on him as a teenager and young adult that details of the trauma were in one sense hardly needed. He had reflected deeply on the way the trauma's effect on him had

played out in his later therapy, training and practice as a counsellor that, beyond what is said in Chapter 9, little further interpretation on my part was called for.

12.2.3. Reflections on individual traumatic histories

Passion in common modern English usage has come to mean any strong emotion, but derives from the Latin *passio*, to suffer. Much, if not most, counselling is to do with suffering so it is somewhat surprising that a library search for 'passion' or 'passionate' revealed few counselling or psychotherapy-related articles or books with either word in the title[61], some exceptions being Dryden (1989), Shohet (2008, 2011; 2015) and Van Deurzen (2015). Passion for their work, however, came across with all the participants in this study (see e.g. pp,125,151,215). Van Deurzen (2015) says

> "We do not manoeuver and manipulate ourselves into passion, we rather find ourselves moved and drawn into it. We fall into passion despite ourselves." (p95)
>
> and
>
> "Most of us live passionless lives for much of the time, because we are guarding ourselves from danger and protecting ourselves from the limits of life ... For this relative safety we pay the price of a decreasing sense of vitality until we flounder into futility and boredom. ... We know from experience that openness and passion will bring disappointment and suffering as well. So we rein ourselves in." (p96)

People who have faced trauma in their lives have often experienced existential crises, and survived them. I suggest that what van Deurzen says here is true – most people are likely to avoid the suffering of being open to passion - but perhaps those who have survived and processed trauma, like the participants in this study and many other counsellors, can unconsciously take the risk of 'falling into' passion with more confidence.

One might suggest that pre-verbal, unremembered or dissociated trauma generates a particular level of fear and confusion in adult survivors. The lack of specific

[61] Excluding those concerning romantic/sexual relationships

memory of trauma may also be connected to another similarity between Morag and Paul. Both said they had been inarticulate in their early experiences of personal counselling. This was not mentioned by the other participants, although Helen, because of her learned self-sufficiency, remembers her lack of spontaneity in both counselling and training situations, preferring to have her thoughts marshalled before voicing them (pp.107, 111). Morag described herself as "withdrawn" (p149), fearing to voice her thoughts even if she dared have them because she was "terrified of thinking the wrong thing" -"if you start thinking the wrong thing you're done for" (p149). Were the "bizarre thoughts" about past unimaginable incidents she had experienced in her breakdown the origin of her fear? Trauma can give rise to disorganized attachment and unbearable conflicts in the infant faced with fear in either themselves or their carers (Bowlby, 1988; Lyons-Ruth, Dutra, Schuder, & Bianchi, 2006; Main & Hesse, 1990; Main & Solomon, 1987; Wallin, 2007). For such infants, 'thinking', or making sense of such conflicts, would threaten survival. Morag's presentation at that time may have indicated some regression to a disorganized attachment pattern. Paul saw his inarticulacy as more straightforward – he just did not have the words. He was alexithymic[62] so unable to identify his feelings let alone have thoughts about them. Looking back he found this inhibiting and confusing when he first had any counselling.

Unlike Paul and Morag the other four participants and I had many memories of different traumas, and made clear connections for ourselves between those memories, our future career paths and the way we now practise counselling. Helen and Jane had grown up in households where parental mental, and in Helen's case also physical, illness had dominated. Arguably Helen's realization that she did not want to work with ill people could be regarded as a turning point or 'epiphany' (Savin-Baden & Van Nienkerk, 2007) which took her out of nursing. Lizzie's childhood was filled with parental neglect in the name of God's work coming first (p185). Surprisingly, perhaps, especially with her later experiences of 'counselling', she did not reject Christian faith, but is hypervigilant about abusive use of power by

[62] Alexithymia: the inability to recognise one's own emotions and to express them, especially in words (Oxford English Dictionary, 2012) [lit: no word for an emotion]. Its first use in psychological literature was by Sifneos (1973).

counsellors. Having witnessed manipulative distortions of faith myself, I am also highly critical of such abuses even outside the counselling field. Fran, as well as having suffered sexual abuse by a school doctor, had an ambivalent relationship with a very angry misogynistic father. She has brought relief to some of her young clients by her ready understanding that they might both love and hate their abusers. She both loved and hated her father.

All of the participants in this study had reflected over extended periods on the effects of their own trauma histories. Trying to make sense of what makes no sense is perhaps a basic human characteristic, and we often explore blind alleys before coming up with something satisfactory. I also believe that whatever one's counselling modality, it is almost inevitable that we will also try to make sense of what our clients tell us. In other words we interpret what we hear, whether or not we share those interpretations with the clients. With the best will, researchers will do so too, even those who make strenuous efforts to 'bracket' (Husserl, 1970, p262) their own perceptions.

I tentatively interpret Paul's image of the "black hole" (p169) as indicative of an existential crisis. Also, admittedly speculatively, perhaps Morag's relief at being "left in peace" points towards a memory of some form of physical interference. With clients, my personal explorations in meaning-making have left me with an appreciation of the ideas of the 'Milan group' (Cecchin, 1987; Selvini, Boscolo, Cecchin, & Prata, 1980) who saw such hypothesising as legitimate, but used the term in a different way from empirical scientists. Their work on family therapy links such hypothesising to a way of maintaining curiosity, which guards the therapist against accepting a family's script (Cecchin, 1987). More than one hypothesis can be held at any one time and is always tentative, and often not shared with the client.

12.2.4. "if other people can't help me...."[63] Seeking or rejecting counselling

When any counsellor encounters a new client, it seems likely that they will carry with them some memory of their own early experiences as a client. Both Morag and Paul described their lives when they sought counselling as close to chaos - Morag's life was "a bit of a bombsite" (p149); Paul's "hitting rock bottom" (p166). I had less of this sense with the other participants who were, at that point, still holding it together in some way. There was less of an air of desperation, and seeking therapy seemed to be a more considered path, even if it had to be suggested by a friend, as in Lizzie's case, and my own. Morag's counselling came after her hospitalisation, initially while she was nursing. For Morag and Paul choosing personal counselling seemed more a matter of survival than for the other participants. However, both Paul's and Fran's initial experiences of counselling were decidedly negative and they both decided that self-help was the route they had to follow to make sense of their distress. Fran positively rejected counselling at that time in favour of self-help. Paul just gave up on it and turned to books. Both moved eventually by different routes into psychological education or training. Lizzie could barely have been described as *choosing* to see a counsellor. It was more akin to coercion. A well-meaning friend set her on a path which neither could have predicted, or would have chosen, if they had not been primed by a particular form of spiritual teaching. Jane's first counselling experience was much happier. Also recommended by a friend, the therapeutic relationship worked well and helped Jane to untangle many of the issues around her dysfunctional family. Helen and I (like Paul) had consulted our GPs initially. Helen was referred unhelpfully to psychiatry. I was given antidepressants. Both decided later that counselling might be a better option.

Fisher and Turner's (1970) work on general attitudes to help-seeking for emotional distress has been followed up by numerous studies which have looked at specific demographic or themed groups ranging from law enforcement personnel (Cornell,

[63] p208 above

2013) to suicidal clients (Martin, 2012), to Arab students (Al-Krenawi, Graham, Al-Bedah, Kadri, & Sehwail, 2009) and to survivors of interpersonal trauma (Schreiber, Maercker, & Renneberg, 2010). Whilst there were many commonalities, these studies revealed different emphases depending on gender, culture, educational background, religion, stigma perception, geographic availability, and other variables.

I have noted that the seven participants in my study had very different experiences and motivations in help-seeking which are likely to have been influenced by different combinations of factors such as the ones mentioned above which have been explored by other researchers. While studies on war veterans, police, domestic violence survivors and refugees address traumatic exposure there appears to be little focus on how trauma itself might influence help-seeking. With the exception of a smaller number of studies such as those by Schreiber et al. (2010) and by Stige et al. (2013) there is even less consideration of how developmental trauma might do so.

Most basic counselling texts (e.g. Jacobs, 2004, p70; Mearns et al., 2013, pp135-140) explicitly or implicitly take for granted the need for clients to have some measure of trust in the counsellor and the process. Such issues of therapeutic relationship or alliance are addressed once a client has taken the step of seeking help, but survivors of trauma, especially developmental trauma, often have augmented problems with trust (Herman, 1992, p52) and this can affect both help-seeking and engagement with a found helper. If one frames trauma within a structural dissociation model (Van der Hart et al., 2006) in which different 'parts' have different needs associated with reactions of fight, flight, freeze, submit and attach (Van der Hart et al., p37) sometimes the needs giving rise to an 'attach' or even 'submit' part overwhelm 'flight' part's needs, and clients can over-attach, and/or submit to a helper. The latter did not seem to be operating in any of this study's participants in relation to initial help-seeking, but once engaged with her first 'counsellor', this could explain Lizzie's relationship with him. The more common version of lack of trust was seen in Fran and Paul's initially walking away from therapy because of disappointment in their therapists. There is surprisingly little published about client attitudes to their therapist in the fairly sizable literature on discontinuation of therapy. Many of these studies on discontinuation (see e.g. Swift & Greenberg, 2012) focus on client

demographics, therapeutic modality, diagnosis and clinic setting. Samstag et al. (Samstag, Batchelder, Muran, Safran, & Winston, 1998) found significance in patient assessment of therapist friendliness, with the least friendly most likely to correlate with early withdrawal from therapy. Of course trust and friendliness are not synonymous but specific data on clients' sense of trust in their therapist seems sparse in relation to drop-out rates. In structural dissociation terms, the 'flight' activated part could be operating, but just as likely the 'fight' activated part might take over (seen perhaps in Fran) creating something along the lines of voting with their feet as a way of saying "you're useless, so f... you!"

12.2.5. How experiences of psychological help influenced later practice

Morag's help had been initially imposed on her when she was sectioned under the Mental Health Act, and her perception at the time that it was irrelevant has stayed with her and profoundly influenced her passion to find relevant ways to help her clients. Paul sought therapy as a last resort, and remembers enough of that feeling to recognise it easily in clients, and to see the establishing of psychological contact to be of prime importance in his practice. He is also very aware that they may be suffering from the confusion and existential fear which had been his experience as a young man:

> "I use that ... from my own experiences of remembering what that's like." (p177)

What Paul expresses here is, in context, a safe use of the kind of identification discussed by Cain (2000) (see above, p39) in which she contrasts ways in which countertransference can cause either unhelpful over-identification with clients or, alternatively, greater empathy. Another important element in developing empathy is on the counsellor accessing, as far as possible, the client's frame of reference – not just cognitively but emotionally. While this is particularly emphasised in person-centred counselling e.g. by Rogers (1951, p29) and Merry (1995, p71), and experiential-process and emotion-focussed approaches (Elliott & Greenberg, 2007),

it is also valued in other modalities by practitioners who work relationally. Mearns and Cooper (2005, p142) give an extended account of a counsellor 'Lesley' who draws on her own experiences to help her empathise with clients. They make a distinction between this practice and projective identification and cognitive social perspective taking. Paul's memory of his own sensing of his "black hole", leading to his work at relational depth, is more akin to Mearns and Cooper's illustration.

While neither Morag nor Paul had their own memories of their childhood traumas, and Morag had started her story with an account of her rape as a young adult, Paul started with how he came to train as a counsellor. He describes the influence of his early trauma on his practice more explicitly than Morag does as he is acutely aware of the hidden story, known or unknown, which might be trapped inside any client he sees. Even in the non-ideal setting of short-term therapy he is determined to let them tell their story (p173), or as much of it as they are able, so that the pressure that story exerts on their psyche would be reduced. He refers to the likely presence of Winnicott's primitive fears (Winnicott, 1965, p240), framing the trauma in terms of existential anxiety. Aware of the "black hole" nature of some trauma, he has developed a very sensitive and strategic way of working, responding individually to "clues" (p179) given by clients so as to maximise benefit to the client whilst keeping them safe from destructive probing into the hole. Paul's frequent reference to psychological connection ties in with an almost physical need to fill a void, to give assurance to the client that s/he is not alone. This connection was what had been missing in his own earlier therapy.

Other participants who made specific reference to awareness of their own experiential memories in relating to their clients similarly use those memories in strategic (another of Paul's favourite words) ways, thus avoiding the pitfall of unhelpful projection of those experiences on to their clients. Lizzie's first 'counsellor' has sensitised her to the devastating effects of abuse by a therapist and she avoids that diligently. It has also led her to develop a high sensitivity to any emerging feelings in herself which could harm a client, for example, "I just felt like swiping him" (p193). She recognises them as triggers from her own past, and takes them to supervision. Fran was an angry young woman when she first sought counselling.

Predictably she reacted angrily to some of her early counsellors, and even in hindsight blamed them rather than herself, now recognising that they failed miserably to relate to her in ways that held any meaning for her. Regarding our early experiences of - generally helpful – counselling, Helen, Jane and I did not appear to have been influenced directly by them in our current practice, other than carrying with us a belief in the process.

Few comments were made by participants about the impact of their basic training on their work with traumatised clients. Those that were made tended to indicate that the training had not really equipped them very well for working with trauma. The most positive was Paul, who valued the attachment focus of his psychodynamic training, but most said they had gone on to more specific post-qualification trauma training which had generally been helpful. Their experiences of personal therapy had often had a more direct impact on their practice. Some, as already mentioned, were of the opposite script type ("I wouldn't do it that way with any of my clients"), but Lizzie and I, and possibly to some extent Jane, had remembered some key elements of therapy and had carried them into our own practice. Lizzie called the maintenance of the social engagement system, used by her later therapist, "burbling" (p204). This is something she does when clients are too upset to speak, remembering its helpfulness for her. The importance of the trust Jane had been able to develop in her first therapist was highlighted by her, and a brief comment she made about counsellor disclosure might be significant too. Many counsellors have been taught that self-disclosure is to be avoided in therapy, but there is an increasing recognition that when handled appropriately it can be helpful (e.g. Hanson, 2005; Knox & Hill, 2003; 2016, and others in that 2016 special edition of Counselling Psychology Quarterly). Without sharing a great deal of detail, Jane's most recent therapist had given her just enough information to know that some aspects of her historical family background were similar. This Jane clearly found helpful, and may well have contributed to her openness in the research interview context. Perhaps she shares 'just enough' with clients too. The most enduring lesson I have learned from my last therapist was the relief I felt at her total acceptance and lack of shock or criticism when I had enough courage to disclose previously well-guarded secrets. Although unremarkable for a

counsellor, in my own practice I aim to be similarly sensitive to clients who are struggling to disclose material which is very painful to them, but possibly my own experience as a client has enabled this to be more instinctual than a learned 'technique'. I also learned from her that very occasionally touch can be appropriate even if this is something that many counsellors, including one of my supervisees, would consider taboo. I am not naturally tactile, but from time to time I no longer fear giving a reassuring pat or even, rarely, a hug if requested. Fran's appreciation of the "brilliant" "brutal" (p213) hypnotherapist she had seen quite early on had not resulted in her borrowing his style, but it could have contributed, along with her rebellious spirit, to her "maverick tendencies", which her supervisor helps her to keep "in check" (p231).

12.2.6. The medical way

"I want CBT". This was said to me by a client who was a doctor, and who genuinely believed that this was the gold standard treatment for depression[64]. The National Institute for Care and Clinical Excellence (NICE, 2005) guidelines, based on positivist empirical evidence (the 'medical model') have been very influential in treatment of emotional distress in this country but are not accepted uncritically by practitioners who prefer to draw on a wider evidence base than those used by NICE (see e.g. Clark, 2011). In Parry's (2000) article on Evidence-Based Psychotherapy she reviews the arguments for and against and suggests that arguments against fall into two camps – one being total rejection, and the other which "does not reject it so fundamentally, but sees it as fraught with difficulties and dangers" (Parry, 2000, p67). Clark (2011) says, more moderately,

> "professional wisdom understands that evidence-based practice can never provide all the practical answers that we need." (p59)

This would be the position that most of the participants in this study would hold. Those who had received treatment in medical settings, with the exception of Lizzie

[64] After discussion I offered to refer her to a Cognitive Behavioural Therapist as I have no specific training in or preference for this modality.

and myself, had rather negative reflections on their experiences. Paul had initially contacted his GP, who was understanding of his need for help, but referred him to counselling which turned out to be inappropriate. Morag was sympathetic to her psychiatric staff's attempts to help within their frame of reference, and even started training in that setting, but concluded by rejecting the then current practices. Helen had had one psychiatric referral from her GP which she found intimidating but gives them credit for deciding that she was not, after all, in need of their services. She had previously had extensive contact with her mother's psychiatrists, and found that experience somewhat overwhelming although necessary at the time. Neither Jane nor Fran mentioned any contact with medical professionals regarding their own issues, but Jane refers to her experiences of isolation (p126) in her mother's mental health issues (and her father's depression). From Jane's comment about having no help whatsoever as a family it seems to me that family support from the psychiatric services who were treating her mother, or from other statutory services, were wholly inadequate if present at all, a situation which is all too often highlighted in the current political debates on health and social care in the UK (e.g. House of Commons Hansard, 2017; King's Fund, 2017). In hindsight she also disputes her mother's diagnosis. Lizzie's experience was quite different from the others. In her psychotic breakdown she had had psychiatric care which she could not fault. In addition, Lizzie was specific in saying that since her own breakdown and treatment she had lost her fear of mental illness when she saw signs of it in her clients (p193). For my own teenage problems I sought help from my GP – a traditional 'family doctor' – who was excellent, though the only tool at his disposal in the 1960s was medication, which saw me through, although I still believe his diagnosis of agoraphobia was incorrect in those days before much was commonly known about trauma.

These diverse experiences of interventions based on a medical model of emotional distress support Clark's (see above, p252) view that evidence-based practice has inadequacies, for all it has many merits too. Unless constrained by the policies of employing organizations, counsellors have considerable freedom in the approach they take to trauma counselling, and the participants in this study all indicated that they try to tailor their practice to individual clients, even if they have a preferred

starting point within a particular counselling modality. None indicated that they eschewed medical models of therapy to the extent of being uncomfortable with clients' use of prescribed medication, although only Morag and Lizzie made direct mention of this. Morag said that she had been motivated to learn about the effects of different psychiatric drugs so that she could more easily recognise the ways in which these might impact on the communication styles of her clients. Lizzie had personally been helped by appropriate medication and psychiatric treatment, and was happy to refer clients to psychiatric services where indicated. Paul has some misgivings about some rigid theory-driven treatment protocols in some organizations and was sometimes anxious when referring clients into the hands of those who might possibly not connect to his clients in the way he attempts to do.

The medical model of distress, whether physical or emotional, is a dominant discourse in Western society (Casstevens, 2010) and some traumatised clients turn, like Fran at one point, to "less legal ways of coping" (p213) in the hope of finding the right substance or behaviour to alleviate their symptoms of dysregulation (Courtois & Ford, 2009, pp26 & 266; Fisher, 2000). Self-medicating, among other coping strategies, not infrequently leading to addiction, is common in traumatised people (Penney, 2012; Sheerin et al., 2016; Stover, Hall, McMahon, & Easton, 2012). Fisher (2000) points out that

> "adult survivors of trauma become ... remarkably adept at inventing *compensatory strategies aimed at self-regulation* [her emphasis] long before they enter the doors of our offices, hospitals, and clinics" (p1)

Though understandable because of addiction's devastating immediate effects on substance misusers and society, therapy for addictions often focuses primarily on behaviour modification interventions. The National Association for Alcoholism and Drug Abuse Counselors (NAADAC, 2009) makes only one mention of trauma in their basic guide for addictions counsellors, and NICE guidelines (see NICE, 2007, 2011; Pilling, Strang, & Gerada, 2007) similarly concentrate on harm reduction. Again, the NHS Choices website does not include trauma as one of the possible causes of addiction (NHS Choices, n.d.). According to Fisher (2000) this might be rather missing the mark, in a similar way to the over-worked GP's prescription of

antidepressant medication, albeit often necessary, which may control symptoms whilst leaving the root cause, which may be trauma, unaddressed. However, even those working in more tightly controlled organizational settings than Fisher, are beginning to see the impact of prior trauma in their addicted clients. Brown, Harris & Fallot. (2013) talk of need for staff to take care to avoid triggering clients' trauma memories, uncovering assumptions and inconsistencies, and to take note of limitations of, and ways to improve, organizational systems (p288). Similarly Covington (2008) calls for recognition of the interrelationship between trauma and substance abuse in the lives of women. When assessing clients with any addictive behaviour, I have learned to try to rule out prior trauma before proceeding.

12.2.7. How long is long enough therapy?

In many medical and other settings, onward referral of trauma clients who need longer term therapy is an issue faced by those working on short-term contracts with clients of limited means because the NHS is one of the few free or low-cost providers available. Paul and Helen worked mainly on short-term contracts, and Jane had done so in her previous post. Paul's anxieties around referring clients on to practitioners who might not make deep connections to them (though he acknowledges that there are many fine clinicians around) could well echo his own negative experiences of counsellors who could not connect with him. Much of my own work is and has been in settings where I have had open-ended contracts so session number limitation is not always an issue. I do, though, sometimes take short-term Employment Assistance Programme (EAP) clients, and have encountered the same fears and frustrations as Paul. I have seen it often in supervisees, particularly where referral to GPs was the only option allowed, or where clients did not have financial resources for private therapy. Helen was concerned about the paucity of primary care NHS counselling in her town, leaving trauma clients with few if any choices for ongoing therapy. Paul was the most explicit in indicating how he managed this issue – he believes that high-quality connection with clients for even only six weeks is a positive opportunity for them to tell their story rather than have it locked in their head. Like Khan (see

above, p31), he accepts the organisational limitations pragmatically. He prepares clients well for accepting that more work might be needed in future, but that for now the crisis which brought them to him has found some measure of soothing.

This study's participant criteria specified that they had all experienced developmental trauma but did not narrow their trauma counselling practice to Complex PTSD (CPTSD) clients. It is possible that their own experience may have had some bearing on their approach to all trauma and the frustrations of working short-term experienced by some could have a number of explanations. One of these is a general acceptance that CPTSD therapy normally takes longer than the 9-12 weeks which can bring about substantial improvement in PTSD symptoms (Cloitre et al., 2011, p625). Cloitre et al. in the same survey of expert clinicians in the field, found that there was no consensus about duration of therapy for CPTSD other than that it was normally longer than this. Courtois et al. (2009, p96) believe trauma therapy is "rarely ... meaningful if completed in less than 10-20 sessions" and may take decades. Ringrose (2013, p63) recommends long initial commitments by therapists treating people with Dissociative Identity Disorder[65]. This is consistent with Kluft's work on the disorder (e.g. 1984) which emphasises the length of treatment needed.

The 6-session model of brief counselling in many primary care settings falls short of even these minima for classical PTSD, let alone CPTSD, and it is hardly surprising that some find it frustrating, the more so if they have known the personal benefits of long term therapy, as had the participants here. Another interesting aspect has been raised by Finnish researchers (Heinonen, Lindfors, Laaksonen, & Knekt, 2012; Knekt et al., 2016) who have looked at long-term outcomes of therapy for anxiety and mood disorders, not from the more common perspectives of modality or technique, but from the personal and professional characteristics of the therapists themselves. The Finnish studies do not link past therapist experience to their personal characteristics, but this could be interesting to explore. The experience of trauma, especially childhood trauma, is well recognised as having significant effects on people's sense of self (e.g. Herman, 1992; Ozturk & Sar, 2016; Rave, 2000;

[65] Dissociative Identity Disorder is usually associated with severe developmental traumatisation (Kluft, 2001)

Saakvitne, Tennen, & Affleck, 1998; Ulman & Brothers, 2009) so it would not be surprising to find, as these researchers have, that the 'self' of the therapist who is a trauma survivor can influence their practice in some way. These and others (see section 2.3.3 above) note that the characteristics of therapists influence their effective use of short- or long-term therapy, and this could be particularly pertinent to trauma counselling, especially in the restrictions on long-term work already discussed.

12.2.8. Practice underpinnings

As addressed in Chapter 3, trauma can be studied and worked with from different ontological and epistemological positions. I have argued that therapists may have to hold different positions in paradoxical tension when working with clients (p51). 'Messy', but frequently effective, mixing of positivist medical insights with postmodern experiential ones was evident in many of the participants' presentations of their practice. The participants represented adherence to different modalities of counselling. Helen identifies as strongly person-centred, and Paul was committedly psychodynamic. Lizzie's core practice was sensorimotor. Jane had trained as an integrative therapist and her main practice experience was in psychological first aid and trauma debriefing. Fran, a counselling psychologist, and Morag, did not specify their modalities. My own initial training was person-centred but I would now identify as integrative. All the participants, even those who had preferred modalities, were open-minded about other approaches. Paul had come full circle, returning to psychodynamic after exploring other approaches. Helen and Morag had engaged in initial training in Eye Movement Desensitisation and Reprocessing (EMDR) and use it sparingly if indicated. Jane was inclined now to dismiss critical incident debriefing (Mitchell, 1983) in spite of having worked in that way for a number of years. That the participants' preferred counselling modalities covered many of those currently represented in the counselling profession has no clear explanation from the data presented here. There is often limited choice of basic training modality, and few counsellors go into training with very much awareness of different theoretical orientations on offer. Schapira (2000) is no doubt right in recommending that people

considering counselling training should explore different orientations to see which might suit them best, but in practice I suggest that few people will buy a book such as hers before applying for a course, especially where there are very few training providers on offer in their locality. Anecdotally very few of the general public, from whom counselling trainees are drawn, are aware of there being different kinds of counselling, so orientation questions are ones which few might even know they might ask. Having said that, all the participants were experienced practitioners and had therefore been exposed to ways of thinking which differed from their initial training. Helen and Paul were the most committed to their core modalities but had returned to them after exploring others. There was however a cross-modality unifying characteristic – the valuing of relationship. Neither Morag nor Jane had a particular loyalty to trauma counselling above other fields and from this sample there does not appear to be a specific connection between chosen modality and the participants' trauma history.

In recent years there have been numerous quantitative studies comparing effectiveness of psychotherapeutic and pharmacological interventions in depression and anxiety (e.g. Chilvers et al., 2001; Roy-Byrne et al., 2010). Similarly there have been quantitative studies comparing different modalities of psychotherapy and counselling (e.g. Smith & Glass, 1977). One of the most often quoted findings is that whatever the modality the most consistent effective variable is the relationship between practitioner and client (Lambert & Barley, 2001). All the participants in this study worked in highly relational ways. Paul's passion to connect with his clients, Fran's to find creative ways to engage hers, Morag's to be relevant, and Helen's love of Rogers' approach all point to the centrality of relationship in their counselling practice. Even those who occasionally used EMDR (Helen and Morag) or Neuro-Linguistic Programming (NLP) techniques like Rewind (Lizzie) used them in the context of an established empathic client-therapist relationship. In all cases interest in such techniques was peripheral, and Lizzie was the only one to refer to her "toolkit". Helen, the participant who as a person-centred counsellor might have been expected to be most resistant to very 'medical' procedures, was very open to the need to take neurobiological research seriously, and to use its findings and techniques

where relevant, as was Morag. In Fran's account of her encounter with some clinical psychologists there is still, in my view sadly, a divide between the reflexive approach of these 'wounded healer' counsellors and those who see no need to "go with their personal stuff" (p221 above). Coming from a scientific background I greatly appreciate some of the very high quality empirical research that has been done in neurotraumatology and I use some of that when appropriate in the psychoeducational aspects of my practice though I still foreground the relational aspect of my work. One of the dangers of too close an adherence to guidelines in trauma counselling – which is seen in some services, as alluded to by Paul (p168) – is that these guidelines are often based preferentially on evidence from empirical positivist research which has side-lined the 'expert' experience of wounded healers. It is of note that one of the organisations[66] dedicated to support and training around Dissociative Identity Disorder speaks frequently of 'experts by experience', meaning those who have been diagnosed with the disorder, and seek to share their insights more widely.

12.2.9. "The Body Remembers"[67], and Triggers in the Counselling Room.

In this, and the next section, I shift emphasis a little from the direct influence of earlier trauma on the participants' practice, to influences which are less direct, but in my view significant. They are both related to the 'self' of the wounded counsellor. This section looks first at physical impacts of a counsellor's own trauma on themselves, and then to effects on them of their clients' traumas. In the following section I go on to discuss how these might or might not impact practice to the extent that conscious awareness can enhance congruence.

Paul and Morag, both of whose early trauma was largely hidden from their conscious memory, made specific comments about bodily awareness. Morag described herself as "quite a sensory-based person" and said she uses her bodily awareness in her

[66] "First Person Plural" http://www.firstpersonplural.org.uk/
[67] Title of book (Rothschild, 2000)

counselling practice. She hinted at some sensory experiences being related to her own past, but had learned to use them in a positive way in the service of her clients:

> "Probably the task for many counsellors is discovering something that you have and then learning how to use it." (p156)

Morag and Lizzie both talked about physical responses in the counselling room, Morag in terms of using them in the therapy, and Lizzie, when talking about hyper- and hypo-arousal (see below), of occasionally feeling "cold" with a client when they have dissociated. Lizzie also spoke of more psychological after-effects of working with traumatised clients – often feeling "kind of uneasy or sad or a bit depressed" (p184). In Paul's post-interview email (see p180 above) he reflected on the physical impact of trauma stories and how this had, over time, led him to give greater attention to self-care.

Much has been written about the psychological effects of trauma, not only on the person who has been the primary subject of the trauma, but also on those who witness it – visually (as, for example, in the case of seeing a child run over) or by report. These indirect forms have been variously called Secondary Traumatic Stress (STS) (Figley, 1983), Vicarious Trauma (VT) (McCann & Pearlman, 1990), compassion fatigue (Figley, 2002, 1995)[68] and burn-out, and some writers use some of these terms interchangeably. In general, however, STS and VT are reserved for effects described in primary posttraumatic stress with some (e.g. Rothschild, 2006, pp12-15) reserving VT for those who witness others' trauma by report only, whilst burn-out is related to a slower onset of vaguer symptoms of tiredness, irritability, dissociation and general ill health. All of these were seen in one form or another in the participants here. Helen recognised her extreme reaction to her friend's son's accident as VT which had also triggered her own traumatic memories. Jane's 'hysterical' reaction following the crocodile river rescue looked like acute STS. Jane described extreme burnout following co-ordinating work on a major trauma incident, while Lizzie, possibly because she had learned to recognise and ameliorate it,

[68] Compassion fatigue is more often used today as a generic term for a reduction in caring engagement on repeated hearing of trauma stories, but in academic trauma literature it has been variously associated with Figley's original identification with STS, and later with burn-out.

described a milder form of VT or threatened burnout. Many writers (e.g. Follette et al., 1994; Van Deusen & Way, 2006; Way, Van Deusen, Martin, Applegate, & Jandle, 2004) focus on the psychological effects of trauma – whether primary or secondary, but others (e.g. Freudenberger, 1975; Pearlman & Saakvitne, 1995; Rothschild, 2000, 2006; Stebnicki, 2007) include the physical effects on those helping traumatised individuals. For Paul and Lizzie this seems an important aspect for inclusion in our understanding of 'wounded healers' and it surprises me that supervisees and colleagues seem often unaware of the impact of their clients' trauma stories on them, physically as well as psychologically. My own somatic reactions, other than suffering from tiredness which is not always directly related to my trauma counselling work though may be a factor, teach me something else. In the account of my own childhood trauma I suggested that I tend to dissociate affect. I suspect that because my trauma involved repeated physical pain I may also dissociate somatic awareness (the S of Levine's SIBAM model. See p83 in Chapter 5 above) as I rarely if ever experience the physical effects in my own body as Morag, Lizzie and Paul describe when with or after seeing clients.

Jane made a particularly interesting comment. She considered that telephone counselling holds its own unique dangers, because she felt that the stories were coming straight into her head from the earpiece. Two of the factors which may have played a part for her are the intensity of the work with acute recent trauma, and the lack of visual information from a face-to-face encounter. Added to Jane's easy recall of visual memories, such as locations in London, her 'right inside your head' experience could have been the more difficult for her because of her need to fill in the client's experience with her own vivid imagination where non-verbal cues from the client were unavailable. Visually impaired people are known often to compensate by developing other senses to a high degree compared with those with normal vision, although such adaptations, as Ceconi and Urdang (1994) say, are unique to the individual. They also say that

> "although she [Ceconi] has a good adaptation to her blindness it is nevertheless 'an ongoing trauma . . . a perpetual state of being . . . you have to protect yourself from an onslaught of stuff . . . if you didn't have

> defenses you'd be a basket case . . . I can readily see defenses that abused children, like [her client], have erected.'" (p189)

For telephone counsellors who would normally in face-to-face work rely on visual clues there is evidence (Bickford, 2012) that they are at considerably higher risk of vicarious trauma than face-to-face counsellors. Ceconi's graphic "onslaught of stuff" appears to mirror Jane's experience and my perception of Jane as the participant who had the most remaining issues with her trauma may be due to the relatively recent ending of her 11 years of telephone work. More recovery time and reflection may have been helpful and could be a cautionary tale for any of us who work for long periods with trauma.

While this phenomenological study in search of phronetic or practical knowledge gives these 'experience-near' examples it does not prioritise generalisation as does some of the quantitative research that has both found, and not found, a correlation between VT, STS and burnout in wounded healers (see section 2.3.2 above). Chouliara et al. (Chouliara, Hutchison, & Karatzias, 2009) review VT in practitioners working with sexual abuse clients and they point to methodological disparity as a possible explanation for conflicting results. The question remains as to whether wounded healers are more or less prone to STS and VT, and/or more or less able to recognise and take steps to minimise them. It seems likely that the more experienced the counsellor and their better use of supervision, including development of a good internal supervisor (Casement, 1973, 1985), goes a long way to strengthen resilience and growth[69] in what can be challenging work.

Symptoms of posttraumatic stress are many and varied[70]. They can be roughly divided into those which supress and those which enhance physical and mental energy. For example hypervigilance is characterised by a state of alertness (high energy), and depression by lethargy (low energy). Anger is a high energy state, and numbing shows low energy. Each symptom is associated with the states of hyper- or

[69] Just as exposure to clients' trauma can lead to vicarious traumatisation, so it can lead to vicarious posttraumatic growth (e.g. Barrington & Shakespeare-Finch, 2013; Manning-Jones, De Terte, & Stephens, 2016).

[70] See DSM 5 (American Psychiatric Association, 2013), ICD10 (World Health Organization, 2010), Herman (1992, p121), Courtois &Ford (2009, Chapter 5).

hypo-arousal (Fisher, 2017; Ogden, Minton, & Pain, 2006; Siegel, 1999) in which the autonomic nervous system responds in protective ways to some aspect of threat – present or past. Lizzie, with her particular interest and training in sensorimotor psychotherapy is very aware in the therapy room of even subtle changes in states of arousal. The image of the 'window of tolerance' (the term coined by Siegel, 1999) between pathological expressions of hyper- and hypo-arousal allows her to

> "intuit and notice and be with not so much the words but what's happening right in the room right in front of you or picking it up in myself thinking 'that doesn't make sense', or suddenly feeling cold or something like that." (p202)

She comments too on nothing being 'fixed' for trauma clients when they are outside the window of tolerance. Much of this awareness is reflected in her own history where the lack of fixity showed a child who was alternately passive and 'stroppy', craving care and rebelling, emotionally repressed and very angry. Such lack of fixity, with its contradictory moods and behaviours is consistent with the traumatising attachment disruption Lizzie experienced in childhood. Some of these contradictions followed her into young adult life, causing her to be resentful and ultimately resistant to the 'rules' of nursing life "I didn't want the uniform. I didn't want to be told what to do" (p189) - and then the submissive attachment to a manipulative and abusive counsellor. She has worked through so many of these reactions that she is now very much aware of them when they threaten to re-emerge through triggering in her client work. Her awareness has contributed to her ability to take appropriate action to reduce the power of any such reactions to triggers when working, and to motivate her to take self-care steps if she realises later that her own trauma memory has been triggered. Helen chose a different way to describe the value of her awareness. She is someone who has a "well-developed internal supervisor" (p118) and relates this to her "heightened sense of empathy" (p118) with particular clients.

Almost all the participants mentioned their vulnerability to their own trauma material being triggered by client material. This is perhaps not surprising amongst those who identified as wounded healers. Morag was the only one not to do so, though she was

open about feeling easily angered by irrelevant counselling practices. Helen gave a particularly graphic description of the triggering of posttraumatic symptoms when working with a client at the extreme end of the trauma spectrum. She now recognises that it would be unwise for her to work with a client at this end of the spectrum again. Similarly, Lizzie was well acquainted with her vulnerability to triggering. She has developed her own self-care strategies for recovering from post-traumatic reactions triggered by her work. Paul recognised his physical vulnerabilities to the work, and again saw the need to be aware of them, and to take care of himself. Helen, Lizzie, Fran, Paul and I all specifically highlighted the value we place on good supervision. Both Fran and I spoke of the value we place on having supervisors who know enough about our trauma backgrounds to be alert to triggering when it occurs and to point us to forms of support or self-help when needed. Some of us have also benefitted from further therapy ourselves from time to time. Jane rather wistfully mentioned the contrast between the fast-moving single sessions in her telephone work and longer-term contact with clients which afforded opportunity to make better use of supervision. Perhaps more supervision might have helped her avoid the extreme stress she suffered near the end of her time there. There might be lessons to learn here about the best frequency of supervision of counsellors who are engaged in very intense short-term work.

12.2.10. Understanding our and our clients' survival strategies.

A question that is worth asking regarding counsellors' own experiences is whether they use those experiences to enhance empathy (as Helen does) or if they project those experiences on to clients. We cringe when we overhear people in social situations saying "I know exactly how you feel. When I ... ." Sadly some of us have had clients report that previous counsellors have assumed feelings in them which were really their own. A client actually said to me once that her previous counsellor had said "If my husband said that to me I'd divorce him". Rogers' (1957) "necessary and sufficient" condition of congruence, I suggest, holds the key to safe and effective

use of our own experiences[71]. Each of the participants had engaged in extensive personal therapy and had understood many of their reactions in terms of their trauma history.

One of the ideas that I have found to make sense to clients and supervisees is the structural dissociation model of trauma (Fisher, 2017; Steele, Van der Hart, & Nijenhuis, 2005; Van der Hart et al., 2006). Fisher (2017) gives a succinct summary of the model:

> "Structural dissociation facilitates negotiating unsafe attachment relationships: if the wish for closeness is held by an attach part, the ability to appease by a submit part, the need for distance by flight, the fear of attack by freeze, and the imperative to control the situation is instinctive for the fight part, then the individual as all the "ingredients" necessary to manage in a dangerous world" (p133)

Fisher (2017, p2) speaks of the relief experienced by clients when she suggests their troubling experiences can be explained by this trauma model, and has blended it (Fisher, 2017, p8) with a therapeutic understanding of Internal Family Systems (Schwartz, 2001; Sweezy & Ziskend, 2013) – a 'parts' model, not restricted to trauma - in which she encourages the 'parts' to understand one another and therefore reduce inner conflict[72]. One aspect is to look at the survival strategies used by early trauma survivors when they were children and young people, and which have been unhelpfully carried into adult life. These strategies can range from the extreme splitting seen in Dissociative Identity Disorder, to less dramatic techniques like hiding behind the sofa when dad is shouting at mum. The little boy who hid behind the sofa finds himself as an adult quite unable to stand up to bullying, or even banter, in his office and keeps his head down but pays the price of continuing suffering. The participants in this study, like most trauma survivors, used strategies which differed according to the circumstances and the resources available to them. These included anger, adaptations to anxiety, submission and dependency, and dissociation.

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[71] Noting however Mearns et al.'s (2013, p116) caution (see p32 above) about externalising congruence.

[72] Fisher's approach is laid out in the cited book, but I am also indebted to her online teaching in her 4-year webinar programme "Working with the Neurobiological Legacy of Trauma" (see http://janinafisher.com/).

Although by no means always rooted in trauma anger is another common posttraumatic symptom (American Psychiatric Association, 2013; Dyer et al., 2009; Herman, 1992; World Health Organization, 2010). Lizzie refers to expressing anger as a child when safe enough to do so. Fran describes herself as a "very angry" (p210) person from early childhood into young adulthood, also within safety limits. I have referred to myself as a rebel (p88). Paul and Morag did not mention anger, and Jane's reference to it was only in the context of being angry for other people, which was similar to Helen's anger with people's attitude to her father's disability. Somewhere along the line those of us who were angry children and young people have been able to process and to a large extent transform that anger from a destructive force into a controlled, usable energy source in our lives and in our work. This has not been a smooth path and in some cases has alternated between expression and repression (Herman, 1992, p121). Lizzie's description of her abusive therapy is the starkest example. From an ultra-rebellious relationship with her parents in emerging adulthood, she turns full circle into an ultra-compliant victim (I use that term deliberately) of a very manipulative 'counsellor'. The road to recovery was far from smooth for her. I was struck, and ethically quite challenged[73], by the fact that she actually once worked with this man at a conference even after she was a qualified counsellor herself before finally saying 'enough!' She gave no indication that she had ever reported him to any professional body at the time, in spite of later affirming that she was "very sharp" as a supervisor in challenging any hint of abusive practice. Her descriptions of her practice show her to be an intensely compassionate therapist, who, even on occasions when she has been triggered ("felt like swiping him"), took her anger to supervision rather than acting it out with the client. The significant issue here, I believe, is her congruence in being sufficiently aware of the possible detrimental effect on her client, for her to take her feelings to supervision.

Fran's transformation is impressive. From such an angry young person, she has clearly tamed that beast so that she derives energy from it and finds creative, cutting edge, safe ways of helping her traumatised young clients. As a teenager Helen's anger was channelled into involvement in disability rights, and in her counselling she

[73] See the Promenade to chapter 10.

has a strong preference for the person-centred approach in which empathy is the core condition that she mentions most. Anger was reserved for her experience of seeking help by attending a course on trauma which went no way towards addressing her real practice encounter with serious trauma. I like to think that my own angry part has also been harnessed in my passion for justice for asylum seekers and others battling cold bureaucracy. Unlike Fran I have never been much of a risk-taker, and I clearly remember my reluctance to 'get my hands dirty' (i.e. be politically involved) by challenging some diplomats in Arabia who seemed to us to have abandoned their nationals to rot in prison there. Like women who wear purple (Joseph, 1974) I am more willing to take the risk of being bold these days, though I craft letters of protest very carefully, informed by a much greater awareness of what is 'my stuff' and what is legitimate argument. With clients who have suffered injustice I will often voice my anger as a witness. I find emotion-free reflections like "you felt angry when ..." rarely touch the spot, especially where a client has been relentlessly and unfairly blamed for their own misfortune and cannot risk 'feeling', let alone expressing, anger even when appropriate. I have much sympathy with Smail's arguments (1996, chapter 5) that therapy can be so pre-occupied by interior processes that moral considerations of a client's context are side-lined. Implied in Jane's "let's bring everything out into the open" (p133) statement about her family story is a similar conviction to my own that authenticity is generally desirable in relationships, the counselling relationship included, provided counsellor congruence is shared only in the interest of the client and not as a way of venting the counsellor's feelings.

Reminiscent of Helen's early involvement in disability rights, we frequently hear in the media of people who have suffered some tragedy later using large amounts of energy to set up charities, self-help groups or campaigning organizations. Anger is not, however, always channelled in this way. When the trauma is not fully addressed, burn-out (Freudenberger, 1975; Lemberg, 1984), power games (Heller & LaPierre, 2012), depression and even criminality can result (Stinson, Quinn, & Levenson, 2016). It can be a bumpy ride for those of us who have found anger to be a useful tool in our youth for surviving early trauma. However, as in many aspects of counselling, recognition of what is going on for us, monitoring ourselves

(sometimes with the help of therapists, and/or supervision), and finding better ways of being is not only possible but can be exhilarating.

I have found in my own practice that depression frequently results from 'depressing' anger. Freud (1917) used different terminology and in her review Luutonen (2007) considers the "anger-turned-in" hypothesis too simplistic, but I have found that used judiciously it can still be a useful working model, and one that I have recognised as true to my own experience. Dissociated anger can also be approached within a 'parts' frame (Fisher, 2017, chapters 2,4 & 5) which is much used by sensorimotor psychotherapists like Lizzie. I too have found this particularly useful where clients have developmental trauma histories. Depression, though a common posttraumatic symptom, is not always trauma-related but I believe it is important, at the very least, to rule out underlying trauma when assessing clients. I have had clients referred to me for 'anxiety and depression' who do simply have a limited reactive condition, or whose troubles are biologically based, but I have also had those in whom posttraumatic stress has been completely missed by the referrer. I have therefore become somewhat agnostic about some of the questionnaires (e.g. GAD7 and PHQ9) used routinely by GPs which may accurately describe symptoms but can lead to inadequate diagnoses.

Anxiety, another common posttraumatic symptom, is not in itself a survival strategy in the way that anger is part of the 'fight' response to trauma[74]. However, both Jane and Helen spoke about the feelings of anxiety which had marred their childhoods. Jane reduced hers by developing her good intellect by working hard at school and doing well academically. This was her escape route from the home and all its difficulties. Still, after she had left home and university her anxieties continued to plague her and she sought counselling. For her, this led to understanding her family dynamics and the effect they had on her – that she, and not only her mother, had been traumatised. For Jane, her cognitive strength was one of her protectors in childhood, but needed to be employed again in adult life to provide the understanding which released her from much of her anxiety. Jane said much less than the other

[74] Although it could be argued that anxiety is a form of hypervigilance which might be a variant of the 'freeze' response

participants about her current counselling practice, but one thing she did say was that she was continuing to be curious, reading around issues that arose in her work and applying new knowledge. This would be consistent with someone who used their intellectual pursuits as a survival strategy in childhood. I can see the same in myself.

Helen's fear and anxiety (and her less prominent anger) were relieved by her becoming a carer – her mother's 'counsellor' from age 11 – and a disability advocate. This this led on to a caring profession, nursing. Nevertheless, the anxiety remained and surfaced when she met her future husband and contemplated issues of long-term relationship and having children. Of the counsellors she saw at different times some were more helpful than others, but I tentatively suggest that her strong attraction to person-centred counselling might indicate that her anxiety responded better to someone who resonated with the carer in her. This is not to say that other counselling modalities are less caring, though it might have been experienced by Helen more overtly in non-directive Rogerian counselling.

In adult life Jane used the intellect which had been a survival strategy in childhood to understand her family dynamics through counselling. Fran and Paul used theirs in a different way. Neither had excelled at school, but in trying to process their emotional confusion and distress as young adults they had turned to self-help study. Both had been disappointed in therapy and believed that if no-one else could help them they would have to do it themselves. By contrast Lizzie reverted in hope to a variant of the religion that had so dominated her family culture, initially suspending trust in her own cognitive resources. Helen had not turned to books in the same way as Paul and Fran, but there was a hint of her need to work things out for herself when she was training. In group work she feared spontaneity until she had inwardly rehearsed her responses.

Once medically out of danger, one of my own survival strategies as a small child was, I am told, to be 'a cheerful little thing'. I would elicit positive strokes that way. This did not work so well when a ready smile and quirky sense of humour competed with depression and anxiety in my teen and adult life. Like Jane, I focussed on academic achievement, and like Lizzie sought help in my faith (though mercifully

not an abusive version, as she had encountered). Like Jane I first sought counselling through a friend who had been helped by the same therapist. Also like Lizzie, I would not have considered that first encounter had I not been told that the counsellor was a Christian[75]. I am very aware of this when Christian clients come to me – aware also that their understanding of faith might be very different from my own. The lessons all this has for me is to be alert to the different ways in which clients' childhood survival strategies might manifest in adult life, and what this can teach me about tailoring counselling to be sensitive to the 'back story' of their search for resolution before they arrive at my door.

A frequently used survival strategy in children is submission to their abuser in a form of pathological attachment (Herman, 1992, p98). This is often recognised in victims of sexual abuse but this strategy is used in other circumstances too, as was seen in both Lizzie's submission (under duress) to her parents, and particularly in Fran's submissive behaviour in face of her father's rage. Fran's submission lived alongside a great deal of anger, which she expressed outside the home where it was safer to do so, and it is the latter strategy which she carried into adult life. Lizzie's submissive strategy, also mixed with anger, was, as we have already seen, one which did cause her considerable problems as an adult until she was able to recognise it and work through it.

My interest in this project was partly motivated by own negative dissociative experiences. Through the other participants' experiences and views I have gained a more balanced view of dissociation in which my theoretical knowledge that it is largely a protective mechanism has become more real. Paul, in particular, was convinced that dissociation saved him as a child. Helen too believed that dissociation in her clients was largely protective. I have come to believe that, putting aside the unpleasant derealisation symptoms, my brain has also made use of protective dissociation. In my case these were dissociated emotional responses (affect) of perceived abandonment and (somatic) experiences of pain and perceived assault. In the course of this study I have become more aware of instances in which

[75] In fairness, this was in the 1980s when counselling had much less recognition of spirituality than it has today, and the church was more suspicious of psychology.

both these areas of dissociated material can threaten to re-enter my consciousness and this has made me more likely, I believe, to recognise this phenomenon in clients.

This section, compared with some of the others, has included more illustrations of the influence my own trauma has had on my own self-awareness but much of the material gleaned from other participants resonates with them. The key similarity with regard to practice is that a counsellor's congruence, born of deep reflexivity, is a vital ingredient in protecting clients from unhelpful projection, which I suggest is particularly detrimental for traumatised clients.

12.2.11. Wound meets wound

This discussion started with a question "what's mine, what's theirs"? Perhaps that is a question that can never be fully answered, but in the messiness and thickness of human experience we derive some sense of what both we and our clients bring to the counselling room when we meet there. We as counsellors are there primarily in the service of our clients and our wounds in that moment are only of value in as much as they might have transformed us into wounded healers. The data suggests strongly that to become a wounded healer, counsellors who have themselves been traumatised as children need to have engaged in a high degree of self-reflection, usually with the help of therapists, trainers and supervisors, and to be able to be reflexive in their practice. This will enable them to establish meaningful empathic contact, uncontaminated by vicarious trauma, triggered reactions or over-identification with clients.

All the participants in this study, except Morag, resonated with the identity of the wounded healer. Morag simply considered that counsellors who had not been traumatised might find it more difficult to get a sense of what was going on for their clients, particularly in a somatic way, but the rest of us felt that our traumas were indeed a valuable asset in our work. Lizzie saw it almost as a "badge of approval" and that we have "earned the right" (p205) to walk with someone on a similar healing path. Paul identifies strongly with the concept, and believes his own early therapy

would have been far more helpful if his counsellors had been wounded healers themselves. In contrast to Helen, who believes that most counsellors, and indeed most people in the care sector, are attracted to the work because they have been wounded themselves, Paul is disappointed in his perception that only a minority of counsellors he meets on CPD courses to whom he would be comfortable to go as a client are people who seem to carry the wounds that would enable them to understand him. Fran believes that the value placed on self-reflection by counsellors allows them to "go to the dark places with the client" (p221) in a way that she found some of her psychologist colleagues were unwilling to do. She has a sense that those who have experienced trauma would have a deeper level of understanding of it in their clients. So although I end as I began with a question, the participants and I have worked together to co-construct some meaning to add to that already known about what it means in practice to be a wounded healer. There may always be a tension in discerning 'What's mine, what's theirs?' when wounds meet in the counselling room, but part of the work of counsellor and client together is to address that tension, and the counsellor's contribution, based on the evidence presented here will be greatly enhanced by the quality of their reflexivity.

Chapter 13. Claims, Implications, and Final Reflections

When I understood, through my own therapy, that my dissociative experiences were trauma-related, I noticed a change in the way I worked. Until then, while I might have recognised descriptions of similar experiences in clients, I had been much less able to use that recognition in a therapeutic way. This realisation, in conjunction with some of the encounters with clients whose trauma had been previously unrecognised, piqued my interest in whether a personal experience of trauma in other counsellors might have similarly augmented their practice. I realised too, though, that without the self-awareness brought about by personal work, reflexive practice, good supervision and therapy, previously traumatised counsellors could be in special danger of projecting their own experiences on to their clients in less helpful ways. These, though, were just my thoughts – I needed to investigate, and the results so far have been presented in this study.

In Section I (Preparation), I have laid down the foundations of the study with an overview of the literature, the philosophy underlying this research, and the methods I have employed. In Section II (Exploration), I have presented the interview data in the form of imaginative dialogues in which the beginnings of co-construction of meaning have taken place. I have then gone on in Section III (Reflection), to bring together some of that meaning-making with discussions of major aspects which relate directly to practice. The more detailed interrogation of the data in Chapter 12, against the broader canvas of the participants' contexts, seeks to draw lessons which can inform and enhance trauma counselling practice.

In this chapter, as I reflect on the data analysis, and in the light of the literature that contextualises this study, I make three claims. I then summarise some specific implications of the findings before outlining my thoughts about the limitations of this study, and to which future research possibilities this work points. Methodological issues have been an important aspect of this study, and I include a reflexive section

(section 13.4) about formulating the research question before ending on a reflection that, even in the midst of woundedness, there is a place for hope.

13.1. The project's claims

I began my thesis with a reflection on the 'mess' of social science (p50) but come now to conclude that, through grappling with the messiness, this study has allowed me to make some claims concerning the impact a personal history of developmental trauma in a counsellor might have in the way they are affected by, and interact with, traumatised clients in the counselling room. These go some way to answering the research question, but it has been my aim to be able to add to the knowledge already available in the trauma counselling fields in a way which can assist practice, and strategic decision-making, in the counselling room and in training, not only of wounded healers, but of any counsellors working with traumatised clients.

13.1.1. Claim 1: Careful consideration of diversity of both counsellor and client meaning-making is of crucial importance in trauma counselling.

Because it seems desirable, and is certainly one of my aims, that research is actually useful in our practice as counsellors, general claims are to be valued. There is some tension here, but it is clear from this study that one significant and original finding is that context, and clients' own meaning-making processes, are individually unique to them. They are markedly diverse – a feature highlighted by Ashworth and Greasley's (2009) idiographic phenomenological research. My temptation was to listen only to these individual voices and conclude that the only general claim that can be made is that one cannot make a general claim. This is not, however the whole picture. Nevertheless, from this study it became clear that the idiosyncratic nature of our own and our clients' trauma, and the inevitably diverse impact this will have on the interactions between counsellor and client, is the primary finding, and one which

seems seldom foregrounded in training and research. Principally, this study shows that what is required is a focus on diversity in our clients over and above the tendency to categorisation, diagnosis, and too slavish an adherence to treatment guidelines. The evidence from this research project points to ambivalence even in conceptualisation of trauma, with different counsellors' definitions tending to relate to their own personal experiences. Counsellors with or without their own trauma history do well to incorporate this knowledge into their practice.

13.1.2. Claim 2: Choices of trauma counselling strategies are often influenced by counsellors' own experiences of what has been helpful to them, and this can be beneficial. However, there needs to be flexibility and responsiveness to the client's own presentation.

Also related to the diversity of experience, my data shows that survivor counsellors appear to be influenced by their own different healing strategies – the ones they employed as children as well as ones learned through their own therapy, training and supervision. The participants' experiences, even in this small sample, brought different skills and ways of working into the counselling room. None showed enthusiasm for the attitude that 'one size fits all' when it comes to trauma counselling, although all were open to using evidence-based methods to augment their preferred modalities, even when these might have grown out of different philosophical soil to that of their core approach. The participants had developed a sensitivity to the unique stories of their clients and they were willing to adapt accordingly. This may not look like new knowledge – many counsellors would do the same - but it does have political implications, to which I turn briefly in the section 3.2 below.

13.1.3. Claim 3: A wide-ranging research strategy, and judicious use of bricolage can capture otherwise hidden aspects of trauma experience.

This study demonstrated that although trauma counselling has benefitted greatly from much empirical research, and from a number of different qualitative methodologies, what is called for in research on trauma counselling is a new, and wider-ranging, methodology. This project has demonstrated such a methodology, which I have called practical (or phronetic) interpretive phenomenology, with the potential end of uncovering some phronetic, or practical, wisdom to contribute to the trauma counselling field. Rather than simply describing those experiences, as a descriptive phenomenologist would do, in an attempt to unveil the essence of experiences, I have used the narratives of each participant to suggest interpretations of those experiences. My aim in doing so is to provide evidence to help any counsellor working in the trauma field.

In addition, in order adequately to address the diversity of trauma experiences and the impact this has in the counselling room, research in the area does well not only to engage in 'experience-near' research, but needs also to be open to incorporating elements of bricolage. In my phenomenological data analysis it became vital to borrow from other research methodologies to capture some of the deeper meanings of the data. This, to my knowledge, has not previously been done explicitly in trauma studies, and my choice to do so is in the hope that it may emphasise the complexity of factors which contribute to experiences of trauma.

When it comes to research on practice, there are also disagreements around what constitutes evidence, with empirically-based studies relied on more heavily by some practitioners and more intuitive and experiential learning prized by others. The participants in this study seemed able to value both.

13.2. A summary of other specific findings

13.2.1. Political implications

Counselling and other psychological interventions cost money. Funding involves political decision-making, and not only in the statutory services. The subject of the limitations to both length of counselling contracts, and paucity of referral options for clients who have insufficient financial resources for private therapy, was of concern to several participants. This was particularly true of those working in services which allowed only short term contracts. Political pragmatism is understandable, but there does seem to be a need to revisit the issue of funding of trauma counselling, and a loosening of the criteria of eligibility.

13.2.2. Recognising countertransference and intersubjectivity

This study has paid attention to the known issues of countertransference and intersubjectivity in the survivor counsellor/client dyad. What has been made clear from the participant data is the crucial importance of survivor counsellors having worked through, in depth, their own trauma issues, to have developed an acute sensitivity to their own as well as their clients' reactions in counselling sessions, to make maximum use of good supervision and continuing professional development, and to engage diligently in self-care strategies. Whilst these are all recommended for any counsellors, the likely vulnerabilities and (dissociated) blind spots of those who have a history of developmental trauma make them vital for safe and effective practice for survivor counsellors.

13.2.3. Remembering, or not remembering, details of trauma

I found it interesting that early trauma memories, or lack of them, may influence the way that clients both seek help, and engage with counselling. We may therefore need to be particularly alert to the possible trauma-related significance of alexithymia in clients whose presentation, non-verbally, is one of desperation.

13.2.4. Counselling modalities

Differences in participants' modalities seemed to have little impact on their perceived effectiveness in trauma counselling. Modality was sometimes influenced more by external factors like geographic or other logistic availability of basic training than by deliberate choice, though an openness to learn from other approaches characterised this group of participants.

13.2.5. Training

A cautionary tale emerged from the data around the participants' differing experiences of both training and personal therapy. Most considered trauma to have been inadequately addressed in basic training and through recognising this had felt the need to proceed to post-qualification training. With the alarming prevalence of developmental trauma in so many of our clients it seems that more emphasis could usefully be put on it in basic training. Related to this, the differences in helpfulness of the participants' personal therapy experiences raises another question. Had some of the unhelpful counsellors encountered by the participants absorbed in their training a belief that they should be able to cope with anything a client might bring? Could it be helpful to include in training a little more encouragement to students to be comfortable about referring on, where this is possible, and that to do so is not an indication of failure? For different reasons this is probably as true of counsellors who have or have not experienced developmental trauma.

13.2.6. Relevance of resilience, vulnerability, reflexivity and self-care for good practice

My own suspicions, outlined in the opening paragraph of this chapter, about the importance of self-awareness gained through personal work, reflexive practice, good supervision and therapy seems amply justified in light of the evidence gathered. Self-awareness and reflexivity are ongoing tasks. The vulnerability of trauma-surviving therapists to triggering can be ameliorated by vigilance in taking these different opportunities for growth and wellbeing. Ultimately a counsellor's reflexive competence through these means will be reflected in the quality of help they can

offer to their clients. However, of note too is that the survivor counsellor's resilience can often be impressively strong, and the abilities forged in their own struggles can give them advantages in encounters with traumatised clients who can benefit from their therapist being unphased by the experiences that are threatening to overwhelm them.

13.3. Limitations of the study

Having chosen interviews as the main method of obtaining data in spite of Silverman's (2007) scepticism about the value of interviews in qualitative research (see pp 66-68 above), a series of interviews, rather than the single interviews, might have increased the scope of the data. The participants self-selected following quite a wide-ranging search. Whilst avoiding professional and personal boundary issues by searching or accepting offers only from people unknown to me, this did place limits on participant engagement. All had busy lives, owed me no favours, and in practice resulted in the opportunity of only one interview with each. Given these constraints, choice of the epistemological, ontological and methodological approach allowed for few generalisations to be made. However, by analysing the data in depth rather than breadth, and making reference to many other studies which have claimed general truth, I have discussed my own results in relation to the findings of others.

An issue facing some counsellors when engaging in research is the need to find an appropriate separation between their counsellor self and their researcher self. This has been addressed in a general way in the Introduction (section 1.4) and more so in in Chapter 4 (section 4.2). With only the one opportunity to interview each previously unknown participant, and being very much aware of the sensitivity of any discussion around personal trauma I found this somewhat problematic. As I reflect on this project I see that in my interviewing I have been less challenging than might have been helpful for the research, approaching the participants with the gentleness I might afford a client in their assessment session. This has left me with perhaps less data than I might have obtained, but also with different data. From the

'conversations', because I have been very careful not to put words into mouths, there are many instances of the participant giving no answer to questions that I pose or reflections that I make. This has been my deliberate attempt to counteract any shortcomings in my interviewing technique.

Having argued for a need to hold paradoxes, ontologically and epistemologically, in the counselling room and in research, but having made a choice to focus in this research project on a postmodern approach rather than an empirical one, I am still aware of the tensions this can create. Having been liberated from an unthinking acceptance of modernist scientific thinking, I remain aware of the lack of 'negative controls' and have to leave it to other researchers to examine in depth the experience and practice of trauma counselling by counsellors who have had a relatively trouble-free upbringing and a healthier developmental pathway than those interviewed in this study. Again, the data and discussions presented here should be read in the context of other studies, which will inevitably create tensions, though hopefully creative ones.

As one of the participants put it (Lizzie p197), trauma is very 'fashionable' at the moment and there has been a burgeoning literature in the past 10-20 years, with many new approaches to therapy being proposed, new definitions offered, and arguments about diagnosis. This, too, is all within the wider context of geopolitical upheaval around the world and changing social discourses here in the UK. People movements are bringing traumatised migrants to our shores in increasing numbers. Even within the settled white British and British-born ethnic minority communities pressures of unrealistic expectations in an increasingly materialistic environment coupled with decreasing social cohesion, greater demands on our medical services and financial constraints on the longer-term therapy that many see as needed in effective recovery from the effects of trauma, have all contributed to urgency in honing trauma-counselling skills within the psychotherapeutic community. There are more aspects of trauma therapy, touching many of these different angles, that have had to be omitted in a study of the present scope, and relevant ones will inevitably have been missed. None of the participants, for example, came from non-British backgrounds. Arguably, a counsellor who is a refugee in this country (and

there are some) may have been able to give some very interesting input to this study. The socio-political aspects of counselling provision in the UK, although touched upon, would be highly relevant to client work with traumatised people who cannot afford long-term private therapy, and whose options are severely limited, geographically as well as financially.

While recognising limitations in any study is important, it also gives opportunity to identify possible future lines of inquiry. I have become interested in gaining a deeper understanding of why clients withdraw, or do not withdraw (as in Lizzie's case), from therapy. Also, it would be interesting to learn more about the specific experience of trauma counsellors who have no significant personal experience of either developmental or later trauma. It would be interesting, too, to explore the experience of cross-cultural counselling where trauma has been a major factor in both counsellor and client, especially where the counsellor is from a non-Western culture. Further explorations could be made into the implications for counselling training of non-British counsellors here in the UK. There is some research on trauma clients' experiences of counselling but more of this would be informative. Ethically and methodologically such studies are more problematic than with therapists, and may be more suited to a longitudinal study.

13.4. A reflexive look at formulating the research question

In these final reflections I find it necessary to return to some of my arguments in chapter 3. I made mention of the 'science wars' (p24) – wars which have sometimes generated more heat than light in placing empirical approaches in opposition rather than in complementary positions to the more exploratory approaches of much postmodern qualitative research. I called, instead, for the need to embrace the paradox of valuing more than one ontological and epistemological position, not only in research but also in the counselling room.

I brought with me to this study my years of learning to be strictly objective in scientific research. Having an intuitive sense, or 'hunch', may have its place in

initiating research, but a hunch (or, in its later more formal development, a hypothesis) needs to be tested quite ruthlessly and discarded if the evidence demands it. Another strand of my learning, acquired largely through counselling training, has been to embrace the counsellor's need to be able to tolerate, or even be comfortable with, 'not knowing'. Here, too, we may have hunches, but to have an attitude more in line with Cecconi's (1987) need to hold hypotheses in a spirit of curiosity, in very open hands, and to have the humility to be willing to be corrected by our client.

I embarked on this research with a hunch, to which I will turn in a moment. First though, regarding the philosophical approach I should take, the struggles I had were in large part connected to how to be rigorous (my scientist voice talked to me about testing a hypothesis to destruction) yet concurrently willing to live with paradox and embrace Hamlet's remarkably postmodern comment to Horatio (Shakespeare, c1601) about there being more things in heaven and earth ... .

I argued for inclusion of elements of bricolage in my methodology (section 3.3.2), but my core approach was phenomenological. It is my belief that phenomenology offers the opportunity to be scientifically rigorous in its insistence on keeping personal assumptions and, yes, hunches, at bay through 'bracketing'[76].

So what was my initial hunch? It was that trauma, and its presentation, both outside and inside the counselling room, was a great deal more complex and context-dependent than it might appear on too restricted a reading of the literature. Should this be true, it would be bound to have implications for both counsellors and clients when they meet in the counselling room. In particular it would likely impact on countertransference and intersubjectivity, and bring into the room the unique experiences of the survivor counsellor, whether of their own trauma, their healing journey, or their initial and ongoing training and supervision.

The influence of context was of primary interest to me. Where good quality research papers contradict each other, as in the examples cited (p39), it may not be that some are right and others wrong, but rather that both are right – *in their context.* I was

[76] I actually prefer the term "bridling" (Dahlberg, 2006) with its idea of reining in a horse which might otherwise be out of control.

open-minded in my hunch about the complexity of trauma and how this might play out in the counselling room. This made the research question difficult to formulate without implying that the history of the counsellor *would*, or *would not*, have an impact. I believed my original 'question' was best couched in terms of 'an exploration' as I wished to be phenomenologically open to what the data would tell me. Only after immersing myself in the data, and noting identifiable, and sometimes diverse, impacts, could I confidently return to re-formulating the question in more positive terms – "What impact does a personal history of developmental trauma in a counsellor have in the way they are affected by, and interact with, traumatised clients in the counselling room?"

We live lives that are 'real' to us in different ways. Outside the realms of fantasy or serious mental illnesses there are the empirical, solid, realities of daily life – what we eat, what we wear, bills to pay, which bus we catch for work. However, there are also the realities which are not so easily demonstrated empirically – the feelings, emotions, and thoughts which enrich or blight what we experience as life. Both of these realities were seen in the data. Although focussing on the more subjective realities, throughout this study I have kept both ontologies in mind as trauma has both objective and subjective aspects, neither of which can be ignored. Both are present in the counselling room when wound meets wound.

Meaning-making, it could be argued, is a natural function of human beings, and what can make life full, or at least tolerable. Failure to make meaning can lead to existential despair. The meaning-making in this project is biased towards a phronetic epistemology, which is context-dependent and feeds on data which is "experience-near" and as I studied the data more and more closely I chose a practical interpretive phenomenological methodology, based on the Aristotelian concept of *phronesis* (see p57) as the one best suited to the kind of meaning-making which could inform practice in trauma counselling.

13.5. Final reflections

As summarised in 13.1 and 13.2 above, the evidence of my study points to wounded therapists having a particular qualitative *potential* to empathise with wounded clients that they might not otherwise have had. Recognition of nuances in the presentation of clients, shared body memories sometimes becoming apparent by non-verbal as well as verbal communication, an alertness to dissociative experiences – negative as well as positive – and a sensitivity, based on intersubjectivity, to what specific intervention might help a particular client, are all ways in which survivor therapists might contribute to effective trauma therapy.

I end with two points made by Peter Martin (2011). One is his call for a distinction to be made between safe practice and certainty (p17). Safe practice in counselling is paramount in all areas, not just trauma, but because of the danger of re-traumatisation, is particularly vital in trauma counselling. Positivist approaches by nature are striving for certainties which may not be available when considering the whole human being in all its glorious complexity. Martin encourages us to live better with fluid states.

The other call he makes, which resonates strongly with me and with the other participants' experience, is made evident in his paper's title "Celebrating the Wounded Healer" and sees the great value in owning our frailty as human beings. He suggests that our woundedness is

> "something to celebrate, as a way to be more human; as a way of exploring compassion and life-affirming joyous action and human intercourse." (p18)

Even in encounters with the awfulness of trauma in our clients, therapists who are themselves survivors can perhaps give the greatest gift of all – a living demonstration of hope.

Appendices

Appendix A

Would you like to participate in my research?

Topic: 'Wounded Healers'

I am a BACP Accredited counsellor and a PhD student in Counselling and Psychotherapy at the University of Edinburgh and am interested in aspects of psychological trauma in relation to counselling practice. I am looking for participants who would like to help me by being interviewed about their experiences as 'wounded healers' in the context of their therapeutic work with traumatised clients.

About the project.

Anecdotal evidence suggests that many counsellors and psychotherapists have their own historic experiences of trauma. Some develop a particular interest in trauma counselling. I am hoping to add to the knowledge of what it means to be a 'wounded healer' and how it might influence practice.

I will be gathering data primarily through a number of in-depth interviews (one or possibly two per participant) at a location of the participant's choice. Interviews will be audio-recorded. Great care will be taken to protect the identity of participants, and all aspects of the research project have received ethical approval by my University.

I have the following inclusion criteria for participants:

1. They are qualified counsellors or psychotherapists, work within the ethical framework of one of the major professional bodies, and have at least 2 years' experience post-qualification.

2. They have personal experience of some kind of recurring trauma in childhood, and this has had a psychological impact, of which they are aware, on their later life. (Examples of 'recurring' trauma might include, but not be limited to, any kind of abuse or lengthy separation from caregivers, but not single traumatic events such as a house fire.)

3. They have at some point explored the issue(s) around their trauma in personal therapy/counselling.

4. They work or have worked with some clients who have trauma issues.

If you are interested in knowing more, and possibly taking part, please contact me in confidence by email at [redacted] or by phone ([redacted]). I will send you a more detailed information sheet, and consent form from which you will be able to see what might be involved and what might be expected of you. Please do not hesitate to contact me for more details.

My location is in the North East of England, so enquiries from the northern half of the country or southern Scotland would be particularly welcome.

I would appreciate any initial expressions of interest (no obligation) by the end of March, but would not have to arrange interviews by then. Thanks.

[redacted]

March 2014

Appendix B

Project information sheet

The research is a study of being a 'wounded healer'. Anecdotal evidence suggests that many counsellors and psychotherapists have their own historic experiences of trauma, and a number of participants will be chosen from those who meet the inclusion criteria, which are:

1. They are qualified counsellors or psychotherapists, work within the ethical framework of one of the major professional bodies, and have at least 2 years' experience post-qualification.

2. They have personal experience of some kind of recurring trauma in childhood, and this has had a psychological impact, of which they are aware, on their later life. (Examples of 'recurring' trauma might include, but not be limited to, any kind of abuse or lengthy separation from caregivers, but not single traumatic events such as a house fire.)

3. They have at some point explored the issue(s) around their trauma in personal therapy/counselling.

4. They work or have worked with some clients who have trauma issues.

Interviews: One-to-one interviews will be arranged in private locations of the participants' choice and at mutually convenient times. The interviews will last for one and a half to two hours and will be audio-recorded. An option of a second, shorter, interview approximately six months after the first will be suggested to give participants the opportunity to add any further reflections they may have had in the intervening months. Between any formal interviews, comments by email would also be welcome. Participants will be given the choice as to whether they wish to review the transcripts of interviews.

The focal points of the interviews will be on the perceptions of the participants of the ways that their trauma has impacted on their practice, what their experiences have been in their relationships with traumatised clients and any reflections they have on the ways in which they choose to work as counsellors, and where. A shorter time will also be spent reflecting on the effects of their trauma on their life in general, on how they processed their trauma both in and outside therapy, how they came to choose to be counsellors. Participants will also be asked about any ways, of which they have been aware, in which dissociation has played a part in the processing of their own trauma or the effect it may have on their practice.

Risks: Anyone who has survived trauma lives with the potential risk of re-activation of aspects of their trauma experience(s) if exposed to triggers, and it is recognised that an encouragement to think and talk about trauma could potentially cause distress to participants. Although every effort will be made to avoid this, participants are asked to ensure that they have adequate support and/or therapy available should they need it.

Confidentiality/anonymity: Any person-identifiable material will be removed from the transcripts.

Security of data: Audio recordings will be transferred as soon as possible to a secure desktop single-user and password-protected computer, and then deleted from the portable recorders. These and secure backup audio files will only be kept until transcripts are completed, and will then be deleted. Electronic and hard copies of transcripts will be kept secure, and these complete transcripts, after person-identifiable material has been removed, will be seen only by the project supervisors. The transcripts will be stored securely for up to 5 years after completion of the PhD project. They will then be deleted/shredded.

Right to withdraw: Participants will be free to withdraw specific material which they consider could lead to identification of individuals or organisations from interview transcripts up to 3 months following the interview, or completely withdraw their permission to use the data up to 6 months after the interview(s). No written request to withdraw up to these deadlines will be understood as final consent to use the data

(without personal identifiers) in the PhD thesis, and consent to use findings and specific anonymised quotations in any future publications.

Benefits: There are no funds available to remunerate participants, but it is hoped that the research will add to our knowledge and thus enhance trauma counselling practice, for ourselves and for others. A summary of the findings will be sent to participants on completion of the PhD, and if further publications emerge from the work, participants will be advised if they so wish. (Please note that PhD theses are now normally available in the public domain.)

Contact details:

Researcher - **Pat Bond** (PhD student)

Email: [redacted]

Phone [redacted]

Postal address (non-urgent mail): Counselling and Psychotherapy, School of Health in Social Science, The University of Edinburgh, Medical School, Teviot Place, EH8 9AG.

Concerns and complaints:

The project's Academic Supervisors, who may be contacted if any concerns arise which participants do not wish to discuss with the researcher are:

Ms Siobhan Canavan, Counselling and Psychotherapy, School of Health in Social Science, The University of Edinburgh, Medical School, Teviot Place, EH8 9AG. email: Siobhan.Canavan@ed.ac.uk. phone 0131 651 6231.

and

Dr Ethel Quayle, Clinical and Health Psychology, School of Health in Social Science, at the same address. Email: Ethel.Quayle@ed.ac.uk. phone: 0131 650 4272

If participants have any cause for complaint, please contact **Siobhan Canavan** who will explain the School's complaints procedure.

Appendix C

Consent form for participants

Personal details:

Name:

Contact address (for mail):

Chosen address for interview (if different):

Email address: Can this be used for confidential emails?

Yes/no

Phone no: Can voicemail messages be left?

Yes/no

Consent, Part A : Agreement to participate in research – to be completed before interview (please tick the boxes and sign and date where indicated.)

1. ☐ I confirm that I have read the project information sheet and that I meet the selection criteria.

2. ☐ I consent to taking part in an interview with the researcher and that this interview be audio recorded.

Signature: Date:

Consent, Part B: Transcription, use of data and withdrawal limits - to be completed after each interview: (please tick the boxes and sign and date where indicated.)

1. ☐ I consent to the audio recording being transcribed, and to the transcriptions be held by the researcher securely for up to 5 years following submission of the

PhD thesis. I acknowledge my right, should I so wish, to read the transcript of an interview and within 3 months of the interview to request removal of remaining person- or organisation-identifiable material of which the researcher had been unaware.

2. ☐ I acknowledge my right to withdraw consent at any time up to 6 months after the interview. No written notice of withdrawal within this time limit will be treated as implicit continuing consent.

3. ☐ I consent to the use of transcribed material, including direct quotations, after removal of all personal identifiers, in the researcher's PhD thesis, and in any subsequent publications.

Signature: Date:

Appendix D

Interview prompts

Intro (after consent form)

- Reminder of what the research is about – looking at the experience of counsellors who themselves have a background of trauma, of working with traumatised clients.
- I'm wondering what are your thoughts about taking part

Becoming a counsellor

- Can you tell me something about how you came to be a counsellor?
- How was trauma covered in your training?

Background

- All people being interviewed have identified themselves as survivors of trauma.
- How did you come to be in therapy as a client?
- When did you become aware that you had issues that could be linked to the trauma in your childhood?
- In relation to your trauma, in what ways has your therapy had significance?

Working with trauma

- Tell me about your experience of working with traumatised clients
- How do you feel about working with traumatised clients? (or, if applicable, what do you think drew you to choosing to work with traumatised clients?)
- Are there any observations you've made about yourself when counselling traumatised clients?

- Have you any preferences amongst the different approaches to counselling trauma survivors?

Dissociation

- Sometimes reference is made to dissociation in conjunction with trauma. Does this have any meaning for you?

Wounded Healer

- The term 'wounded healer' is sometimes used by therapists. Is this something you identify with?

Appendix E

Historical overview of trauma treatments

This is included only as an appendix because although of interest its relevance to the current project is marginal. However, it illustrates again the importance of bearing in mind the wider discursive influences on meaning-making and practice which have already been addressed in section 2.1.1.1.

Trauma treatments in the past are consistent with the theories of trauma which informed them. When shell shock was considered moral weakness or cowardice, 'treatment' was punishment, not infrequently by execution. However, the desire of anyone in the healing professions is the relief of suffering. We can see that in Medical Officers, if not in World War I military commanders. It is present too in their successors, even those of us who sit today in counselling rooms listening to the pain of clients who struggle with trauma symptoms. Those earlier Medical Officers looked to neurophysiological theories of trauma and physical, chemical and surgical procedures were often employed. Some were more extreme than others. In the early days of World War 1 (WW1) Crile (1915) recognised emotional breakdown in serving soldiers but said that all that could be done for them was to administer morphia. However by the 1940s the same surgeon (Crile, 1940) was taking much more invasive and radical measures by surgical denervation of the adrenal glands in an attempt to reduce sympathetic activation (Krystal et al., 1989). During and after WW1, some clinicians used psychoactive drugs, sub-shock insulin therapy (Teitelbaum et al., 1946) and mild electroconvulsive therapy (Rado, 1942). Those who saw war neuroses in less physical terms claimed effectiveness for hypnosis (Taylor, 1821) though Rado (1942) criticises this treatment because of high relapse rates, even if initially promising. Away from the combat context posttraumatic symptoms were often viewed through Freudian spectacles as 'hysteria', and hypnosis (Wells, 1944) and psychoanalysis (which Freud himself had adopted in preference to

hypnosis) were commonly chosen treatments. According to Van der Kolk, although hypnosis was a treatment of choice for some 100 years, it has been used rarely since the 1990's controversy around 'false memory syndrome' (Van der Kolk & Najavits, 2013, p521). A middle ground position was advocated by Pascal (1947) who described success in using relaxation (rather than hypnosis) in short-term psychotherapy to enable patients to recall traumatic childhood incidents which seemed to explain psychosomatic physical symptoms in adulthood. In this way a cure was claimed to be effected.

Organic and psychological theories of trauma overlapped, with one or other predominating at any one time, and treatments similarly overlapped or were combined. Psychological treatments, predominantly hypnosis, but also some newer treatments like logotherapy (Frankl, 1946) were in the ascendant between the World Wars and in World War 2 (WW2) but physical treatments were still practised. This picture of such diversity of treatment gives us an idea of the struggle to address the psychological aftermath of the trauma of war, and it is worth bearing in mind that these clinicians were considering, in the main, primary trauma in adults. If the diversity of treatment, and the variation in effectiveness from one patient to another, is considerable in this group, how much more can we expect it to be in an even more heterogeneous population, including children and adults who were traumatised as children.

Literature on civilian cases in the 1900s until after WW2 is sparse. Combination treatments of physical and psychological interventions were described by Teitelbaum et al. (1946) but Klingman's paper in the late 1950s (1958) marks a shift back to research interest in the biological causes of neurological disease processes. By the 1980s more attention was given to biological mechanisms (e.g. Kosten & Krystal, 1988; Van der Kolk, Greenberg, Boyd, & Krystal, 1985) and, reminiscent of Crile's (1915) administration of morphia. More publications on pharmacological treatments for PTSD appeared (e.g. Falcon, Ryan, Chamberlain, & Curtis, 1986; Frank, Kosten, Giller, & Dan, 1988; Levenson, Lanman, & Rankin, 1982; Shestatzky, Greenberg, & Lerer, 1988; Van der Kolk, 1987). Not all produced convincing results. In a small survey of combat veterans with PTSD (Birkhimer, DeVane, & Muniz, 1985)

medication was shown to be generally inadequate, and Van der Kolk (1987) acknowledged that much more research was needed to elucidate the effectiveness of pharmacological treatments. Even by 2006 Freeman (2006) noted that in spite of many randomised controlled trials that evidence for drug treatments lags behind that for psychological interventions.

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