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EXPERIENCED CLINICIANS: TRAUMA RECOVERY AND THE HEALER

(Thesis format: Monograph)

by

Felicia Star Epp

Graduate Program in Education

2

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Education

The School of Graduate and Postdoctoral Studies
The University of Western Ontario
London, Ontario, Canada

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CERTIFICATE OF EXAMINATION

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Felicia Star Epp

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Experienced Clinicians: Trauma Recovery and the Healer

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Abstract

The prevalence of childhood abuse in Canada is reflected in the experience of many clinicians. While some studies examine the lives of these Experienced Clinicians, few examine this issue from a relational perspective. The purpose of this qualitative study was to describe, using their own voices, the essence of the experience of Experienced Clinicians, to examine and understand their experience of recovery and resilience and how this has influenced their professional lives. The data came from interviews with clinicians who report a history of childhood abuse and who have a current clinical practice. The participants were asked to describe, (a) the factors and experiences that influenced their recovery from childhood abuse, and (b) how these experiences have shaped and influenced their clinical practice. This study merges theoretical, educational, and practice literature and provides recommendations for graduate level education and support for clinicians.

Keywords

Experienced Clinicians, Child Abuse, Resilience, Relational Cultural Theory (RCT), Counsellor Education

Dedication

This project is dedicated to my mother; without you I would have never known about the unseen alligators I would need to fight, nor had the strength to fight them. To my father you remind me not to take myself too seriously, with you, I know I am loved. To my brothers and sisters, Kelly, Rebecca, Alina, David, Dustin, Daniel, Ruth-Anne, and Jonathan; thank you for keeping me grounded, laughing and occasionally indisposed. To Kryska, Chubb Chubb, George, Gobi and Chloe; I appreciate every moment of distraction, warmth, softness and entertainment you give, you are all essential ingredients in my procrastination. Last, but not least, to my partner Joseph, your love, understanding, and relentless humour is what gets me through each day.

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I cannot forget the contributions of my dear sister Rebecca Epp and good friend Cali Hoffman, for their skill with editing and transcription. In addition, my therapist Felisa, who reminded me of the importance of this work and gave me the template for a good therapist.

To all of my family, I wish I had the space to acknowledge you all! I love you, and I thank you for the support, the Sunday afternoon phone calls, the late night texts and the impromptu trips to Winnipeg. With you I feel connected, with you I know who I am.

To my participants I thank you for your candour your warmth, your strength, and your inspiration. You are this project, without the bravery of people willing to share their stories we would still be in the dark ages of this field.

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Literature Review

Introduction

Childhood abuse is now a well-acknowledged topic in clinical counselling literature. We no longer have the luxury of denial; the voices of those who have survived abuse are now echoing though the literature. As our awareness of abuse expands, so does our realization that survivors of abuse or *experienced persons* are part of the fabric of industry. They are doctors, lawyers, teachers and counsellors, and they are consumers and providers of mental health care. Amidst the research on childhood abuse is recognition that experienced persons exist amongst us, referred to as survivor therapists, wounded healers, or experienced clinicians. Experienced clinicians, however, are typically spoken about, and not necessarily spoken to. Discourse in trauma and abuse is inherently political, and the dialogue about child abuse, mental illness, and woundedness in the field of psychology is about oppression (Herman, 1992). As long as we continue to present the neutral clinician, free from psychological disturbance, as the ideal, we contribute to binary thinking, creating a separation between psychological health and the experience of adversity (Jordan, 2008). It is for this reason we need qualitative studies to capture the individual experiences of those who have lived through childhood abuse. This study merges theoretical, educational and practice literature with lived experience by asking experienced clinicians to share their experience of abuse and recovery, mental health, education and their professional life.

The following literature review first presents a brief overview of Relational Cultural Theory (Banks, 2006; Jordan, 2001, 2008, 2010; Miller, 1976), and then presents an examination of the existing literature on experienced clinicians, including the

prevalence of childhood abuse within the clinician population, and the influences of abuse both in general and specifically as they relate to a clinician population. Next, I examine clinical issues including boundaries and countertransference, therapist development and motivations, recovery and resilience, and issues in clinician self-disclosure. Finally, I examine mental health stigma for the experienced clinician.

A Note on Language

Feminist psychology challenges the status quo, asks us to reframe our knowledge and to consider the use of language (Brown, 2005). In keeping with feminist ideology, I made the choice, whenever possible, to use the term *experienced* person as opposed to *survivor*. Survivor is a label that suggests an identity and in doing so it can take away from a description of a person more then it offers. The term experienced, however, suggests that the person has gained something. The word itself does suggest negative of positive value, it simply implies that the person who experiences violence has been altered by that experience. It adds rather than takes away. Similarly, I used the term *influence* as opposed to *impact(s)*. Impact has a violent connotation and it suggests passivity on the part of the person who is impacted, where as influence suggest agency.

Relational Cultural Theory

Feminist theory examines the sociological, political, and gendered power structures that have informed much of the discourse in psychological thought. It challenges us to reconsider some of our basic assumptions (Brown, 2005). Relational-Cultural Theory (RCT), developed out of the Stone Centre at Wellesley College and based on the work of Jean Baker Miller (1976), is a feminist model of psychological development and therapy that considers the person's unique context. RCT offers a

challenge to the dominant discourse in psychological thought arguing that humans naturally move towards self-enhancing relationships, require community and belonging, and are strengthened through interdependence (Banks, 2006; Jordan, 2008; Jordan, 2010). RCT opposes the dominant, paternalistic view that we must strive for independence and separation (Banks, 2006). Theorists of RCT propose instead that connection and interdependence are the desired goal of development. One of the central tenants of RCT is the central relational paradox; supporters of RCT argue that when relational disconnections occur people develop strategies of disconnection to preserve their sense of self. These strategies of disconnection, however, prevent the person from experiencing the healing that can only take place in authentic mutual relationships. The goal of Relational-Cultural therapy is to provide such a relationship. The therapeutic relationship in RCT is the vehicle for change; it is founded upon authenticity, mutuality (the therapist is fully present in the relationship and is willing to be influenced by the client), respect, and *radical empathy* (Banks, 2006; Jordan, 2001, 2008, 2010). Radical empathy is a term coined by theorists of RCT to describe a type of empathy that goes beyond trying to connect with a client's emotional content. To be radically empathic, one must be willing to truly experience the others emotions and to be open to being influenced by that experience.

Research on Child Abuse

The Canadian Department of Public Health and Safety reports a total of 36% substantiated cases of childhood maltreatment out of the 235,842 suspected cases investigated in 2008. An additional 8% of cases remain suspicious but lack clear evidence. An important consideration is that these cases represent incidences where an

order of investigation was made by child welfare authorities. It is reasonable to assume that the percentage of children who experience maltreatment may actually be higher than the rates reported. Childhood maltreatment includes emotional abuse or neglect, physical abuse or neglect, sexual abuse and witnessing domestic violence (Public Health Agency of Canada, 2010).

Prevalence of clinicians affected by childhood abuse. Following the explosion of research on child abuse in the late 1980s and early 1990s, Elliott and Guy (1993) estimated the rate of childhood sexual abuse amongst female clinicians to be approximately 43.3%, with physical abuse at 13.8%. These numbers were significantly higher than rates of abuse reported in a sample of non-mental health professionals. There were significant between-group differences, which may confound the results. For instance, the sample of mental health professionals came from lower socio-economic backgrounds, and they were better educated and older at the time of data collection (Elliot & Guy 1993). Nuttail and Jackson concluded in their 1994 study that rates of childhood abuse amongst clinicians are similar to population norms. They conducted a study with a stratified sample of 1635 clinicians representing four disciplines (clinical social workers [39%], paediatricians [32%], psychiatrists [43%], and psychologists [44%]). The authors discovered the rate of childhood sexual abuse in their sample to be an average of 17% (13% male and 20% female), with physical abuse at a rate of 7.1% overall. These reported rates were considered similar to *clinical populations*; however, several differences were noted. The differences were primarily lower rates of incest, shorter durations of abuse (which may indicate lower levels of impairment, as the authors point out), higher rates of sexual abuse in males (suggesting there may be something

unique about male therapists), and lower rates of abuse in the paediatric sub-profession. This last finding was determined through post hoc analysis and the authors urge us to interpret this with caution (Nuttail & Jackson, 1994).

The discrepancy in prevalence between the two studies may be in part due to the lack of clarity in the exact definition of abuse. In the study by Nuttail and Jackson (1994), the use of highly specific definitions of physical and sexual abuse may have lowered the rates of reporting abuse (Briere, 1992). Alternatively, issues such as, a sample of only women, an over representation of social workers and the participants' academic knowledge of abuse in the Elliott and Guy (1993), study may have elevated the reporting of abuse. Through regression analysis, Elliot and Guy found that in their sample, choice of profession was not significantly correlated with an increased tendency report to abuse accurately. Several concerns over the findings are noted, namely that clinicians may under or over report experiences of abuse and subsequent distress. In the three studies above, it remains unknown if experienced clinicians are more or less likely to participate in research that asks them to disclose their own history of abuse.

The influence of abuse. Research indicates that the specific abusive event alone cannot predict the range of sequelae. The traumatic event combines with each individual's biological predispositions, his or her learned behaviour responses, and supports available to them immediately following the event (Levine, 1998). The potential influences of abuse and neglect on a child's development are numerous and include neuropsychological changes, memory impairment (El-Hage, Gaillard, Isingrini & Belzung 2006), and educational disruptions (Eckenrode, Laird & Doris, 1993). A child is more likely to become parentified, experience guilt and self-blame, have difficulty in

relationships, low self-esteem (Herman, 1992), poor emotional and nervous system regulation (Levine 1998), and is at risk for further revictimization (Messman-Moore, Ward, & Brown, 2009). Many of the effects of abuse in childhood can lead to the diagnosis of a mental illness or learning issue (Courtois & Gold, 2009). Abuse in childhood is associated with the failure to complete high school (Horsman, 2006) and premature withdrawal from college or university (Duncan, 2006).

Longer-term influences for the adult survivor are equally numerous and may lead to complex changes in personality structure and coping strategies ranging from anxiety, depression, impaired self-reference, tension reduction behaviours (cutting, substance use), numbing through dissociation, nightmares and other intrusive experiences (Briere, 1995). Other broad effects include struggles with basic trust and safety, changes in spirituality, worldview, self-concept, and esteem, and the ability to make or maintain healthy relationships (Herman, 1992). According to Judith Herman, the "core experiences of psychological trauma are disempowerment and disconnection from others" (1992, p.133). Like Herman, theorists of Relational Cultural Theory posit that when faced with an overwhelming threat, we disconnect from relationships in order to preserve our sense of self. Sustained disconnection, however, results in isolation (Jordan, 2008). Disconnection is maintained in many ways, through overt actions on the experienced person and through internalized beliefs. Shame and self-blame for instance are powerful forces that lead experienced persons to isolate themselves resulting in an inability to engage meaningfully with themselves, with others and with the world.

While experienced persons are found in nearly every occupation, they are disproportionately represented in mental health impatient and outpatient units, drug and

alcohol rehabilitation centres and the penal system (Herman, 1992). Considering these numerous barriers to healthy development and vocational success, the proportion of individuals who report a history of child abuse within counselling and psychological professions may appear perplexing. Given the high level of academic achievement necessary for acceptance to a program and completion of a counselling degree, one can assume that experienced persons within the counselling profession have achieved a level of self-awareness, growth, and success that defies statistics. Further, it indicates that experienced clinicians may have something important to say regarding survival of child abuse.

Experienced Clinicians in the Literature

Research on experienced clinicians has focused primarily on determining if there are measurable and predictable differences in demographics, professional conduct, and competence differences between those with a history of abuse and those with no history of abuse. Pope and Feldman-Summers (1992) conducted a survey with APA registered psychologists to find out if personal experience with childhood abuse contributes to knowledge of, and competence in, treating childhood abuse cases. The study obtained a respectable 58% response rate, however, the authors note that it was unknown if experienced clinicians were more or less likely to respond to the survey, a factor which would significantly affect prevalence rates. The authors reported that approximately one-third (33.1%) of the participants reported having experienced some form of sexual or physical abuse as a child or adolescent. In all categories but one, women were more likely than men to report abuse as a child. The exception was physical abuse (i.e., 13.1% of men reported physical abuse compared to 9.1% of women). The authors report that in

their sample women clinicians were more likely to believe they possessed the competence to treat abuse. The authors posit that there may be a relationship between the experience of abuse and feelings of competence to treat abuse, but this was not empirically determined in their study. The authors indicate that a personal history of abuse does influence the therapists' practice; however, the exact nature of this effect remains unknown. Pope and Feldman-Summers argue that more communication with experienced clinicians is needed, as they may possess important experiential knowledge (1992). Other studies have found that experienced clinicians report fewer marriages, fewer children, and higher rates of non-traditional intimate relationships (Nuttail, and Jackson, 1994). Experienced clinicians are also more likely to be professionally involved in family violence cases at a rate of 12% versus 8% for those without experience, and are more likely to believe allegations of abuse (Nuttail & Jackson, 1994). Lastly, they are more likely to consider abuse as significant or serious (Follette, Polusny & Milbeck, 1994).

Wounded healing. The tendency of individuals with experiences of loss and trauma to be drawn to the profession of counselling has been referred as wounded healing. Dan Stone (2008) explored the concept of the *wounded healer* in a self-reflective review of existing literature; he suggests that the woundedness of the clinician is "...our vulnerability, which is our key to opening the flow of healing to others, and then back again to ourselves" (p.49). Stone argues that the wound is both a powerful source of empathy and understanding, but also a source of great risk. Similarly, Barnett (2007) suggests woundedness may be what initially draws individuals to the clinical field, out of compassion and a desire to heal themselves.

A qualitative analysis of clinicians' choice of profession by Barnett (2007) posits that they often have unconscious motivations that draw them to this line of work. Barnett found that all nine therapists in his qualitative study had experienced loss in some form before age 20. The participants in Barnett's study described experiences with countertransference that lead the author to suggest that the studied therapist's narcissistic needs, unmet dependency needs, and/or separation difficulties may be being met in the therapy room. He argues this may result in difficulties dealing with negative transference and in boundary violations. He suggests that in general the desire to help and appear competent may be an attempt to hide vulnerability and compensate for childhood humiliation or incompetence (Barnett, 2007). The author's analysis used high amounts of interpretation and all the participants were psychodynamic in orientation, which makes it difficult to determine generalizability of these findings to other populations. Barnett (2007) argues that it is through the process of recovery and the subsequent heightened self-awareness, that wounded healers are able to overcome their initial motivations and become better therapists. All humans are vulnerable and wounded; it is the admission of, and recovery from, our wounds that allows us to empathize. Recovery is what makes the healer, not just the wound.

Clinical Issues

A number of studies looking at experienced clinicians have focused on the impairments they might bring to their work or risks they are likely to encounter, particularly if they are working with a survivor population. Concerns include an increased risk for vicarious traumatisation (Mac Ian & Pearlman, 1995), difficulty managing countertransference reactions (Briere, 1992), and boundary violations

(Mathews & Gerrity, 2002). Each of these issues will be examined critically looking for a balanced perspective and a relational context where appropriate.

Countertransference. Countertransference, in the therapeutic relationship, occurs when the material presented by the client activates personal material for the clinician (Ginot, 2009). It has been suggested that abuse-related countertransference is especially problematic for experienced clinicians (Briere, 1992). Gamble and Neuman (1995) predict that "responses to clients' transference may be particularly troublesome for those new therapists who are themselves survivors of interpersonal violence or childhood abuse (as they) may identify more closely with the client role than with that of the therapist at the early stages of their professional development" (p. 341). Countertransference may be a particular concern for clinicians who are unaware of their own abuse history because of memory impairments (Feldman-Summers and Pope, 1994). It may be difficult for these clinicians to contextualize their reactions, as the original context evades memory. Experienced clinicians in Cain's (2000) study claimed that for them, countertransference is a "double edged sword", in that it has the potential to be harmful (through over identification with clients and harmful self-disclosure), but it can also be helpful. Its usefulness depends on the clinician's willingness to address, through self-refection or consultation, countertransference as it occurs. When it is recognized and fruitfully considered, countertransference becomes one of the most powerful tools a clinician can possess. The sample in Cain's study was unique in that all participants were willing to disclose a history of psychiatric hospitalization; consequently, the author cautions the reader not to assume that all clinicians with histories of abuse or psychiatric illness are capable of negotiating countertransference with such high levels of self-awareness.

According to Ginot (2009), countertransference reactions are inevitable and powerful "enactments." Successful negotiation of these reactions allows the counsellor to adjust their behaviour in therapeutic ways. Further, he describes empathy, like countertransference, as an emotional enactment, arguing that our own emotional reactions are activated and carefully considered in the context of the therapeutic relationship. Countertransference from this perspective is necessary for the therapeutic process and attempting to separate the self by avoiding personal reactions in the therapeutic relationship are misleading, counterproductive and ultimately harmful.

Boundaries. Traditional Freudian psychological literature defines boundaries as a "place of resisting intrusion" (Jordan, 2010, p.14). In this conceptualization, maintenance of firm boundaries is essential for the clinician. Mathews and Gerrity (2002) posited that difficulty in negotiating boundaries is potentially hazardous for the experienced clinician who works with other experienced persons. The authors suggest that since experienced persons' boundaries were violated as a child, they are likely to struggle to develop healthy boundaries in adulthood. Their study attempted to quantify boundary violations in a sample of experienced clinicians conducting group counselling for experienced persons. The study failed to obtain significant results; however, this must be interpreted with caution, as numerous methodological issues may have compromised the results. These issues include a definition of boundaries that had not been standardized (developed through focus groups), coupled with very low response rate (8%) and extremely low rate of childhood abuse (< 1%) far below both the professional and clinical norms.

Offering a more flexible interpretation of boundaries Pope and Keith-Spiegel (2008) differentiate between what they refer to as *boundary crossings* and *boundary*

violations. They suggest that strategic boundary crossings such as letting sessions run over time or attending clients' special events can be helpful, whereas boundary violations like sexual relationships are always harmful. Similarly, many RCT theorists believe that some actions, traditionally considered as boundary violations, such as crying with clients, or self-disclosing personal experience of abuse are, in fact, therapeutically useful (Jordan, 2010). Relational theorists "see the boundary as a place of meeting, learning, differentiation, and exchange" (Jordan, 2010, p.14). The degrees of empathy expressed by experienced clinicians need not be viewed as boundary issues, but as deeply respectful and radical empathy.

Vicarious traumatization. Another identified risk factor for the clinician frequently addressed in the literature, is vicarious traumatization (VT) or secondary traumatization, clinical terms for what Charles Figley (1993) described as "the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other" (as cited in Hesse, 2002, p.296). Empirical studies on VT have produced conflicting results. Pearlman and Mac Ian (1995) found much higher rates of psychological disturbance in therapists who stated they had a history of trauma. The authors comment on what they found to be protective factors, namely: experience, supervision and work environment. The extremely high number of participants reporting a personal history of trauma (60%) suggests that these results require further analysis. An earlier study by Elliott and Guy (1993) found contradictory evidence regarding impairment in experienced clinicians. The clinicians in this study reported lower levels of distress in current functioning despite elevated rates of childhood abuse and trauma. The results of this study must be interpreted with some caution, as it was based on a

sample of women alone, with an over representation of social workers. Additionally, there is concern that social desirability may play a part in symptom reporting amongst a clinician population (Briere, 1992). Elliott and Guy (1993) suggested that the combination of training and therapy might be responsible for the contradictory lower levels of distress found in their sample. A study by Follette, Polusny, and Milbeck (1994) found that child abuse was not correlated with increased VT in their sample of clinicians. These confounding reports may be due in part to the measures used to assess functioning and symptomatology and by the author's bias; it is possible that assessing vicarious traumatization in experienced clinicians is confounded by the clinician's original trauma. Likewise, Benatar (2010) found that experienced clinicians do not appear to be more vulnerable to VT than their counterparts without such a history.

What makes a good therapist? Wolgien and Coady (1996) conducted a qualitative study of therapist views on why they believe they are helpful therapists, as part of a larger study examining how their helping skills developed. Their study consisted of semi-structured interviews with eight therapists who were asked about the development of their helping skills. The authors found that the majority of the participants (seven out of eight) indicated the influence of painful experience (in either childhood or adulthood) as being part of their development. All of the therapists who cited difficulties as contributing factors to their own development made reference to some sort of support, either formal or informal (development workshops, training), as playing a major role. The consistent message is that suffering mediated through healing, coping and growth is an essential factor in the development of helping ability. Furthermore, six of eight participants described relationships with significant others as being essential in

their development. The majority of the therapists, (seven of the eight) reported being influenced by their clients and stated that the therapeutic relationship helped them professionally grow. The reciprocal nature of the relationships named by Coady and Wolgien's participants, their willingness to be impacted by their clients as opposed to striving for detachment, is consistent with mutuality as described by Relational Cultural Theory (Jordan 2010). The authors are clear that qualities they specified as being helpful were part of the selection process and may have biased the results. They suggested that additional research is needed to see if the results would change if a different method of selection were used. The results obtained by this method are interesting; they describe woundedness, healing and relationships, as well as mutuality, as key factors in truly helpful psychotherapy.

Coady and Wolgien (1997) suggested that applicants to graduate level training programs should be asked about personal difficulties, and in particular, how these were dealt with, and that this be made part of the entry process rather than relying solely on grades. They argue that students with difficult childhood experiences often doubt their own abilities and motivations to become therapists, and that training for counselling should focus more on the development of the person. Similarly, Mander (2004) reports that in some cases selection for candidates for training in psychotherapy is based on finding the client within the clinician. She states "the candidate will be examined for evidence of a self-reflective capacity and of a willingness and ability to put himself into someone else's shoes, (...) which will be the result of life experience, suffering, loss or mourning" (162). Supporting this view, Relational Cultural Theory argues that the vulnerability of experienced persons may be a complex form of strength. Jordan (2008)

suggests that "we reframe vulnerability as an experience in which we are open to the influence of others at the same time that we are open to our need for others (....) when we are vulnerable, we are capable of being "moved" by internal affective experience" (p.213). In this context, vulnerability is essential within the therapeutic relationship to be able to respond with empathy.

Recovery

If the core disturbances in child abuse are disconnection and isolation, it logically follows that trauma recovery would involve re-establishing relationships and experiencing mutual empathy. Mutual empathy is the experience of seeing the influence you have on another person. It is a reciprocal relationship in which, you see your own value reflected in another's gaze (Banks, 2006; Jordan, 2008). In a qualitative meta-synthesis of 51 reports describing the essence of recovery, Draucker et al. (2009) found that 27 of the 51 reports contained responses from experienced persons that healing entailed "regulating their relationships with others ..." (370). The theme of relationships was echoed in Lynch et al's (2007) article titled, *The Story of My Strength.* The authors identified a consistent theme of "inspiration though connection" or positive connections with significant others, suggesting that healing from trauma is not an act of independence but rather one of interdependence. So central is the 'relationship' that Pearlman and Saakvitne (1995) suggested, "The process of building the therapeutic relationship is the therapy [italics added] with trauma survivors" (as cited in Fisher, 2005, p. 27). The centrality of the relationship in both trauma and recovery provides a clue as to the success of experienced people as clinicians; perhaps the salience of relationships in their lives has drawn them to the work of providing relationships for others.

Resilience. Resilience in psychology is a term that indicates protective and facilitative traits that promote healthy adaptation to trauma. Much of the research on resilience has been studied in populations that reported a traumatic event without experiencing adverse reactions. This absence of traumatic symptomatology was considered the definition of resilience (Lynch, Keasler, Reaves, & Bukowski, 2007). In contrast, Harvey's (1995) ecological theory of trauma describes eight domains that comprise an individual's experience of trauma. To Harvey, recovery is not an absolute, but rather a dynamic process involving struggle, coping, and resilience. In her theory of trauma, recovery is defined, not as the absence of symptoms but rather as an improvement within a domain. She suggested that management of symptoms is a more realistic view of recovery then a complete abatement of symptoms. Resiliency in Harvey's theory represents a domain in which the survivor has strengths that can be drawn upon to cope with stressors. As the individual moves through the process of recovery, she gains more and more strengths that continue to improve her coping (Harvey, 1995). In agreement with Harvey, Lynch et al. (2007) suggested that an individual does not have to be symptom-free in order to be resilient, and looked at resilience in clinical populations (those actively distressed and seeking help for trauma related symptoms). The participants in their study reported occupational or educational success, important relationships, and the ability to help others as being factors in their resilience. The authors concluded that resilience operates on a continuum, with strengths being available even in the midst of crisis. These strengths can be harnessed to complete the difficult task of recovery. Lam and Grossman (1997) identified five protective factors that correspond to the development of resiliency in experienced persons lives. These

factors include (a) a middle to upper social class, (b) having a supportive family environment, (c) having access to good health, educational and social welfare services, (d) having additional caretakers besides the mother, and (e) having relatives (especially grandparents) and neighbours available for emotional support.

Resilience can be summarized as the continuum of flexible and dynamic personal strengths, relationships, and opportunities. These offer the survivor protection, challenge, and opportunity for growth, which then allow for the successful negotiation of trauma. Based on this definition and an awareness of the numerous hurdles that must be overcome in order to become a clinician, it is evident that experienced clinicians are resilient. The voice of these highly resilient experienced persons can provide valuable suggestions on how clinicians might better help young experienced persons of abuse thrive.

Beyond Recovery: Growth, Wisdom, and Gifts

Researchers have explored the idea that the surviving and successfully managing a traumatic experience can lead to positive gains for the survivor. According to Linely, "positive adaptation hence reflects that something has been gained following the trauma, rather than that something was lost but recovered (i.e., a homeostatic return to baseline), or that nothing was lost despite the trauma (i.e., resilience)" (2003 pp. 602). For example, the tendency to view abuse as serious (Follette, Polusny & Milbeck 1994) or to believe clients when they claim to have been abused (Nuttail & Jackson, 1994) can be seen as a positive gain because of a personal experience of abuse. Tedeschi and Calhoun (1996) developed the conceptual framework for Posttraumatic Growth (PTG), which encompasses the positive transformative result of living through and dealing with

traumatic life events. The domains affected by PTG are: a greater appreciation for life, closer relationships, new possibilities, increased personal strength and spiritual change (Tedeschi & Calhoun 1996 in A.I Sheikh 2008). Posttraumatic Growth has been found in populations as diverse as persons who have experienced rape, cancer, and war; some studies have assessed it in populations of experienced persons (Sheikh, 2008).

Attunement, empathy, and wisdom are possible intra-psychic gains borne out of the resolution of suffering. The concept of attunement, described best by John Bowlby in attachment literature, describes the emotional engagement of mother and child, a sort of emotional reciprocity by which the infant's needs are experienced by the mother and the mother's attentive emotional states are experienced by the infant (Golombok 2000). In contemporary literature "attunement is a term used in the attachment and neurobiological literature to describe a relationship in which one person focuses on the internal world of the other, and the recipient of this attention feels felt, understood, and connected" (Bruce, Manber, Shapiro & Constantino, 2010, p.85). The similarities between this description of attunement and RCT's conceptualization of mutual empathy are striking. Judith Herman describes attunement in victims of childhood abuse as a survival strategy "They (children) become minutely attuned to their abusers inner states. They learn to recognize subtle changes in facial expression, voice and body language ..." (1992, p.99). What was originally an automatic hyper-arousal response to threat can become, in the adult survivor, an enhanced ability to attune empathically to others.

Linely (2003) outlined what he believed to be three dimensions of wisdom that are true in both process and outcome of trauma: (a) recognition and management of uncertainty, (b) integration of affect and cognition, and (c) recognition and acceptance of

human limitation. Wisdom is described here as, "a person's expertise in the fundamental pragmatics of life. That is, high level abilities of knowledge and judgment about the essence of the human condition, and the ways and means of planning for, managing, and understanding how people might best lead their lives, within the context of whatever values they may hold to be important" (Baltes & Staudinger, 2000 as cited in Linely, 2003). The relevance of wisdom for the therapeutic relationship cannot be overstated.

Disclosure and Stigma

Childhood abuse, like mental illness, is a stigmatized identity (Chaudoir & Fisher, 2010). Stigma has frequently been described as "a mark against" and is often associated with stereotyping, judgment, and discrimination (Byrne, 2001). Unlike a visible disability, abuse and mental illness are referred to as 'concealable identities', meaning the individual has a choice whether or not to disclose their identity (Chaudoir & Fisher, 2010). The choice to disclose is a difficult one, especially when faced with the possibility of discrimination. Research has indicated that the response received to a disclosure is associated with changes in self-esteem (Bos et al 2009). A Dutch survey of mental health outpatient clients found that most people with a concealable identity are selective about disclosure. The survey found that those who are not selective experience negative effects on their self-esteem (Bos, Kanner, Muris, Janssen & Mayer 2009).

Stigma has effects beyond self-esteem as it can adversely affect the individual's professional and occupational life. In a first person case study, Schiff (2004) discusses her recovery from mental illness. She draws attention to the schism within the field, the 'us' (the healthy, knowledgeable clinician), versus the 'them' (the sick client in need of healing). She argues that fear of discreditation and stigma has prevented many clinicians

from disclosing their own personal struggles with mental illness. Research into the life histories of clinicians has shown that the rates of psychiatric hospitalization (Elliot & Guy, 1993) and diagnoses of a mental disorder (Cain, 2000) are equal to that of the general population. While child abuse is by no means a mental illness, the severe emotional and psychological reactions to this trauma result in diagnoses such as Post Traumatic Stress Disorder (PTSD), Borderline Personality Disorder (BPD), Major Depressive Disorder, or anxiety related disorders for experienced persons who seek help (Courtois & Gold, 2009; Herman, 1992). While some clinicians may feel safe to disclose their experiences of abuse, they may be less inclined to disclose a psychiatric history for fear of discreditation or stigma (Cain, 2000; Schiff, 2004).

Stigma is a relational issue; the pressure to remain silent is the pressure to remain disconnected, or to disconnect. Self-disclosure is an act of vulnerability and facilitates connection when received in a supportive way. Determining the safety of disclosure is an essential task of recovery; a survivor cannot begin to heal until they are part of a safe enough relationship in which they are truly seen (Herman, 1992). For many, the professional environment of academia is not a safe place to disclose. By permitting an atmosphere of silence, we invite experienced clinicians to disconnect, raising the concerns that the silence imposed on clinicians with a personal HCA or psychiatric history may contribute to issues in countertransference and VT. Without someone to contact for supervision, the clinician experiencing negative reactions may choose to attempt to solve the dilemma on their own. In his study of clinicians with a history of psychiatric hospitalization, Cain (2000) found that the theme of stigma in relation to self-disclosure came up amongst the majority of participants. The participants suggested that

changing the climate surrounding disclosure may decrease stigma and provide more opportunities for clinicians in training to openly discuss their experiences and fears throughout their education, a time when the skills to deal with later troubles can be developed and practiced in a safe learning environment. Courtois and Gold (2009) echo this suggestion in their recent report challenging educators to include core training in trauma therapy in order to increase professional knowledge in this much-needed area and create a climate that is more open to discussions of childhood abuse. Wagner and Magnusson (2005) state that abuse and violence are never fully resolved. Experienced persons must learn to live with their histories and trauma; they cannot simply forget about it or get over it, and the residual effects may last a lifetime. The traditional attitude in academia is that we should hide our wounds. In agreement with the feminist ethos "the personal is political" (Hanisch, 1969), Wagner and Magnusson argue that trauma and violence need to be recognized, and survivor considered, in public institutions (2005).

Research Questions

This study sought to answer the following five research questions:

1. How do experienced clinicians describe their recovery from childhood abuse?
2. What do experienced clinicians believe are their resiliencies?
3. How do experienced clinicians translate their history into a means to help others?
4. How does a history of childhood abuse and recovery influence a counsellor's experience of self in personal, professional, and academic contexts?
5. Is the disconnecting silence of childhood abuse maintained in professional social and academic environments?

To answer these questions I chose a phenomenological approach. This approach seeks to

describe the essence of a phenomenon, in this case the experience of child abuse, recovery, and clinical work, and then to interpret the experience of the participants. Data in phenomenological studies is obtained by asking participants to reflect on certain themes, and these reflections provide raw data in the form of first person narratives (Creswell, Hanson, Clark Plano, & Morales, 2007). Phenomenology is a highly respectful method of data collection for it allows the participants' individual experiences and voices to be heard; they are not asked to attempt to fit their experiences into a pre-described set of statements. Phenomenological studies do not aim to generate a new theory, but instead aim to describe the phenomena at hand (Creswell, Hanson, Clark Plano, & Morales, 2007). The use of a qualitative method is useful for research when relevant variables are unknown, when there is a paucity of research on the phenomenon of interest, and when complexity, process, and depth are more desirable than determining quantifiable results " (Marshall & Rossman, 1995).

An extensive search reveals the paucity of qualitative studies that look at the lives of experienced clinicians as cohesive wholes, including elements of their experience both as a survivor of abuse and as a practicing professional. One reason for this may be that quantitative studies offer complete anonymity to participants, thereby reducing the potential stigma and increasing the tendency to disclose. Another possible explanation is more political in origin, positing that researchers have avoided talking to experienced clinicians because of child abuse stigma, and experienced researchers have avoided talking about themselves for the same reason. Herman argued that researchers of trauma are often devalued and discredited within the academic community for the very same reason that experienced persons are devalued and discredited within society (Herman,

1992). Due to the nature of stigma, and the professional pressure to hide their history from colleagues and supervisors, experienced persons are often once again silenced in their professional lives. There is a need to hear the voices and experiences of this population and Qualitative research provides a useful and transparent method to share these voices. The purpose of the study is to describe the essence of the experience of Experienced Clinicians, to describe and understand their experience of recovery and resilience and how their experiences have influenced their professional lives.

Method

A Note on Methodology

As a counsellor in training, I am keenly aware of my own woundedness and the position of experience from which I speak. My own experiences play an integral role in what I choose to research and the theoretical orientation that frames my research. I have come at this project from a strength-based perspective. The use of Feminist Psychology and Relational Cultural Theory (RCT) allowed me to ground my interpretation of the data in previously established theory. Theory informed the research questions and guided the analysis of the data.

The Feminist perspective of trauma is that it is about oppression; in the pursuit of social justice, there is a need to hear the voice of oppressed people (Brown, 2005). RCT is an approach to psychological thought that is inherently phenomenological in practice, requiring radical empathy and mutuality on the part of the therapist/interviewer (Jordan, 2010). RCT demands of its followers a new type of engagement, challenging us to be present in our clinical and research work, recognizing that we as people are a critical element in our work, and asking that authenticity be the norm, rather than an exception (Jordan, 2008). To achieve this level of authenticity the researcher clearly describes his or her own position with the understanding that bias cannot ever be removed from the research process. The process of ownership of bias allows the researcher a degree of transparency so that they might bracket their position and interact with the data honestly. Bracketing in phenomenological studies contributes to the trustworthiness of the results obtained.

Recruitment

The participants for this study were volunteers from a sample population consisting of graduates of a Master's level Counselling Psychology program at a major Canadian University and members of the Canadian Counselling and Psychotherapy Association. The criterion for inclusion included: (a) lived experience of any form of childhood abuse, (b) the personal safety to discuss sensitive and/or painful issues, (c) access to support in the case of painful emotional reactions, and (d) experience working in a counselling role at least part of the time. A criterion that describes child abuse was not provided to be inclusive of a wider range of experiences. Criterion (d) was necessary so that the participants might be able to reflect on how their history has influenced them as counsellors. Three women clinicians volunteered and fit the inclusion criteria for participation in the study.

Procedure

All potential participants were solicited by an email (Appendix A) briefly describing the study and the desired population. Interested parties were asked to contact the researcher for further information. Respondents were replied to via email and pre-screened by telephone (Appendix D) to ensure that they met the criterion for participation. All participants were delivered a project information sheet and the informed consent form (Appendix B and C). Once informed consent was obtained, dates and times for the interview were arranged. All interviews followed an interview script (Appendix E) to ensure consistency. Participants were asked to provide some basic demographic information, including their gender, years in practice, and the client population they worked with. The semi-structured interviews consisted of 20 open-ended

questions and probes framed around two overarching categories: (a) the factors and experiences that describe recovery from childhood abuse, and (b) how early experiences have shaped and influenced clinical practice (Appendix F). The interviews, lasting 60-90 minutes, were conducted in person at either the participant's home or office. This project was approved by Non-Medical research Ethics Board (Appendix G).

Analysis

The data was analysed using Creswell's steps for qualitative analysis as a guide. All of the interviews were tape (voice) recorded and transcribed verbatim. The raw interview data for each participant was reviewed closely several times to get a sense of the overall meaning and to look for recurring ideas or concepts. A short list of simple 'nodes' was generated using initial impressions of the interviews and previously reviewed literature as a guide. Using the Qualitative analysis software 'NVIVO v8' significant statements, sentences and quotes in the first interview were coded using those initial nodes. New nodes were added, using the participant's own language whenever possible, as significant ideas emerged. The second interview was coded in a similar fashion, using the original nodes and the new ones generated out of the first interview. As before, new nodes were added to capture significant ideas or concepts. The third interview was coded in an identical manner. The next step in coding was to go back over the first and second interview and complete the coding process with the now completed node list. Next, the data coded under each node was reviewed and similar nodes were merged until the nodes represented independent concepts. At this point the literature was used as a guide to combine codes under broader and broader categories until five themes emerged. It was necessary to retain several sub themes within the broad themes in order

to capture the complexity of each theme. Further revisions to the naming of the themes and sub themes were completed to achieve language agreement throughout the study and remove vague or confusing terminology.

Throughout the analysis, ongoing collaboration with the project supervisor helped to achieve agreement on the thematic development and interpretation of the data. Additionally the participants, who expressed interest, were contacted for member checks. One of the participants and I had the opportunity for ongoing discussions about the themes. All three women were contacted towards the end of the study, given an opportunity to reviewed the themes, and read over the statement describing the participants. The use of member checks allowed for the testing of the accuracy of analysis with the participants before it is put in final form. Collaboration and member checks create(s) space for alternative interpretations and contribute to the trustworthiness of the study. The five themes were described using direct quotes and statements to illustrate their meaning and to keep the author's interpretation grounded in the original data. The use of direct quotes from the participants in the write-up of the study increases confidence in the findings of the study. Finally, the themes were interpreted, explored, and discussed through referral to the literature. Throughout the process, I kept a journal where I reflected on the personal meaning of the interviews, the emotional reactions I had to the work and made note of my biases and impressions.

Results

Participants

The three experienced-clinicians selected for interviews are all Caucasian women in the mid 50's to mid 60's. They all graduated from a Master's level counselling psychology program at a major Canadian university. Their years in practice range from one to 20 years. All the women work(ed) primarily with women who have experienced sexual trauma community-based agencies. One of the women additionally works in a public agency with mothers and children exposed to women abuse. For all three women, counselling is their second career; each had an earlier career in a care-giving profession. One of the women left the counselling profession after a year of practice to return to her original career, she is now retired. Two of the women are survivors of sexual abuse committed by a family member and for one there were multiple perpetrators. The other is also a survivor of a terrible car accident. Both of these women repressed the memories of their abuse for many years remembering the abuse while involved with the counselling profession. The third woman was raised in a verbally violent and physically abusive home; she was repeatedly exposed to women abuse perpetrated by her alcoholic father. She witnessed the physical assault of her brother and mother and was subject to inappropriate comments by her father. Additionally, she is aware that her father assaulted more than one of her female friends in childhood.

All three women received formal therapy from a professional psychotherapist or psychologist. All three women were married and each has two grown children. Two of the women remain independent while the third in a stable intimate relationship. At the time of the interview, each woman indicated that she considered herself emotionally and

psychologically healthy enough to discuss her history safely. Pseudonyms, chosen by the women were used during the analysis. All identifying details, including the pseudonyms, have been stripped from the transcription and quotes to protect their anonymity.

Overview

Five general themes, each consisting of several sub-themes, emerged from the data:

1. Recovery is a journey (resilience, self care and coping, the terribly hard part of healing, and meaning).
2. Transformative relationships (protective, damaging, and healing).
3. Sources of disconnection (isolation, shame, otherness, and stigma).
4. Gifts from the past (counselling is a calling, advocacy, and therapeutic traits).
5. The profession as process (learning from clients, learning from the literature, professional issues, and self awareness).

Recovery as a Journey

This category captures the idea that recovery is a living process. Throughout the interviews, the women referred to their "healing journey" or their "path." They all acknowledge that healing occurs at different points in the lifespan and that it is a continual process; it is not a destination, but is active, dynamic, and unique. None of the women claim to be 'recovered'; instead, one participant explicitly claims that she is "still recovering." Likewise, Another participant explains that she is currently in a good place in her healing process. The journey of recovery includes the women's unique expressions of resilience, their strategies for coping and self-care, an acknowledgement of the difficult parts of healing, and finding meaning.

All of the women described themselves as resilient. They explain that their *resilience* is made up of multiple factors. Some, such as innate temperament or protective factors, have always been present. Others have developed over the years, where as others are the result of conscious effort. One woman in particular addresses how resilience is recognized in retrospect and that part of her work today as a therapist is in helping children see their resilience. One woman reflects on how her experience of her own resilience has not been stable and that there have been times when she did not feel resilient. The two women who repressed the memories of their abuse consider this ability as one of the factors of their resilience. One of the women considers repression a genetically inherited trait.

Two of the women describe their ability to get angry as resilience that has allowed them to survive.

> I am a fighter and I have a really strong core and I've, I'm, there's a part of me, even as a kid, as I said when I was 9 I had a, there was a violent rape by my father. I feel like in that moment, that night I made a decision, I could have either curled up in a ball and died or, (...) something happened for me that night and I got angry and, I think that saved my life. I was angry and from that moment on I was often seen as somebody that was too independent and I was told that my whole life. I was too independent and I was there was an anger about me that people noticed. They were, well why aren't you being, you know, and now I know why. And but it saved my life so um, that for me was a moment of, of profound resilience.

> I'm a fire, my dad would yell at me, and let me tell you I was still getting very

> triggered. It's not that I wasn't scared to death of his anger, but I would yell right back. So, I'm a fighter. (…) My anger has saved me; I get angry a lot.

Another women identified her creativity as a source of strength that she has been able to call on during difficult times:

> Writing and journaling has been a big outlet for me too, you know. I don't consider myself artistic but I think I am creative, so my healing journey I've been kind of innovative, you know, I would go into therapy and my therapist would say to me, 'well, what are we going to do today'…

All three women stated that their intelligence has been a factor in their recovery. Their education provided the women with a place to experience mastery and to channel their anger.

> I've thought a lot about this. I was really good in school, and I believe that was very, very important to me. Especially public school, when I hit high school all hell broke loose, but what happened was I became this really, I don't know what happened with me. But public school I was always the favourite student um, and I worked really hard in school.
>
> I was a really mouthy, sassy, English student kid, but bright in literature and, I started doing well in school in, well grade 5 on and the anger fuelled that.

For one participant her success in school allowed her to leave home at 17 to continue her studies. For all three women an undergraduate degree was empowering, leading to a career and relative independence. For another of the women, learning about feminism and women's issues gave her a framework with which to understand her experiences:

> I knew as a young child that something was really wrong with my house, (…)

> which is why I got angry at a really early age. It was wrong and I didn't know, but I just knew it was wrong. I knew that it wasn't right but I didn't have the language for what it was and why it wasn't alright. My undergrad gave me the words for that and allowed me to call myself a feminist. And I am incredibly grateful to that, to my feminism, to my social justice perspective.

While none of the women described themselves as religious or as active members of a formal religious institution, all three women considered themselves to have a deep sense of spirituality.

> I also have a profound faith and I had some profound spiritual experiences during the initial phase of blowing open.
>
> I love nature. I love it. And I think that's a real strength too, that's my sense I think of spirituality because I don't have formalized source of religiosity, which I'm really okay with. It doesn't really speak to me.
>
> Faith has been, not religious faith but more spiritual faith has been a big factor in my recovery. Feeling that there is something greater, something you know, that healing is a process and I will come out the other end and, being fascinated by the process. I find always, I think part of me was always observing and thinking, this is bizarre but it's interesting.

Learning *self-care and coping* is an ongoing part of the healing process. One participant explains that the use of alcohol has been both an unhealthy and healthy way to cope for her. She states that she has used alcohol in a self-destructive manner as a young adult; however, her relationship with alcohol has changed over the years. She finds that now it helps her overcome some of her shyness in social situation or helps her relax after

a difficult day. For another woman, finding a balance in her life has been important, a self-described workaholic she now finds it necessary that she devote more time to herself. One participant describes her need to find balance between time spent with others and time to be with her self. Likewise, another woman cares for herself by "honouring her introversion"; she works towards balancing her need for solitude by reaching out for connection to her friends and her children. All three women reflected on their caretaking role honouring the fact that it helped them cope and gave them a role to perform.

> I helped everybody else that was around, picking up strays, people, animals, whatever; running myself ragged doing that, (...). I focused on other people and on being the helper, I was a xxx for 15 years before I went into counselling and was a real caretaker of others, so my dynamic with people was about that, often being needed by others, that's kind of how I operated.

> I was a defender, I was a defender of my mother, and I was a defender of my brother.

> I found myself at one point in my life being a rescuer for a few people and I really realized that that victim/rescuer role is not good for either party. Being a rescuer is kind of a one-up position, it makes you feel like you're somehow healthier or more stable or more, you know.

All three women care for themselves by exercising their right to privacy. Choosing when and to whom they share their story.

> My colleagues are wonderful and they support me it's not like we sit and talk about my story or anything but some of my close friends that are in the work know and some of them don't and it doesn't matter you know, I get to decide all

that.

> I am not really open a lot to friends about my experiences. I have friends now that are therapists that I share more of myself. I'm pretty private. The fact that I'm telling you this is actually a big step for me because of our relationship. I'm pretty proud of it. Very few people at work know that I'm a single mother, that I'm a single woman. So that may be a way of healing, you know.

All of the women in this study spoke of the *terribly hard part of healing*. Recovery for them was a difficult process and at times required sacrifice and resulted in significant loss. All three women referred to the financial struggle to attain good therapy. Each woman has experienced periods of depression; additionally they report anxiety, flashbacks, or headaches. The symptoms have at times caused disruption to their everyday functioning.

> Well, the biggest struggle that I've had has been dealing with depression, and I took three different leaves of absence from my job at three different points.

The loss of relationships was another price to pay on the road to healing. All three participants were met with disbelief and a refusal of accountability when they disclosed to their families of origin. Two of the women made the difficult choice to protect their selves by ending their relationships with their parents or members of their families of origin. Similarly, Another of the women met with denial and a refusal of support when she went to her mother. There were additional losses, friendships, and marriages that could not withstand the pressure the women's healing put on them.

> My world changed a lot, my life changed a lot, there was a lot of loss involved and it wasn't about me, it was them not being able to handle that and in time I

> learned to be okay with that and accept it. People were used to see me together and some people couldn't handle it; my husband couldn't handle it. He did the best he could with looking after our life but he wanted me back the way I was before, and it changed me.

For the women who repressed the memory of their abuse for many years, the process of remembering was terrifying and overwhelming.

> Well you see when I remembered I was flooded with memories and I had a psychotic episode and I spent a week in XXX hospital (...). The psychotic episode was as big a trauma, I think, as the original abuse. It was a re-traumatization. I had gone to a retreat where they did a lot of emotional and expressive work and it was overwhelming for me, listening to other people's trauma as well as recalling my own. And so, the process of recovery from that has taken years.
>
> For 5 years I hardly slept, every time I lied down, I had new memories and flashbacks; it was terrible.

A final subtheme in the journey of healing is the process of finding *meaning* in their lives and coming to a place of peace and understanding.

> The whole premise of what I'm writing about is that recovery is possible, and yeah. So I think if I could kind of sum up what we've been talking about, for me, it's been the support of friends, the support of a therapist and my writing and my faith, my faith in the process, my faith in a greater meaning to life. I've always believed there was some meaning to what I was going through, there was some reason, or some, you know.

> I'm really clear about who I am and what I've done and I'm really proud of myself of what I've done. I've had the courage to do some things that were very, very difficult to do.

Transformative Relationships

The women each described how connections with significant others were central in their healing journey. All three women explained that connections to their friends, family, therapists and educators were the most important factor in their recovery. Relational connections, for the women, have been a source of protection, healing, or damage. They described *protective* relationships that helped them survive the abuse; for instance, a teacher who supported and encouraged one of the women helped her stay connected to her education, a resource that eventually permitted her to leave home at 17. One woman recalled that spending summers at her grandparent's cottage allowed her to temporarily escape the abuse at home. While many of her memories of her childhood remain cloudy one of the women explained that she remembers her mother as being very loving. Another participant shared that despite the violence, her home was often a gathering place for her friends. This offered her protection because while her friends were visiting, her father would generally behave. One participant describes the profound influence that simply being seen and loved by someone had on her ability to survive:

> My aunt XXX had a profound effect, and it was simply because she saw me, I felt 'seen' and noticed and celebrated, I felt like she loved me, I could actually feel her loving me and so she probably had, you know, one of the greatest influences.

Relational connections were essential to the recovery process for the women. They explained that it was in and through relationships that they did their *healing*.

> When my mother died I created a ritual where I gathered my women friends together and I had a silver cord and I cut the cord to represent all the things that I wanted to let go of, along with my mother. And then I had one of her necklaces and I put on the necklace and I said all the things that I wanted to keep, you know, the good things my mother had given me. And then we passed around a big chocolate bar, because my mother loved chocolate, so we shared the chocolate, and it was a wonderful ritual because we had potluck dinner afterwards and all my friends talked about their mothers. It was a very bonding and very healing experience, not only for me but for the other women that were there, so, at different points in my healing journey I've tried to be creative like that and create things that meant something to me.

For the women in this study, relationships with their children were a crucial part of healing and recovery. Healing allowed them to be better mothers and being a mother inspired them to heal. For one participant being a mother was a factor in her remembering and in her choosing to get the help she need.

> I'd had a daughter and I was fine with being a good mom to her and it was wonderful and then I had a son and I was terrified about having a son. I was afraid, unconsciously I think I was and this was, I didn't know about my abuse and I was afraid that I would be raising a perpetrator, is what I was afraid of, which is a common thing that I hear from women about their sons. So that's what really, having a son and not feeling like I could get as close to him as I had to my daughter and the guilt I had around that is probably what pushed me to finally face the truth about my life.

One of the women found that becoming a mother empowered her to end the cycle of violence. She explains that being able to make the change generationally has been invaluable in her healing journey:

> My children, okay here I go again, they have grounded me, they have kept me humble, they keep me real and I've never experienced love like I've experienced with them. (...) I altered the way I mothered from the way I was mothered. I mean, that was a very big conscious choice and that doesn't mean stuff didn't flow out because it does and then I made mistakes.

Another participant found that negotiating boundaries as a mother helped her deepen her relationship with her daughters:

> Well, my relationship with my daughters has been key, you know, it's been a fine line of how much to tell them, not to overwhelm them and yet to be honest with them. I think all of this, the remembering later in life and struggling through periods of depression; it's made my relationship with my daughters stronger because we've had to get angry with each other. (...) I've worked really hard at having a reciprocal relationship with them and asking for help when I needed help and being there for them too, not all being one sided. So that's, those relationships with my daughters have grown and evolved over the years.

All three women have sought out and received personal therapy. The relationship with a therapist was seen as integral to doing the work of healing.

> My relationship with therapists; that has been really important. I've learned from all of them, I still quote so many of the therapists, if they said something to me I think, huh I'm going to log that. So that has been invaluable.

> I've had a good therapist that I've seen for 20 years off and on. Yeah, some periods I go quite regularly and then other times I may not see her for 6 months or more, but, it's been, like having a partner through this whole journey.

Connection has not always been healthy for these women; in fact relationships have had *damaging* power in their lives. The abuse the women experienced as children was relational abuse. Each of them experienced overt violence in the form of incest, rape verbal abuse, and witnessing abuse as well as more subtle violence in the form of emotional neglect or a lack of protection in their lives.

> My mother would never look at me because I think that her looking at me, triggered her own stuff. So there were years that my mother didn't even talk to me she would talk to me through my XXX sister, if you can imagine and there were five kids really close together in the family. So it was a busy household but she wouldn't look at me.

> I told my mother and father that I believed that I'd been sexually abused by my uncle, which was my father's brother, and my mother, was very adamant that that couldn't have happened because they never left me at his place. I have a picture of me waving goodbye to them when I was left there, my aunt and uncle were babysitting me, so I know that they had left me there. And my father said, well, I'm not surprised because he knew that he, he said, my brother was a pervert.

The experience of damaging relationships in their early lives exerted influence extending beyond childhood. For one participant there has been a connection between her early relationship with her father and her later unhealthy intimate relationships:

> My intimate relationships with men have not been good. Again, there's a

connection in how I grew up, it wasn't modelled for me, I didn't know see a healthy relationship and I struggle with that concept because so many people don't grow up with healthy relationships yet they go on to find them. It's not that simple, but I have not been, I have not had good relationships with men. I have been with men that have been abusive; I've been with men who loved the way I look, like the trophy aspect of that. So again, there's that superficiality piece to it and I've always been a woman who men like, to my detriment.

Sources of Disconnection

The participants described instances of isolation and disconnection from their families, their friends, and from society. At times, the disconnection was outright in the form of stigma and discrimination. Other times disconnection is experienced internally as a feeling of separateness or *isolation.*

I was in a family of five though and I had a xxx sister. We were the oldest, and so probably not as much isolation as a lot of people who are being abused, and I had a lot of friends, a lot of family, and a lot of people around me and I had a xxx (sister) that was always kind of dragging me to do stuff. But I often felt alone in the midst of a crowd of people.

To the question, did you experience isolation as a child? One woman responded: That's an interesting question because I think that's two-fold whether it's physical isolation or emotional isolation. And I was poorly supervised as a child and especially as an adolescent and even as a young child so I think there is an isolation piece there. But I think I was more, I was often psychologically isolated because I am quite different from the rest of my family.

One participant, whose memories of her childhood remain cloudy and fragmented, assumes that isolation was a part of her experience growing up. She does recall that when she convalescing from her car accident in the hospital that she was frequently alone, her parents were not available to sooth her when she was afraid. It was common for the women to experience a disparity between the external presentation of their homes and lives and their lived reality. Two of the women were reared in upper middle class homes, which to the outside world appeared secure, privileged, and respectable.

> Nobody, nobody knew, so when I was a kid, so, we were seen as a very well respected family, my mother was president of the catholic women's league, my father was a businessman, you know, on the surface, it looked like the great family but I always felt like there was something profoundly wrong with me, so that was my own feeling.
>
> It was really interesting, because my house was the house that people gathered at. We had a pool; we were very middle class when I grew up. There was a bit of a facade there that my house was the house that people came to, my friends always slept over there.

Later in life when the women confronted their parents as adults, they were met with denial, disbelief, or non-support.

> My family wasn't supportive at all, I asked my mother to help me with some money for therapy, she said 'why do you need therapy? Forget the past and get on with it.' That was her.
>
> I confronted my family and they would take no responsibility for anything they see themselves as these wonderful upstanding people and how I dare I and stuff.

> So I walked away from my family, my birth family which was huge and very difficult and but a lot of loss, but it comes down to a choice between yourself and your family.

One participant suggested that most often the sense of separateness and otherness that persist into adulthood is actually *shame* or self-stigma:

> I find that a lot of the worry about the stigma is our own stuff that we project out on to other people and worry that other people are going to judge us.

One of the women acknowledged that shame, was indeed, a component of her isolation:

> There's stuff I haven't told XXX (personal therapist), there's a shame piece I bet. In terms of, not shame about the stuff that wasn't my fault, but my behaviours that are probably connected to that.

One participant described her feeling of *otherness* as being the cumulative result of her experiences and choices with her awareness of society's judgment and wilful denial of important issues.

> I'm a relatively serious person even though there're moments that I like to laugh but I for the most part, I was a serious kid. And there's just seriousness, the world has so much woundedness and I'm aware of that. And I think it keeps me angry at so much of that, of what the world is. And that's isolating because not everybody wants to talk about that, even my own daughter says, 'mom, do we have to talk about that?'

All of the women have encountered *stigma*, and judgment, either for their symptoms, or for the way they chose to manage and cope with their experience. One woman found that her efforts to cope and heal were met with misunderstanding and

discrimination:

> I had department heads who were calling me while I was off wanting me to do work at home and didn't understand at all what I was going through. When I returned, several times, I applied for counselling positions within XXX and I wasn't even given an interview. (...) I think that human resources were not that sympathetic to people who are even just encountering stress in their job, yeah.

Another woman explains that her choice to protect herself by not seeing her father has been subject to judgment:

> There is a stigma of being a single mother, but I think I've received judgment when I chose to stop seeing my father. There is all kinds of judgment about that. *Oh, you're the daughter.* My mother is dead, my brother lives in XXX, my father lives in XXX, and I haven't seen him in over 10 years and I don't want to. But there's judgment about that, *What do you mean you don't want to see your father*?

All of the women sought help at one point in their healing either from a physician or from the mental health system. Two of the women found that they were met with disrespect, pathologizing attitudes, and, a general lack of understanding of trauma.

> I had an experience with a psychiatrist for two visits. He was okay, but the system really, I felt, he was away one weekend and, and I had somebody else, it was a horrible experience and how. I was a XXX, so I knew the game and, I was treated me really disrespectfully and they didn't want to know about my abuse, they wanted me, it was very, I was so enraged, it was about, *you have a husband and children your job is to go home and look after everybody.* Meanwhile I am like in horrible shape (...). So I felt really stigmatized, this was back in the

eighties, it wasn't that long ago. Very um, pathologised, they wanted to find something wrong with me.

There was a point where I was in a pretty low period of depression and my daughters took me to XXX hospital on XXX there. Well, we were in the waiting room, the psychiatric waiting room, there was a table there with straps on it to hold you down, the chairs were bolted down. We tried to bring a chair in from the hallway just so we had room to sit. They wouldn't let us bring a chair in because they were afraid I was going to throw the chair. And I said, does the stretcher really need to be in this room, I feel like it's telling me that if I don't behave then you're gonna. (...) But the worst part was I went to go to the washroom, there was no toilet paper, no soap, no paper towels, and no toilet seat. Somebody had taken the toilet seat off and they hadn't replaced it. I complained to the cleaner who was in the hallway, and I said, that bathroom needs to be cleaned and restocked. And she said to me, *oh it's always like that*; she turned and went the other way. So I went to the washroom out in the main waiting room, it was stocked with everything, it was clean, there was a toilet seat. And I just thought, you know, the stigma of psychiatric patients waiting to be seen by a doctor, and this is what, in the year, this was two years ago.

One woman identifies her place of work as an environment that is not safe to disclose her history:

Very few people would probably know except very close colleagues, say we're on teams at XXX, so some of them would know, well they would know I'm a single mother. They would know I'm single. Would they know my, what that I was

impacted as a child? No, I don't share that. It's not safe to, XXX is not safe.

Gifts from the Past

All of the women describe positive consequences of their history and their recovery journey. They share that their experiences altered them from who they were and who they might have been had they not experienced abuse. They describe how surviving abuse and going on to help others have given them a sense of purpose. They also explain how many of the traits needed to be successful counsellors were borne of and honed through their struggles.

The women acknowledge the life altering power of childhood trauma and of the healing process.

> I probably would be different if I been, brought up in a family that was, that was, safer, but some of the things about me that I really love are things that have come out of the struggle out of trying to manage all that.

All three women have been caretakers of others, choosing early professions that positioned them as helpers. Their choice to eventually pursue a career in Counselling is, according to one woman, "no coincidence." For the women in this study a career in *counselling is a calling*, not merely a professional choice. One participant captures this shared message beautifully when she responds to the question "what motivates you to help other people:

> hmm, I guess the biggest thing is because I have healed, my life is great, and I feel this wonderful sense of contentment and peace and acceptance. I want to give that back you know. I've a real profound belief that that's what my purpose on this earth is. To help others you know.

Surviving childhood abuse and engaging in the healing process inspired in the women a desire for *advocacy* and involvement in the women's rights movement.

> I wouldn't be in this work if I hadn't been abused I'm sure I would probably be um, sitting in a second row of an orchestra playing a violin is my guess (...) I see myself doing that without the story I was shy. I'm not shy now, I mean I, I've got a shy self, but the abuse forced me to be a real advocate and very involved in the women community and feminism and I made a lot of changes in my life and I can be very outspoken. That wouldn't be who I was if this stuff hadn't happened.

> I think as I said earlier I decided I needed to make a difference in the lives of children and I just made that decision pretty early in life, in my early 20s. Thus, how many years later, 30 something odd years later I'm still working with children and as I continued to grow and develop and evolve and get thicker and deeper I realized that the issues are so big and so large and so, the level of woundedness is so much that I want to make a difference. That seems so sort of, banal, but I just, it's just who I am. It feels like that's who I am, is to have and live and the whole personal is political, to live a life of social justice and it's what I do, and I do believe that 'personal is political', it's how I live my life. I do the work but I also live my life that way.

> I'm writing a book because I want to get it out in the open. I want to break the silence. You know. I want people to talk about mental health issues. Because, I don't care who you are, everybody has struggled with something in their life, but people don't talk about it.

The women explain that the *therapeutic traits* and skills needed for counselling came naturally to them because of their experiences with suffering. Each woman agreed that they had enhanced empathy because of their past experiences. Other traits they identified as being the result of experiencing abuse and recovery included compassion, the ability to listen, passion, perception, and attunement.

> I have compassion because I get, like right down to the core of what the suffering feels like um but that's an advantage in lots of ways and it's you know, blessings and curses often go hand in hand.

> I feel like I'm a good listener, and I think that's a gift that I can give to people. It's like, comparable to giving someone a bus ticket downtown who is stranded and needs to take a bus. It's just a little gift that I can give to someone else.

One participant describes her deep empathy for her clients as coming from her connection to her own woundedness:

> I think my experiences have been able to help to understand children and what their lives are, and to understand women's lives and single women's lives and mothering and absolutely. And it's, my woundedness has allowed me to understand woundedness. Absolutely. I would argue you can only do this, I mean everyone is wounded but, I think to really understand the level of woundedness that this world is you've got to have a high level of woundedness and you've got to have awareness of that and you've got to have done the work.

Likewise, another woman attributes her "people smarts" to having been hypervigilant to the presence and intentions of her abusers in childhood:

> I have good timing with people I'm really perceptive. You know one of the gifts

> in this work of being abused is that you tend to be hypervigilant and that's a real asset in the work cause you can read people really well.

The Profession as Process

Each woman in this study describes an interactive relationship with the counselling profession. They explain how they learn about themselves from the literature and from their clients. They also share that managing clinical issues like boundaries, countertransference, and vicarious traumatization have helped them further their healing. In a reciprocal fashion, furthering their healing has enhanced their practice and their ability to negotiate clinical issues.

The counselling relationship has provided these women with an opportunity for *learning from clients*. Each of the women has been able to learn more about themselves and more about the healing process from the women they work with. This knowledge is used to further their own healing journey as well as to help their other clients.

> I learn from people I have interactions with. Children teach me, women, wounded women teach me. So I'm really mindful of that, and I don't call myself an expert, I refuse to.

When asked question number 14, *Do you think that past experience of being a child have had an effect, if any, on your counselling ability*? one woman described how her interactions with clients alerted her to the fact that she was not prepared to be a counsellor:

> Yes, I think it's the reason why I didn't last very long at it. It wasn't so much that I was being triggered but I think I didn't, well, I didn't know enough about grounding myself and I didn't know enough about helping others to learn to

> ground themselves. (...) You know, my experience was diving in and then becoming overwhelmed myself. So I needed to learn that for myself so I could help other women learn that.

Learning from the literature on trauma and recovery has been key in both their personal healing and in enhancing their clinical practice. The two women who are actively working in the field also described ongoing professional development, attending seminars and conferences as being essential to their recovery and their clinical practice. One participant explains that her involvement as a volunteer counsellor in the area of sexual assault familiarized her with the signs of repressed abuse so that she was able to identify what was happening to her when she started getting her memories. When asked to describe her resilience, one of the women went to the literature first to identify what the literature suggests:

> I see that how profound school and your ability to do well how much that impacts your level of self-esteem. It is profound, and that's what the research says, especially for latency-aged kids and it was certainly for me.

Likewise, another woman explained her childhood coping behaviours in terms of her current understanding of the influence of trauma:

> Kids have a deep internal sense of badness when bad stuff is happening to them so what I did, like many survivors is work really hard to be good.

All three women reported that managing *clinical issues* has been an opportunity for personal and professional growth. For instance they describe how negotiating boundaries has taught them about their limits as counsellors and as people.

> What I had to learn was about boundaries. I had to learn well, where do you start

> and where do I, you know, your story is impacting me and my experience is impacting you, and so I had to be careful that I wasn't taking on their energy.

One woman reflected on the need to define the limitations of her responsibility with clients at the same time as respecting the emotional response she has to her client's struggles:

> It's sad for me sometimes to sit with people and I can see and feel their potential and yet the their abuse has blocked their ability to go there and so all I can do is offer the gift for them to pick up but if they don't pick it up it's not my choice.

Like boundaries, managing countertransference reactions had personal relevance for the women in this study. One of the women explained that she is unable to work with men who have experienced abuse because of the dynamic of transference and countertransference. Awareness of countertransference allows her to set the limits on the clients she will see in her practice. This knowledge has come from trying to work with men who have experienced abuse:

> But men want to blame the women, the women want to blame the women too, but men really want to blame the women, their moms and when that gets projected onto me and then I feel like I'm with my father and it's not a good experience.

The women acknowledged the cost of caring and their unique vulnerability to experiencing vicarious traumatization.

> Even though I know I'm getting to the end, I'm feeling that I need to possibly do something else. My level of vicarious trauma is such that I'm starting to realize that and that's really, really important to know that and to have awareness about that. I'm feeling a bit used up, again the more compassionate you are, the more

> compassionately fatigued and I work from a heart place and my heart is well, I would argue it's breaking. So, I wonder at how much longer I can do it.

One of the women reflected on how the possibility of vicarious traumatization has given her the impetus to further her healing:

> I think we are more susceptible to that (vicarious traumatization) but it also you know, it's a blessing as well because it's what pushed me to really figure out my stuff that I would never had the opportunity to be pushed at.

Self-disclosure to clients is a topic with which two of the women wrestled. One of them explained that she does disclose her history when she feels it is appropriate and is in the "service of the work". She was also able to reflect on the times that self-disclosure was not effective. The other is particularly cautious about self-disclosure, choosing to explore the intent of the clients questioning rather than disclosing. She has found it useful to share some aspects of her experience as opposed to actual content:

> I'm very specific and I'm very careful. I, many women at the XXX say to me, I'm guessing you were abused, sexually abused. Yup, or, lots of women say, I wonder if you were an abused woman, domestic violence. I don't go there. I say, tell me why that's important to you, or I'll say, as a woman, 'by the fact that I'm a woman, I would argue that I fit on the continuum on all those aspects', I say that. Because I think that's really important to acknowledge that as women that's just part of who we are (...). So, I say that but other than that, no.

Likewise, self-disclosure in other environments has been negotiated with caution.

> I don't talk about it. I don't say I grew up in a violent home, I don't say that. Most of my friends know that my dad was an alcoholic and is an alcoholic I would

> assume. So there's that piece, but that's a piece we all, you know, a lot of my friend's fathers were alcoholics, it was allowed. But no, I don't think so, I guess I am pretty private. I don't talk about it. I don't call myself a, I don't label myself that way so probably that's why.
>
> Well I'm very careful who I disclose to, and so, it was very negative with my mother, it was very negative with my mother and I've already talked about that a little. I did have trouble with the supervisor where I was counselling and that was dicey, you know, that was dicey. Other than that, I really didn't disclose to anybody that I worked with, I mean they knew I was off for depression but they didn't know the roots of it.

A second women agreed that self-disclosure to clinical supervisors has not been a favourable experience for her; she recommends that other experienced clinicians negotiate this decision with caution:

> I have found it has been my experience that it is not wise to share with supervisors. There is an evaluative piece just by the fact that they have to do a performance review on you, and a lot of them don't know how to do that well. Because I'm a strong woman, a lot of supervisors are threatened by me. So, I guess this is my advice, be very careful, tread very carefully when disclosing anything personal to supervisors. It's been my experience, it comes back to bite you in the ass.

Conversely, the third women explains the importance of sharing enough of her story with a supervisor so that they were able to help her identify issues she might be having with clients:

> Supervisors, yes, my supervisors have always known that, yep, again not details, but if I was getting triggered in the work or getting over involved and one of the hooks can be sometimes to over identify with a client that, a client that's like you, we can over identify and miss stuff. So, it felt important that they know, and for the most part, I can't remember ever telling a supervisor being a bad experience. A good supervisor would acknowledge that we all come with a story and um, we all have our hooks in the work and knowing what your hooks are is wonderful. It's dangerous if you don't know what your hooks are.

Self-awareness comes from doing the work of personal therapy, but is also essential for doing the work of a counsellor. Likewise, being a counsellor has been given these women the responsibility and desire to become incredibly self-aware.

> Being a therapist has pushed me to do my own work so incredibly thoroughly because you will, get triggered more because you've got more junk to get triggered.

> I was a child exposed to woman abuse and didn't realize that for a really long time. I grew up in a very violent, very abusive household. I was doing this work for a long time before I realized oh my god I was a child who was exposed to woman abuse. And I think it's why I'm good at what I do. I connect with children really well and I think that's why.

Discussion

Overview

The demographics of the participants are consistent with the characteristics of participants represented in the literature examining experienced clinicians. Two of the women describe themselves are currently single; the third is in an intimate relationship. All three women feel connected with some form of spirituality, were/or are working with survivors of abuse, believe allegations of abuse, and consider abuse serious. They differ statistically from the norm in that they are all parents. The findings, which relate to recovery, relationships, and disconnections, are consistent with the literature on survivors of abuse. Findings specific to experienced clinicians are compatible with previous research on wounded healing (Barnett, 2007; Stone, 2008) and posttraumatic growth (Tedeschi, & Calhoun, 1996). The data suggests that for experienced clinician's, management of clinical issues is interrelated with the ongoing recovery process. The discussion that follows examines each of the themes individually, and then considers their interconnectedness.

Recovery is a Journey

Data in this theme suggests answers to the questions, (a) how do experienced clinicians describe their recovery from childhood abuse? and, (b) what do experienced clinicians believe are their resiliencies? Throughout their interviews, the participants would refer to their path, or journey of recovery. They spoke of ongoing recovery and challenged the concept of 'overcoming abuse'; instead, they described a process of integration or continuous learning and growing. This theme is consistent with Harvey's (1996) ecological model, where recovery is viewed on a continuum and is not determined

as complete absence or abatement of symptoms. Recovery, for the women in this study, is a process that requires ongoing self-analysis, awareness, and continual effort towards balance; it involves integrating the abuse story into the self-concept. If recovery is the process, then resiliencies are the skills required to engage in the process. Some aspects of resilience are unearned, that is, they are genetic or familial, circumstantial or the result of other environmental factors (Lam, & Grossman 1997). These women in this study named protective factors that are consistent with the literature on resilience such as being raised in white, middle class families, and having access to extended family or additional caretakers (Lam, & Grossman 1997). Two of the participants named their ability to repress memories as resiliencies. Temporarily forgetting allowed these women to survive their home lives, avoid some of the more damaging forms of coping (substance use, unsafe sexual practices, self harm) and function well enough to leave home, obtain an education, and start a family. The memories of the abuse came to them at a point in their lives characterized by relative stability. Other resiliencies, named by the participants, such as creativity, spirituality, and intelligence are familiar in the research on resilience (Benatar, 2000; Harvey, 2007; Lynch et al, 2007).

The women in this study identified anger as a central resiliency, explaining that anger was a factor in their survival and their success. Anger is an important consideration when addressing women's recovery from childhood abuse. The 'normal' socialization of women typically excludes healthy models for anger (Miller, 1991). Women and in particular little girls are expected not to get angry. Feminist analysis of anger positions the presence of anger as a "sign of returning health" (Bulter, 1996). Anger is the opposite of self-blame; it correctly places the responsibility of the abuse on

the abuser. Anger in this vein is a healthy response to oppression. The women in this study found that the experience of anger made them resolute and gave them the strength to fight through the most difficult periods of their lives. The anger bolstered them up, so that they would not give in to the despair.

Two of the women recalled one of their early coping strategies as caretaking and protecting others in their lives. The third participant identified caretaking as a role she played in later relationships. Coping in this way gave them a role to play in connection with others. The tendency of women and young girls to connect in this way has been labelled the "tend and befriend" phenomenon by Shelley Taylor (2006). Taylor found that when faced with threat of annihilation female members of the species would move into closer proximity to one another to provide support and affection. Caretaking is empowering, women feel stronger when they are able to help others (Jordan, 2008). The choice to transform this early resource into a career in counselling is an adaptive strategy. The counselling profession entails caretaking in a deliberate way; the caretaking is aimed at assisting the client in meeting his or her own goals. Effective counsellor education facilitates the transformation of a drive to care for others into a useful, non-exploitive skill.

Of particular relevance for this discussion is the role of education and learning in these women's lives. Intelligence, a hereditary trait, was developed into a vehicle to attain academic success. Success in the school system provided an escape from the home environment, access to friendships, positive role models and ultimately provided opportunity to achieve gainful employment and further academic experiences that cumulated in their career as counsellors. The women speak of the changing nature of

their coping strategies, coping styles that served them in their youth needed to evolve in order to continue meeting their needs. Part of the change reflects maturity and aging.

A discussion on recovery would be incomplete without addressing the difficulty of healing. The women in this study encountered difficulties that are consistent with the literature including depression, anxiety, insomnia, flash backs, vocational disruption, hospitalization and medication, which were all very much present in their lives. Additionally they described estrangement from family members, the loss of friendships, and divorce as some of the relational costs of their recovery. Simultaneously, however, the women in this study were able to manage the demands of both family and career and their resiliencies were present amidst considerable distress. Harvey (2007) explains how "when resilience is defined as multidimensional it becomes possible to see trauma survivors as simultaneously suffering and surviving" (p. 15). The ability to navigate these losses with integrity is an indication of these women's resilience. Estrangement from family was a choice for these women. As they confronted their family with the crimes from the past, each was met with denial or refusal to take responsibility. In order to honour their healing, two of the women had to walk away from their families of origin.

To survive the losses in their lives each women has engaged in a process of meaning making. Victor Frankl (1952), who spoke most eloquently about the seeking of meaning in suffering, considers meaning making to be one of the most important tasks of survival. Connecting to something greater following the experience of suffering is a domain when assessing Post Traumatic Growth (Tedeschi, & Calhoun, 1996). The women's spirituality, creativity, and intellect were resources in developing an understanding of the meaning behind their experiences. Finding meaning is both a

process in recovery and a result of this process. Meaning for these women is consistent with Linely's (2003) description of wisdom; it is an integration of the events of their lives, the way they think and feel about themselves and their understanding of how best to live their lives.

Conceptualizing recovery as a process is valuable knowledge for experienced student clinicians. Identification as a recovered person draws to mind a closing off to experience. Seeing recovery as a life task asks student clinicians to place themselves in a vulnerable position and challenges them to be accepting of uncertainty. However, in this position of vulnerability and uncertainty, they remain open to a lifetime of growth and change. They enter the profession with humility and respect for their peers, educators, and clients.

Transformative Relationships

Data coded at this theme addressed the original research question, how do experienced clinicians describe their recovery from childhood abuse? Given the centrality of relational connection in Relational Cultural Theory's framework, it comes as no surprise that a theme emphasizing relationships emerged during the analysis. This theme underscores the central role that connection and relationships play in women's healing. Relationships are curative, protective, damaging, terrifying, and consuming. Violence occurs in relationships and it is through relationships that healing may occur (Herman, 1992; Jordan, 2010; Lynch et al, 2007). Studies on resilience and recovery from trauma have found that the presence of at least one supportive relationship in the child's/woman's life is associated with more positive outcomes (Higgins, 1994 in Lynch et al., 2007). While isolation was a factor in each participant's life, it was balanced by

the presence of family and friends, connections that offered protection, escape, or distraction from the abuse. It is likely that having these relationships gave these women the skills to stay in connection with others. All three women when asked about recovery were clear that it was in relationships that they found healing. The women in this study demonstrate a *relational acuity*; they were able to walk away from unhealthy connection and enter into healing relationships. A therapeutic relationship with a personal psychologist or psychotherapist was and is a significant source of healing for each of the women interviewed. While counselling is the choice of many survivors wishing to recover from their abuse, many individuals recover without seeking professional help (Harvey, 2007). The fact that the women in this study were either already working in the counselling field or actively pursuing their counselling degree when they began their recovery journey likely played a role in these women's choice to opt for a formal therapeutic relationship.

The role of motherhood was not discussed in the literature yet proved significant when examining the transcripts. The relationship of mother to child is one that is tested by trauma and recovery but is also one where the task of healing can bear its best fruit. One of the women's love for her children, and her motivation to heal through parenting is profound. Of particular significance was one women's description of intergenerational change. While this carries with it much hope, it also carries with it much responsibility. Mothering is an opportunity for women to be the mother they wished they had. This goal, however noble, in the mother who has experienced abuse, may lead to anxiety and concern that they are going to fail their children, perhaps in the same way that their mothers failed them (Caplan, 2000). Mother's, in general, are held responsible for nearly

everything that occurs in their children's lives, particularly childhood abuse and especially when the perpetrator is her husband or partner. Mothers are blamed for both knowing and not knowing about the abuse (Caplan, 2000). Clearly mothering is a very important issue for women who have experienced abuse and one that requires attention for student counsellors, as they all have mothers, will work with mothers, and daughters, and may be mothers themselves or face the challenges of mothering one day.

Relational Cultural Therapy underscores the centrality of relational disconnection at the heart of all dysfunction (Jordan, 2010). Child abuse/sexual abuse is a deeply damaging event that takes place within a relationship. The damaging relationships in these women's lives were not just the ones with the abusers but included those with the people around who failed to protect them as children. The influence of a violent and invasive event on the developing psyche cannot be overstated (Herman, 1992; Jordan, 2010). While people are naturally drawn towards soul sustaining relationships, when destructive relational experiences occur in order to protect the 'self' people begin to push away from healthy interactions and develop relational strategies that can maintain dysfunction (Jordan, 2010). The presence of protective and healing relationships in these women's lives served to ameliorate the development of more pervasive strategies of disconnection.

Sources of Disconnection

Data from this theme answers in part the questions (a) how does a history of childhood abuse and recovery influence a counsellor's experience of self in personal, professional and academic contexts? and, (b) is the disconnecting silence of childhood abuse maintained in professional social and academic environments? Disconnection

occurs when misuses of power, abuse, and misunderstandings occur in relationships. The oppressed person experiences disconnections as feelings of isolation, fear, and shame. The relational violence the women experienced as children was a profoundly disconnecting force. Their experiences denied and disguised through silence and secrecy, the women were aware of the discrepancy between the external presentation of their families' lives and the horror within their homes. This external discrepancy was internalized and experienced as a sense of badness or *otherness*. The internalization, by children, of abuse is consistent with the literature on child abuse (Fisher, 2005; Herman, 1992). When left unresolved, internalized abuse can act as a barrier to developing further relationships. One participant illustrates this when she shares her ongoing struggle to be "sufficiently intimate" with others. She identified as continuing to struggle with intimacy and is arguably the most private regarding her history. Of the three, she works most closely with the public mental health system and is generally without support in her work environment; perhaps this is but one reason for her experiences.

The participants' agreed that there is some stigma to being an experienced person, and observed that this stigma is typically encountered in institutional or public environments, such as the government or medical system. The women reported that the medical and public mental health system was, without question, the most stigmatizing environment they encountered. They described a lack of knowledge of women's issues and trauma as being the reasons for the stigma. One participant was the most outspoken about the stigma of mental illness. Her experiences in the hospital system inspired her to write her story in an effort to shed some light on the issues faced by women recovering from their abuse. She reflected on what she saw as the silencing of experienced women.

In her experience, it was not safe to talk about struggles with mental illness. Additionally, in agreement with Schiff (2004) she argues that talking about the experience of trauma and mental illness is particularly unsafe within the mental health profession. Like Schiff (2004), she observed, an oft unspoken division between the counsellors and the clients, a division that suggests that mental health and authority reside on one side and distress and seeking of support reside on the other.

One participant reflected on one of the ironies of the work of counselling. She argued that counselling experienced persons of abuse is isolating, because of the social reluctance to speak of abuse. The work she does with her clients is about forming and nourishing connection. However, she finds it necessary to be silent about her work in personal relationships in order to maintain connections. Christine Courtois and Sandra Gold (2009), Judith Herman (1992) and Sandra Butler (1996) among others have reflected on the social denial of trauma and the isolating nature of trauma work. Experienced clinicians who work with other survivors of abuse may find that they are doubly impacted by the silence and stigma of trauma.

It is difficult to disentangle stigma from shame. This entanglement is perhaps what has allowed victim blaming to go on so long. It is far easier to argue that a woman's experience of oppression in the mental health system is a convoluted expression of her internalized abuse than it is to recognise the systematic ways that women are silenced in our society. Bonnie Burstow (2003) suggests that the oppression of those who are experienced with abuse is due, in part, to two 'elitist' fallacies: (a) The world is essentially benign and safe, and so general trust is appropriate, and (b) people who have been traumatized have a less realistic picture of the world than others.

One participant makes an interesting point when she states that much of the worry about stigma is self-stigma and shame. Encounters with external sources of disconnection likely confirm and perpetuate this internal self-system. The challenge of overcoming stigma in society is partly about helping to heal internalized oppression in order to identify correctly and challenge external oppression. When shame is resolved, women are able to interact with their environments with greater flexibility (Herman, 1992; Jordan, 2010). Counsellor educators need to be knowledgeable on trauma so they are aware of the issues faced by experienced clinicians and are able to provide support for students as they embark on professional development. Learning about trauma and recovery will help to prepare educators to identify the internal shame and isolation that create barriers to educational engagement and to support experienced students as they find ways to provide safety.

Gifts from the Past

Data in this theme speaks to the questions (a) how do experienced clinicians translate their history into a means to help others? and, (b) how does a history of childhood abuse and recovery influence a counsellor's experience of self in personal, professional, and academic contexts? The gifts referred to in this theme are the transformations of trauma, the positive consequences of suffering. Firstly, I want to comment on the life-altering power of traumatic experience. Child abuse is not experienced in the same way as normal developmental experiences, which are integrated into the generally cohesive sense of self. Instead, there is a sense when speaking to the women in this study, that their abuse radically shifted the natural trajectory of their lives. Abuse is experienced as a violent disruption to a child's natural development (Herman,

1992). The women explained that they believed they were faced with a choice, to give in to the tragedy or, to fight against it. The drive towards advocacy is connected to this idea of fight. Advocacy is the harness for these women's righteous anger. Feminist therapies speak about the value of advocacy for women's healing (Israeli, & Santor, 2000).

In a similar way, the women in this study described their entry into the profession of counselling as a calling. Having worked previously in caretaking roles, the progression to counsellor was an organic one. Barnett (2007) found in his study on counsellor motivations that many people enter the profession with unconscious motivations. He found that it was only later in their career, after much personal reflection, that many clinicians' are able to identify their underlying reasons for becoming a counsellor. His concern was that one of these reasons might be an unconscious desire to "heal themselves." This self-healing drive was thought to contribute to use of the therapeutic relationship for selfish aims. The women in this study argue instead that their healing was what allowed them to be better counsellors. As they healed personally, they were able to give more back to their clients. The women suggested that counselling was their purpose, helping others gives meaning to their suffering.

All of the participants agreed that there were positive gains from surviving their experiences of abuse. Compassion and empathy for others who have suffered was clearly identified by the women. One participant spoke explicitly of her perception and timing. In agreement with Judith Herman (1992), she acknowledged that the tendency of chronically abused children to be attuned to their environment was an asset in the work because it allowed her to catch subtleties in client communication that might be missed

by other counsellors. The source of these women's empathy is their healing from their woundedness; they work from a place where they are incredibly vulnerable, using their intimate understanding of suffering as a way to connect. Their awareness of their vulnerability and willingness to work from an incredibly open and receptive place is their strength and their access to radical empathy (Jordan, 2008). In agreement with Barnett's (2007) findings, the women in this study stated explicitly that their woundedness and experience with trauma was what gave them their empathy and passion for their work with clients; however, it was their recovery, which allowed them to do the work effectively. It is not enough to simply know what it is like to suffer; it is imperative to know how to heal.

The women in this study make clear that they believed all persons are wounded in some way. Relational psychotherapists suggest that trauma and abuse be considered on a continuum, arguing that everyone has experienced some form of relational trauma that influences their adult patterns of interaction (DeYoung, 2003). Without awareness of their own relational woundedness, young clinicians risk covertly supporting the fallacy that separates helpers from those in need of help. In the words of one woman:

> Some people do this, they do this them and us kind of thing like there's those people who are wounded and need the help, and then there's us that got it all together. Its bullshit, it's a lie and its wrong and its dangerous um we're all human beings walking the journey and everybody's doing the best they can.

The call to engage in their own therapeutic process before counselling others is valuable advice to all student clinicians.

Not all survivors of abuse indentify with the positive gains of their history,

however the women in this study certainly do. In fact, at one point One woman reflects on how she rarely thinks of the barriers to her recovery but focuses instead on why her history makes her strong. She suggested that her strength-based perspective is likely what allowed her to be successful in her recovery. The value of a strength based perspective is informative for counsellor educators, not only is it respectful and empowering for the client, but it can help transform the worldview and self-appraisal of the counsellor as well.

The Profession as Process

Data coded at this theme helped to answer the question, how does a history of childhood abuse and recovery influence a counsellor's experience of self, in personal, professional, and academic contexts? Profession as process emerged as a way to capture the interactive way the participants engaged with the profession. The women in this study described a relationship with counselling that is reflective of the RCT's description of mutuality (Jordan 2010). As they worked with clients, they were constantly engaged in a process of self-reflection, integrating the information from the literature and their client's experiences with their own self-knowledge. By doing so, they were able to find new awareness of their experience. They simultaneously apply knowledge gained from their recovery process to their understanding of the literature and their client's process. This is not to say that literature is only deemed useful if it held truth for them personally. What was important here was the process of examining the literature as both an academic and professional as well as one to whom the literature speaks. There was a deep and highly personal quality to their interactions with the profession.

The role of the counselling profession; the exposure to literature, the opportunity

for personal growth and relational demands of the therapeutic relationship, was so significant to their development as persons that it was through engagement with the profession that these women were able to remember and recognise their woundedness. For two of the women, their remembering began as they ventured into the field of counselling. For one woman it was through engagement with her clients that she realized that she too was a survivor of childhood abuse, a connection she had not previously made. For these women, the counselling profession was an integral part of their healing journey. Further, through engagement with the profession, the women in this study were able to make educated choices regarding their own care. Privy to language and education not readily available to the public, they were able to access care in an informed way. They were aware of the options in mental health care, take a critical stance towards the medical model of care, and chose treatments that fit with their understanding of how experienced persons heal. The development of trauma specific models of care has given experienced persons more humane options for treatment that have proved to be successful in ameliorating the more distressing sequelae of child abuse (Courtois & Ford, 2009). Increasing public education on trauma and its treatment can serve to empower experienced persons to choose the best model of treatment for their needs.

Specific professional issues found a home in this theme. Boundaries, countertransference and vicarious traumatization are of particular concern when experienced clinicians are considered. It has been assumed that countertransference reactions might be overwhelming leading to the development of vicarious trauma (Cain, 2000) or that experienced clinician's might struggle with boundaries because of their own violated boundaries (Matthews & Gerrity, 2002). Only one of the women reported

significant issues with boundaries and she attributed that difficulty navigating boundaries to her lack of education. When she completed her degree, there was no specific training on trauma therapy and vicarious trauma was yet to be considered an important topic in popular counselling literature. Ultimately, her difficulty with boundaries left her overwhelmed and she made the decision to leave the profession. Since her graduation, many counsellor education programs have introduced training in trauma therapy; however, trauma courses are as of yet not mandatory for registration with the Canadian Counselling and Psychotherapy Association (CCPA, 2011). While no such mandate exists, counsellor educators should consider including in their roster of courses education on trauma theory, vicarious traumatization, and other issues related to working with survivors of abuse.

The use of self-disclosure, with clients, is, among others, a much debated boundary issue (Little & Hamby, 1996; Matthews & Gerrity; Norris, Gutheil, & Strasburger, 2003). Relational-Cultural theorists and feminist psychotherapists suggest that self-disclosure may be useful to strengthen the therapeutic relationship (Jordan, 2010). For experienced clinicians, however, disclosure of their experience is more complex than sharing their marital or parental status; it positions both the counsellor and the client in a place of vulnerability. One participant describes the potential helpful and hurtful effects of sharing her history with a client. On the one hand, self-disclosure can communicate a message of hope; alternatively, it may encourage comparisons between the clients and counsellor, comparisons that may feel shaming to the client. Like all boundary crossings, self-disclosure requires assessment of the therapeutic intent behind the disclosure (Herlihy & Corey, 2006). Participants in this study describe negotiating

this boundary with flexibility and careful consideration.

Similar to the participants' in Cain's (2000) study countertransference reactions are considered by these women as opportunities for learning. Not only can countertransference provide an indication of what might be going on for the client, but it also alerts the clinician to what might be going on for them. The ability to recognise that a countertransference reaction is the result of an unresolved personal issue saves the clinician from projecting their issues onto the client. Managing such projections helps to arrest victim blaming and pathologizing attitudes, and helps to prevent dangerous boundary violations (Norris, Gutheil, & Strasburger, 2003).

According to some of the literature on vicarious trauma (VT), the fact that all three experienced clinicians in this study work(ed) primarily with other experienced persons places them at a higher risk for becoming vicariously traumatized (Mac Ian, & Pearlman, 1995). Literature that is more current has found that this is not the case. Experienced clinicians' are at no greater risk for VT than are any other clinicians working with experienced persons (Benatar, 2010). One of the women attributed her risk for experiencing vicarious trauma more to her increased empathy, not to her experience of abuse. This is an important distinction to keep in mind. One woman on the other hand speaks to the nature of the work as being responsible for her "compassion fatigue." This is in keeping with Charles Figley's (2002) original conceptualization of VT being the "natural consequence of caring." Vicarious trauma need not be considered a sign of deficit in a therapist, but rather an indication of empathy and an opportunity for further healing. Management of VT requires the clinician to be keenly self-aware.

Self-awareness is both a product of and a process in recovery, likewise self-

awareness is necessary for doing the work of counselling and is gained though experience. Healthy management of clinical issues is made possible by having the self-awareness to recognize when a boundary is reached, or if a countertransference reaction is the result of unresolved personal issues. Experienced clinicians who have processed their own trauma are in a privileged position relative to clinicians who have not experienced childhood abuse or processed their own relational traumas. Having done the work of self-exploration, they are poised to enter the therapeutic relationship with an evolved understanding of their strengths, limitations, and potential challenges in the work.

One of the women's responses were coded under this theme less often relative to the other themes; this is likely because she was in the counselling profession for only a short time. Her limited experience however was very informative. She had the self-awareness to recognize that the profession was not for her. This is hopeful, in that we can trust to an extent that experienced clinicians are self-regulating, and they are not *impaired in the ways one might imagine, but are able to self-direct and can identify when* the work is too much.

Complexity

This study set out with the intent to describe the essence of the experience of experienced clinicians, to describe and understand their experience of recovery and resilience and how their experiences have influenced their professional lives. What I discovered is that, for these women, counselling, trauma and recovery are interwoven conceptual experiences. It is difficult to separate their recovery from their professional experience because, as they describe it, recovery, for an experienced person is living.

Judith Herman (1992), states that the third component of recovery is a process that involves integrating all of the fragmented parts of self into a cohesive narrative and that this process involves all facets of life. From childhood to motherhood, from grade school to retirement, to recover is to learn how to live fully.

Data obtained through interviewing the women was broadly categorized into five general themes. These themes, informed by Relational Cultural Theory, described the various connections, disconnections, and processes that relate to their recovery and their professional lives. When viewed as separate themes much of the complexity is lost, however, when viewed together a picture emerges; a picture of three women whose lives were forged in unspeakable experiences, but whose strength prevailed. Thus, three multifaceted, beautiful, intelligent, self-reflective women step into the light. We see how resiliencies such as caretaking and intelligence were used to survive abuse and how those same resiliencies were harnessed to succeed in a career that would set the stage for further healing. The women have both experiential and academic understandings of the dynamics of healing in addition to the wisdom that comes with time. They were able to reflect on the complexity of life and connect it back to their own experiences, as well; they could apply these reflections to achieve a greater understanding of how people can best live their lives. Their wisdom was a gift that informed practice, was continually developed, and was reshaped though interaction with the counselling literature and profession. The importance of connection underlies every theme, connection with self, with the literature, with clients and with society. Ultimately, this study has described a process of disconnection and reconnection. It is about trauma, isolation, recovery, and the desire to help that is borne out of these experiences.

Summary

This study has described three women; three stories, three lives that exemplify resilience, survival, recovery, compassion, and commitment to change. The women who so graciously and courageously offered to share their experiences with hurting, forgetting, remembering and healing, offer valuable insight that can be used in the service of others who are at the start of the journey as clinicians. What has made these women's stories so helpful is their ability to speak from so many positions - as clients, former students and as counsellors. From their positions of experience they were able to speak to what they believed was needed in graduate counsellor education. In particular, they mentioned their wish for highly specialized training in trauma therapy and for graduate programs to emphasize the need for self-awareness. They also stressed that all people are wounded, that even students who have not experienced childhood abuse or other traumas have experienced some form of relational trauma.

Two of the participants demonstrated what it takes to be a good clinician; they do so by owning their mistakes, by having the courage to look at their selves, and to share that with others; they are both *wounded healers* and *good clinicians*. The therapists interviewed in Wolligen and Coady's study (1996, 1997) described how knowing their woundedness, and learning, and growing through their relationships with clients and others in their lives was key in the development of their helping ability. The women in this present study have described the same.

One of the most salient findings of this research is that recovery is not an absolute and cannot be defined by the absence of symptoms. If it were, many experienced persons would likely never be considered fully recovered. The women in this study continue to

experience distress because of their childhood abuse, however, this does not make them impaired counsellors. A more accurate definition of recovery would consider that acceptance (of both self and others), courage, connection, vulnerability, tolerance of ambiguity and a willingness to be uncertain are important signs of recovery.

Limitations

The limitations of any qualitative study depend on the rigor of record keeping, the credibility of the participants and the extent to which the results can be transferred to other populations. A central limitation of this study is the homogeneity of the sample. The sample is clearly missing a male perspective, however, the unique experiences of women and men warrant the use of a gendered sample. The participants selected all work, almost exclusively, with other experienced persons and therefore represent a small subsection of the counselling profession. Racially, ethnically and socially the sample is limited as all of the women were middle class, Canadian, and Caucasian with Christian backgrounds. All the participants attended programs that emphasized a feminist and social justice perspective and were, as a result, exposed to similar language and ideology.

Another factor that limits the results of this study is low response rate (less then 2%). The reason for the low response rate may be due to the method of recruitment. Email is not always the most reliable method of getting in contact with people. Some potential participants may be reluctant to reply to email, as it is not always a secure and private method of communication. Another possible explanation for the low response rate is that the clinicians who chose to participate were those who experienced the most success in their recovery and felt the most resilient. It is reasonable to assume that experienced clinicians who are currently distressed or have encountered major struggles

in their practice are more reluctant to discuss their experiences. Other studies on experienced clinicians have suggested that this reluctance may be due in part to factors identified in the literature review such as fear of stigma or personal shame (Benatar, 2010). As a result, those who chose to participate may not be an accurate representation of all experienced clinicians in this population.

Lastly, the use of theory to frame the study influenced the questions designed for the interview, the wording of those questions, and the delivery of the questions. Further, since it is not possible to bracket one's assumptions entirely, the information received is coloured by the researchers' implicit biases. In this study, the findings could be subject to other understandings and interpretations, in particular the choice to examine these women's experiences from a strength-based perspective may have neglected some of the more troublesome or symptomatic aspects of their functioning. A deficit-based model may paint a very different picture of these women's lives.

Strengths

One of the strengths of this research lies in its unique Canadian perspective. A careful review of the literature found a paucity of published research on experienced clinicians. This study is relevant for Canadians in lieu of the changes in legislation that are in progress within the counselling profession. As the Canadian Counselling and Psychotherapy Association (CCPA) moves towards increasing professionalization with the creation of the new College of Counsellors and Psychotherapists, research that gives voice to the service providers of the profession is important. It is imperative that we do not lose the human quality that makes counselling unique amongst the human sciences. A second strength lies in the method of inquiry, by choosing a qualitative approach to this

research; I was able to obtain rich information that was not subject to the restriction of asking clients to fit their experience into a set of pre-described statements. Additionally, this method allowed participants to provide additional information that might not have been foreseen by the interviewer. Another strength of this study is the transparency with which it was undertaken. Research that is honest about perspective and reflects researcher self-awareness balances studies that focus solely on obtaining quantifiable results.

This study has drawn attention to the need to prepare counsellors who possess not just the technical skills necessary to do the work of counselling, but the intrapersonal skills as well. This study has shown that even in the face of high levels of distress and suffering the women in this study have the ability to self-regulate. Their self-awareness is the key to their ability to navigate their professional lives with integrity. Evaluation that considers the experience of distress, as a sign of impairment would exclude many highly gifted counsellors. An important question to consider is this: At what point does distress lead to impairment in clinical practice? In this study, the inclusion of a participant who did not experience long-term success as a counsellor also provides a valuable perspective.

The decision to approach this research with a strength-based perspective brings a significant contribution to the counselling literature. Much counselling research on experienced persons has focused on identifying deficits or areas where change is needed. Harvey (2007) reflects on the vast majority of individuals who experience trauma and recover without ever seeking professional help. Similarly, the vast majority of experienced clinicians do not report distress or impairment in their counselling ability

(Elliott, & Guy, 1993). The successes of experienced clinicians provide valuable information for counselling practioners. Lastly, this study has succeeded in creating the impetus for numerous future research undertakings discussed in the following section.

Future Research

One consideration for future research would be replication of this study with a larger more diverse sample. The inclusion of a sample that is diverse in terms of ethnicity, gender, and educational background would increase the transferability of the results. Studies that examine any of the themes found in this study in greater depth will help to expand understanding of experienced clinicians. Another direction for future research can be to explore this topic with a sample of only male clinicians. RCT has been considered a theory that is primarily aimed at the psychology of women. Jordan (2010), however, has suggested that RCT's applicability extends to men. We need more research to determine if this is indeed the case.

The role of anger in resiliency proved significant in this current study. Future research might consider anger more closely. Specifically, a study that examines women's anger in response to childhood abuse is warranted. As we know there are gendered expectations for the expression of anger; do these expectations play a role in women's recovery from abuse?

In response to the increasing professionalization of the Canadian counselling field, research that considers counsellor education is greatly needed, specifically research that examines the entrance protocols of counsellor education programs. Coady and Wolligan (1997) have suggested that entrance examiners 'look for the client within the student'. Future research may want to determine if this can be determined in a systematic

way. More precisely, how might educators be able to assess a graduate applicants readiness to engage in the process of self-reflection? Further, if readiness can be determined and self-awareness is a skill that can be quantified and successfully taught to students, how might graduate programs go about providing an environment in which self-exploration can take place?

Another direction for future research is to develop additional methods of evaluation of counsellor education programs. Are there ways to ensure that programs, are not only, ensuring that their student clinicians are academically prepared for the work of counselling, but are psychologically prepared as well? Another important consideration is the acceptance protocol itself. Is there stigma or discriminatory attitudes imbedded in the selection of future graduate students?

An interesting question for further research relates to the orientation of the program from which an experienced clinician graduates. As noted, the participants in this study all graduated from programs that identify as having a feminist and social justice perspective. The question for researchers then is whether these women's views of their recovery would be different had they been exposed to different models of healing. Are experienced clinician's recovery trajectories influenced by the literature and by the theoretical orientation of an educational program?

Implications for Practice

A Note to Counsellor Educators

This present study, like its predecessors, urges graduate programs to consider specialized training in trauma essential to the curriculum for counsellor education (Courtois, & Gold, 2009). Studies in vicarious trauma have found that education on trauma plays a vital role in helping clinicians identify their levels of vicarious trauma (Courtois, & Gold, 2009). Additionally, education on mental illness in general has been found an effective way to help combat stigma (Bryne, 2001). It is reasonable to anticipate that education on trauma will have similar rewards.

Counsellor educators are advised to consider the unique needs of the experienced student counsellor. In their role as educators, they are responsible for creating an environment that is safe and welcoming to the experience of diverse populations. The attitude and education of counsellor educators can effectively communicate to the experienced student whether their history is welcome in their program. It is imperative that educators recognise that while counsellor education is an increasingly competitive academic program they do not forget that a student counsellor's greatest tool is their 'self"; if experienced students are covertly asked to hide parts of themselves, then the profession as a whole suffers. Educators need to communicate that they are accepting the whole person into the program. Silence on important issues like violence and trauma communicates that there is something shameful about these experiences (Herman, 1992).

Counsellor educators need to be prepared to address topics such as learning to establish safety and making decisions about self-disclosure to faculty, peers and in supervisory relationships. Additional topics to discuss are professional issues such as

countertransference and boundaries in order to (a) normalize the issues, and (b) provide guidance on how to utilize them in the service of the work and in their own healing. I am not suggesting that counsellor educators take the time to discuss every issue that might arise for experienced clinicians explicitly in the classroom, but by creating an atmosphere of safety and transparency, experienced students are given the space to ask for their needs. Another consideration for counsellor educators is to encourage students to engage in a process of self-examination, and challenge them to consider their motivations for pursuing a career in counselling, so that they might be more aware as to some of the needs they may be trying to meet through their relationships with clients.

A final consideration for counsellor educators is to consider the perspective of the program itself. Judith Jordan suggests "we need to offer models of courage that emphasize our ongoing need for connection and encouragement. Similarly, we need to challenge the construction that suggests desire for connection and need of others is the territory of weak and emotionally immature women" (Jordan, 2010, p.212). Models that attend to the use of language, and consider the impact of social pressure may not only be empowering to the client but to the counsellors themselves.

A Note to Students and Young Clinicians

Perhaps the most salient piece of advice for experienced student clinicians is the recommendation to do the work of recovery. Further, experienced student clinicians should understand that recovery is an ongoing process. The claim of being recovered is generally an idle one; the experience of trauma continues to exert influence throughout the lifespan. Equally important is that experienced student clinician's understand that the influence exerted by their traumatic experience is not necessarily a negative one. That

the experience of trauma can be both, a source of incredible strength and wisdom, as well as a source of struggle and pain. Students are encouraged to identify their resiliencies and gifts and to honour their valuable perspectives. The strengths borne of struggle through adversity are many.

Experienced student clinicians are encouraged to, if they have not already, move into healthy connection with their peers, supervisors and colleagues. Healthy connection helps to foster a sense of belonging and creates support. If isolation is the enemy of healing, than connection is its greatest ally. In tandem with moving into connection is developing an awareness, in experienced students, that they not are alone in their graduate programs or work places. If the statistics on prevalence of child abuse, and traumatic experience amongst clinicians are accurate, then experienced students can anticipate that, they are surrounded by others who share their history. With this comes an acknowledgment of everyone's woundedness. Since relational trauma occurs on a continuum (DeYoung, 2003), it behoves the experienced student to recognise the many forms that relational trauma may take. Lastly, I would encourage experienced students to consider conducting research in the area of relational trauma and recovery. Advocacy through research, social justice endeavours, and client education are some of the ways that a world without childhood abuse might be realised. I leave you with one of the women's recommendations for young counsellors:

> One of the things that I really believe we need to focus on as therapists is connectedness with women and helping young women to know how important that (connection with other women) is. Men will come and go, but those relationships, those are key (...) so many of the women that I work with are so

isolated and they don't have female friendships and crave them, they don't even necessarily know that that's what they crave, but they are so lonely and so isolated.

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Appendices

Appendix A: Email Invitation to Participate

My name is Felicia Epp, and I am a Masters candidate at the Faculty of Education at The University of Western Ontario. I am conducting research into the lived experience of counsellors who are also survivors of childhood abuse and would like to invite you to participate in this study. In order to participate you must identify yourself as a survivor of childhood abuse and consider yourself emotionally and psychologically prepared to discuss your history. Additionally you must be engaged in providing counselling services.

If you agree to participate in this study you will be asked to participate in a 60-90 minute audio recorded interview. The interview will consist of a series of semi-structured open-ended questions asking you about your experience of recovery from childhood abuse, your strengths, the challenges you face and how these influence your counselling ability. You will also be asked to provide some demographic information. In order to ensure that I am representing the participant's information fairly and accurately, I am inviting potential participants to be re-contacted for a brief follow-up 'member check'. There is no obligation to participate in this portion of the study.

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time for any reason without question.

The information collected will be used for research purposes only. All information collected for the study will be kept confidential, however the law states that I must report to Children's aid if you indicate that a child has been harmed or is unsafe.

If you are interested in participating, or if you have any questions regarding this study or would like additional information you may contact me (Felicia Epp) at or my research supervisor Dr. Susan Rodger at

Sincerely,

Felicia Star Epp

Appendix B: Letter of Information

Experienced Clinicians:
Trauma Recovery and the Healer

LETTER OF INFORMATION

Introduction
My name is Felicia Epp, and I am a Masters candidate at the Faculty of Education at The University of Western Ontario. I am currently conducting research into the lived experience of counsellors who are also survivors of childhood abuse and would like to invite you to participate in this study.

Purpose of the study
The aim of the study is to describe the experience of graduates of a master's level counselling psychology program at a Canadian university, with personal experience of childhood abuse and recovery, to better understand their experience of recovery and resilience and the influence of that experience with violence on their professional life.

If you agree to participate
You will participate in a 60-90 minute audio-recorded interview with me (Felicia Epp). The interview will take place in-person at a location of your preference or at the university in a private room, or via telephone if you are living outside of the immediate London area. The interview will consist of a series of semi-structured open-ended questions that ask you about your experience of recovery from childhood abuse, your strengths, the challenges you face and how these influence your counselling. You will also be asked to provide me with some basic demographic information such as your gender, your years in the counselling field and the population with whom you work. In order to participate, you must identify yourself as a survivor of childhood abuse and consider yourself emotionally and psychologically prepared to discuss your history. Additionally you must be engaged in providing counselling services.

Voluntary Participation
Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time for any reason without question.

Member Checks

In order to ensure that I am representing the participant's information fairly and accurately I am inviting potential participants to agree to be re-contacted for a brief follow-up. There is no obligation to participate in this portion of the study.

Confidentiality

The information collected will be used for research purposes only, and neither your name nor information, which could identify you, will be used in any publication or presentation of the study results. All information collected for the study will be kept confidential, however the law states that I must report to Children's Aid if you indicate that a child has been harmed or is unsafe. Your information will be seen by my supervisor (Dr. Susan Rodger) and me (Felicia Epp). No other person will have access to your personal information. Additionally you will be asked to create your own pseudonym to use throughout the study. Following the analysis of the data, any information linking the pseudonyms with the your identifying information will be destroyed. Any verbatim quotes used in the final paper will be altered to disguise identifying information. All confidential material will be encrypted and stored by the researcher in a secure location, a locked cabinet for hard data, and password-protected file for soft data for a period of 5 years, at which time all material will be destroyed.

Risks & Benefits

No harm to you because of participating in this study is anticipated. However, some of the topics may be distressing, which is an unavoidable risk in any study that deals with childhood abuse. To minimize this only those participants who feel they have the emotional and psychological safety to discuss these topics will be invited to participate; additionally access to supervision or, counselling resources is a requirement for participation. By participating in this study you will have the opportunity to share your story of recovery and by doing so may contribute to the body of research on recovery from childhood abuse.

Questions

If you have any questions about the conduct of this study or your rights as a research participant, you may contact the Manager, Office of Research Ethics, The University of Western Ontario at 519-661-3036 or ethics@uwo.ca. If you have any questions about this study, please contact Felicia Epp, ,
or my research supervisor Dr. Susan Rodger, .
This letter is yours to keep for future reference.

Sincerely,

Felicia Star Epp

Appendix C: Consent Form

CONSENT FORM

I have read the Letter of Information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

Name (please print): _____

Signature: _____

Date: _____
(D/M/Y)

Name of Person Obtaining Informed Consent: _____

Signature of Person Obtaining Informed Consent: _____

Date: _____
(D/M/Y)

Appendix D: Telephone Screening Script

Hello ---

I want to thank you for expressing interest in being a participant in my research study

The purpose of today's call is to determine whether you meet the requirements of this study.

I am going to ask you a few questions, please answer them honestly and to the best of your knowledge.

1. Are you currently employed as a counsellor/clinician providing counselling/psychotherapy services?

2. Do you consider yourself an experienced person/clinician – that is do you identify as an adult survivor of childhood abuse – please note that I do not need to know that nature of your abuse unless you believe it is relevant, what matters is that you believe that you were abused as a child?

3. Do you consider yourself emotionally and psychologically prepared to answer questions about your recovery and the challenges you faced as a child, young adult and professional?

4. Do you have an established relationship with a supervisor or personal counsellor with whom you could go to for support if you experience a distressing emotional reaction because of participating in this study?

If no to any of questions 1-4

I thank you very much for your time; it is my ethical responsibility to decline you as a participant at this time. My first priority is to the participants of this research project and their safety, and so we need all participants to have the resources in place to support them. The second priority is for the requirements of my research, and so we need to ensure that all participants share these particular life and work experiences, in order to have consistency in the data. I very much appreciate your interest in my study. If you have any questions as to why you are unable to participate please feel free to contact the Office of Research Ethics, The University of Western Ontario at 519-661-3036 or ethics@uwo.ca or my research supervisor Dr. Susan Rodger,

If yes to questions 1-4

I am happy to include you as a participant in this study. At this time, I would like to schedule an interview. This can take place in person, at a location of your

preference, I can offer a private room on the university campus, or if it is more convenient, it can take place by telephone. The interview will take approximately 60-90 minutes of your time. Thank-you again, and I look forward to speaking with you.

Appendix E: Telephone Interview Script

Hi -----

I want to thank you for taking the time to speak with me today.
Our conversation today is going to be audio recorded. This is being done so that I can focus on what is being said without having to take notes; the tape will be used for the purpose of transcription and will be heard only by me. I will be the person who transcribes the interview, once the transcription is complete the audio recording will be destroyed and the transcribed interview will be stripped of indentifying information in order to preserve your confidentiality.

Do you agree to have this conversation audio-recorded? (If yes proceed, if no terminate the interview)

Before we begin, do you have any questions for me about this study that you would like answered before we begin?

I have a series of questions for you, feel free to answer them any way you like, the questions are not designed to have a specific answer and in many ways are just jumping off points for you to share your story with me.

If at any point in time you feel that you are becoming distressed or affected by our conversation, please let me know, we can take a break, change topics, reschedule, or you can discontinue the interview with no questions or consequences.

So if you are ready I would like to begin ---

Interview questions (appendix f)

I want to thank you again for sharing your story with me, I am honoured that you would be willing to speak with my today.

We have talked about some really important and emotional things today and I just want to check in and see how you are feeling.

Would you be interested in receiving any resources that might be of support to you? If in the days following this interview if you find yourself having any reactions, for example difficulty sleeping, recurrent thoughts or changes in mood please contact your supervisor or counsellor for support, also you may contact me or my supervisor for any reason.

Do you have any additional questions, or information's you wish to share that you not get an opportunity to share earlier?

You indicated before that you would be willing to be re-contacted for member checks. This would be an informal conversation just for me to tell you how I interpreted something you have said and giving you the opportunity to let me know if you agree. I also may contact you to clarify something you have said. Are you still comfortable participating in this?

Thank you again and we may be in touch.

Appendix F: Interview Questions

Demographic info

Gender
Years in practice
Client population (specialty)
Pseudonym you would like me to use for you in my notes and write-up (all of your data will be stored under this name)

Interview Questions

1. Did you experience isolation as a child?
2. How did you cope with the isolation?
   probes – overachievement, daydreaming, art, trying to be liked etc.
3. Have you had difficulty connecting with others?
   probes – personality factors, being shy, withdrawing, being irritable or fearful etc.
4. How do you believe you were able to overcome your abuse?
   probes – formal therapy, friends, family, education etc.
5. How does the concept of resilience apply to you? Have you always seen yourself as resilient, or did it develop?
6. How did you develop your resiliency or ability to cope and function? (Factors like Intelligence, creativity, spirituality or other attributes?) (Bryant, 2006)
   probes - Resilience can be summarized as the continuum of flexible and dynamic personal strengths, relationships and opportunities. These offer the survivor protection, challenge and opportunity for growth, which then allow for the successful negotiation of trauma.
7. What would you describe as the most significant part of your healing?
   probes – personal therapy, achievement, parenthood, etc.
8. What are some of the barriers/challenges you encountered throughout your recovery?
   probes – Depression, anxiety, educational/vocational disruption, family breakups, diagnosis, medication
9. Tell me about your relationships over the years; do some of them stand out for you? Can your describe what was unique about that relationship?
   probes – describe more than one relationship (intimate partner, parent, friend, child) what did that relationship offer to you, how did you grow – what did you offer to them.
10. Have you ever felt stigmatized, or made to feel ashamed, because of your past?
    probes – from friends, family, mental heath system, literature, policy's, education, places of employment.
11. If so, how have you dealt with it?
12. What motivates you to help others?
13. Tell me about your assets

14. Do you think that your past experiences have had an affect, if any, on your counselling ability? (Bryant, 2006).
15. Do you think that you have increased empathy for those who suffer, because you also have suffered? (Bryant, 2006).
    probes –did you always see yourself as empathic?
16. What (additional) therapeutic traits do you think that you developed, if any, because of your background or early woundedness? (Bryant, 2006).
17. Can you describe some of the challenges you face in your professional life?
    probes - (countertransference, boundary negotiation, burnout or vicarious traumatization).
18. What has been your experience with disclosure, to colleagues, supervisors and/or clients?
19. Do you ever feel isolated in your professional life because of your experience?
    probes - do you ever feel disconnected from your colleagues, from your clients?
20. How do you stay connected to yourself, your clients, your colleagues and supervisors?

Appendix G: Ethics Approval Notice

Office of Research Ethics
The University of Western Ontario
Room 4180 Support Services Building, London, ON, Canada N6A 5C1
Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca
Website: www.uwo.ca/research/ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. S. Rodger
Review Number: 17220S
Review Date: September 30, 2010
Revision Number: 1
Approved Local # of Participants: 15
Review Level: Expedited

Protocol Title: Experienced Clinicians: Trauma Recovery and the Healer
Department and Institution: Faculty of Education, University of Western Ontario
Sponsor:
Ethics Approval Date: September 30, 2010 **Expiry Date:** May 31, 2011
Documents Reviewed and Approved: Revised participant recruitment and eligibility of subjects. Letter of Information and Consent, Email Invitation to Participate, Telephone Script, Poster.

Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Non-Medical Research Involving Human Subjects (NMREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the applicable laws and regulations of Ontario has granted approval to the above referenced revision(s) or amendment(s) on the approval date noted above.

This approval shall remain valid until the expiry date noted above assuming timely and acceptable responses to the NMREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the study or consent form may be initiated without prior written approval from the NMREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the NMREB:

a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) all adverse and unexpected experiences or events that are both serious and unexpected;
c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the NMREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the NMREB.

Chair of NMREB: Dr. Riley Hinson
FDA Reg. #: IRB 00000941

Ethics Officer to Contact for Further Information			
☑ Grace Kelly (grace.kelly@uwo.ca)	☐ Janice Sutherland (jsutherl@uwo.ca)	☐ Elizabeth Wambolt (ewambolt@uwo.ca)	☐ Denise Grafton (dgrafton@uwo.ca)

This is an official document. Please retain the original in your files.

cc: ORE File