Therapists' construction of their clients' trauma-related intrusive memories in the context of client distress

A Grounded Theory Analysis

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INTRODUCTION TO PORTFOLIO

This portfolio comprises three pieces of work that bring together three aspects of my training in counselling psychology. Firstly, it presents an original grounded theory research study, which explores how therapists construct and make sense of their clients' intrusive trauma memories in the context of the clients' psychological distress. Nine psychologists were recruited for this study for face-to-face semi-structured interviews, where the research questions were explored from their perspectives. In line with the demands of the adopted method of analysis, the direction and focus of the research was largely driven by the participants. Curiosity and openness were important components to the study in my attempts to respect the participants' subjective experiences and meanings. The second piece of the portfolio is a publishable paper that succinctly reports the findings of the original research study. The final piece of the portfolio is a client case study and process report that is based on my therapeutic work with a female client, which critically explores unhealthy dependency and its role in the client's anxiety problems. As with the research, I attempted to experience parts of my client's world as she sees it by listening and engaging with her perspectives.

These three pieces fit together as a collective body of work through a theme of meaning making that was important in my therapeutic journey with the case study client, whilst also being critical with regard to my use of constructivist grounded theory for the research study. Meaning making refers to the process that an individual uses to construe, understand and make sense of the self, life events, and relationships, with these retaining, reaffirming, modifying or replacing fundamentals of their orienting structure to develop more nuanced,

complex and functional systems. The theme represents an endeavour that I see as a quality

embedded in counselling psychology (Basseches, 1997). The theme of meaning making also

runs through the therapeutic work I presented in the client case study and process report,

which I present as an embodiment of my use of Cognitive Behavioural Therapy (CBT) for the

treatment of a female client whose dependency tendencies are evident in her relationship

with her parents, in therapy, with the MDT and the service. Although I did not originally intend

to compile work around this theme, I have come to recognise that my personal and

professional interests in this subject area drew me in this direction to understand how

individuals make sense of their trauma-related intrusive memories.

The meaning making was inherent in my use of CBT with this client as we attempted to

collaboratively make sense of how her childhood experiences of being "smothered" by her

parents may have contributed to her developing a mental representation of herself as

vulnerable and ineffectual, contributing to her dependency traits as she looks to others for

nurturance, reassurance and support (Bornstein, 2005). This CBT collaborative approach works

in tandem with the social constructivist approach to analysis that was adopted for this doctoral

research study as I acknowledge that data and analysis are created by a collaborative process

between the researcher and the participant (Charmaz, 2006). It is hoped that this approach

will contribute to greater depth, meaning and understanding of how therapists construct and

make sense of their clients' intrusive trauma memories in the context of the clients'

psychological distress. This notion of meaning making goes hand in hand with the

understanding in Charmaz's constructivist grounded theory, which "assumes the relativism of

multiple social realities, recognises the mutual creation of knowledge by the viewer and

viewed, and aims towards an interpretive understanding of subject's meaning" (Charmaz, 2003, p. 250).

The epistemological standpoint of constructivist grounded theory acknowledges that reality is constructed by the individuals as they assign meanings to the world around them (Appleton & King, 2002). From this perspective it is thought that meaning does not lie dormant within objects waiting to be discovered but is created as individuals interact with and interpret these objects. Similarly, in using CBT to formulate the client's difficulties, it was proposed that the anxiety she experiences when she has to manage tasks independently is a result of maladaptive interpretation of stressful events or objects. This interpretation is personal to the client, in that another individual may perceive it differently. Moreover, I have come to discover that ambiguity and multiplicity are at the heart of counselling psychology (Goldstein., 2010), with the discipline accommodating "plurality of viewpoints, multitude of possibilities and infinite variety of potential truths" (Kasket, 2012, p. 65). The notion of multiple realities in meaning making was eloquently captured by educational critics Neil Postman and Charles Weingartner in the chapter titled "Meaning making" of their 1969 book *Teaching As A Subversive Activity*:

> …we prefer the metaphor "meaning making" to most of the metaphors of the mind
> that are operative in the schools. It is, to begin with, much less static than the others. It
> stresses a process view of minding, including the fact that "minding" is undergoing
> constant change. "Meaning making" also forces us to focus on the individuality and the
> uniqueness of the meaning *maker* (the *minder*). In most of the other metaphors there

is an assumption of "sameness"...The "garden" to be cultivated, the darkness to be lighted, the foundation to be built upon, the clay to be moulded - there is always the implication that all learning will occur in the same way. The flowers will be the same colour, the light will reveal the same room, the clay will take the same shape, and so on...such metaphors imply boundaries, a limit to learning...What happens to the learner after his mind has been moulded? How large can a building be, even if constructed on a solid foundation? The "meaning maker" has no such limitation...He continues to create new meanings...

Moreover, considering several psychological difficulties are often precipitated by a traumatic or stressful event, there are arguments that meaning making in the context of such situations can represent a central aspect of coping and adjustment (Park, Riley & Snyder, 2012; Steger & Park, 2012). From a meaning making standpoint, challenges surface if the reality of the traumatic event cannot be adaptively assimilated into global meaning and the individual is unable to accommodate aspects of their global system to situationally construct meaning out of the experience (Holland et al., 2015). These violations of meanings can contribute to psychological distress and lead to strained efforts to reconcile one's appraisal of the trauma and the global meaning. The client case study and process report employs a CBT approach that encompasses an attempt to make sense of significant trauma events, challenge and modify maladaptive meaning structures, such as core beliefs, so helping the client to develop alternate ways of constructing meaning and generalising the skills to multiple contexts and situations. This therefore broadens the worldviews of the person and enables them to regain a sense of purpose and direction in life.

My motivations for focusing on the topic of trauma-related intrusive memories are diverse, but I became interested whilst working within an NHS specialist substance misuse service where I had the opportunity to provide therapy to clients who were mostly affected by childhood traumatic experiences that had become representations of their views of themselves, others and the world. This notion was reinforced by Young, Klosko, & Weishaar (2003) who proposed that early childhood experiences often shape our perception of reality, and although whilst functional at some point they may become maladaptive overtime. I found that some of the clients I worked with reported intrusive memories of trauma, which tended to contribute to their psychological distress and subsequent substance misuse. My desire to make sense of how therapists construct their clients' experience of trauma-related intrusive memories is underpinned by my work in the service. Following that, I went on to work in an NHS inpatient mental health service where I provided psychological therapy to complex clients who presented with severe and enduring psychological difficulties. I discovered that most of these clients reported having experienced early trauma. In view of this, an understanding of how therapists construct and make sense of their clients' intrusive trauma memories in the context of the clients' psychological distress became the focus of inquiry for the research.

Although the portfolio has been arranged around the theme of meaning making, there are a number of broad themes woven throughout including the connection between myself as the researcher and the participants, as well as the connection between myself as the therapist and the client I presented in the client case study. The concept of connection refers to the quality of the observable client-therapist relationship, considered to be "a measure of intimacy and

mutuality between client and therapist... the existence of a trust that permits the open sharing of emotionally laden material, seemingly without undue concern for negative responses from the therapist" (Sexton et al., 2005, P. 104). I was curious about answers to many questions such as: What is the implication of connection in trauma work? Does it strengthen the therapeutic work or does it pose a hindrance? How are trauma clients perceived within the mental health system and what are the impacts of this perception? How do trauma clients survive within a mental system? Mistrust of and dependency on mental health services was evident in my therapeutic work with the client I presented in my client case study and process report. Simultaneously, the process by which clients navigate the creation of trusting relationships in the context of severe mistrust of the service was also a reoccurring theme in the presented research study, in that it plays a significant role in their experience, recovery and perhaps ability to make sense of their experiences.

I have found the therapeutic work with my clients to be very enriching and rewarding, and moreover, I consider it to be a great privilege to be let into the lives of others and hope I can continue to nurture these relationships. This notion was often reported by the psychologists who participated in the research study. I hope that this portfolio may demonstrate that although trauma work can be very difficult, especially with the challenges and limitations of working for an organisation under severe pressure, it is still possible to find it rewarding and invigorating in view of its potential to provide opportunities for self-discovery, understanding, and personal and professional growth. I hope the readers will find the portfolio enlightening, encouraging, and relatable to their own practice as well as discover something rewarding.

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Section A: Doctoral Research Study

Therapists' construction of their clients' trauma-related intrusive memories in the context of client distress

A Grounded Theory Analysis

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Supervised by: Dr Renata Pires-Yfantouda

ABSTRACT

Quantitative research has shown that individuals who report intrusive memories of traumatic events often experience psychological distress. There is a need for qualitatively focused research, which would allow for an understanding of how therapists construct and make sense of their clients' intrusive trauma memories in the context of the clients' psychological distress. The research involved face to face semi-structured interview with nine qualified psychologists about their experience of working with trauma clients. The data were analysed using constructivist grounded theory (Charmaz, 2006). The research study facilitated nuanced understanding of clients' trauma memories from the perspective of therapists. It explored the process of the therapists looking within to make sense of the impact of their clients' trauma experiences on them. It also allowed the researcher to examine how the therapist changes as a result of their engagement with trauma clients. Grounded theory analysis demonstrated that therapists constructed some important categories. These include; trauma memories as threat to sense of self, appraisal processes of trauma memories, discovering survival strategies, therapists' process in therapy with clients, therapists changing and reflecting as a result of trauma work and therapist discovering coping strategies. The findings indicate that trauma work also brings some rewards and privileges in the form of strength, growth, and empowerment. The research findings have important implications for policy and practice, service quality, and the well-being of therapists and their clients.

CHAPTER 1: INTRODUCTION

1.1 Overview

This chapter provides an account of the current understanding around intrusive memories, which is followed by a critical literature review of studies that have investigated the association between intrusive memories and a range of psychopathologies. It will present both quantitative and qualitative research. The review will also give an account of current literature around the impact of trauma work on therapists. The chapter contextualises and communicates the rationale for this study on the relationship between trauma-related intrusive memories and psychological distress. It will explore its relevance to counselling psychology and my personal relationship to the topic.

1.2 Introducing trauma-related intrusive memories and psychopathology

Hallmark symptoms of post-traumatic stress disorder (PTSD) are intrusive thoughts and images of a traumatic event or occurrence (Brewin & Holmes, 2003). Intrusive memories of traumatic events are included in one of the four major symptom clusters for DSM-5 diagnosis of Post-traumatic Stress Disorder (PTSD; American Psychiatric Association [APA], 2013). The field of trauma studies is predominantly dominated by the influence of the diagnostic category for PTSD; an ideology of illness which views the therapist as the expert on the trauma client, rather than the client being the expert on themselves(Murphy & Joseph 2014) . Consequently, this ideology determines a specific therapist-client style of interaction that rules out other forms of psychotherapeutic interactions. There has been a recent shift in the field, with the introduction of person-centred and positive psychology perspective to trauma. These

approaches hold the therapeutic relationship as critical, understandably if we consider trauma

as experiences that shatter our sense of self and assumptions of the world, it becomes clear

the important role therapeutic relationship will play in rebuilding it (Murphy & Joseph 2014).

Some of these approaches will be explored in section 1.3.4.

Trauma-related intrusive memories have been shown to be relatively common in everyday life

(Mace, 2005) and present in several psychological disorders, including depression (Birrer,

Michael, & Munsch, 2007; Kuyken & Brewin, 1999; Reynolds & Brewin, 1999), psychosis

(Morrison et al., 2002; Steel, Fowler, & Holmes, 2005), and anxiety (Day, Holmes, & Hackmann,

2004; Hackmann, Clark, & McManus, 2000). More specifically, Reynolds and Brewin (1999)

found that intrusive memories were highly distressing, were accompanied by physical

sensations and would often last for a period of minutes. The trauma memories were

associated with a variety of distressing emotions, including hopelessness, fear, anger, sadness

and guilt. The presence of intrusive memories has been shown in studies employing non-

clinical samples (Coryell, Endicott, & Keller, 1991, 1992). There is limited qualitative research

that has explored the experience of intrusive trauma memories and psychological distress.

Therefore, studies that allow an in-depth and idiographic understanding of the presence of

intrusive memories in psychological distress may provide a significant contribution to the field

of psychology. This literature review will consider and appraise theories and research into

trauma-related intrusive memories and psychological well-being, whilst exploring its

association with a number of psychological disorders.

1.3 Literature review

1.3.1 Rationale for the review

The literature review aims to examine the current state of understanding of the phenomenology of trauma-related intrusive memories particularly in their association with psychological distress. Academics have long considered the importance of imagery within psychopathology in understanding emotional distress (Beck, 1970; Lang, 1977). Intrusive memories are defined as involuntary recollections relating to events that appear spontaneously in consciousness (e.g. Brewin & Saunders, 2001; Holmes, Brewin & Hennessy, 2004). Intrusions can take the form of sensory mental images or verbal thoughts. Psychological distress is a state of emotional suffering characterised by symptoms of depression such as loss of interest, sadness, hopelessness and symptoms of anxiety which includes restlessness and feeling tense (Mirowsky & Ross, 2002).

Tenets of the stress-distress model posit that the defining features of psychological distress are the exposure to stressful events that threaten physical or mental health, the inability to cope effectively with these stressors, and the emotional turmoil that results from this ineffective coping (Horwitz, 2007; Ridner 2004). For the purpose of this literature review, psychological distress is used to describe a range of symptoms that are commonly held to be troubling, and is inclusive of conditions such as anxiety, depression, PTSD and psychosis. Whilst several approaches perceive psychological distress as something troubling, humanistic approaches have conceptualised it as important emotional states supporting and motivating the processing of trauma-related experiences (Tedeschi & Calhoun, 2004). The review will examine the current understanding of trauma-related intrusive memories, by considering different

theoretical approaches including humanistic, cognitive and psycho-analytical approaches to understanding trauma-related intrusive memories.

The literature review will also examine some of the previous quantitative and qualitative studies that have investigated the presence of intrusive memories across the spectrum of aforementioned disorders, comparing and contrasting the characteristics and functions of intrusive imagery, and the aetiology and maintenance of the psychopathologies. Finally, the review will examine the current understanding of the impact of clients' trauma experiences on the therapist. Working in the field of psychology can be exhausting, with therapists who specialise in trauma work developing 'burnout', a phenomenon that comprises vicarious traumatisation, secondary stress, and compassion fatigue (Katsounari, 2015). This review will examine literature on the effect of trauma work on therapists, hence, informing the research community about therapists' experiences of their clients' trauma.

1.3.2 Scope of the review

This literature review seeks to explore the following questions:

1. According to previous research, what is the relationship between trauma-related intrusive memories and psychological distress? It will explore psychological distress across the spectrum of PTSD, depression, anxiety disorders, and psychosis.

2. According to research, what is the impact of trauma work on the therapists? This will explore its impact in the form of vicarious traumatisation.

In order to find journal articles and up to date information on the research topic, the following data bases were used; PsycARTICLES, PsycINFO, Web of Science and Scopus.

The research area was investigated by using various search combinations of the following terms and phrases:

"intrusions" "intrusive memories" "intrusive trauma memories" "trauma-related intrusive memories" "trauma memories" "psychological distress" "post-traumatic distress" post-traumatic stress" "psychological well-being" "psychological disorders" "intrusive memories and PTSD" "intrusive memories and depression" "intrusive memories and anxiety" "intrusive memories and psychosis" "therapist traumatisation" "vicarious traumatisation" "vicarious trauma" "secondary trauma stress" "secondary traumatic stress" "post-traumatic growth" "post-trauma growth" "vicarious post-traumatic growth" "vicarious post-trauma growth" "psychological growth" "growth paradigm".

The keywords and phrases were largely chosen because they appeared to be most relevant to the research topic. The review focused on papers and books published between 1994 and 2017.

1.3.3 Psychological models of trauma

A variety of theories have been proposed to explain the development of trauma-related intrusive memories, which has been shown to be present in a number of psychopathologies

such as PTSD, anxiety disorder and depression. The section will review psychological theories

that have been influential in the understanding of trauma, including cognitive theory and

humanistic approaches. I will also draw on earlier work particularly the psycho-analytic theory

around repetition compulsion that is evident in trauma experiences.

1.3.3.1 Cognitive approach to trauma

One of the major cognitive theories of trauma stress is the dual representation theory of PTSD

introduced by Brewin, Dalgleish & Joseph (1996) that proposed that traumas experienced after

early childhood results in two types of memory. One is verbally accessible memories (VAMs)

that are easily verbally recalled and may give rise to emotions related to the traumatic event

such as recurring distressing recollection of the event. The second one was labelled

situationally accessible memories (SAMs) that cannot be deliberately accessed; it is assumed

that these memories remain unconscious until triggered by a cue, causing symptoms such as

dreams and flashbacks that recreate the emotions present at the time of the trauma along

with its original intensity. It is argued that successful emotional processing of the trauma is a

largely conscious process that depends on exposure to SAMs to enable cognitive readjustment

by providing accurate sensory and physiological information about the trauma event, and

conscious effort to integrate the conflicting trauma-related information with pre-existing

schemas about the world. They proposed that there are three potential outcomes of

emotional processing, which includes the desired integration, the pathological chronic

emotional processing and premature inhibition of processing.

Ehlers & Clark (2000) built on the classical cognitive theory of anxiety to propose the notion

that it is not the trauma itself that causes psychological distress for the trauma survivor but

that the cognitive appraisals of what happened play a central role in the persistence of PTSD.

Ehlers & Clark (2000) demonstrated those trauma survivors who go on to suffer persistent

PTSD process the trauma in such a way that leads to a sense of current threat. It is argued that

this sense of threat is affected the individual's excessive negative appraisal of the trauma and

the consequence, which has a tendency to generate strong emotions such as shame, anxiety,

anger or guilt as well as physiological symptoms (Dunmore, Clark & Ehlers., 2001). These

appraisals can contribute to external threat, hence perceiving the world as dangerous

'Everyone is after me' 'Nowhere is safe'. It can also contribute to internal threat where they

perceive themselves as incapable or losing control 'I can't protect myself' 'I am going mad' 'It

was my fault'. They added that this is likely to result in misinterpretation of situations and

PTSD develops when the traumatic memory induces a sense of current threat which is

promoted by excessively negative appraisals of the traumatic event.

The trauma recalls become biased by these appraisals and requires attention for a successful

outcome. It was further suggested that certain stimuli may become strongly associated with

specific responses, causing the condition to be maintained if not addressed. Further, the

negative appraisals have being shown to motivate the individual to engage in maladaptive and

avoidant behaviours as a way of controlling the threat. Although, these behaviours may

present as helpful, they are likely to exacerbate the PTSD symptoms as the person is unable to

disconfirm the negative appraisals. For instance, some trauma survivors intentionally control

trauma-related intrusive memories; however, such suppression has been shown to have a

paradoxical effect of intensifying their intrusions (Davies & Clark, 1998; Williams & Moulds,

2007). Furthermore, cognitive theory of PTSD has demonstrated that the sense of current

threat can also depend on the nature of the trauma memory itself, in that PTSD has been

associated with traumatic memories that are not well integrated into existing autobiographical

memories (Brewin & Holmes, 2003). This may account for the difficulty some trauma survivors

have in intentionally recalling aspects of the memory, allowing trauma-related cues to trigger a

re-experiencing of the symptoms and strong emotions.

1.3.3.2 Psycho-analytic approach to trauma

Sigmund Freud drew attention to the repetition compulsion theory, which refers to the

tendency for a trauma survivor to repeat a traumatic event or its circumstances from the past

over and over again (van der kolk & Ducey, 1989). This process has been shown in form of

dreams in which memories and feelings associated with the past trauma are repeated. The

nature of the trauma response and information processing is believed to determine the

repetitive behaviour leading to 'traumatic re-enactment', that is the behavioural enactment

and automatic repetition of the past traumatic experience. The memories of the traumatic

experience are dissociated, unsymbolised and unintegrated, therefore placing the behaviour

out of the context of verbal and conscious control, resulting in a lack of awareness of how it

happened and how to prevent it next time. This theory proposes that there is a lack of control

over the repetition of trauma, coupled with an unconscious need to repeat the traumatic

scenario, hence the compulsion (Van der kolk, 1989). Freud described this notion succinctly

"He reproduces it not as a memory but as an action; he repeats it without, of course, knowing that he is repeating... he cannot escape from this compulsion to repeat" (Van der kolk & Ducey, 1989, p. 271). Under these circumstances, trauma survivors would usually attempt to arrive at an explanation for their behaviour as they struggle to make sense of it. They are likely to interpret it in an unhelpful way, causing them to helplessly re-expose themselves to further trauma. Freud proposed that in order for feelings to be experienced, it is important that words are represented with them, which allows the emotions to move away from their repressed state and become conscious, a role therapy may play (Sashin, 1993).

1.3.3.3 Humanistic approach to trauma

Within the humanistic approach, the adverse psychological reaction to trauma-related experiences has been subject to a few theoretical frameworks; notably, the person-centred approach to the processing of trauma-related information explored by Murphy & Joseph (2014). This practice is based on the non-directive approach introduced by Rogers (1951), an approach based on the idea that our unconditional positive regard and empathic understanding are embodied within and communicated through the expression of congruent empathic response to client's narrated experience (Grant, 2010). Moreover, the post-traumatic stress phenomena also fit within Rogers' (1959) person-centred personality theory. It is proposed that the incongruent trauma experience and self-structure may result in defences actively denying or distorting experiences , hence preventing the accurate process of symbolisation, which lead to a disorganisation of the self. Within the person-centred approach, it is argued that trauma clients are too often offered standardised therapy which

aims to reduce their symptoms, and with this ignoring the person and their perception of what has happened to them which brings them to therapy.

It is suggested that experience of psychological trauma is an indication that a disorganisation in the self-structure has taken place when the individual was exposed to the trauma. More so, it has provided new information about the self and the world that challenges existing expectations, which places the self-structure under a significant sense of threat (Joseph, 2003). Therefore, within person-centred approach the therapist is supposed to guide the trauma survivor to move towards greater congruence in order to regain sense of equilibrium. In person-centred therapy for trauma, it is proposed that the therapist must not be directive, instead to aim to create an environment that is conducive to growth, to experience unconditional positive regard which is communicated through empathic reflections that result from staying with the client's moment by moment experiencing (Murphy & Joseph, 2014). This is based on the notion that human beings have single motive of actualising tendency; it is assumed that under the right condition the individual is able to act in a socially constructed manner and towards post-traumatic growth. In order to be able to do this, it is important that the trauma survivors are able to develop and realise that they have sense of agency, which will help them to realise that although they cannot change the past, the future is within their grasp to be shaped (Joseph, 2011).   Murphy & Joseph (2014) reported that despite the distress experienced by their clients they find them to be resourceful, resilient and striving towards their way of being. The concept of post-traumatic growth is further explored in section 1.3.3.4.

Person-centred approach to post-traumatic growth requires the therapist to work at relational

depth, a notion introduced by Mearns & Cooper (2005). This process requires letting go of

anticipations, to be fully present and available in the therapeutic relationship, engaging in

deep listening, where the clients is permitted as much space as necessary. This involves

listening without the aim of interpreting, listening to the whole being of the trauma survivor

including the words, emotions and metaphors, which allows the development of empathy for

the client's traumatic experiencing, which may potentially result in post-traumatic growth

(Murphy & Joseph, 2013).

1.3.3.4 Post-traumatic growth

Previous research has shown evidence that trauma survivors report learning something

valuable about themselves in the aftermath of a traumatic event (Joseph & Butler, 2010).

Research has acknowledged this concept as post-traumatic growth, which arise through the

struggle and engagement with traumatic experience, where they attempt to make sense out of

them, trying to cope with negatively changed perception of the world (Joseph, 2004; Joseph &

Linley, 2006; Tedeschi & Calhoun, 2004). It has been suggested that this sense-making process

may be involuntary, where states of avoidance and intrusion alternate, often described as

post-traumatic stress (Joseph & Linley, 2006). The changes that people may experience

following trauma experience may consist of three dimensions (Tedeschi & Calhoun, 2004). The

first dimension comprises of report of enhancement in relationships, such as valuing their

family and friends more. The second dimension is in the development of improved views of

themselves, such as reporting greater sense of resiliency and strength. The third dimension

may be changes in personal philosophy, such as realising what really matters. Post-traumatic

growth outcomes have been reported in several traumatic experiences including

transportation accidents (plane crashes), natural disasters (earthquakes), interpersonal

experiences (sexual abuse, physical abuse), medical problems (cancer, heart attack) and in

other life experiences such as bereavement and relationship breakdown (Gibbons, Murphy, &

Joseph, 2011).

Joseph (2011) argued that the traumatic event cognitively initiates the development of post-

traumatic growth. Joseph et al (2012) added that that this process may become more

intentional, proposing that this growth is dependent on the openness to internal and external

experience. This notion is based on the theoretical approaches that have been developed to

understand post-traumatic growth, for instance the organismic valuing theory (Joseph &

Linley, 2005). This theory proposes that a trauma survivor is intrinsically motivated towards

accommodation of the new trauma-related information to increase psychological well-being.

This can be a new sense of mastery, where they feel able to take on new life challenges. This

notion is based on the person-centred approach which suggests that post-traumatic growth is

the normal response to successful working through of the traumatic experience. A meta

analytic review by Helgeson, Reynolds & Tomich (2006) concluded that instead of seeing

intrusive thoughts and avoidance that accompanies PTSD as indicative of poor mental well-

being, they propose that it is evidence that the trauma survivor is contemplating and

considering the implications of the trauma vent for their lives, something that may lead to

post-traumatic growth.

It has been suggested that person-centred therapy is an approach ideally placed to facilitate post-traumatic growth (Joseph & Murphy, 2012). As unconditional positive self-regard is an important component of the therapeutic model, Murphy, Demetriou & Joseph (2015) conducted a cross-sectional study to explore the association between the theoretical construct of unconditional positive self-regard and the phenomenon of post-traumatic growth. They found that unconditional positive self-regard was positive correlated with post-traumatic growth, with the association mediated by intrinsic aspirations, a notion they regarded as the organism's attempt to engage in activities that have an intrinsic value to them. The study was criticised for collecting data from broadly Caucasian individuals living in an Island in Cyprus, which therefore raises questions about the generalisability of the findings. The cross-sectional design does not allow causality to be determined, future research may consider longitudinal design where data are collected at different points, allowing the researcher to explore the effect of time on the mediating effect of intrinsic aspirations of unconditional positive self-regards and post-traumatic growth. Nonetheless, the research is a very important one as it provides supportive construct level evidence for person-centred therapy for facilitating clients' post-traumatic growth.

Several researchers have reported that reports of post-traumatic growth may sometimes be illusory and a way of coping with distress (Frazier et al., 2009; Yanez et al., 2011; Zoellner & Maercker, 2006). Boerner, Joseph and Murphy (2017) have reported that post-traumatic growth may not necessarily reflect "real and constructive positive change"; instead defence

mechanisms may explain such invalid and illusory reports of post-traumatic growth. The study used university sample which does not represent a wider range of trauma survivors. The correlational nature of the study gives no information about causality or long-term processes. This is important to note as the association between post-traumatic growth and well-being is likely to change over time. Boerner, Joseph and Murphy (2017) predicted that actual post-traumatic growth if looked at cross-sectionally is associated with greater distress and predicts greater well-being subsequently. The authors identified that they could have underestimated the number of traumas as the subjects initially reported their most traumatic event, until it was expanded to allow multiple answers following requests by participants.

Joseph, Murphy & Regel (2012) proposed an affective-cognitive processing framework for understanding post-traumatic growth. It suggests that post-traumatic reactions indicate the need for affective-cognitive processing which are natural and normal states. It posits the central theoretical premise that people are intrinsically motivated to move towards psychological growth, however social-environmental and psychological factors may facilitate or impede the intrinsic motivation towards growth. The framework introduces a common factors approach that is useful to all therapists from all orientations, allowing an understanding of issues relevant to clients. The therapist's task is to facilitate more effective processing in the understanding that once this is achieved the client will automatically move towards post-traumatic growth. The authors suggested beginning with the traumatic event and clockwise through event cognitions, appraisals, emotional states and coping, as a repetitive cyclic process. The process is influenced by personality and social environmental conditions, which

goes on until the resolution of the discrepancies between the pre-trauma assumptive world

and the new trauma-related information.

The post-traumatic affective-cognitive processing model is an approach to working

therapeutically with trauma clients based on the theory of the human organism as continually

striving towards maintaining or enhancing itself (Joseph & Murphy, 2013). Therapist should

therefore endeavour to remove hindrances to growth by helping to create with social

environment that allows clients to grow. The therapist will be able to facilitate deeper

emotional expression and help in gaining access to primary emotion schemes, which allows

them to live with lower levels of distress. With construction of the relational environment,

client may be able to internalise the relationship and learn that emotional processing is

something manageable, and potentially continue when therapy ends. Murphy & Regel (2012)

proposed that if the concept of post-traumatic growth is understood in this way, it raises

questions about the assumption that traumatic stress reactions are inherently pathological.

The concept of post-traumatic growth is an important perspective that can be integrated into

clinical practice, especially as trauma research has mainly focused on the detrimental effects of

trauma and confounded understanding of trauma recovery to deficit-oriented model.

However, it has been argued that the post-traumatic growth concept is not well understood,

therefore cannot be measured with reliability and validity or described in a theoretically

substantial manner (Hagenaars & Van Minnen, 2010; Tedeschi & Calhoun, 2004). Researchers

have measured post-traumatic growth in very different ways, with some relying on interviews

while others used post-traumatic growth instruments (Tedeschi & Calhoun, 2004). While some research used long term trauma experiences (such as foreseeable death of a loved one) others used short term traumatic events (such as fatal car accident) (Tedeschi & Calhoun, 2004). In view of this, the adaptation process to these different types of trauma experiences may differ and perception of growth may play a different role. Also, the validity of self-reports of growth have also been questioned, as the findings may be different when compared to an objective measure of post-traumatic growth. Therefore, behavioural performance task could contribute to the question of the veracity of reports of post-traumatic growth. These debates can only be resolved through empirical research, therefore more longitudinal and process-oriented researches are highly needed for better understanding of the phenomenon. Such research is likely to reveal whether reports of post-traumatic growth reflect real changes over a period of time or are perceived improvements in the absence of real changes.

1.3.4 Intrusive trauma memories and psychopathology

Our understanding of trauma memories has developed since Beck et al, (1974) recounted that their 'anxiety neurosis' patients reported that spontaneously occurring images preceded or were simultaneous with their anxiety attacks. Since then, advances have been made in PTSD, depression and psychosis with systematic investigations allowing it to grow as an area of interest. Therefore, the primary focus of the literature review is on the association between intrusive memories and a variety of psychopathologies, which will be explored in this section.

1.3.4.1 Anxiety disorders and intrusive trauma memories

Involuntary images and visual memories have been shown to feature invariably in clinically anxious individuals (Hirsch, Meynen, & Clark, 2004; Wells & Papageorgiou, 1999) and in cognitive models of social anxiety (Hirsch & Holmes, 2007; Ng, Abbott, & Hunt, 2014). Hackmann et al. (1998) carried out one of the pioneering empirical studies of imagery in social phobia. The study compared patients with social phobia to non-patient controls who were required to recall recent social situations in which they felt anxious. They found that almost all the patients suffering from social phobia reported having experienced negative images of themselves from the observer perspective. On the other hand, non-patient controls were significantly less likely to report such images. A limitation of the study is that it did not include a control group of patients with an anxiety disorder other than social phobia. There is a possibility that the differences between participants with social phobia and controls may have been a consequence of high trait anxiety as oppose to it being a characteristic of individuals who are likely to be anxious in social situations. It would have been useful for the study to demonstrate that individuals suffering from social phobia differ in the frequency and content of their social images from anxiety disorder patients who have similar trait anxiety scores but are less anxious in social situations.

A follow up study by Hackmann et al. (2000) found that intrusive images were associated with earlier unpleasant trauma events that occurred prior to the onset of the disorder. The images contained experiences of being criticised, humiliated, bullied and so on. Therefore, this would suggest that early unpleasant memories can contribute to the development of negative

images, which may then make the memories worse. Similar findings were reported by Coles, Gibb, & Heimberg. (2002). There are some limitations of the research by Hackmann et al. (2000). They focused on post-treatment cases and assessed imagery before the start of treatment. It may have been more advantageous for them to have a shorter interval between social anxiety episodes and assessment of imagery. Also, it may be beneficial to replicate the study using a non-patient sample. They however argued that the type of treatment may not have influenced the results as approximately equal numbers of patients received psychological and drug treatment with the findings similar in both groups. Notwithstanding, the findings of the study reinforces the importance of several aspects of treatment, for example focusing on correcting distorted image the sufferer has of the public self and shifting from internally to externally focused processing.

Homer and Deeprose (2017) carried out an in-depth analysis of the phenomenology of negative imagery experienced by socially anxious people using thematic analysis. The analysis found major themes for intrusive images and three for deliberately generated images. The intrusive images were found to be primarily visual, auditory and somatic sensory modality. They also found that participants who experienced intrusive imagery scored higher on the depression anxiety stress scale, and moreover, this was shown to increase with the frequency of intrusion. The study successfully used computerised image questionnaire to investigate the imagery experienced by participants rather than semi-structured interview. It is thought that the computerised image questionnaire allowed increased standardization and minimal experimenter input, therefore it can be assumed that the images were valid representations of

participants' experiences. Whilst this adds to the credibility of the research, it is possible that

other forms of anxiety and depression may contribute to the imagery, therefore it would be

worthwhile for future research to control for differential effects of anxiety and depression on

intrusive social imagery. Also, a relatively small sample of subclinical socially anxious

undergraduate students were employed for this research, future research should consider

using a larger sample that includes non-anxious and clinically socially anxious groups to allow

for generalisation of findings and the identification of between group differences.

In view of the evidence of intrusive images in social phobia, imagery rescripting has been

proposed as an effective treatment (Holmes, Arntz & Smucher, 2007; Hunt & Fenton, 2007).

Wild, Hackmann, Clark's (2007) trial of cognitive therapy for social phobia used reliving, verbal

restructuring and imagery rescripting techniques to update early unpleasant memories in

patients. They found significant improvement in negative beliefs, image and memory distress,

fear of negative evaluation and anxiety in feared social situations. Wild & Clark (2011) found

that negative self-images linked to earlier traumatic memories contributed to the maintenance

of social phobia. They explored how imagery rescripting updates negative imagery in social

phobia. The findings from these studies support the view that it may be worthwhile to look at

the possible origins of the problem and not only the symptoms of social phobia so as to target

key memories that carry dysfunctional meanings for the survivor as they have a tendency to

provide input to recurrent images of the self (Wild, Hackmann & Clark, 2007). The imagery

rescripting procedure used by Wild et al (2011) involved a number of therapeutic interventions

such as cognitive restructuring, reliving and compassionate imagery. It has been argued that

we cannot be sure of the interventions that are most effective, and it is not shown empirically whether they are all important to the procedure. WIld, Hackmann & Clark (2007) reported a small sample size, while they found a significant change at one week follow up, longitudinal research is required to determine whether the benefits of imagery rescripting will be maintained over a long period of time. WIld, Hackmann & Clark (2007) did not have a control session, therefore it is unclear whether imagery rescripting led to the change.

All in all, intrusive memories and images related to traumatic experiences are considered to play an important role in the maintenance of the disorder (Hirsch & Holmes, 2007). Intrusive imagery associated with traumatic memory is experienced in a variety of anxiety disorders, including OCD (Coughtrey, Shafran, & Rachman, 2013; Lipton et al., 2010; Speckens et al., 2007), agoraphobia (Day, Holmes, & Hackmann, 2004), health anxiety (Muse et al., 2010) and eating disorder (Somerville, Cooper, & Hackmann, 2007; Cooper, 2011). Within the clinical area, it is fair to say that theoretical explanations of intrusive memories are generally restricted to PTSD, for example the dual representation theory of PTSD (Brewin, 2001; Brewin, Dalgleish, & Joseph, 1996). The theories have commonly proposed the idea that disturbance in memory is central to the disorder. Reviews by Brewin and Holmes (2003) and Brewin (2007) identified a co-relationship between the diminution of voluntary trauma memory and increased involuntary memory of the trauma. However, it must be proposed that since intrusions are solely restricted to PTSD in previous research, it would be of great importance to study their role in other psychological disorders. Moreover, there is a need for a revised

comprehensive model that considers a range of psychological disorders and encompasses intrusive memories and images.

1.3.4.2 PTSD and intrusive trauma memories

Hackmann et al. (2004) conducted a study investigating the presence of intrusive memories in PTSD, in which he interviewed 22 PTSD patients. It was found that patients typically described the intrusion of between one and four highly repetitive trauma memories that also consisted of sensory experiences. It was found that the majority of the trauma memories consisted of moments signalling that the traumatic event was about to happen or that the meaning of the event had become more threatening. This therefore suggests that intrusive memories may be of an anticipatory nature. The findings were deemed to be credible as they were consistent with Ehlers et al's (2002) interpretation that intrusive trauma memories can be understood as re-experiencing stimuli that indicates impending danger that has become warning signal of future threat to the survivor. The study was not without its limitations. There was a relatively small sample of patients interviewed, therefore raising questions about the possibility of replicating the findings. It was also indicated that the traumatic events in the sample were of relatively short duration. In view of this it is suggested that people who experienced more prolonged traumatic events may present with different types of intrusive memories. Future studies should consider systematically assessing all the moments when the meanings of the event became traumatic. This is likely to determine if they are linked to the patient's intrusive memories. Also, it is unclear whether bodily sensations that represent re-experiencing of sensations form the trauma are different to those that represent stress response to having a distressing memory. Further to this, Hackmann et al. (2004) commented about the small

proportion of repetitive intrusions that did not correspond to actual events, hence the study

included imagined scenarios that may not have been present in the actual traumatic event,

despite having a strong thematic connection to it.

On the other hand, Holmes, Grey & Young (2005) found that 77% of trauma memories were

linked to the worst moments of the trauma, as identified by the participants. Holmes, Grey &

Young (2005) also found that the themes in intrusive images within PTSD were related to

"hotspots" and connected to a sense of threat to one's physical integrity and one's sense of

self, for example, issues around abandonment and low self-esteem. The research therefore

suggests that the "hot spots" may be when patients experience a severe negative view of

themselves. Nonetheless, Holmes, Grey & Young (2005) were the first study to develop a

qualitative coding framework to describe cognitions reported during the significant points in

trauma. Reportedly, the coding showed good inert-rater reliability. There are several further

limitations of the study. There was a relatively small sample size which may explain the lack of

difference between intruding versus non-intruding hotspots in the emotional or cognitive

themes. The study required self-report of intrusions and hotspots which may have introduced

bias to over-reporting or under-reporting. It may have been advantageous to include blinds

raters to make matching ratings. It may have been useful to use blind rater. Brewin et al (2010)

has commented that the differences in methodology between the Hackmann et al's (2004) and

Holmes, Grey & Young (2005) raise questions about the exact timing of intrusion content

relative to the traumatic event (Brewin et al., 2010).

Reynolds and Brewin (1999) reported that 42% of PTSD patients reported that some of their intrusive memories involved an out-of-body experience, where they observed themselves from an external perspective during the trauma. Similar findings were obtained by McIsaac and Eich (2004) who reported that 36% of their PTSD subjects experienced intrusive memories from an external perspective. They added that the patients who reported intrusive memories from an external perspective described more emotional reactions, physiological sensations, and psychological states. In relation to the frequency of the spontaneous memories, Birrer et al. (2007) found that the entire sample of PTSD patients reported trauma-related intrusive images, with similar findings in patients with chronic PTSD. Birrer et al. (2007) also reported that participants experienced their intrusions as either daily or weekly occurrences.

The above studies are not without their limitations. It must be acknowledged that the prevalence reports may have been affected by the way in which intrusive imagery was defined. In the area of PTSD, Birrer et al. (2007) appear to measure intrusive images directly, where others have examined the sensory components of intrusive memories. In some of the above-mentioned studies subclinical samples were employed, therefore the findings may not accurately reveal the extent to which intrusive imagery is experienced in clinical populations. Also, McIsaac and Eich (2004) employed a correlational design; therefore, we cannot know for certain whether vantage points or the type of people who opt for one retrieval perspective over the other resulted in the different subjective attributes and information content. Speckens et al. (2007) investigated the characteristics of intrusive images in terms of their durations. They found that in PTSD the spontaneously occurring images are experienced for less than one minute to a few minutes, with similar findings reported by Birrer et al. (2007).

However, it is possible that the duration of the intrusive images may be influenced by the individual's degree of controllability, although there is no known data to support this. At the same time, the duration of the images may be related to other factors such as the significance of the content (Conway, Meares, & Standart, 2004), although the research did not address this possibility.

1.3.4.3 Psychosis and intrusive trauma memories

Intrusive mental images have also been shown to feature in psychotic presentations. Morrison and colleagues (2002) reported that 74% of the psychotic individuals sampled in their research experienced negative intrusive images which seemed to be associated with their psychotic symptoms, with a majority of them experiencing the intrusive images in conjunction with their psychotic symptoms. Accordingly, Morrison et al. (2002) proposed that intrusive images may be involved in the maintenance of psychotic symptoms. Garety et al. (2001) who proposed the cognitive model of psychosis argued that it is feasible that imagery may contribute to the maintenance of distressing auditory hallucination present in psychosis via a number of pathways. These include maintaining negative appraisals of voices, maintaining the misattribution of the voices as external, its tendency to create negative emotional changes that trigger auditory hallucination or by maintaining negative schemas that have been inherent in those individuals presenting with psychotic symptoms.

Ison et al. (2014) carried out a study exploring the use of imagery rescripting with people with psychosis who experienced intrusive images or memories and heard voices, whereby a one-off

imagery rescripting session was used with four participants with psychosis. The findings

indicated clinically significant reduction in distress, negative affect, and reduced conviction in

the beliefs associated with the imagery at one-week follow-up, which was maintained for

three of the four participants after one-month follow-up. This therefore provides further

evidence that imagery rescripting may be useful for the treatment of psychosis, and moreover

may be used as an extension of cognitive behavioural therapy for psychosis as concluded by

Ison et al. (2014).

1.3.4.4 Depression and intrusive trauma memories

Research has suggested that intrusions are common in those suffering from depression. For

example, Kuyken and Brewin (1994) interviewed women suffering from depression who had

experienced childhood sexual and physical abuse. They found that about 85% of these patients

had experienced spontaneous memories of the abuse within the past week. Moreover, there

was an association between the level of intrusion frequency and the severity of depression.

The findings cannot be generalised to the population at large as they only recruited female

patients. Also, the participants completed the Impact of Event Scale (IES; Horowitz, Wilner, &

Alvarez, 1979), which is more tailored towards PTSD and therefore raises questions around its

ability to fully capture the experience of depression. The study does not effectively determine

the direction of causality in the relationship between early abuse, intrusive memories and

avoidance, and depression severity as proposed by Teasdale (1998). Although it is possible that

the greater severity of depression may lead to more frequent intrusive memories, the nature

of the design does not allow such conclusions to be made. It would be best investigated with a

longitudinal study. Despite the limitations, it must be emphasised that this was the first study to find that women with a history of childhood abuse have more intrusive memories of the abuse during a depression episode. Also, the rationale for the study was clearly stated with regard to the lack of research on the intrusive memories of childhood trauma in a depressed state. The authors suggest valuable clinical implications of the research in relation to the processing of the emotional memories within cognitive behavioural therapy (CBT). Brewin et al. (1996b) found similar results in a sample of both men and women with clinical depression.

Several literatures have demonstrated that intrusive memories play an important role in the experience of depression. Brewin, Reynolds, & Tata. (1999) found that 73% of their sample of patients with depression reported intrusive memories, and that measure of intrusions and avoidance of these predicted symptoms of depression at 6 months follow-up, even after controlling for levels of depression at baseline. This study made a significant contribution as it was the first longitudinal investigation of the presence of intrusive memories in depression. It lends support to the argument that the study of involuntary, intrusive autobiographical memories is of great importance to the understanding of depression. There are major limitations with the study. Firstly, the researchers used a small sample size and therefore may not have had the adequate statistical power to reliably investigate the presence of intrusive memories in depression. Also, there was no matched control group, which makes it impossible to make comparisons.

Patel et al. (2007) investigated intrusions in 39 patients who met the criteria for depression. They found that 44% reported one or more intrusive memory. Thus, there is evidence that

many people with depression experience intrusive memories; however, these studies did not

use a control group, so it is difficult to be clear how common intrusions are in people without

depression. However, some limitations have been highlighted from this study; it is impossible

to conclude whether the intrusive memories were present at a high frequency before the

onset of depression or whether depression is associated with the increase of intrusive

memories. As the study did not use a non-depressed control group, it can be argued that

frequency of intrusive memories may be due to other concurrent stimuli like life stresses.

Despite the limitations, it is worth mentioning that the researchers clearly expressed their

operationalised definition of intrusive memories. The fact that participants reported highly

distressing intrusive memories suggests that such memories are of potential interest.

Among other studies that have investigated this issue, Spencely and Jerrom (1997) compared

women with depression to a matched control group. They found that both intrusions and

avoidance of childhood memories were higher in the depressed group. The cross-sectional

design used does not allow firm conclusions to be made about the direction of causality. They

failed to assess for the presence of co-morbid disorders such as PTSD, which would have

ensured the findings were attributable to depression and no other psychopathologies.

Although the study may be inconclusive to a degree, it successfully replicated previous findings

in the field. The inclusion of a recovered-depressed and non-depressed control group allows

appropriate comparison to be made with the depressed sample. More specifically, the

inclusion of a recovered-depressed group is valuable given that depression is a highly recurrent

disorder (APA, 2000), therefore it would be beneficial to investigate this group's experience of

intrusive memories. The findings lend support to studies that have found that rumination and

suppression are maladaptive processing styles in depression (Ehring, Frank, & Ehlers, 2008;

Just & Alloy., 1997; Rude et al., 2002).

Brewin et al. (1998) compared cancer patients with a diagnosis of depression to controls

matched on age, sex, type of cancer and stage of disease. Patients who also met criteria for

PTSD were excluded from the sample. Cancer patients with depression reported significantly

more intrusions than controls and were more likely to report that their intrusive memories

began at the same time as, or were exacerbated by, the onset of depression. This was the first

study to investigate autobiographical memory functioning in a sample of physically ill

depressed patients and the first to find that depressed individuals experience more intrusive

memories than matched controls. By recruiting cancer patients, the researchers were using a

suitable group diagnosed will an illness that has been linked to depression (Spiegel, 1996);

moreover, the challenging, complicated and prolonged nature of cancer treatments allowed

cueing recall of autobiographical memories. The stringent methodological controls employed

gives greater confidence in the findings, for example, excluding patients with co-morbid PTSD

ensures that a group that has been found to frequently report an experience of intrusive

memories does not pose as a confounding variable (Birrer et al., 2007). However, it should be

highlighted that the subjects retrospectively reported their experience of depression and

intrusive memories; hence the reliability of the data is questionable. Also, as the research is

cross-sectional it would be premature to make firm conclusions about the direction of

causality.

Research has shown that depressed individuals tend to report distressing, vivid, sensory intrusive memories of negative life events. However, the cognitive mechanisms that contribute to the maintenance and subsequent persistence of depression are equally important. The way in which the intrusive memory is appraised is critical in depression. The cognitive model posited by Ehlers and Steil (1995) proposes that it is the negative interpretation of intrusive memories (e.g. "It means I am going mad") that predicts the onset of PTSD. This is because the negative interpretation increases the associated distress and may result in the use of cognitive strategies in an attempt to control the memories e.g. avoidance and suppression. This current research proposes that the appraisal of intrusive memories will likewise play a role in the maintenance of depression. It has been shown that attributional biases contribute to the maintenance of depression (Abramson, Seligman, & Teasdale, 1978; Beck, 1967; Morris, 2007). Therefore, it is possible that this attributional bias may also play a role in a depressed individual's appraisal of intrusive memories.

Newby and Moulds (2010) compared depressed, recovered-depressed and never-depressed participants on measures of intrusions and appraisals of intrusions. There was statistically significant difference between the groups with clinically depressed participants more likely to report intrusive memories, compared to recovered-depressed and never-depressed participants. Moreover, the depressed group reported more negative appraisals of the intrusions than the never-depressed controls. This study makes a valuable contribution to the body of research as it is the first to investigate difference in the appraisals and response to intrusive memories amongst the groups. Also, the researcher's use of open-ended questions allowed them to truly establish the cognitive and behavioural strategies used by participants in

response to their experience of intrusive memories, as opposed to using measures of appraisals which may not always be applicable to all the participants. It was noted that inter-rater reliability of participant responses was strong. A limitation of the study is that it focused solely on negative intrusive memories; investigating positive intrusive memories may be worthwhile. Also, there was an assumption that participants engage in strategies in direct response to the experience of negative emotions about their intrusive memory. As the study employed a cross-sectional design, it would be impossible to conclude the direction of causality; reported appraisals may be already held strategies and not necessarily specific to their participants' intrusive memories. Thus, there is evidence to suggest that whilst intrusions are fairly common in many people, individuals with depression report higher levels of intrusive memories, more negative appraisals of these intrusions, and that the frequency of intrusions predicts later levels of depression. This has led theorists to argue that intrusions may play a key role in the maintenance of depression (e.g. Brewin et al., 2009).

Newby and Moulds (2011) conducted a systematic investigation of the content and characteristics of intrusive memories in a clinically depressed, recovered-depressed and never-depressed group. The participants completed a battery of self-report questionnaires that indexed for intrusive memories, and avoidance characteristics. The findings demonstrated that the depressed group reported higher levels of intrusion-related distress, associated emotions (sadness and helplessness), and memory vividness. Also, it was found that depressed participants reported higher levels of avoidance than the never-depressed group. The differences reported were statistically significant. This study is very comprehensive and possesses much strength. Their inclusion of a recovered-depressed and never-depressed

groups allows comparison to be made and enables the authors to conclude to a great extent

that the characteristics of intrusive memories are unique to depression. Moreover, as

depression has been shown to be recurrent, a study that includes a recovered-depressed

group is meaningful. Further, they assessed for the presence of co-morbid Axis disorders and

excluded participants who identified with PTSD or Acute Stress Disorder symptoms, which

ensured the findings could be attributed to depression. Furthermore, it was noted that

participants were provided with a detailed definition of intrusive memories, ensuring they

were all clear on what was expected of them. Despite the obvious strengths of the research,

there are a few limitations of this study. The reliability of the retrospective rating of intrusion-

related emotions is questionable, as ratings by depressed participants may reflect their current

low mood (Kuyken & Dalgleish, 1995). Also, due to the cross-sectional nature of the design, the

direction of causality is inconclusive. Finally, they cannot rule out the possibility that co-morbid

anxiety disorders may explain the significant differences between groups. The study did not

investigate whether the depressed group experienced more intrusive memories than the other

groups as they only tested one intrusive memory.

Depressive symptoms have been found within non-clinical populations, albeit in milder forms

and considered to be part of normal individual differences (Bostanci et al., 2005; Bywaters,

Andrade, & Turpin, 2004; Stordal, Mykletun, & Dahl, 2003). These symptoms have been

measured using relevant validated scales such as the Beck Depression Inventory: 2nd edition

(BDI-II; Beck et al., 1996). Likewise, intrusive memories have been found in non-clinical

samples (Brewin, Christodoulides, & Hutchinson, 1996a). Consequently, it has been shown that

intrusions can be induced in a non-clinical sample using the trauma film paradigm. Holmes and

Bourne (2007) conducted a review of the trauma film paradigm in their investigation of

analogue peri-traumatic cognitive mechanisms underlying intrusive memory development.

Their review provides an effective experimental tool for understanding the mechanism that

may be significant at memory encoding to form intrusive memories, as opposed to relying on

retrospective accounts of real past trauma, which is unreliable as people tend to have difficulty

recalling past emotional states (Candel & Merckelbach, 2004). Pre and post-mood state

questionnaires and diaries are used to consolidate the methodology. This has given rise to the

prospective analogue design for investigating trauma-related intrusive memories (it would be

unethical to deliberately expose participants to real trauma). Considering the difficulties faced

when with conducting research at the time of the real trauma, the analogue design provides a

useful tool for studying response to trauma in a laboratory (Holmes, Brewin & Hennessy, 2004;

Lazarus et al., 1965). Also, it has been found that intrusions produced in a laboratory condition

are somewhat similar to naturalistic intrusive memories (Schlagman & Kvavilashvili., 2008).

There are a few limitations to the methodology. It is paramount to acknowledge the influence

of making potential participants aware of the nature of the violence depicted in the trauma

film. This awareness may result in a form of self-selection, eventually producing a somewhat

psychologically tough group of participants, which could skew the findings. Furthermore, it

must be acknowledged that participants' responses to some of the items on the scale may be

affected by a recent trauma or stressful event. Further, the diary measure of intrusions

depends on introspective report, and discerning the aim of the experiment by the participants

can influence the recording of intrusions (Baddeley & Andrade., 2000). Also, it is questionable

whether watching trauma-related film can produce trauma similarly to first-person experience of trauma, especially when there is no direct relationship between the viewer and the victim. Currently, there is a shortage of studies that have used the trauma film paradigm in the investigation of trauma-related intrusive memories in depression, therefore, future research may benefit from employing this approach.

Several literatures have demonstrated that intrusive memories play an important role in the experience of depression. However, the cognitive mechanisms that contribute to its maintenance and subsequent persistence of depression are equally important. Starr and Moulds (2006) conducted a cross-sectional study that examined the appraisals of intrusive memories and their association with the maintenance of depressed mood. Semi-structured interviews were carried out to identify the experience of intrusive memories during the week prior to the interview amongst 84 participants. They were administered self-report questionnaires that indexed affective and cognitive responses to the memory. Results indicated a correlation between negative meanings of intrusive memories and depression. It was also found that negative meanings of intrusions were positively associated with distress and cognitive avoidance strategies. Finally, intrusion-related distress and the use of rumination as a coping strategy were correlated with depression.

The study supports a trans-diagnostic approach to understanding the cognitive and behavioural processes that underpins maintenance of depressed mood (Harvey et al., 2004). It

suggests some useful clinical implications, especially around the use of CBT techniques to modify maladaptive appraisals of intrusive memories. Notwithstanding, the study is not without its limitations. Using a sample of undergraduate students makes it impossible to generalise the findings to the general population. It is possible that other stressors such as educational demands may have affected the findings. Inferences about temporal relationships cannot be made due to the cross-sectional design; it is possible that depression may lead to negative interpretation of intrusive memories. The use of retrospective self-report measures raises questions around its reliability as it indexed specific cognitive variables of interest; therefore, participants were not allowed to provide open-ended responses that may indicate other strategies. Future study should adopt a longitudinal design using near real-time monitoring.

Moulds et al (2008) investigated whether safety behaviours in response to maladaptive appraisal of intrusive memories play a role in the maintenance of intrusive memories and depression. Participants were recruited based on their high score on BDI-II and were asked to identify appraisals and their responses to intrusive memories using the Safety Behaviour and Intrusive Memories Questionnaire (SBIMQ). The study adopted an open-ended style of questioning, which gave participants the opportunity to identify a range of cognitive responses to the negative meanings they attached to their intrusive memories. It consequently underlined the importance of screening for the presence of intrusive memories, and appraisal of the memories in the assessment of depressed clients. There are some limitations with this study. The use of SBIMQ is problematic as it assumes that the occurrence of an intrusive memory leads to the activation of negative appraisals which leads to the use of safety

behaviours. This implies that participants may have identified with a negative appraisal when they may not necessarily have done. It is possible that the negative appraisal may be associated with their current depressed mood and not particularly a fixed pattern of interpretation of memories. Also, the research did not recruit a matched control group, therefore not allowing for comparison to be made with the appraisal styles. Also, it prevents conclusions from being drawn about the extent to which the characteristics are unique to depression.

While the phenomenon of trauma-related intrusive memory development can undoubtedly be debilitating and impairing, therefore warranting an interest in reducing its frequency, it is proposed that intrusive memories may exist for potentially adaptive functions. Krans et al. (2009) conducted a review of theories and experimental studies that have explored the potential functions of intrusive memories. It was suggested that trauma-related intrusive memories may have a self and directive function by providing the individual with detailed sensory and physiological information about the event, which is needed for the emotional processing of the event (Brewin, Dalgleish, & Joseph, 1996). The warning signal hypothesis by Ehlers et al. (2002) was also discussed. This is based on the idea that intrusive memories help to prevent future harm as they provide information of impending danger. Conway et al (2004) proposed that trauma-related intrusive memories may play a role in the protection of self-coherence as traumatic events are believed to directly threaten self-related goals and the coherence of the self. For example, the trauma-related intrusive memory may function as a protection of the belief that one is in control. The main limitations of the hypotheses are the lack of research that could lend them empirical support. Hence, the highlighted functions

underline the value of conducting future research that would investigate the content of intrusive trauma memories, especially in relation to their functions, to obtain a comprehensive understanding of intrusive memory development in depression.

If intrusive memories play a maintaining role in depression, psychological treatments that target intrusions may reduce depressive symptomatology. To this end, Brewin et al. (2009) investigated the effectiveness of imagery rescripting as a treatment for depressed patients with intrusive memories. The depressed individuals were given about eight sessions of imagery rescripting as a stand-alone treatment, a treatment that involves imagining entering an image or memory, from an observer perspective and then re-entering the image again from the field perspective with the observer self still present. Brewin et al. (2009) found that participants who received imagery rescripting showed significant improvement in their depression, which was maintained at one-year follow-up. Similar findings were also obtained in two further studies (Wheatley et al., 2007). These findings add weight to the suggestion that intrusions may be an important mechanism in the maintenance of depression.

The effectiveness of other treatments has also been investigated. Newby et al. (2014) compared the efficacy of Computerised Bias Modification positive appraisal training (CBM) with therapist-delivered CBT session (CB-Education), both of which aim to target and modify negative appraisals of negative intrusive memories. Sixty participants that met the criteria for dysphoria completed baseline ratings for negative intrusive memories, negative appraisal and Impact of Event Scale. The participants were also randomly allocated to one of CBM, CB-Education or no intervention control group. It was found that for the three groups there were

significant reductions in mood, intrusive memories and negative appraisals after one week. The CB-Education group showed the greatest reduction in intrusion-related distress, followed by the CBM group.

The findings provide some evidence for the association between maladaptive appraisals of intrusive memories and distress in depressed mood. However, the study is not without its limitations. There was a small sample size which may have contributed to its inability to detect group differences as there was not sufficient power. Therefore, it is not possible to conclude that one group was superior to the other. The researchers acknowledged the need to repeat the study with a large sample size. It is possible that important variables may have confounded the findings as the groups were not matched on variables such as therapist contact and the specificity of the targeted appraisals. Also, it must be acknowledged that understandably, the study relied upon self-report measures which may be subject to social desirability bias. Finally, the interventions were also limited to single session and a one-week follow-up. Replication of the study should consider multiple sessions and a longer follow-up in order to explore the efficacy of repeated administration of treatment and maintenance of gains. All in all, the study highlights the importance of assessment of intrusive memories in treatments for depression, especially considering its tendency to contribute to distress.

1.3.5 Review of qualitative research into trauma-related intrusive memories

There are limited numbers of qualitative research studies that have explored the presence of trauma-related intrusive memories in psychological distress. Evans et al. (2007) investigated

the nature of the intrusive memories experienced by perpetrators of crime. The researchers conducted semi-structured interviews with a representative sample of 105 young offenders who had been convicted for serious assault. The intrusive memories related to their assault were assessed, amongst other factors. A detailed thematic analysis of the content and meaning of intrusive memories was carried out using the IPA method (Smith, 1995; 1996) and the transcripts were analysed for recurring themes. They found that 46% of young offenders described significant intrusive memories of the serious assault. The analysis of the content of intrusive memories showed that the intrusive memories were largely characterised by the first sensations of the moment the event became threatening to the perpetrator. It was concluded that the findings were consistent with the warming signal hypothesis (Ehlers et al., 2002).

Harvey and Bryant (1999) also carried out a qualitative investigation of the organisation of traumatic memories by individuals with and without acute stress disorder (ASD). The researchers conducted structured clinical interviews based on DSM-4 criteria on participants who had been involved in a motor vehicle accident within 12 days of the investigation. Data coding and analysis demonstrated that disorganisation of narrative and description of dissociation were more evident in ASD participants than non-ASD participants. It was suggested that disorganised memory structure may affect the access to and modification of traumatic memories. There is a need for further qualitative research on the experience of intrusive trauma memories, especially in the role they play in the maintenance of psychological distress. This need therefore, adds weight to the value of the proposed research.

1.3.6 Effect of trauma work on trauma therapists

Professionals who work in the field of trauma are susceptible to being affected by the traumatic material of their clients (Gibbons, Murphy and Joseph, 2011; Smith, 2007). When providing psychological treatments, therapists are exposed to hearing about their client's trauma, with literature indicating that this can influence their general well-being whilst also placing greater demands on both the expertise and the personal resources of therapists. Subsequently there has been longstanding concern about the consequences of providing psychological treatment to clients who have endured difficult traumatic experiences, including violence, childhood sexual abuse, rape, war, genocide and many more. The theoretical concepts of vicarious traumatisation and secondary traumatic stress (Figley, 1995) have been posited to describe these adverse effects. However, the constructs of vicarious traumatisation and secondary traumatic stress are contentious with there being limited empirical evidence to support them. They are also argued to be inconsistent and unclear (Devilly, Wright, & Varker, 2009; Elwood et al., 2011). Moreover, there is a significant overlap in what the two concepts explain, as indirect exposure to trauma is related to the degree of secondary traumatic stress as well as vicarious traumatisation. It has been explained that their theoretical foundations are quite different (Chouliara, Hutchison, & Karatzias, 2009). Secondary traumatic stress involves the development of trauma symptoms parallel to PTSD such as intrusion, avoidance and arousal due to indirect exposure to client's trauma. On the other hand, vicarious traumatisation relates to disrupted beliefs and changes in the therapist's way of experiencing self, others and the world following exposure to client trauma narratives and symptoms (McCann and Pearlman, 1990). The research will focus on body of research on vicarious traumatisation. This is important as it contributes to a process of change in the survivors'

world view and frame of reference as well as psychological, physical and spiritual well-being (McCann and Pearlman, 1990).

While therapists are taught the principles of the profession which includes the importance of professional boundaries, therapists sometimes find themselves in situations where they are repeatedly exposed to the powerful content of the client's trauma experiences which may lead to vicarious traumatisation. It has been argued that the process of vicarious traumatisation often involves counter-transference processes (Gibbons, Murphy & Joseph, 2011). Counter-transference is based on the concept that emotional reactions stem from the unresolved and unconscious conflicts of the therapist that arise in response to the feeling expressed with the transference of the client (Dalenberg, 2008). In situations where a therapist may be experiencing a great degree of stress as a result of exposure to their client's traumatic material, there may be an increased risk of the client's trauma becoming traumatic for the therapist through counter-transference. It has been suggested that intense experience of counter-transference may increase the likelihood of developing vicarious traumatisation (Gibbons, Murphy & Joseph, 2011). It has also been shown that professionals who are more likely to experience counter-transference associated with strong emotional distress are practitioners who are less self-aware and have limited understanding of the theory and concept of counter-transference (Latts & Gelso, 1995). In view of this, therapists who are less self-aware, insightful and reflective may have their resilience to client's traumatic material compromised.

Previous research has demonstrated that certain therapist characteristics and work characteristics may influence the way and extent to which therapists are affected by their client's trauma narrative; these include therapist's treatment style, interpersonal style, personal history of trauma, the meaning of life events to the therapist, professional development, and personal stressors, support, work setting, the nature of the material presented by their clients, and stressful client behaviour (Pearlman & Mac Ian., 1995). There is a small body of literature on the concept of vicarious traumatisation. Munroe (1991) found that exposure to combat-related trauma clients correlated significantly with intrusive symptoms in the 138 therapists who were recruited for the study. Schauben and Franzier (1995) investigated vicarious trauma, disrupted schemas, PTSD symptoms, burn out and coping in 118 female psychologists and 30 female rape crisis counsellors. They found that the greater number of clients to have experienced some trauma was correlated with the likelihood the psychologists would identify themselves as experiencing vicarious trauma, as well as with a disruption in their schemas.

More recent studies have also investigated the concept of vicarious traumatisation. Makadia, Sabin-Farrell, & Turpin. (2017) employed a web-based survey to investigate the relationship between trauma exposure and well-being amongst trainee clinical psychologists. The participants' well-being was measured based on psychological distress, trauma symptoms and disrupted beliefs. It was found that exposure to trauma work was a significant predictor of traumatic symptoms, but trauma work was not related to psychological distress or disrupted beliefs. This study therefore fails to support the notion that exposure to trauma work creates a change in belief system for psychologists who experience vicarious traumatisation; moreover,

it does not demonstrate a relationship between exposure to trauma work and psychological distress. This vicarious traumatisation literature indicated that doing trauma therapy can have an effect on the therapist, with distinct characteristics such as past trauma, personal stress and working conditions increasing the likelihood of trauma-related symptoms.

There are some major strengths of the above study as it drew upon a large sample of clinical psychology trainees, whilst also identifying and controlling for potential confounding factors. However, it must also be acknowledged that it was uncertain how representative the sample was due to the largely Caucasian female sample. The study was cross-sectional in nature, which suggests that the findings may not be reliable over time, whilst we also cannot imply causality. The researchers did not have a method for measuring the extent of trainees' exposure to client trauma, as trainees self-identified as having engaged in trauma work. It may be worthwhile for future research to consider the nature of the therapeutic work and participants' ratings of the severity of client trauma. Also, it is notable that the significant correlations between exposure to trauma work and trauma symptoms were all quite low, whilst exposure to trauma work uniquely only explained a small fraction of the variance in trauma symptoms. This therefore indicates that other factors may be contributing to levels of trauma symptoms. In view of this, future studies should consider other factors that may contribute to the level of trauma symptoms, but which were not considered in the above study, such as coping strategies.

1.3.6.1 Post-traumatic growth in trauma therapists

While most of the research into post-traumatic growth has examined the notion in direct

trauma survivors (as addressed in section 1.3.3.4), a growing body of literature is indicating

that post-traumatic growth can also be experienced by therapists (Linley & Joseph, 2007;

Linley et al, 2005). This notion has been termed vicarious post-traumatic growth, a concept

defined as "psychological growth following vicarious brushes with trauma" (Arnold et al.,

2005). Coleman et al (2018) interviewed psychotherapist and psychologists working in NHS

specialist trauma services and explored the impacts of working therapeutically with complex

psychological trauma. The clinicians reported that the interactive process of engaging in

trauma work brought allowed them to experience vicarious post-traumatic growth. They

described developing through their work and obtaining a sense of fulfilment and of doing

something meaningful. They also reported improved clinical skills and sensitivity to therapeutic

relationship as occurring through their work, which helped them with professional

development. There are some limitations of the research, for example the participants in the

research did not disclose their own self-care strategies. Future research can explore specific

distortions in clinicians and their self-care practices. The research was carried out within NHS

services and with NHS clinicians; this raises issues around the generalisability of the findings. It

may be worthwhile if future research recruits a wider sample of clinicians from different

sectors, including primary care NHS services, voluntary agencies and independent sectors.

Furthermore, based on the theories of post-traumatic growth, it has been suggested that

factors specific to the therapist, the interpersonal relationship and the working environment

are predictors of the likelihood of the therapist experiencing vicarious post-traumatic growth

(Linley & Joseph, 2007). With the potential benefit of vicarious post-traumatic growth, studies have looked at identifying the key moderators of the phenomena. Brockhouse et al (2011) examined the variables that could potentially moderate vicarious traumatic growth in a group of 118 therapists that completed measures of vicarious exposure to trauma and growth, measures of empathy, sense of coherence and perceived organisational support. They found empathy to be an important moderator, as having high level of empathy positively predicted growth. Whilst the researchers used national recruitment strategy and recruited participants from different therapeutic orientations, the possibility of self-selection bias cannot be ignored. It is impossible to infer causality from the findings as the correlation design allows uncertainly about the direction of association. More so, the researchers reported that the response rate was low and sample size was not representative of therapist population. Notwithstanding, this is a useful finding as empathy is particularly relevant to trauma exposure within the therapy setting, conveyed as the practice of understanding that is reflected in perspective taking (Hojat, 2007). While empathy has been reported as contributing to burnout when therapists are not able to maintain boundary, it has also been reported in the experience of psychological growth by therapists (Harrison & Westwood, 2009). Other research has shown sense of coherence and organisational support as key moderators of vicarious post-traumatic growth in therapist (Linley & Joseph, 2007).

1.3.7 Implications of the literature review

As demonstrated in the literature review little is known about the extent to which trauma memories are present within psychological distress from a more experiential perspective (Moulds et al., 2008). Therefore, studies that allow an in-depth and idiographic understanding

of the presence of trauma memories in psychological distress may provide significant

contribution to the field of psychology. More importantly, research has not taken into account

the therapists' experience of their clients' trauma-related intrusive memories. It is suggested

that qualitative research that explores how trauma therapists make sense of and are affected

by their client's trauma experiences will make significant contribution to the field of trauma

research. Furthermore, while NICE guidance has recommended Trauma-focused cognitive

behavioural therapy as the treatment of choice (NICE Guideline 26 for PTSD, 2005), the

literature has also shown that person-centred and experiential therapies may be well placed

for building an evidence base for working with traumatised clients. The fact that these

humanistic approaches are based on the growth paradigm of psychological distress offers

great opportunity to contribute to this field of study. Hence, further research into aspects of

person-centred and experiential theory and their relationship with trauma would be important

for the advancement of the trauma research. The review has also brought to light the risk of

vicarious traumatisation from exposure to client's trauma narratives to trauma therapists;

therefore, highlighting the importance of developing healthy support systems at work and

outside of work, that would potentially allow growth in trauma therapist rather than burnout.

1.4 Relevance of literature to Counselling Psychology

There is important implication of the review to the field of counselling psychology as the

concept of post-traumatic growth opens a new way of thinking about trauma that would

resonate within counselling psychologist. Whilst the concept has mainly being investigated in

person-centred therapy it is argued that growth may be possible within other forms of

therapy. More, the review has shown that therapists are sometimes affected by their clients'

trauma narratives, hence reinforcing the importance of them being aware and open to the possibility of being changed by their clients whilst remaining present and available in the therapeutic relationship. Also, there are important implications with regards to the treatment of individuals suffering from psychological distress. Within clinical practice, it may be advantageous for counselling psychologists to routinely ask their clients about their experience of intrusive memories, the meaning they attach to these memories, and the idiosyncratic cognitive strategies they adopt to manage them. Therefore, where relevant during psychological assessment and psycho-education, counselling psychologists should include information about the prevalence of intrusive memories in different psychopathologies to challenge maladaptive strategies. It has been suggested that CBT for the treatment of depression could target the reoccurring intrusive memories during therapy (Brewin, 1998; Brewin, Reynolds, & Tata, 1999). This may provide an opportunity for therapists to reinterpret and cognitively reframe negative intrusions in a more positive way.

CHAPTER 2: RESEARCH METHODOLOGY AND STRATEGY

2.1 Overview

This chapter provides a detailed description of the rationale for adopting many of the

important decisions related to the chosen methodology. It will give an account of the

development of the research question, location of the study within a constructivist paradigm

and the choice of grounded theory, where rationale for its choice is provided and comparison

is made with other approaches. The chapter includes a detailed description of the research

procedures, ethical considerations, time tabling of the research project and analytic process.

2.2 Research question

The development of the research question(s) is an essential stage in the research process, as it

directs several processes and the methodology that will be ascribed by the research (Burck.,

2005).

The primary question proposed in the current research was *"How do therapists work with*

clients' trauma-related intrusive memories?" Specifically, it aimed to answer the question

"How do therapists construct and make sense of their clients' intrusive trauma memories in the

context of the clients' psychological distress?" The study also attempted to answer the

question "How do therapists understand the impact of trauma work on their psychological

well-being?" This question was explored based on the phenomenology of vicarious

traumatisation.

Some assumptions underlie this research. They are as follows:

- There is something unique about trauma-related intrusive memories that justify the decision to examine them.

- Trauma-related intrusive memories may affect people in different ways and can be present in different psychopathologies.

- Trauma-related intrusive memories may include some psychological and potentially social processes that impact on the individual.

- Therapists may be able to represent their clients' experience of intrusive memories and its impact on them.

- Some therapists may be willing to discuss their experience of working with trauma clients.

- It may be possible to represent trauma-related experiences in language and I will be able to construct an understanding and interpretation of their narratives.

- Therapist can look within to explore how trauma work may have impacted on them

2.2.1 Research aim

The primary aim of the research was to explore how therapists construct and make sense of their clients' intrusive trauma memories in the context of the clients' psychological distress. Furthermore, the research aimed to generate a theoretical explanation for therapists' experience of their clients' account of the experience of having intrusive memories. Simultaneously, a qualitative approach allowed me to explore how therapists make sense of the impact of trauma work on their psychological well-being. It was expected that this will inform further research and discussion regarding provision of client-focused treatment. A

qualitative approach is required in order to achieve this, hence the adoption of grounded theory.

2.2.2 Rationale for current research

This study presented an opportunity to contribute to the existing literature in this field, more importantly; it aims to augment the limited qualitative research that has been carried out by extending our understanding of intrusive memories in the context of psychological distress. This is supported by the recognition of the value of research with a qualitative focus (Harvey & Bryant., 1999; Moulds et al., 2008) to better understand how distressed individuals make sense of their trauma-related intrusive memories and the meaning they attach to it. It has been suggested that qualitative approaches that investigate the phenomenology of intrusive memories and coping mechanism adopted would better capture the subtle and complex phenomena that mental images are (Birrer et al., 2007). Previous research has shown a relationship between trauma memories and certain psychopathologies such as anxiety, depression and PTSD; however, none has taken an idiosyncratic approach to investigating how therapists construct and make sense of their clients' intrusive trauma memories in the context of the clients' psychological distress. It is also clear that research needs to consider the impact of trauma work on the therapists' psychological well-being.

2.3 Research paradigm

Researchers are expected to communicate the philosophical and theoretical framework underpinning their research study and the knowledge it aims to produce (Carter & Little., 2007; Ponterotto, 2005). These frameworks relate to four main categories:

- Epistemology, which is defined as "fundamental theory of knowledge and the ways in which it can be produced" (Pidgeon & Henwoood, 1997). Crotty (2003) defined it as "a way of understanding and explaining how we know what we know".

- Ontology, which relates to the nature of reality and what can be known about reality (Ponterotto., 2002). Crotty (2003) defined it as the "study of being", which is concerned with "what kind of world we are investigating, with the nature of existence, with the structure of reality as such".

- Axiology, which concerns the role of the researcher and their values within the research (Ponterotto, 2005). It is the study of values, as undoubtedly our values affect how we do research and what we value in the result.

- Methodology, which relates to the research procedure and processes (Ponterotto., 2005). Crotty (2003) defined it as "the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and the use of the methods to the desired outcomes"

2.3.1 Overview of research paradigms

In the process of identifying the research paradigm that is the best fit for this study, I drew on the work of Lincoln, Lynham, & Guba (2011), a comprehensive source produced by authors who have written a lot about research paradigms. Lincoln, Lynham & Guba (2011) identified five main research paradigms: positivism, postpositivism, critical theory, participatory cooperative, and constructivism.

Positivists adhere to the view that there is a single true reality that can be known, that only factual knowledge gained through the senses including measurement is trustworthy, a position labelled naive realism. This paradigm tends to propose a direct relationship between this reality and objective knowledge that can be gathered by the researcher (Ponterotto., 2005; Willig., 2008). Postpositivists also believe in the existence of a single true reality; however, they are of the view that it cannot be fully captured in completely objective terms (Lincoln, Lynham & Guba, 2011; Ponterotto., 2005). With regard to their methodological process, positivists and post-positivists are very similar in that they are the core philosophical underpinning for quantitative research, and both aim to produce objective knowledge (Finlay, 2006; Ponterotto, 2005). For this reason, it is understandable that efforts are made to exclude researcher's values from the research process, instead maintaining a position comparable to a chemist in a science laboratory (Lincoln, Lynham & Guba, 2011; Ponterotto., 2005). The role of researchers adopting this ontological position is limited to data collection and interpretation through an objective and quantifiable approach.

Critical theory is based on an ontological position called historical realism. It takes the view that reality is shaped by a range of social, political, cultural, gender and ethnicity-related influences (Lincoln, Lynham & Guba, 2011). It aims to make prominent power relations and historical struggles for privilege. It emerged in association with several social movements that identify varied dimensions of the domination of human beings within modern societies. The approach emphasises how knowledge has the potential to contribute to tackling inequalities and emancipating oppressed groups by providing descriptive and normative bases for social

inquiry. It acknowledges that the values of researchers are central to the goal of disrupting the status quo, with researcher-participant interactions identified as key elements to empowering participants and groups (Ponterotto, 2005).

Participatory-cooperative paradigm is based on the co-creation of the human mind and culture within a given cosmos, a reality in which human intelligence, body, mind and spirit actively participate (Reason, 1998). Hence, what emerges as reality is the outcome of an interaction within the given cosmos and the way the mind engages with it (Heron & Reason, 1997; Lincoln, Lynham & Guba, 2011). It is based on an epistemology that prioritises practical and experiential knowledge. It advocates a methodology based on partnership and democratic decision making between all parties in the research process, including deciding on the questions of interest and suitable methodologies (Heron & Reason, 1997). For example, the approach adopts participatory action research that emphasises collective inquiry and experimentation and which is grounded in experience and social history in order to understand and attempt to change the world. It acknowledges that researcher values are important to the inquiry and are directed towards the goal of facilitating human flourishing, as oppose to other approaches that emphasise exclusion of the researcher in the research process and focus on reproduction of findings (Lincoln, Lynham & Guba, 2011; Reason & Bradbury, 2008).

A constructivist research paradigm, which is sometimes labelled constructivist-interpretivists, rejects the existence of single real world, instead it perceives multiple, constructed realities

(Ponterotto, 2002, 2005). This position is based on the relativist ontological position that suggests that truth is relative; reality is subjective and generally influenced by experience, social interactions and context. Inherently, it posits that learning is an active contextualised process of constructing knowledge as opposed to simply acquiring it, with each person having a different interpretation and construction of knowledge process. Therefore, this paradigm recognises that knowledge is constructed in the mind of the individual and influenced by inter-subjective interaction, which in essence denies the notion of single 'true' reality (Finlay, 2006; Lincoln, Lynham & Guba, 2011). It is conceptualised that researchers are an integral part of a social interaction; therefore, it is impossible to isolate them from the research process. However, researcher should make efforts to explore their values, experiences and preconceptions.

2.3.2 Adopted research paradigm

This research was influenced by constructivist epistemology which adopts a qualitative framework. Constructivism asserts that reality is constructed by individuals as they assign meaning to the world around them, therefore assuming that multiple subjective realities exist (Appleton & King, 2002; Willig, 2012). Inherently, it denies the existence of single real world, perceiving multiple constructed realities (Ponterotto, 2005). I believed that therapists have unique realities and will tell us something about their thoughts and feelings as they respond to and experience their clients' difficulties, especially in terms of trauma memories. This is very much in line with Crotty's (1998) suggestion that meaning does not lie dormant within an object waiting to be discovered; rather it is created as individuals interact with and interpret

the object. This is fundamentally based on an ontological position labelled relativism, which perceives truth as relative, reality as subjective and influenced by experience, social interactions and context. Willig (2008) proposed that this ontological position recognises 'knowledges' as oppose to knowledge, that tends to be constructed in the mind of the individual and influenced by intersubjective interaction, and therefore is more of a reflection of multiple realities (Lincoln, Lynham & Guba, 2011). In keeping with the relativist ontological position, I admit that the analysis and interpretation of the data was continuously influenced by my experience and unique view of the world; therefore, I do not suggest that analysis can accurately and truthfully represent the interviewees' subjective world (Willig, 2012). Consequently, I included my personal standpoint when conducting the research (Madill, Jordan & Shirley, 2000). Constructivist grounded theory therefore proposes a version that "assumes the relativism of multiple social realities, recognises the mutual creation of knowledge by the viewer and viewed, and aims toward an interpretive understanding of subjects' meanings" (Charmaz, 2003, p.250). With this in mind, knowledge was acquired through in-depth interpersonal engagements between the participants and I, thereby lending itself to qualitative research methods such as face-to-face interviewing (Ponterotto, 2002, 2005).

2.4 Reflexivity

Reflexivity is an essential component of the constructivist-interpretivist research paradigm underpinning this study and the field of counselling psychology. Reflexivity necessitates an "awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgement of the impossibility of remaining 'outside of' one's

subject" (Willig, 2008, p. 10). This requires the researcher to engage in a process of conscious

reflection on their subjectivity and the dynamics of intersubjective interactions with the

subjects of the research (Finlay, 2002; Kasket, 2013). It is not enough to just engage in this

process silently and independently. Researchers are expected to reflexively demonstrate a

degree of transparency about the research activities, not merely silently engage in the

reflexive process. When a researcher reflects on the impact of their prior knowledge base and

values, the research becomes a more credible piece to the audience, as it gives them the

freedom to examine the knowledge it produces with an impression of the researcher in their

subconscious (Elliott, Fischer, & Rennie, 1999; Kasket, 2012). For this research I have engaged

in extensive reflexive exercises as highlighted by Etherington (2004) and Finlay (2002). I will

also be informing the reader of my personal stance on trauma experiences and psychological

distress, while acknowledging that my adopted therapeutic modality will likely influence

interpretation and construction of the research data (Please see section 2.4.3).

Willig (2008) suggested categorising these reflexive activities into three groups; personal,

epistemological and methodological reflexivity. The aim is to be open about my personal

experience and how this may potentially play an active role in shaping the research and impact

on me (Cutcliffe, 2000; Finlay, 2002). Finlay (2002) proposed that despite the effort, it is

important to recognise that our reflexive actions can only be partial, but one must also keep in

mind that reflexivity could 'go too far', overriding the contribution of the research participants.

For this reason, I will aim to find a balance so that my reflexivity will be for the benefit of the

research.

2.4.1 Epistemological reflexivity

I also considered the role of my values and assumptions on the research as informed by my academic background. As mentioned above, there's an interaction between myself and the participants, therefore was not possible for me to be neutral since already held beliefs, and personal and vicarious experience of trauma may have played a role in the analysis. I perceived myself as an integral part of the research process and believe that the knowledge generated would have been influenced by my presence and could potentially differ from what is derived by another researcher. I also acknowledged that the constructivist paradigm offers a philosophical framework that is coherent with his therapeutic approach within clinical practice. Nonetheless, it is important to be aware that people may have different experiences and make efforts to be non-judgmental during the interview process. I found it important to check the meaning of certain words whilst interviewing clients, and this directed interpretation and helped me to avoid misunderstanding. Although, the research question should be focused it is important that it was open ended to allow the generation of theory (McCann and Clark, 2003).

2.4.2 Personal reflexivity

I acknowledge that my experiences, assumptions, interests and beliefs may have influenced the research process, a notion that has been alluded to by several qualitative researchers (Fossey et al., 2002; Willig, 2001, 2008). I did a personal reflexive recording at the early stage of the research, where I commented on my own motivations, interests and preconceptions; this was later typed up into a Word document and reviewed. I wrote in a reflexive diary during this research to capture feelings, responses or preconceptions, especially after interviewing participants, where I made notes of significant personal associations and memories, which I

reflected on when analysing the data. I wrote in the reflexive diary at different stages of the

analysis and during thesis write-up.

I have friends and family members who have gone through and shared the nature of some of

their traumatic life experiences. Moreover, I conducted quantitative research on trauma as a

requirement of my MSc programme in Clinical psychology and mental health. This reflects my

interest in trauma and some of the findings from my previous research have formed the basis

of the current research. There was a desire to have a better understanding of the

phenomenon and its characteristics from a more intimate position rather than simply the

numerical data, which of course has its own values. However, I was initially apprehensive of

this as I have limited experience in qualitative research. I assume that the adopted approach

will facilitate personal development through learning and understanding of a new

methodological approach.

Also, my role as a trainee counselling psychologist was beneficial in that I had to engage in a

process of self-reflection. I used a reflective journal to avoid imposing my predetermined

knowledge and values whilst obtaining new meanings from the participants. The journal

helped me to distinguish between my personal experiences and that of the participants. I was

aware of the possibility of bringing my personal or vicarious experience of trauma and

intrusive memories to the current research, which may influence the process of research from

the research question to data analysis. I remained vigilant of the mixture of feelings and my

perception of the participant's experiences. As a client myself, I reflected on the nature of my

life experiences and those that were shared by friends and family members and the role these may have played in shaping who I am today.

Professionally, I had been working as a mental health practitioner for a few years prior to embarking on my clinical training and during the training. I have worked in a number of mental health settings across my career, including inpatient and forensic mental health setting, substance misuse service, community mental health team and supported housing for mental health patients. Although, my motivations for focusing on the topic of trauma-related intrusive memories are diverse, I became really interested whilst working within an NHS specialist substance misuse service where I had the opportunity to provide therapy to clients who were mostly affected by childhood trauma. I have been privy to professional and personal reactions of colleagues and allied staff in different settings, with them often sharing their personalised and distanced reactions in response to client traumatic material. As such it is important that I acknowledge the clinical and personal reasons driving this research. More so, I have long been interested in the role systems play in improving or worsening trauma experiences for clients and therapist. It is fair to say I have become curious as to whether this is a unique experience within the settings I have worked in or exists as part of the wider NHS system.

Personally, I have sometimes experienced what I would term "emotional tiredness" when working with complex trauma clients; where I experienced extreme tiredness after working with clients with significant trauma history. At the beginning of my doctoral training I found that I sometimes became consumed in the world of my clients and this seemed to result in me experiencing this "emotional tiredness". However, in the last two of years I have been learning

to separate myself from the experiences of my clients, something personal therapy and supervision has been helpful with.

2.4.3 Personal perspective on trauma and psychological distress

It is important that I share my personal perspective on trauma and psychological distress to allow transparency. I admit that as the researcher I will be an integral part to the research, particularly in the interpretation of the data. I mostly use CBT in my therapeutic practice; therefore, there is a likelihood that my interpretation is informed by my psychological stance. With this said, I consider trauma to be a deeply personal experience, a concept I believe can only be defined in terms of the person suffering it. I believe that people vary in their response to trauma. In some cases, similar and even identical external trauma experiences may not affect the survivors in the same way. It is possible that a feeling of helplessness can occur in one individual following the trauma while another person may possess greater tolerance or internal capacity before the trauma occurs, which potentially protects them from experiencing it as distressing. I consider trauma to be a combination of an external event or set of experiences with an internal process of registering it, remembering it, associating to other dimensions of one's life triggered by it and, in this way, giving significance and meaning to it. Some individuals may experience the triggers as reminder of the feelings of helplessness which transforms the here and now from benign to unsafe and affectively unbearable.

Everyone uniquely processes the world, including traumatic moments. However, what is important is understanding the unique meanings trauma holds for the trauma survivor. In

regard to the uniqueness of meaning-making in trauma experiences, I am of the opinion that the interpretation may be a reflection of previous experiences. Although, I understand why the medical approach place high value on diagnosing distressing trauma experiences and treating the symptoms associated with it, I believe this may not necessarily solve the problem over the long term. With this said, it would be beneficial to recognise and acknowledge the possible historical sources, the meanings attached to the trauma experience, its impact on their well-being, relationships and life. This perspective holds the client's appraisal of trauma memories as important to their experience of distress. On a whole I would say whilst my perspective on trauma and psychological distress is informed by cognitive-behavioural therapy approach, my tendency to focus on the person as oppose to simply reducing the symptoms also aligns me to the person-centred approach which considers the client as the expert in therapy as oppose to the therapist.

2.5 Research design

2.5.1 Rationale for adopting a qualitative research methodology

The research adopted a qualitative approach which facilitated insight into how participants (therapists) make sense of their clients' experiences of intrusive trauma memories. This is underpinned by my degree of constructivist epistemological perspective to develop a theoretical understanding of how therapists make sense of and construct their client's experience of trauma-related intrusive memories in the context of psychological distress. Qualitative research emphasises the importance of meanings and how individuals makes sense of the world (Willig, 2001), allowing a degree of flexibility in the methodological approach and facilitating the investigation of sensitive topics as the researcher can make connections with

participants. Therefore, I rejected the positivist approach that considers the world as unitary and the researcher as emotionally distanced, unbiased individual using techniques of the natural sciences to understand human behaviour. The acknowledgement that everyone has his or her own world and uniquely interprets events, behaviours and experiences in different ways is fundamental to this approach (Pidgeon & Henwood., 1993). The idiographic nature of the current research appropriately integrates with the qualitative paradigm as it allows for detailed investigation of the therapists'' subjective experience of their clients' trauma-related intrusive memories.

I considered qualitative approach to be a better fit with the open-ended research question motivating this study; moreover, it is a better fit for the aim of developing understanding inductively as oppose to testing hypothesis (Willig, 2008). Also, most of the research about intrusive trauma memories has adopted quantitative methods, therefore proposing a research that explores how therapists construct and make sense of their clients' intrusive trauma memories in the context of the clients' psychological distress is invaluable. It has been proposed that grounded theory methodology is appropriate when new theoretical explanations are needed to increase knowledge in the field (Grbich, 2007). Therefore, grounded theory was deemed appropriate for this research because the research questions and problems suggest the need to develop a sound theoretical foundation for establishing how therapists construct and make sense of their clients' trauma-related intrusive memories in the context of the clients' psychological distress. The chosen methodological approach presents an opportunity to contribute to greater methodological diversity within the field of psychology and psychological research into trauma memories. The value in creating remarkable

methodological diversity is based on my belief that it will make a significant contribution to the understanding of therapists' experience of their clients' trauma memories.

2.5.2 Overview of grounded theory

Grounded theory is a systematic approach to qualitative research that involves the construction of theory through the analysis of data (Glaser, 1978). It focuses on conceptually identifying and explaining an on-going pattern of social behaviour, through constant comparison and interchangeability of indices (Glaser, 2002). The constructivist version of grounded theory proposed by Charmaz (2003, 2006) suggests that data is constructed by the researcher and participants through an interactive process where they construct a shared reality. It concedes that it is shaped by the researcher's perspectives, values, interactions and environment. It assumes multiple realities and multiple perspectives on these realities, therefore adopting a realist and postmodernist positions. The constructivist approach will be adopted for the current research.

2.5.3 Rationale for using grounded theory

I considered a number of approaches when choosing qualitative research methods for the current study. I chose the constructivist grounded theory proposed by Charmaz (2003) because it allowed an interpretation of how participants construct their realities, presenting multiple perspectives, which distinctly differs from the classic grounded theory that aims to conceptualise latent pattern of behaviour. Therefore, it allowed me to provide an understanding of how therapists make sense of their client's experience of traumatic intrusive memories. Moreover, as the approach is designed to focus on the "processes" and "change"

(Charmaz., 2003); it allowed me to analyse the impact of clients' trauma-related intrusive memories on the therapists working with them. Grounded theory was particularly useful for this research as it promotes the generation of new theory. I was hopeful that adopting grounded theory analysis might enable model building and theory generation, with the belief that the approach presents the option to become more interpretative in the later stages of the study. It must also be highlighted that grounded theory is a fascinating methodology for me a trainee counselling psychologist as it aims to bridge theory and practice, which is in line with the scientist-practitioner approach the field ascribes to (Fassinger, 2005). Also, I am not convinced that another approach will allow for immediate response to possible emerging findings of the research.

The original formulation of grounded theory by Glaser and Strauss (1967) was not chosen because of their views on the use of existing literature and data collection. They suggested that refraining from a literature review would allow the theory to emerge from the data rather than being imposed from the existing literature. This is based on the notion that a researcher can be "removed from the research process" for an objective theory to be discovered (Lincoln, Lynham & Guba, 2011). Personally, I did not think it was feasible to conduct the research in isolation of a literature review. Moreover, the constructivist approach leans towards my adopted epistemological perspective, in comparison to the original version which seems to have a positivist leaning. Inherently Charmaz (2000) argued against most grounded theorists' objectivist status that "data do not lie…" by proposing that data are reconstructions of experience and not the original experience itself, which she termed as "narrative constructions" (p. 514). Other researchers have contested the notion that a researcher can

somehow be removed from the outcome of the research (Flick, 2014). I believe that it is impossible to carry out research without the influence of personal bias and interpretations on the data. Therefore, I recognise the interactive nature of data collection and analysis, whilst fostering the development of qualitative research that studies the experience of people who live it and from multiple perspectives. All in all, I believe that constructivist grounded theory is more suitable for the research as it has the potential to portray the participants' experience in its fullness.

Constructivist grounded theory is not without its shortcomings. Hernandez and Andrews (2012) expressed concerns that conceptualising research as a form of co-construction between researcher and participant presents a danger that the researcher perspective is given more importance over that of the participant. I intend to avoid this by including participants' words at all stages in the coding process and in the write-up. I aim to engage and communicate about the process of researcher reflexivity throughout the study. Constructivist grounded theory has also been criticised for abandoning theory development in favour of rich description (Glaser, 2002). In order to avoid this, I propose that the construction of abstract explanations of how therapists construct and make sense of their clients' trauma-related intrusive memories will be grounded in descriptions that participants shared during the research interview.

2.5.4 Critique of constructivist grounded theory

The constructivist grounded theory has become a popular approach in qualitative research studies, especially in the discipline of psychology. Several researchers have drawn on the work of Charmaz (1995, 2000) in formulating their argument for assuming a constructivist approach

(Jones, 2002; Dobson & Dickert., 2004; Madill, Jordan, & Shirley, 2000), thereby, buttressing the argument that the constructivist grounded theory is desirable because "data do not provide a window on reality. Rather, the 'discovered' reality arises from the interactive process and its temporal, cultural, and structural contexts" (Charmaz, 2000, p. 524). Focusing on the data enables multiple meanings to be elicited and by positioning the researcher as an important part of the process, their interaction with the participants produces rich data, which the researcher observes and defines (Charmaz., 1995b). The constructivist methodology presents an approach that allows meanings to be made from data and for participant's experiences to be rendered into readable theoretical interpretations. Therefore, this challenges the notion of the researcher as a "distant expert" (Charmaz, 2000).

Similarly to other qualitative approaches, grounded theory offers insight into individual experience as a whole. However, the research methodology can elicit and analyse qualitative data to identify important categories with the aim of generating a theory grounded in the data. There may be further benefits in allowing the important categories that emerge through the qualitative endeavour to further enhance quantitative investigations by eliciting some of the previously unidentified beliefs adopted by clients around their intrusive memories as understood by therapists. This may potentially enhance the validity of future quantitative research into the meanings attributed to trauma-related intrusive memories by individuals suffering from psychological distress. Furthermore, it has been argued that the constructivist approach considers both data and analysis as created from shared experiences and the relationship with participants and other sources of data, hence placing great emphasis on

studying the phenomenon (Bryant., 2002; Bryant & Charmaz., 2007a., 2007b). Moreover, the

approach goes beyond studying how individuals conceptualise their experiences, but studies

why participants construct meanings and actions in specific situations (Bryant, 2002). There is

an acknowledgement within the constructivist approach that the generated theory is a result

of the researcher's interpretation of the participants' construction of meaning; therefore, the

resulting theory is not able to stand outside of the researcher's view. (Charmaz, 2008a).

It has been suggested that Charmaz has simply re-modelled the original grounded theory,

which may pose a remarkable dilemma for all researchers, in that while it is paramount that

methodologies are open to evolution, researchers have to be wary of the point at which the

methodology is changed so much that it no longer resembles the original, in this case

grounded theory methodology (Byrant, 2009). Glaser (2002) also criticised constructivist

grounded theory for opposing the openness of the classical methodology by predetermining

one particular lens through which data is analysed. In this way it differs from the classic

grounded theory that can use any type of data and refrains from attaching itself to any

theoretical perspectives therefore is free from any ontological or epistemological lens.

Constructivist grounded theory instead chooses to adopt the lens of the researcher and that

which is appropriate to the data. Bryant (2009) has suggested that preoccupation with the

philosophical positions may "distract from the simplicity of its purpose", which is to generate

theory from its data. Breckenridge et al. (2012) argued that epistemological perspectives and

ontological stances should not be discrete and incompatible, rather, should be seen as

proposing complementary approaches to understanding social phenomenon. However, on the

other hand, in constructivist grounded theory, the researcher is expected to explicitly

acknowledge and explore their philosophical position in the early stages of the research as this

will frame the usefulness and potential impact that the literature review conducted before

data collection and analysis will have on the generated theory (Mills, Bonner, & Francis, 2006).

The application of a constructivist grounded theory methodology presents methodological

limitations in relation to researcher bias, which is inherent in a constructivist grounded theory

study. Also, there may be limitations in the ability to generalise the knowledge constructed

within a social context. It has also been argued that the reflexive process within a

constructivist grounded theory relies a great deal on the researcher's subjective

interpretations and perspectives of the data, which is shaped by their values. This may pose

limitations on the validity of the emergent grounded theory. I chose to conduct the research in

a setting within my area of expertise and familiarity, which allowed me to reflexively interact

with participants. An unfamiliar setting may pose restrictions in my ability to identify concerns

that may been inherent within the study.

2.5.5 Rationale for semi-structured interview

I chose semi-structured interview as most appropriate for this study because it offers flexibility

in its approach, as questions can be tailored to suit interesting topics that come up during

interviews. In this way, it allowed me to further investigate areas of uncertainty that could

potentially be useful. It is assumed that the approach tends to allow the participants to feel

relatively comfortable discussing their experiences of working with trauma clients whilst also

sharing the personal impact of working with the client group. I chose not to use focus groups

as it is anticipated that therapists may not be as open when discussing the impact upon them

of working with trauma clients. Willig (2008) suggested that people find it more difficult to

discuss personal topics in group settings. It has been argued that researchers must be mindful

of the tendency to focus on cognition at the expense of emotion, behaviour and social context

when conducting semi-structured interviews (Kvale & Brinkmann., 2009). I was hopeful that

my therapeutic practice would help me to pay attention to the emotion inherent in the

participants' narratives. Moreover, constructivist grounded theory may contribute to creating

a focus on social and interpersonal contexts and processes.

2.6 Critical comparison of alternative qualitative approaches

As already mentioned, a number of qualitative approaches were considered when choosing a

research method for the current research project, before settling on constructivist grounded

theory. They include Interpretative Phenomenological Analysis (IPA), discourse analysis and

narrative analysis. They will briefly be considered here.

2.6.1 Interpretative Phenomenological Analysis (IPA)

IPA is an approach to qualitative research that aims to explore and understand participants'

understanding of the phenomenon being investigated (Smith, Flowers, & Larkin, 2009, Smith &

Osborn, 2008). IPA relies on the researcher's views to make sense of the lived experience of

the participants, through the practice of interpretation. This is regarded as a double

hermeneutic, the process whereby the researcher makes sense of the participants' sense-making (Smith, 2004). IPA usually utilises individual semi-structured interviews for data gathering as it is an appropriate methodology for gathering subjective accounts that emerge from the participants' description of their lived experience. A major strength of IPA is its ability to address the "wholeness and uniqueness of the individual", (Malim, Birch, & Wadeley, 1992). However, this has also been a limitation of the approach as generalisations are largely not feasible and also deemed "subjective, intuitive and impressionistic" (Malim et al., 1992). However, it has been emphasised that the aim of IPA is to sacrifice breadth for depth by reporting richer depth of analysis as opposed to making premature generalisations, therefore allowing participants' experience to be heard and shared (Smith, 2004, Reid, Flowers, & Larkin, 2005).

It has been suggested that there are difficulties when trying to make a significant distinction between IPA and grounded theory, as they share a similar method of analysis and data collection, alongside other techniques, when producing data (Brocki & Wearden., 2006; Willig, 2008). For example, symbolic interactionism is important in both methodologies, as they both concentrate on "how meanings are constructed by individuals within both a social and personal world" (Smith & Osborn, 2008). Despite the similarities, there are fundamental differences between grounded theory and IPA in their theoretical grounding. Grounded theory is suitable for discovering relationships between process and social phenomena, with consideration of the social-cultural perspectives and multiple positioning. This makes it

appropriate for research investigating trauma-related intrusive memories from the

perspectives of a therapist.

IPA sampling tends to use homogenous samples as a small sample is deemed to provide

sufficient perspective with adequate contextualisation (Smith & Osborn., 2003). On the other

hand, grounded theory uses theoretical sampling, which aims to continue to collect data

considering the analysis until no new themes are emerging, hence potentially establishing

theory from a broader population. IPA is inwardly focused, in that it looks at the experience

from the inside, while grounded theory investigates what comes out of the data, therefore

looking at the collective view from the inside out. Furthermore, considering the research

question and hence the need to develop a theoretical understanding of the extent to which

trauma-related intrusive memories are present in individuals suffering from depression, it

would be worthwhile to adopt a research methodology that enables the development of a

theoretical foundation of the phenomenon. Grounded theory methodology has been shown to

be appropriate when new theoretical explanations are needed (Grbich, 2007), a function IPA

would not be able to fulfil.

2.6.2 Discourse Analysis

This approach originated from linguistic studies and is concerned with the language being used

by the participants. Discourse analysis specifically analyses how individuals create and enact

identities and activities through language (Gill, 1996; Potter, 1996; Wetherell et al., 2001).

Although, language is in itself meaningless, through mutually shared and agreed use of language meaning can be created (Gee, 2005). As with most qualitative research methodologies, semi-structured interviews are often used for primary data collection. However, it has been suggested that in discourse analysis, the objective of an interview is to capture an individual's language, which will provide insight into how they achieve their objectives and position themselves in relation to others (Gee, 2005). The researcher and participants are known to use language to present themselves and the phenomenon they represent in a particular way. More specifically, a researcher using same words with a participant does not necessarily imply they share the same meaning. Therefore, the objective of discourse analysis is to understand the meaning behind the language employed by participants in any given situation or context, which will involve probing for intertextual meaning (Burr, 1995). This is different to grounded theory and IPA, where the researcher and the participants can assume their verbal expressions will be understood as spoken and intended, therefore only probe for detail and clarity. Grounded theory is also different to discourse analysis in its attempt to generate explanatory theoretical understanding of basic social processes studied in context. In relation to the proposed research, it is assumed that some reality exists about the presence of intrusive memories in depression as suggested by the literature. However, the extent to which the phenomenon will emerge from participants and its characteristics are yet to be understood.

2.6.3 Narrative Analysis

Narrative analysis is a research method that is known to fit well with psychological therapy as it conceptualises the individual's account of themselves, this narration is viewed as constructions of identity (Linde, 1993, Riessman, 1993, 2001). Ricoeur (1985) proposed that narratives are fundamental to communication as we use them to make sense of our lived experience. Narrative analysis provides us with a structure, and we employ the forms and genres of narratives available when plotting our story. These influence people to share common explanations and understanding (Fisher, 1987). Three different approaches to narrative analysis were proposed by Riessman (1993). The life story analysis involves the construction and translation of an account from the interview, where the researcher retells the person's story, taking their perspective and examining how the accounts are "emplotted" and which genres the person draws on (Burck, 2005). Another type of narrative analysis selects a sequence of core narratives within an interview and examines the structure and thematic connections between them (Labov, 1972). The third analysis involves re-transcribing the narrative as poetic stanzas which enables the analysis of the metaphors within it, therefore revealing new meanings in and out of the account (Gee, 1991). It has been argued that narrative analysis is essentially a hermeneutic study that attempts to gain entrance to the perspective of the speaker and the audience (Labov, 1997). This inherently deepens our understanding of what language and social life constitutes. Narrative analysis has been criticised for its lack of grounding in an epistemological foundations, and at times has been deemed to be to variable, going from phenomenology to realism and empiricism. It has also

been criticised for not providing information on the number of participants' narratives that would be sufficient for analysis.

The adopted research methodology approaches grounded theory through a constructivist lens that addresses how multiple realities are made with the important involvement of the researcher in the process, which is grounded in a strong philosophical framework. Congruence between the philosophical positioning and the methodology is especially important; the generated theory reflects the participants' lived experiences and multiple perspectives, which is primarily linked to counselling psychology as a discipline. Considering the alignment between constructivist grounded theory and the proposed research that explores how therapists construct and make sense of their clients' trauma-related intrusive memories, it is proposed that the constructivist grounded theory offers a valuable methodology for research in this field.

2.7 Ethical considerations

The research was conducted in accordance with the BPS and HPC Codes of Ethics and Conduct (2009, 2010). I sought and received ethical approval from City University Research & Ethics Committee before beginning data collection. During the recruitment stage and prior to the commencement of interviews I gave participants comprehensive information about the nature of the research. I made them aware of their right to withdraw from the research at any time, while also informing them that this would not affect any form of compensation that had been offered or received by them. In such cases, any data from the participants would be destroyed

in accordance with the BPS code of conduct (2009). No deception was used during the study; participants were informed that the data gathered would only be for research purposes and would remain confidential throughout. Further, the information obtained from the participants during the research study was kept secure, in a locked filing cabinet in my home to avoid disclosure to unnecessary sources and if published would not be easily identifiable as theirs as all the data was anonymised. I considered the potential impact of discussing some of the narrative. Therefore, all participants were debriefed following the interviews, with me giving appropriate time to manage issues that might arise in the discussions. The participants were given information and contact details for local support groups and organisations in the event of any concern after the study had ended. I ensured I maintained boundaries with the participants to avoid possible conflict.

2.8 Participants and procedure

2.8.1 Initial literature review

The use and timing of the literature review has often been a contentious issue in grounded theory, with a number of theorists arguing that the methodology requires grounded theory researchers to carry out their research without an extensive review of literature (Cutcliffe, 2000; Evans, 2013; Glaser & Strauss, 1967; Holton, 2008; McGhee, Marland & Atkinson, 2007). However, a comprehensive summary of the changing perspectives on this issue provided by Dunne (2011) proposed the importance of the researcher's justification and explanation of why and how existing literature will be used. The purpose of the literature review is to identify research that has been done around trauma-related intrusive memories, following this, developing research questions and an approach that allows the generation of new knowledge

that could make an original contribution to the research area and counselling psychology as a discipline. This research followed an approach consistent with the principles of constructivist grounded theory, by conducting an initial review of literatures into trauma-related intrusive memories during the design of the research. Hence, there is risk of preconceived ideas being imposed on the analysis, expecting this to be bracketed off would be untenable, therefore a memo was used to record emerging ideas and reflections to identify moments where there is a realisation of a connection between the data and existing literature.

2.8.2 Participants - inclusion and exclusion criteria

A sample of 9 qualified psychologists from various NHS psychological services was recruited for the current study, with the interview focusing on multiple clients they had worked with or were currently working with clients who experienced trauma memories. It was important that they had sufficient trauma work experience to enable them to provide rich data for the research. Psychologists from varied psychological school of thought and therapeutic approach were interviewed. Please see table 1 for representation of participant pseudonyms, therapeutic modality and work setting. It is assumed that the participants' therapeutic modality and the theory of distress they ascribe to will have a significant impact on their construction of their clients' experiences. The participants were given the freedom to refer to multiple clients during the interview process. Individuals who are receiving treatment for trauma related mental health problems were excluded from the sample, to protect them from the sensitive nature of the research area. Participants were recruited through advertising the study via posters and emails to places that provide psychological services, such as NHS, GP surgeries, and voluntary therapy services.

Table 1: Sample profile

Participant pseudonym	Therapeutic modality	Work setting
Jade	Cognitive Analytic Therapy	NHS Service
Jason	Schema therapy	NHS Service
Clara	Schema therapy with CBT and mindfulness techniques	NHS Service
Charlotte	Trauma-focused cognitive behavioural therapy and schema therapy	NHS Service
Sandra	Trauma-focused cognitive behavioural therapy	NHS Service
Jessica	EMDR and Sensorimotor psychotherapy	NHS Service
Kathleen	Cognitive Analytic Therapy	NHS Service
Charmaine	Trauma-focused cognitive behavioural therapy	NHS Service
Tara	Trauma-focused cognitive behavioural therapy	NHS Service

2.8.3 Data collection and design

I employed qualitative research methodology for the current study. Data was gathered

through face-to-face semi-structured interviews. The interviews were approximately 90

minutes long. The interviews explored how therapists make sense of their client's experience of trauma-related intrusive memories and their role in psychological distress. The interviews also explored how therapists make sense of their clients' trauma-related intrusive memories. Neutral, open-ended, exploratory questions and prompts were employed (Smith, 1995). The interviews were recorded with the aid of a voice recorder, with the participant's consent. I used reflection during interviews to check understanding of the content of participant responses. An information sheet was presented to participants and written informed consent was obtained. Information about the study was also summarised verbally to each participant to ensure they understood what their involvement would entail and to give room for any questions by the participants. When the interviews were concluded participants were given an opportunity to provide feedback to the interviewer and share their reflections.

Grounded theory was used to generate a theoretical explanation from the data, which could be tested against data subsequently collected. In accordance with grounded theory, an analytical approach whereby data collection and data analysis are closely related and simultaneously conducted was employed. This allowed data collection and participant selection to be shaped by on-going analysis which aimed to refine the emerging concepts, themes and theory.

2.8.4 Sampling

Recruitment was driven by purposive and theoretical sampling. Purposive sampling was initially used to recruit qualified psychologists with experience in trauma work who utilise varied therapeutic intervention, in order to obtain a range of experiences. In keeping with the

principles of grounded theory, I employed theoretical sampling; and performed data collection

and analysis simultaneously whilst remaining open to new data. This allowed me to identify

hypotheses from the data analysis. Recruitment continued until data saturation was achieved.

2.8.5 Data transcription

Interviews were transferred from the voice recorder to a password-protected computer file

and transcribed using Windows Media Player into a Microsoft Word document shortly after

each interview was conducted. The transcription key in the work of Gail Jefferson (cited in

Potter & Wetherell, 1994) was used for this research. I removed identifier names and replaced

them with false names; also, lines of text were numbered for ease of reference in the write-up.

Specifically, in the transcript I identified myself by the letters AI and the participants by their

pseudonym. The pseudonyms used to identify participants are as follow: Jade, Jason, Clara,

Charlotte, Sandra, Jessica, Kathleen, Charmaine and Tara. A relatively conservative approach

for transcription was adopted, with details such as tone, pauses, pacing and volume

transcribed, especially if the detail appeared to be meaningful or there was an evidence of a

change to the meaning of the text. Hammersley (2010) suggested that a transcript can only

capture some of the data in a research interview and therefore cannot be considered an

objective and complete account of the interaction, a notion I agree with. For this reason, I

sometimes listened to the tape whilst following the transcript to capture the essence of the

interaction. This also enabled me to check for data accuracy and allowed me to become

familiar with the data. Nonetheless, it would be ill-informed to consider it to be an objectively

complete account of the interaction.

2.9 Data analytic process

The less prescriptive appraisal of grounded theory proposed by Charmaz (2006) was employed for this research, and informed data collection and analysis. Three forms of coding were used (open, theoretical and constant comparative). Coding is the key element that linked data with emerging theory, to describe what is happening as well as the meaning (Charmaz, 2006). The data was coded using Max QDA and transferred into a Microsoft Excel file where lines of data, labels and concepts were recorded along with line numbers. Each label was recorded along with the quote in an adjacent column in an Excel spreadsheet.

The essential objective of the analytic procedures in grounded theory is to help the researcher to maintain momentum in a conceptual direction (Charmaz, 2013). McGhee, Marland, & Atkinson, 2007) explored this notion and considered an inductive-deductive relationship as being inherent in grounded theory, as it generally begins with an inductive process whereby researchers explore a topic of general interest with an open mind, prioritising the emerging data over pre-existing literature or theories and over time the process becomes deductive as categories are constructed from the data and developed through further data collection. In consequence, analytic process in constructivist grounded theory demands insistent interaction with data by the researcher, whilst also staying close to the emerging categories or concepts, as proposed by Bryant and Charmaz (2007). The stages of analytic process that I used for the current research are described below, which follows the guidelines set by Charmaz (2006, p.10.).

2.9.1 Initial coding

This involves defining the actions and meanings of the data; this process is one of the key stages of grounded theory analysis (Charmaz, 2008). Data was coded line by line by attaching labels to sort and compare interview extracts to make sense of the emerging findings. I completed the initial line by line coding quite quickly, writing short and action-oriented codes in spontaneous ways to avoid over-interpretation of data. This follows an approach consistent with constructivist grounded theory that requires researchers to stay close to the data by using action-oriented coding and keeping notes short and precise (Charmaz, 2014). This was helpful in describing what might be going on in each line and in avoiding making loose descriptive codes that can result in the loss of the meaning of the data. I listened to the audio recording of the interview during the initial open coding in order to clarify and check the accuracy of transcription. I also reviewed the initial codes against the transcript to ensure I stayed close to the data. I found that I struggled with this to an extent as instinctively I was looking for themes. On reflection, this may be because of the way I engage with clients when I see them in therapy; moreover, my previous experience of qualitative research was in thematic analysis. For this reason, it took conscious effort for me to code in a way that seemed more appropriate to grounded theory analysis.

2.9.2 Focused coding

The next phase of coding is the focused coding, where I began to put the data back together after its fragmentation in the line by line coding. I aimed to synthesise a number of different codes and data paying in attention to what seemed to be more meaningful, in that they occurred frequently, account for large amounts of data and were pertinent to the research

questions (see appendix 10 for sample of coding systems and coding segments). Thus, it could be said that focused coding views the wider picture through a larger segment of data at a macro level, unlike the initial coding that seems to zoom in on data at a micro level. This process helped to identify the emerging concepts and interpretive ideas without losing the details obtained from the initial coding. Focused coding continued until the construction of hypothetical categories which led to the construction of major categories and later emerging core category. Throughout the coding process comparative methods were used to compare experiences for similarities and differences.

2.9.3 Memo writing

Memos about codes and comparisons were made throughout the analysis to capture emerging hypotheses and to facilitate the theory building and write-up, as well as to identify and record relationships between categories. This is an important tool for moving analysis in a conceptual direction (Lempert, 2007). There are two main types of memos, procedural and analytic (Esterberg, 2002). Procedural memos focus on the process and evolution of research, assisting the researcher to be aware of connections made with the pre-existing literature and the resulting direction of analysis (Lempert, 2007). On the other hand, the objective of the analytic memos is to capture thoughts, questions and ideas about the meaning of the data at hand. Thus, memos make a valuable contribution to the expansion of ideas, providing a space in which a researcher can engage in critical reflexivity (Charmaz, 2014).

I made a decision to write memos as part of the analytic process. I tried to include participants' words and codes in each memo so as to try to stay connected to the data. I found that it also

helped me to check my ideas against the data and identify the gaps in my knowledge (See appendix 11 for sample memo). I sometimes found that my attempt to stay close to the data left me overwhelmed, therefore decided to create moments of freedom from the huge amount of data to which I was trying to do justice. As recommended by Charmaz (2013) I asked myself important questions such as;

- "What is this data a study of?"

- "How does it compare with what I thought it was a study of?"

- "What is the larger story at play here?"

- "What process is at issue here? How would you define it? To what extent is it explicit or does it remain implicit?"

- "Under which conditions does this process develop? How do I think, feel and act while involved in this process?"

I found that asking myself these questions kept the process moving forward, and a degree of distance for the data was welcomed. The questions reminded me to refrain from being thematic, instead helping me to be focused and interpretative, staying close to the data, therefore keeping analysis grounded and minimising the tendency for conceptual leaps in the analytic process. I was able to clarify connections and comparisons within the data, adding richness to the research process.

2.9.4 Further data collection

This involved further data collection to develop more focused codes and to advance memos. Coding was more focused on meaning rather than summarising statements. Participants were

recruited with the explicit purpose of category and theory development, which is called theory

sampling (Hallberg, 2006). Therefore, this stage involved the theoretical sampling of additional

participants with the view of developing the categories. I produced a revised interview

schedule with questions related to the emerging categories (see appendix 8 for revised

interview schedule). During these interviews I asked participants questions about how the

clients are perceived within the system and how they see themselves with the system, in

relation to the nature and dynamic of their relationship with the service. I used identical

recruitment approaches, advertising the need for two qualified psychologists. Two

psychologists volunteered and were interviewed shortly afterwards. I was open to the

possibility that the subsequent interviews might lead to the development of new ideas or

categories. The final two interviews were put through the same analytic process of

transcribing, coding, memo writing and categorising as the first seven interviews.

2.9.5 Analytical categories

These were derived from the initial coding and memo writing in order to define ideas as well

form preliminary analytical categories. Any gaps or questions identified about the data were

documented to be followed up in later interviews. The categories are substantive process

constructed from the data that are conceptual, interpretative and precise (Charmaz, 2006). I

engaged in several attempts to capture the process identified in the codes and themes. For

instance, "sensing loss of agency" "abuse is re-experienced within the system" and "avoiding

the predatory memoires" were potential categories that I started to develop however I

decided against selecting them as main categories as I felt they did not fully capture the major

processes and not sufficiently grounded in data (See Table 2 for a table illustrating the links

between transcript data, codes and categories).

2.9.6 Constant comparative analysis and negative case analysis

The analytic approach was informed by the principles of constant comparison that encourage

me to ensure the richness of their data (Willig, 2008). This was achieved by moving back and

forth between the identification of similarities and differences within emerging categories

(Willig, 2013) with the aim of constructing categories that are grounded in the data. The

process involved comparing parts of the data with other parts of the data, comparing codes

with data and codes with codes. This process facilitated the identification of emerging

subcategories and ensured categories were simplified into smaller meaningful entities so as to

ensure that the complexity of the data is retained, and all instances of variation are captured

by the emerging theory (Willig, 2013).

Negative case analysis was utilised to develop emerging theory in light of data by looking for

instances that did not fit (Willig, 2013). Following this, the category was adjusted or elaborated

to capture the diversity of the data and where appropriate explanation was proposed to

qualify the existence of the negative case, permitting it to remain in the existing category.

2.9.7 Theoretical saturation and integration toward theory development

In theory, data collection and analysis are supposed to cease once theoretical saturation has

been achieved. Theoretical categories are therefore 'saturated' with data and no new data can

change the properties of core categories (Charmaz, 2006) and no new patterns or categories

can be identified (Charmaz, 2014; Willig, 2013). However, the notion of theoretical saturation

has been challenged by a number of authors, who have questioned how a researcher is able to

proclaim with certainty that no new insights can arise from the data (Bruce, 2007; Hallberg,

2006; Willig, 2008). Moreover, it is proposed that the time limitation that comes with doctoral

research project like mine lend studies conducted using this method to an abbreviated form of

grounded theory (Pidgeon & Henwood, 1997; Willig, 2008). Further, Dey (1999) stated that the

term 'saturation' is imprecise and instead suggested using the term 'theoretical sufficiency' as

a way of moving away from a prescriptive grounded theory and acknowledges the researchers'

subjective role in deciding when categories are saturated. In this research rigorous constant

comparative analysis was utilised for the interviews until it seemed unlikely that new

categories would emerge and inconsistencies in the data were accommodated or accounted

for. With this in mind, the research aimed for Charmaz's (2008, pp. 132) "plausible account" of

how therapist make sense of their clients' trauma-related intrusive memories in the context of

their clients' psychological distress. Through a process of constant comparative analysis, the

categories were sorted in order to identify a core-connecting category, main categories and

sub themes. Research supervision was utilised to assess the quality of initial analysis, the

formation of emergent categories, the synthesis of integrated categories and theory

development. (See Table 2 for an illustration of the journey from transcript through to coding

and emerging categories).

The final stage in the analytic process comprised of theoretical sorting of categories, including

attempts to elevate categories to main category or core category status, before arriving at the

model presented in the discussion chapter.

Table 2: Illustration of the links between transcript data, codes and categories. (In keeping

with recommended practice, participants were allocated pseudonyms - McCann & Clark,

2003c)

Transcript data	Initial codes	Focused codes	Emerging Categories
"…the one with the dissociative presentation… had intrusive memories… her flashbacks were very extreme and mostly in the therapy setting, primarily because her use of dissociative strategies meant that she would often not remember outside the therapeutic setting and sometimes inside the therapeutic settings erm... the other client had very frequent intrusive memories really whenever she stopped, as soon as she slowed down immediately they would be waiting to intrude and that was what she found so difficult and… managed that by just being too busy to think or feel …" (Jade)	Client characterised by diagnosis Intrusive memories in therapy Doing/active Inactivity in therapy Trauma memory is active	Acting with a purpose Defending against the intrusions	Avoiding the predatory memories
"…it's very distressing because one she's re-experiencing the abuse, the feeling of powerlessness, helplessness…then the next layer comes with you know er... "It can't be real, it didn't	Abuse is re-experienced Feels Denying the occurrence of the trauma	Experiences self as having no control over mind	Threat to sense of self

happen, it's just me, I must be going mad" so that adds more the whole anxiety and depression. Depression is fed by the helplessness..so the helplessness she experienced during the abuse is perpetuated later so it carries on…" (Jason)	The experience causes distress I can't stop the memories, and nothing will make it better	Loss of agency	

2.9.8 Pluralistic-pragmatist analytic perspectives

The analysis presented reflects a conscious effort to be flexible in the analytic approach, a notion that could be regarded as 'pluralist-pragmatist'. In order to do justice to the diversity of the data, different levels of analysis were included, for example, aspects of the data were explored at a phenomenological level. Social constructionist and cognitive approaches were also at play, thus resulting in the use of different types of language, representing different levels of analysis. Therefore, psychological language was used to try to capture inner feeling states, whilst cognitive approaches were adopted to explore beliefs and ways of managing trauma and its impact. The pluralistic analytic approach was adopted in response to the richness of the data, which allowed me to consider a number of different levels of the data. This was a conscious endeavour as my objective was to be data-driven, hence moving between these different levels of analysis. For instance, when participants referred to the resilience that is inherent in some of their clients who have suffered from trauma, we explored how social construction of trauma clients as 'vulnerable' may mean mental health practitioners forget about their resilience.

2.10 Evaluating quality of this study

The evaluation of standards of quality of data in qualitative research is of high importance. The quality of the presented research is informed by guidance from grounded theory researchers (Charmaz, 2006), counselling psychology researchers (Morrow, 2005; Willig, 2012; 2013) and other qualitative researchers (Elliott, Fischer & Rennie, 1999). Elliott, Fischer & Rennie (1999) recommended a comprehensive set of quality guidelines for qualitative studies, which includes the researchers' disclosure of personal and theoretical perspectives, shedding light into aspects of the reflexive process and making sure to include examples. To maintain good quality during the research process, I owned my perspectives and was clear about my adopted theoretical orientation and personal values, admitting that it is impossible for my values and experiences to be fully separated from the construction of the analysis. I appropriately clarified how the research paradigm fits the research questions. I have engaged in personal, methodological and epistemological reflexive processes throughout the process of conducting and writing up this research. Extracts of my reflexive notes can be seen Appendix 12.

The research included the use of concurrent data collection and constant comparative analysis, theoretical sampling and writing of memos, which I believe creates an awareness of the quality and scientific merit required of grounded theory research as concluded by Elliott & Lazenbatt (2004). I also discussed the approach to coding and engaged in the process with colleagues and experienced qualitative researchers during study groups, whilst also comparing the coding. Also, I provided information on the extensive coding and analytic process in the methodology chapter, with extracts of transcription, coding, memos and categorisation process provided in appendices 10 and 11. Finally, I considered guidance specific to

constructivist grounded theory, with Charmaz (2008, identifying credibility, originality,

resonance and usefulness as four key quality criteria. See section 4.6 for information about

how this study attempted to meet the identified criteria.

CHAPTER 3: RESEARCH ANALYSIS

3.1 Overview

This chapter will provide an account of the outcome of the analytic process which followed transcription of the data from the semi-structured interviews. It will present a core connecting category and other categories that emerged from the analysis through constant comparison. The categories will be grounded in extracts from participants' narratives and experiences.

3.2 Introducing research analysis

The primary aim of this research is to explore how therapists construct and make sense of their clients' intrusive trauma memories in the context of the clients' psychological distress. Concurrently, it will explore how *therapists work with clients' trauma-related intrusive memories* and explore how therapists understand the impact of trauma work on their psychological well-being. It is acknowledged that the participants varied in the degree to which they discussed their clients' experiences of trauma-related intrusive memories and their own experience of working with this group. Some participants formulated their ideas based on what they had being told by their clients whilst it was also noticed that some described imagined ideas about how intrusive memories were experienced by their clients based on their knowledge of the client. In other words, participants shifted between lived experiences of working with trauma clients to postulations about their clients' experiences. Therefore, I acknowledge that the therapist is a mediator and I have a degree of faith in the reality of the therapist telling us something useful. The extensive nature of the data makes it incomprehensible to present an exhaustive account of the categories. The categories most

saturated of the participants' accounts and those most closely related to the aims of the research are prioritised and presented here.

3.3 Psychological distress in trauma memories

The therapists that participated in this research were able to construct the trauma-related experience of multiple clients they had worked with during the semi-structured interviews. The participants constructed their clients' experience of trauma memories as contributing to the clients' psychological distress. A range of feelings were associated with intrusive images, including fear, sadness, anxiety, threat and helplessness. From the therapists' perspective their clients' experiences of intrusive memories tended to significantly impact on their mental well-being, particularly in the form of anxiety and depression. They also described their impact on the clients' relationships. The feeling of hopelessness and helplessness was described by the therapists as being expressed by their clients due to the intrusive nature of the memories, especially when past abuse was being re-experienced through their intrusive memories.

Charlotte -"it impacts on her mental health, she becomes very low in mood, her anxiety increases, self-harm increases, suicidal ideation increases, her relationship with those around her is affected. Erm I think partly because of her feeling that they don't understand…erm her experiencing being frightened to let people know what's going on in her mind" (485).

Jessica - "her thought patterns would be things like I'm not good enough, I'm not woman enough I can't please I'm not going to be able to please him and yea erm and erm emotion are things like, she describes sadness, resentment, self-blame, a lot of self-blame and shame and

guilt and of course she's got a lot of physical responses, physiological reactions that you also see as well" (688).

The therapist further described instances where the feelings of hopelessness and helplessness that accompanied the intrusive memories resulted in clients becoming suicidal and at times attempting suicide as they struggled to see an end to their suffering. The quote below describes how the cyclical distressing impact of intrusive memories experienced by clients led to them feeling suicidal.

Jade - "it's very distressing because one she's re-experiencing the abuse, the feeling of powerlessness, helplessness, erm and of course then the next layer comes with you know er…"it can't be real, it didn't happen, it's just me, I must be going mad" so that adds more to the whole anxiety and depression. Depression is fed by the helplessness from all of that, so the helplessness she experienced during the abuse is perpetuated later so it carries on, sometimes for her it comes to a time when she just wanted to end her life… she has tried before" (143).

Figure 1: Memo - Personal reflexivity on the interview
In the first couple of interviews there were moments when I felt awkward, especially as I was interviewing a female psychologist, I was nervous about asking them questions that related to the sexual content of the intrusive memories experienced by their clients. I was wary that it could be seen as me enjoying it, and for this reason I noticed I refrained from asking them specifically what the intrusive memories contained when it became obvious that the client had experienced sexual abuse. This social awkwardness was also apparent in the participants, when they struggled to get their words out, lowered their voice, laughed awkwardly.
Looking back at the transcript my awkwardness came across through my silence or sometimes lowered voice, whilst also refraining from speaking directly about the related topics. My identification as a man and worries about how I could be perceived meant I didn't feel free to speak freely about the sexual content of the intrusive memories. However, having noticed this issue I later began to ask the participants questions that were related to the abuse they suffered and the associated intrusive memories. I became more open to these discussions and encouraged participants to speak about topics if they were comfortable doing so, with the understanding that not all the participants would feel comfortable about it.

3.4 Intrapersonal and Interpersonal discourse in the experience of trauma-related intrusive memories – core connecting category

The participants reported that their clients found the intrusive nature of the trauma memories to be critical to their mental well-being, relationships, and their adopted ways of coping. They reported that their clients struggled with their sense of self and identities in view of their on-going intrusive trauma memories whilst they also explored the role mental health system plays in their re-traumatisation and adoption of survival strategies. The participants also constructed the impact of trauma work on them and the role the mental health system played in its maintenance. The experiences shared by the participants indicate that the experience of trauma-related intrusive memories involves intrapersonal and interpersonal discourse. The main categories and their relationships to the core category is addressed, as shown in Table 3.

Table 3: Relationship between core connecting category and main categories

Category title	Category overview	Link to intrapersonal and interpersonal discourse of trauma-related intrusions
Threat to sense of self	Explores perceived threat to sense of identify and self-esteem. Trauma is presented as current, increasing feeling of distress.	Intrapersonal discourse
Appraisal of trauma memories	Outlines the impact of interpretation of the memories. It explores the role	Combination of intrapersonal and interpersonal discourse

	of cues and anticipation of intrusive memories	
Discovering survival strategies	Identifies the instinctive attempts to manage intrusive trauma memories	Identifies initial automatic attempts to defend against trauma memories.
Therapists' process in therapy with trauma clients	It examines the therapists' process in exploring the connection between them and the client. It explores the benefits and challenges of feeling connected with clients	Illuminates intrapersonal discourse
Therapists changing and reflecting as a result of trauma work	Therapist reflects on how trauma work has changed them and their clients. It explores the influence of the mental health system on client re-traumatisation	Extrapolates intrapersonal and interpersonal discourse
Therapists discovering coping strategies	Explores attempts to manage impact of trauma work	Considers interpersonal and intrapersonal discourses for coping

3.5 The threat to sense of self and trauma memories

Traumatic events may lead to different responses, which can include phasic alterations of self-identity experiences. These may be linked to a sense of current internal threat for example a threat to one's self-perception as acceptable or worthwhile which becomes challenged as a result of the intrusive memories, which may then inhibit or distort self-perception.

Table 4: Subcategories of 'Threat to sense of self'

Threat to sense of self
Losing sense of self as thinker
Losing sense of agency
Here and now quality of trauma

3.5.1 Losing sense of self as thinker

It appears that the degree to which an individual's sense of self is affected also determines how distressed they become. Therapists' understanding of their clients' distress was that the clients whose sense of self was threatened became vulnerable to psychological distress as what they had always believed was challenged by the intrusive nature of the memories. The quotes below illustrate how a client began to experience anxiety after they began to lose sight of themselves as a result of the intrusive memories, as gathered from the therapist's perspective.

Jade - "…once she had stopped and had crashed and had been to the mental health services and wasn't working then the intrusions started to come and they didn't fit into her belief that she had had a good childhood…so this was her anxiety 'what on earth happened? How much of this is me, what's there's? who am I?, all over the sense of who she was… all about her

sense of herself in light of these intrusive memories and...not being able to get rid of

them...that loss of control" (35)

Jason – "...and then all these "I don't recognise myself, it's not me" because before when she

had this strong coping style which kept her quite steady but then with that stress from outside

she could no longer cope..." (225).

It can be difficult for trauma clients to maintain a sense of self as the author of their thoughts,

especially when the thoughts come and go from their awareness without a degree of executive

control that non-traumatised individuals experience (Cicchetti & Toth, 1994). Although, to an

extent we all experience unconscious processes that determines what we focus our attention

on, the majority of the time the content of our consciousness is related to circumstances and

goals that we consciously recognise, therefore providing us with a sense of control and

ownership of our thoughts.

3.5.2 Losing sense of agency

Furthermore, in relation to the interrelationship between a clients' sense of agency and

psychological well-being, as formulated by the participants, clients' sense of control around

trauma-related intrusive memories plays a significant role in the development of depression.

The intrusive nature of the memories can make individuals perceive themselves as lacking

agency, which could lead to them either giving up altogether by not trying to engage in things

that may improve the situation. Alternatively, some clients may exert too much control, and

when it becomes apparent that they can't control the intrusive memories they may experience a sense of powerlessness.

Jason – "…so that adds more to the whole anxiety and depression (and) is fed by the helplessness from all of that, so the helplessness she experienced during the abuse is perpetuated later so it carries on…it comes to a time when she just wanted to end her life…and has tried before" (143).

Sandra – "…when it felt out of control (intrusive memories) he felt out of control, he wasn't so you know, he didn't know what to do, so it's kind of yea…when it seems like there's no triggers for the intrusive memories it feels so out of control, that's when it feels a bit very distressful…" (623).

From the participants' perspective it is clear that they conceptualise the lack of personal agency that comes with intrusive memories as playing a significant role in anxiety and depression. They related it to a lack of control over their mind and life bringing about feeling of helplessness and hopelessness.

3.5.3 Here and now quality to the trauma memories

A factor that is very much associated with the here and now quality of the intrusiveness is the high content of sensory modalities that enhances the distressing experience of trauma memories. In the current research therapists reported that their clients relived the trauma experience with the impression that the sensory features were current threats to them.

Jessica – "it looks as though you know it is a very immediate as if quality, as if the memory is still very live very raw, I think it's that traumatic quality isn't it, like it's happening right again now, like… for example with the woman client… you can see she's kind of, she flushes up a bit here (touches chest)… feelings here in her chest, and heart region so signs of adrenaline release I would say" (706).

Clara – "You could almost just kind of feel... you have little girl in front of you and...really want to help her, save her in that situation, the drowning...I was anxious about her all the time because...she always talked about wanting to die and you just never quite know if she would or not…when she was having those flashbacks, I was very anxious about where she was and how to get her out of it" (315).

The quotes above indicate that therapists sometimes became involved in the experience, triggering emotional responses from them. They suggested that a high content of sensory modality within their trauma memories increased the likelihood of them becoming distressed as evident in the quotes.

3.6 Appraisal of trauma memories

An important factor related to psychological distress is the participants' narrative of their clients' interpretation of their intrusive memories.

Table 5: Subcategories of 'Appraisal of trauma memories'

Appraisal of trauma memories
Internalising self as defective
Initial response to trauma
Acceptance of past trauma experiences
"Out of the blue" nature of trauma memories
Anticipatory nature of trauma memories

3.6.1 Internalising self as defective

The quotes below illustrate how the clients' appraisal of their trauma memories may contribute to intrusive memories. From the therapists' perspective it appears that when the clients interpreted the presence of intrusive memories as meaning that there was something inherently bad about them, and believed they were to be blamed for the intrusive memories, they became distressed, due to the self-loathing that accompanied the dysfunctional appraisal.

Jessica - "all that shame, self-loathing, "I'm a bad person, I must be a bad person" gets internalised like a stick of rock and they just have a conviction that they're not worth it, defective and it runs through them true and true...from those kind of experiences that were never repaired" (700).

Therapists also narrated that some clients negatively interpreted their inability to control their thoughts as evidence that they were going mad, which resulted in cognitive strategies such as avoidance, rumination and suppression. The therapist below describes their client's negative interpretation of the intrusive memories and its impact.

Jade - "I mean you know even the less complex client came saying "I'm crazy, this is mad" and that's her prove that she couldn't even control her thoughts, that fantasy that we do that all of us do, that if she was normal that she would only think about the things she wanted to think about and she wouldn't find herself ruminating… so there is the fantasy view that normal people's minds work in one way and theirs work in a completely different way because they are going mad" (45).

3.6.2 Initial response to trauma

It is widely known that the response to trauma disclosure plays an important role in the sufferers' emotional response and appraisal of their experience. In the current research, therapists reported that the response to their clients' initial disclosure contributed to their appraisal of the trauma. Kathleen - "she did try to talk about it when she was younger but people were denying it for her, some people didn't believe, so that was the trauma on top of the trauma" (919).

Tara - "There's an assumption that it must have been their fault, especially when there's been a lack of validation or lack of enquiry, erm or a lack of safe space to explore it, so stays in you and it's scary being alone with it. In some model of therapy you can argue that there's an anger attached to having had the experience that's sort of led to this…" (1152).

The quote demonstrates that it is important for traumatic experiences to be validated, whilst showing non-judgmental and compassionate approach, which is likely to reduce the feeling of shame or guilt that tends to be associated with traumatic experiences.

Figure 2: Memo - Research reflexivity during data analysis
My interest in this research topic dates back to my previous research into trauma, which I carried out using a quantitative research methodology as a requirement of my master's degree. Although it augmented my interest in this current research, as I felt a need to look closely at the experience of trauma, it was important for me to ensure that my analysis was not informed by my previous findings and other existing research, therefore ensuring that my analysis fell within the remit of the data. In view of the above, when I noticed the participants making reference to a link between trauma memories and psychological problems such as depression and anxiety, I looked at the data closely to ensure it was indeed generated from the transcript and not from a pre-existing knowledge. This is something did throughout the data analysis.

3.6.3 Acceptance of past traumatic experiences

Acceptance encompasses a period of coming to terms with some or all the issues surrounding trauma experiences, the start of a positive outlook and adoption of healthier coping strategies. The therapists reported that clients varied in reaching this acceptance period, as for some it happened quickly while it was a gradual and variable process for others. Jason addressed the notion that failure to accept painful experiences only serves to "invalidate core experiences" which may impede psychological growth.

Jason - "...if you invalidate your core experiences and... out of touch with what you really feel...you haven't got much chance do you? Because you're not listening to what is really going on...you can't really do anything about it, if you deny there's a problem then you can't deal with it" (151)

It was reported by the participants that acceptance of traumatic experiences allowed their clients to have more adaptive relationships with the trauma memories and the attributed meanings. Tara suggested that Acceptance Commitment Therapy (ACT) was very useful in eliciting such growth.

Tara - "...something like acceptance commitment therapy where...rather than changing the content of the thought you're...changing their relationship to the experience, their relationship to the memory, so what it represents to them, what it says about them, what it means to them...I find that model very useful because it means they can say "I can make space for that experience in my history, in my narrative, in my story, in my life but it needn't be the dominating one...I have life that is beyond and outside of that...reconnecting with the bigger picture of their life..." (1238)

3.6.4 "Out of the blue" nature of trauma memories

The therapists in the current research seem to indicate that clients varied in their awareness of their triggers, with some being very aware and finding ways over the years to manage them. On the other hand, participants also gave narratives about clients who had no awareness. It was reported that when intrusive memories are triggered by situations that the clients do not have obvious connection with, they perceive the intrusions as "out of the blue", and are likely to be more distressed.

Jade - "she was particularly aware of smells, and textures of food...there would be some textures that would trigger her...she had struggled with food on and off, erm she was particularly aware that not being believed was a very powerful trigger for her so... over the years had become much more aware of what her triggers were" (73).

One of the participants described their client as experiencing a sense of hopelessness due to the ever-present fear that the intrusive memories can be triggered by "any little thing".

Jessica - "part of the older woman's despair and fear, sense of hopelessness...is the fact that she gets triggered by any little thing that sometimes she can't even identify...it just feels like this mammoth task where on earth does she begin? She gets no sense of control she can get triggered anytime by anything, MASSIVELY, it is exhausting, absolutely exhausting and terrifying" (758).

3.6.5 Anticipatory nature of trauma memories

The participants reported that their client's anticipation of intrusive memories was an important component of the process. They constructed their clients' anticipation of the intrusive memories as contributing to their clients' experience of psychological distress. A therapist used the phenomenon of hyper-vigilance to describe this notion.

Sandra - "...it almost feels like he knew it was coming cos she's charging towards him... to him the anticipation is definitely a very significant aspect of it, and that's what he really remembers, just knowing that he was going to get hurt..." (599).

Kathleen - "what this particular guy has described to me was that he would hide behind the sofa when his mum came down the stairs, so it's the vigilance of being ready for the attack... when he was young his mum stamped on his head... so it's not the pain... it's the kind of threat of it happening again ... just before it happens the kind of now there's no way out of it anymore... (887)

3.7 Discovering survival strategies

The behavioural response of individuals to intrusive trauma memories and the degree to which they engage in strategies to control their intrusive memories have been shown to play a significant role in the maintenance of intrusive memories and the psychological distress associated with them (Ehlers & Steil, 1995). These strategies include suppression of thoughts, safety behaviour, rumination, selective information processing and activation of emotions such

as anger and guilt. The presence of some of these strategies will be explored below, as narrated by the participants.

Table 6: Subcategories of 'Discovering survival strategies'

Discovering survival strategies
Avoidance of predatory memories
Dissociation as a form of escape
Trauma amnesia
Denial of trauma event or its effect
Control as a way of coping

3.7.1 Avoidance of predatory memories

When participants were asked about how their clients experienced the intrusive memories, they described them as being very active and predatory and were determined to keep them at bay; it gave an impression of them engaging with the intrusive memories by having to work very hard to avoid them in order to protect themselves from the impact. However, the therapists expressed that actively avoiding the trauma memories can become overwhelming and uncontainable.

Jade - "…the other client had very frequent intrusive memories..whenever she stopped, as soon as she slowed down immediately they would be waiting to intrude...she found (it) so difficult and she managed that by just being too busy to think or feel for a long time…it all got

too much... constantly nipping at her, there would be some intrusion about anything and everything really." (33).

Jessica – "…I think some of the veterans try to do some sensation seeking stuff, like highly dangerous things…because if you're power gliding or something you're not having memories of something that happened to you, it makes you very present in the present moment" (774).

People who experience trauma-related intrusive memories often make deliberate efforts to avoid thoughts and feelings about the traumatic events, whilst also avoiding activities and situations that may trigger the intrusive memories.

Charlotte - "she tries not to think and talk about them (intrusive memories)…she tries to cut off a lot…she would just find it all too much, it frightens her to talk or think about these things. I think for fear that they'll become worse or people won't understand" (487).

From the perspective of therapists in the current research it appears that although these strategies may have been effective at one point, it can become exhausting overtime.

Jessica - "...exhaustion, complete nervous exhaustion, mental exhaustion because…it is taking up so much of their resources, so much of their time, it's really trying not to deal with it, or

trying not to be triggered... being very hyper-vigilant of any triggers… almost everybody

reports being absolutely exhausted, often quite numbed out... driven to things like drinking or

workaholic, any kind of addiction basically, any kind of distractions that can get them not

thinking about it... " (748).

3.7.2 Dissociation as a form of escape

One of the most common ways people cope with overwhelming psychological trauma is

dissociation, a complex mental process that involves a change in a person's consciousness,

disturbing the normally connected functions of identity, memory, thoughts, feelings and

experiences.

Jade - "I think the intrusions were primary for her and her whole presentation…but the

dissociated presentation became the problem, but it was about a strategy to manage the

intrusions, if you stop to think about it like that, the solution became the problem, but it was a

solution to manage intrusive memories and flashbacks which were just too awful to tolerate"

(33).

3.7.3 Trauma amnesia

It must be highlighted that not all trauma survivors can clearly remember their traumatic

experiences, with some individuals only having a vague recollection of "something", whilst

others are unable to recall anything traumatic happening. Memory loss related to traumatic

experiences may serve as a protective function against the intrusive memories and associated

distress. It has been suggested that there is evidence of subtle problems for intentional recall

for some individuals who have experienced trauma (Halligan et al, 2003). Specifically, people with PTSD, who have shown a level of confusion about the order of events, sometimes have gaps in their memory or find it difficult to remember details that are important for the distressing part of the traumatic event (Halligan et al, 2003). The quote below describes instances where the therapist has worked with clients that have shown evidence of trauma amnesia.

Sandra - "I've had clients that...only remember certain parts of the memory... there's gaps, there's a lot of gaps... sometimes there's just ideas of what could have happened...sometimes clients have... they remember little things...they remember situations around the abuse, just after it happens, just before it happened...just images of them being in the bathroom with their...underwear on the floor, things like that but the actual event is what they're not remembering..." (631).

3.7.4 Denial of trauma event or its effect

Denial is another common psychological defence against trauma, which involves disavowing the existence of traumatic realities by keeping them out of conscious awareness. It can involve denying the traumatic event occurred or denying that it was traumatic. Although the construct of denial may appear somewhat similar to the construct of trauma amnesia mentioned in section 3.7.3, it is suggested that the conscious effort reported to be made by clients to disavow the existence of traumatic realities makes it a separate construct. The quotes below illustrates how trauma clients use denial as a way of coping.

Jason - "…her voice if you like...kind of burying it under the carpet "it didn't happen, we were a great family" and completely ignoring this chaos, utter chaos that was going on within the family…she felt profoundly unsafe and of course because of her mother's behaviour there was no point telling anyone about her being abused, because no one would listen anyway, so what she did was bury it, denying herself, so she internalised that voice...what she says is "I'm fine, there's nothing wrong with me, I don't know why I'm here" and within a few minutes she breaks down, collapses into tears "I'm falling apart, I can't function" shifting from one schema mode into another"(145).

Kathleen - "even deny that it's happened, the patient initially had full denial of events, erm or they might know that something has happened but deny that it was bad, because they can't feel the badness and negative feelings that come with it… they might do all sort of…crazy acting out behaviour to not have to think about the trauma… as in aggression to others, or sexual behaviour or spending, or become very depressed..." (917).

3.7.5 Control as a way of coping

In response to the experience of intrusive memories that undermines peace of mind, people understandably often suppress these unwanted memories from awareness by using a number of strategies to control them.

Jason - "…the other lady who was sexually abused by her friend's father (tried to manage her intrusive memories by), erm drinking, drugs, self-harm, suicidal attempts erm also being overly controlling, perfectionistic, she also had quite bad OCD, so when she found it entirely chaotic she started controlling ERRverything around her" (210)

Clara - "she managed her intrusive memories by binge eating and the overdoses, there was some cutting as well, I think she would superficially cut her legs and her arms when she felt quite overwhelmed…the overdoses felt like they were more for her to fall asleep and not have to cope, especially with the nightmares as well" (390).

3.8 Therapists' construction of the impact of trauma work

The therapists interviewed reported experiencing a degree of psychological distress as a consequence of their therapeutic work with trauma clients, and they also narrated that they sometimes found the emotional impact of the work to be long lasting. In the process, they associated a range of emotional experiences to the trauma work, including worry, frustration, helplessness, and hopelessness. The participants suggested that they generally struggled when they began trauma work, although over time they found ways of managing its impact. The participants below describe the demanding nature of trauma work, where they become overwhelmed with the clients' presentation and on reflection manage to recognise its impact on their emotional well-being.

Jason - "In the past I feel chaos in my own head thinking "oh shit how do I deal with these?" because actually trauma, complex trauma is quite a challenging area I think for most psychologist… you need quite a lot of resources and knowledge to be able to help these people. Now after years of learning a lot about it and practising I feel much more confident, but still there are moments when I feel "I don't quite know where to go next" … It's not often that it happens now thankfully but it happens … you are constantly dealing with so many complications at the same time, you know managing crises that come up…it's quite draining, it can be quite demanding and exhausting" (229).

Clara highlighted below how she sometimes experienced helplessness when she felt unable to help her client when she was experiencing trauma memories in their most distressed state and found herself becoming frustrated with the client.

Clara – "I did feel in the early stages, I felt a bit frustrated with her when there was this trauma memories coming through… it was just the sheer nature in which she would just disappear into that memory and knew that you couldn't interact with her at that time, erm kind of made you feel helpless, frustrated but helplessness about that" (379).

The participants below spoke about struggling to switch off after working with particular trauma clients, being unable to relax. Jessica suggested that this usually happened with her

when she experienced a degree of connection with the client and would discuss the client in supervision.

Charlotte – "She's one of the few people that I struggle to completely switch off from, erm (6) she's made suicide attempts on the ward...I go home on Friday and at times during the weekend think "I hope she's okay" and then I kind of check on the computer to see if she's okay…" (524).

Jessica - "ever so often there's a session that really gets me going and I will be thinking about it...I would let rip in supervision and go rahhhhh. Often it's if I've felt connected… another client ages ago...she was only a little girl and her mum was a heroin addict and she sold her daughter to GROUPS of men for sex and that was how she lost her virginity… That took me quite a few weeks to process, I was SOO ANGRY, my supervision group got that at the time, and that was often referred to and that took me a long time to process that one, I was really really upset..." (788).

Tara expressed that in addition to the emotional demand of trauma work, she finds that she is more likely to question herself, her ability to create change in the client, her vulnerability and agency. She also suggested that she finds that her inner experiences sometimes mirror those of the trauma client.

Tara - "...those were some patients where you had to kind of have a bit more of a deep breath before you go into the room to see them, OR... maybe a little more time afterwards to kind of decompress… you feel a bit more STUCK.. you know "am I missing the boat? Am I just rushing them and I need to slow down, why are they not going further into this"… a lot of counter-transference as well, how you feel about yourself as a therapist, how you feel about your ability to help, how you feel about your agency, your vulnerability, am I able to do this? I wonder if that somewhat mirrors their sense of vulnerability, and sense of expertise or control of living their lives and being competent resilient adults, competent resilient people" (1242).

Sandra below describes how she finds she sometimes absorbs the emotions that her clients find difficult to connect with or express, which often results in her feeling drained, heavy and exhausted.

Sandra - "I think with a lot of clients they can't hold certain emotions and can be very numb, very difficult to connect with certain emotions…being someone who can at times absorb emotions… I leave the room and get very emotional…and I don't realise why, and then I realise (on reflection) I took in a lot of things that maybe the client wasn't able to express themselves, so when you get to this feeling-based presence in the room, you can absorb a lot of feelings that are coming from the client... that's where it's being a bit heavy for me…it has affected my mood..." (655).

Jade described the tendency for her exposure to her clients' trauma-related intrusive memories to increase her vulnerability to physiological experiences, having absorbed some of the feelings. Marci et al. (2007) similarly found that when high emotions and empathy were experienced by the client and therapist, similar physiological responses were experienced.

Jade – "I personally also get physiological feelings erm so you know sometimes when my clients are talking about things I feel it…I've begun to use a bit more of the kind of body psychology stuff…where they experience things in their body, and what it might be saying to me when I get a churning stomach, or the kind of sick feeling or whatever it is…sometimes it can be scary…" (83).

3.9 Therapists' process in therapy with trauma clients

During the research interview, I observed that the participants shared the process of being with the clients in therapy, paying attention to the impact of the work on them and the synergetic processes that were inherent in the dynamic.

Table 7: Subcategories of 'Therapists' process in therapy with trauma clients'

Therapists' process in therapy with trauma clients
Establishing human connection with clients
Value of empathy to trauma recovery
Sympathy disguising as empathy
Awareness of boundary and limitation

3.9.1 Establishing human connection with clients

Participants spoke about the importance of feeling connected with their clients, emphasising the human connection that should be inherent in the alliance as opposed to simply focusing on the use of therapeutic techniques.

Charlotte - "I think at times my anxiety increases significantly, so when she dissociates or bangs her head previously it's really difficult…sometimes I just want to give her a great big hug when I think about the trauma that she's had…I feel like I have a really good connection with her…(8)I kind of have to, actively remind myself of boundaries, I can see how easy it would be when working with her that you might not hold your boundaries quite as tightly as you would with other people" (520)

3.9.2 Value of empathy to trauma recovery

Also, in line with the human connection they experience towards clients, a few clients described the importance of empathy in their work with trauma clients and how it helps them to recover from their difficult experiences. Jessica talked about the sustenance of the human connection that appears to remain consistent even when they finished with a client.

Jessica -"I really try to stay very socially engaged with them…really have a two-way connection with them as two human beings and I think that makes a huge difference somehow in terms of

how I remember them… and how I remember them afterwards and I think when I've done review sessions with them 6 months later or a year later…there's always been that human connection…" (792).

Clara expressed that she finds that she is sometimes more willing to go out of her way for clients if she feels that human connection towards them; it appears their willingness to allow her into their worldview means they are more likely to elicit empathy from her.

Clara - "it got to a point when I was like 'I don't know when I'm going to be involved in this case and come here' I was thinking there's something about her that I was going out of my way, taking that rescuing kind of role again with her because… you kind of really could connect with her …you really kind of felt for her…" (355).

3.9.3 Sympathy disguising as empathy

Some of the participants spoke about the tendency to feel pulled in by clients to be sympathetic when they were experiencing strong emotions.

Sandra - "I haven't come close to the intensity of what some of the things the clients are bringing, it almost makes me feel like…there's a feeling of how can I even try to understand them? ….I feel like in some ways, it's as if I'm putting myself in the client's shoe, and… I think the client is like you can't even understand me, you're just this therapist that's just sitting here

trying to understand my life, I grew up in this, look how I grew up, what are you going to understand?" (643).

Charmaine talked about recognising that it is more useful to be empathetic towards than sympathetic towards clients.

Charmaine - "with the way she described it, erm obviously I felt like "that's a terrible thing for her to have experienced" … I felt that empathy for her… for a young person at that age to have gone through all of that…and not have anyone to tell until…her 70s…must have been devastating for her… I was able to maybe reflect back to her…in an empathic way" (1098).

3.9.4 Awareness of boundary and limitation

A pivotal element in the therapist process in therapy with trauma clients is the effort they have to make to maintain boundary due to the subconscious desire to want to go beyond expectation. Subconscious desire in this context refers to the therapists' automatic actions and reactions which they become aware of when they think about them. Some of the participants expressed that through their experience of working with trauma clients they had come to the realisation that there is limit to what they are able to offer the clients, which they often struggle with.

Charmaine - "…there's also a part of me that knows there's only so much I can do… people have to take responsibilities for themselves as well, I can't always be taking on board the

emotional content of other people as it were….obviously things can affect you…TRAUMATIC THINGS that people have gone through and…as a person you have to empathise with that…but…there's a place I have to cut that off… it's not something that I'm going to take on board now that it's my responsibility to solve this person's problem…" (1104).

3.10 Therapists changing and reflecting as a result of trauma work

The participants involved in this research talked about going through a process of self-reflection, whereby they began to think about their position with their clients, looking at themselves in relation to their work and in the context of the system. On reflection they were able to recognise the difference their therapeutic intervention made to their clients' well-being. Likewise, participants also spoke about becoming more aware of the changes it created in them and the new perspectives that trauma work gave birth to.

Table 8: Subcategories of 'Therapists changing and reflecting as a result of trauma work'

Therapists changing and reflecting as a result of trauma work
Recognising recovery in clients
Therapists' self-reflection: Awareness of growth through trauma
Rewards and privileges of trauma work
Surviving within the mental health system
Bilateral distrust within the system
Trauma memories conceptualised as a systemic issue

3.10.1 Recognising recovery in clients

Jason referred to a client who had reached a place of recognising she was not to blame for the sexual abuse she suffered at the hand of her abuser. Charlotte spoke about a client who began to reduce her self-harming incidences after coming to the realisation that it was advantageous to express herself in therapy.

Jason – "she was able to get past that and was able to rationalise it, so that it was entirely his fault (the abuser), she didn't make it happen, she didn't ask for it, that was the purpose of therapy, making sure she wasn't taking responsibility for what she couldn't control" (177).

Charlotte - "…she has now made a link that as painful as it is to talk about it, that actually the head banging has decreased, she still does it but not as often, the self-harm has decreased, she still does it but not as often. So…swings between thinking actually no it is helpful talking about these things to then kind of swinging back to no I just need to forget that any of these ever happened" (492).

3.10.2 Therapists' self-reflection: Awareness of growth through trauma

The participants described how trauma work changed the clients, with them experiencing some changes and new realisations as a result of their engagement with trauma work. Charmaine constructed her client as "growing through the trauma".

Charmaine - "she did suffer all that trauma and struggled through therapy for a long time but she ehm she got stronger through it yea erm instead of being wary about what the future holds she was of the opinion that having gone through the horrible experiences she can get through literally anything that is thrown at her...without a doubt the support network of people around her helped her to grow through the trauma" (1064)

Some of the participants described being able to recognise the resilience demonstrated by some of their clients who had been able to manage the day-to-day struggles of life, managed their family and career until their traumatic life experiences began to show forth in the form of intrusive memories.

Sandra - "I'm amazed by the strength and resilience he showed, towards the end of therapy he began to say his experience with his mother has now put things into perspective for him...of course it's something (trauma) no one wants to experience but he began to see life in a totally different dimension..this was just sooo amazing to me" (655)

Jessica - "She went from all that self-loathing and depression erm about how her life was damaged and her having no control to her showing so much resilience and realising all that she has achieved, children, working as a teacher despite the awful awful trauma she had been through" (676)

The therapists also described changes in their perception of themselves, the clients and other people as they reflected on how trauma work changed them. Sandra expressed below that her exposure to trauma work has allowed her to take a different perspective on things.

Sandra - "it grounds me because it makes me feel like there's a lot of, a lot of materials that I've been witnessing through the clients that has really allowed me to take a different perspective on a lot of things around me, so that's where it stays and doesn't disappear once I leave the room" (653).

3.10.3 Rewards and privileges of trauma work

Some of the participants considered the privileges and rewards that come with working with individuals with traumatic life experiences. They expressed appreciation for the trust that had been bestowed on them by the clients despite their difficult past experiences.

Jade – "for me it's a real privilege to… be able to build a trusting relationship with people who have been so badly hurt and are prepared to take risk and to think together about...how you might do something different… it's been a real learning curve doing a lot of that work..." (83).

Jessica - "the session can be so humane and so human and so resourcing, I can walk out of a good session and… think "I don't need to get paid for this, this is the best job in the world, I'm privileged to be working with this person who is actually so amazing to have got here to have survived" (800).

Tara expressed that, although challenging she finds trauma work to be worthwhile. She recognises that the client group tends to bring out a "huge amount of compassion from her", which reinforces the desire to do her best to support them.

Tara - "I've thought about what a real privilege it is to allow me into their world, it's always been really meaningful to me… it's not the kind of thing where the challenge gets in the way of wanting to do the work…ultimately it really reinforces the fact that you want to do what you can to support them with the resources that you've got. I think you can also get a huge amount of learning from someone...you can really witness some quite incredible things" (1242).

3.10.4 Surviving within the mental health system

The therapists highlighted an awareness of systemic problems and the role in plays in the well-being of their clients. They conceptualised the mental health system as one to be survived as opposed to one that allows them to thrive. The participants explored the chaos and lack of trust that exists between clients and the professionals working within the mental health system

Jade – "complex trauma clients invite and create unconsciously chaos around them in the system, and so it's really difficult to maintain the level of communication to ensure that the client is not at some level playing mummy off against daddy within the system…we made it really clear that this was a whole-team approach in a way that erm those kind of erm, and it's

seen within the system as manipulative but of course it's survival isn't it? These are the strategies that these people needed to survive their complicated messed up childhood" (29).

Clara spoke about the tendency for one of her clients to use self-harm and suicidality as a way of surviving within the chaotic mental health system.

Clara - "I think in terms of control as well…she would often take overdoses but in kind of a level not enough to… kill her, she would sort of tell professionals half of it but not sort of tell people how much she took and what she took. So it almost felt a bit like controlling…what that did to us, in terms of our anxieties as well …maybe it's her way of coping with trust…" (347).

Some of the participants expressed their frustration with the limitation of working within the mental health system, especially the constraint they feel in relation to the kind of services they can offer to their clients. Jade specifically spoke about the importance she places on focusing on having "good enough endings", such that the client does not leave the services feeling re-traumatised, something that she found wasn't always possible within due to the constraints posed by the service.

Jade - "it brings up a sense of constraint uhmm within the health service about how you can work with these people, the limits of what we can do, and as I said the more complex of the two clients created huge problems within the system such that it made our ending very difficult and that still brings up some very difficult emotions for me because she'd been traumatised enough and I didn't want to add to her difficulties at all…I try really hard to…focus

on the endings and good enough ending…it wasn't possible with that particular client and that leaves me frustrated 18 months down the line, I've had a bit of a struggle with that, you know around what could have been different, a resentment of the limitation of the system around that" (109).

This frustration of staff within the mental health system is further evidenced by Jessica's quote below, where she questions the validity and value of labelling that is inherent within the mental health service that continues to rely on the medical model as a way of understanding trauma and mental health difficulties.

Jessica - "I think the DSM-5 I…needs to be redone …I don't think it serves us well. I think there's a lot of trauma that comes up when we see people with just depression that actually at the moment currently is unrecognised, not worked with and not worked with properly and I think that we can end up re-traumatising people by getting them to talk about it…" (666).

3.10.5 Bilateral distrust within the system

It makes sense that trauma clients would find it extremely difficult to open up to professionals, given their past experiences of being abused or maltreated. Tara referred to the client's distrust of the system and the professionals working within it.

Tara - "I think also she found it very difficult to describe it until she felt able to trust the person that she was working with, so it was a big issue, it took a while to come out as to what it was that was getting in the way of her feeling normal and sexually safe and what not" (1126).

The participant's narratives explored the possibility that distrust within the system may indeed be bilateral, in that as much as the client does not trust the professionals, some of the professionals sometimes found it difficult to trust the client's trauma narrative.

Jade – "I'd had no experience of this kind of dissociative identity disorder, and I wasn't sure if I believed in that diagnosis and I did an awful lot of training and research around that to learn...at times it really felt like erm a whole other part of herself was there in control and the bit I was usually speaking to was nowhere to be seen... I was very sceptical and I worked with her for two years erm and either she needed an Oscar or that kind of level of dissociation happens…" (41).

Kathleen went on to explore her processing of circumstances where she had been sceptical about her client's experience; apparently this is often related to their narration of the event.

Kathleen - "…I don't know (6) I don't know It depends a little, some people I don't believe... something about how they say it "Is this really true?"...it's often the way people say it, or is

heard...there might be some personality issue going on there where there's a bit of exaggeration or something theatrical about it "really?" erm sometimes I can feel annoyed when people laugh it off because I think "hang on you are dismissing this, this is serious stuff, let's get back to it" (963).

3.10.6 Trauma memories conceptualised as a systemic issue

Tara commented on the importance of treating the clients' trauma-related intrusive memories as issues the system has to hold rather than simply something located within the client, hence optimising the service being rendered to the client.

Tara - "working systemically can also be important, helping someone to see the way the trauma may fit, the memory may fit in the wider system and who else might be able to support them with it, so ... they needn't be alone with it… some of it may not need to be shared, the kind of ripple effect, the implications of it, potentially things that others can support them with" (1234).

A few of the participants spoke about the importance of taking a multidisciplinary team working approach when working with trauma clients. There is fear that the pressure within the system may mean the value of MDT working is being dismissed.

Jade – "…one of my fears and concerns is that there is more pressure within the political system to have generic workers where social workers and nurses...and OTs are drawn in to do pretty much the same things and it's all about care coordination, we lose something because

all of that profession brings different focus and attention... there's a pressure to move away

from that…" (27)

All in all, a number of the therapists involved in this research appeared to experience a degree

of frustration with the mental health system, particularly in relation to how punitive they

perceived it to be, as well as its limitations in regard to the services that can be offered.

3.11 Therapists discovering coping strategies

The participants in this study were also able to identify a range of coping strategies they found

to have been effective in their management of the emotional content and distress that may

come with trauma work. These include mindfulness, personal therapy, supervision,

engagement in enjoyable activities and journal writing. They reported the importance of self-

awareness through the process, whilst also becoming aware of the strength of working within

a team and with other professionals.

Table 9: Subcategories of 'Therapists discovering coping strategies'

Therapists discovering coping strategies
Being mindful of the emotional content
Awareness and acceptance of the challenges trauma work entails
Collective management of vulnerability
Supervision as a container

3.11.1 Being mindful of the emotional content

Sandra talked about the importance of being mindful of their presence when in the therapy room with clients so as not to become easily overwhelmed by the story and emotions of the client.

Sandra - "…I think understanding counter transference-transference sometimes when it comes to what's going on with you because certain type of clients… do bring out material when it comes to what they're presenting, so having an awareness is important I think…. being grounded, in the sense of being mindful of your own presence in the room and when you leave because in the room if you're not mindful you get very taken… by the content, taken in by the story, taken in by the emotion, and when you leave the effect spills over …" (659).

Jason - "I think one thing that really helps is keeping notes… when I keep note I don't feel like I have to hold a story in my head, I put it on paper to externalise it, I don't need to remember anything… when I need to get it I can find it…where as if I don't fully process, it feels like I need to remember something, I need to carry it with me, whereas with notes, I'm able to let it go... not very extensive ones but just main points...and just living my own life away from my client's life (laugh)" (247).

Charmaine talked about the importance of maintaining emotional boundaried so as not to become too affected by her client's trauma narrative, and with this identifying the client's responsibility in the therapeutic process.

Charmaine - "there has to be a certain boundary otherwise I wouldn't be able to do it... that's how I protect myself professionally and personally… I think STRONGLY for me I got to a place of saying well there's responsibility… the person has, and I sometimes feel like people do say things…to shock you …some people say something right at the end, and I have to say you know 'Ok we'll probably have to think about that for the next time we meet because we can't go into that now'" (1106).

3.11.2 Awareness and acceptance of the challenges trauma work entails

Jade talked about having the freedom to be true to herself and admit that working with trauma clients is very difficult. She expressed that it is important to have this awareness in order for her and other psychologists to know how to be with such client groups.

Jade – "…the nature of who I am and having being qualified for a long time now I'm comfortable to say that…I find it difficult but I think there's a lot of anxiety there that if you say that there's an assumption that you're not good at it, whereas for me I think that awareness is important… and the recognition of just how difficult it is and how present and alert and ready you need to be…" (91).

Jason shared his experience of burnout 5 years into his psychology career, however upon recognising the impact of the work on his well-being, he decided to take some time off, a decision that has helped him to continue in his career.

Jason – "there's always a risk of burn out in our profession and it can happen quickly after you graduate if you're not careful, even myself after 5 years I didn't know if I could do this job anymore but I found my way here. One thing that I did, I took a sabbatical for three months, I went travelling, that was the best thing I could have done at the time, just get away and not work with clients, considering I had worked with clients since I was a student, that was great experience" (253).

3.11.3 Collective management of vulnerability

Clara and Tara expressed that having adhoc opportunities and informal space to have dialogues with colleagues about difficult and successful sessions can help them to manage the vulnerabilies that can come with trauma work.

Clara - "I'd often… just offload to them (colleagues) (laughs), or the care coordinator about a session, not in a huge amount of depth but just to kind of "pheew that was a heavy one"… really important for me and helped and… definitely a bit of space before another client, so I try to organise my days so that I have some time after her and supervision a lot of supervision

(laughs) for help and support…on the days I saw her I was probably more tired in the evenings afterwards (sighs)" (406).

Tara - "…having colleagues, having supervision is great but it's also the in between, its moments with colleagues you trust where you don't need to say too many words, you don't necessarily need to name the patient… It might not be the challenges of it, it might also be having a moment somewhere in the week to celebrate even in a very simple way something that's going well with a patient to the so-called success of the work you've done…" (1256).

3.11.4 Supervision as a container

All the participants spoke about the Importance of having good one to one and group supervisions when working with clients that experience trauma-related intrusive memories. There is sense that good supervision gives the therapist freedom to be vulnerable.

Charmaine - "if there was something like that that did affect me in that way I'd obviously have to talk about it and bring it up with my supervisor and use that space to do that… I've got to a place in terms of boundary for myself as well, you know if that makes sense we're all human but I know that there part of me that says "well this work is not something that I want to stay with me" (1100).

Jessica - "the other thing is working with a good team…like a good supervisor, good

supervision group, I think that's really key because then you feel supported, and safe and

contained and therefore you can contain, you know that you can go and sort of dump stuff if

you need to" (798).

Therefore, it can be concluded that supervision is critical to the well-being of therapists,

especially as it provides space to process difficult sessions and reflect on the impact of their

work. This is likely to reduce chance of having own reactions to client's trauma narratives, and

with this maintaining their level of functioning and professional development.

CHAPTER 4: DISCUSSION

4.1 Overview

This chapter aims to further develop the categories and provide a tentative model that

explains how therapists construct and make sense of their clients' intrusive trauma memories

in the context of the clients' psychological distress. Concurrently, it will also present a model

for exploring how therapists understand the impact of working with complex trauma on them.

This chapter will draw attention to the contributions this research study makes to the

knowledge in this field. The strengths and limitations inherent in the research will be

described, and the implications for future research and clinical practice will be considered.

4.2 Discussion and interpretation of research data

This research adopted a constructivist epistemology which explores how psychological

therapists construct and make sense of their clients' intrusive trauma memories in the context

of the clients' psychological distress. In order to do this a grounded theory methodology was

adopted as it was assumed to be best to capture trauma memories in the context of

psychological distress from the perspective of the therapist. The research comprised a GT

analysis of 9 semi-structured interviews that had been conducted with therapists. The

categories and sub-categories most closely related to the aims of the research are presented

here. This discussion will further develop the presented findings in light of existing research.

4.2.1 Trauma-related intrusive memories and psychological distress

The participants who took part in this research constructed trauma-related intrusive memories as a contributing factor to their clients' experience of psychological distress. The findings provide further support for existing quantitative research that found intrusive memories to be prominent in many types of psychopathology. These include psychosis (Morrison et al., 2002; Steel, Fowler & Holmes, 2005), anxiety (Day, Holmes, & Hackmann, 2004; Hackmann et al., 1998; Hackmann et al., 2000) and depression (Birrer et al., 2007; Dalgleish & Watts, 1990; Kuyken and Brewin, 1999; Reynolds & Brewin, 1999). A number of participants reported that their clients' anticipation of the reoccurring memories caused them a great deal of stress, which resulted in them becoming anxious and depressed. Moreover, it must be considered that when a person experiences something as threatening they are more likely to adopt attention bias, and may be prone to remembering very negative past events, which may then compound their emotional vulnerability (MacLeod et al, 2002). Attentional bias refers to the phenomenon of selective attention mechanism towards negative stimuli or threatening material (Matthews & MacLeod, 2005).

It has been well documented that cognition drives anxiety, with the compelling argument being that catastrophic interpretations provide a condition for the elicitation of panic and depression (Bar-Haim et al., 2007; Cisler, Bacon, & Williams, 2009; Lichtenstein-Vidne et al., 2017; Mathews & MacLeod., 2005). According to the model, stress and anxiety result in an autonomic arousal that is perceived by the individual, which then prompts anxiety and further autonomic arousal in a vicious cycle. With the participants in the current research, they reported that their clients' traumatic experiences haunted them when they felt threatened,

humiliated or experienced failure or loss in some way. The memories of such experiences are likely to return at certain times when they feel stressed or in a situation that resembles past experiences. We often perceive this as providing confirmation of previous negative or critical beliefs; as a result, the feelings experienced at the time of the event may flood back, causing them to experience psychological distress. It must be acknowledged that research has not yet resolved the causal direction between anxiety and attentional biases; therefore, it leaves it empirically ambiguous. However, the current qualitative study sheds some light on to how therapists experience their client's accounts of the experience of having intrusive memories.

Furthermore, participants constructed their clients' **interpretation of the trauma memories** as playing a significant role; therefore, the meanings attached to trauma memories have important implications for their perception of themselves, the world and other people. The cognitive model posited by Ehlers and Steil (1995) proposed that it is the negative interpretation of intrusive memories (e.g. "It means I am going mad") that predicts the onset of PTSD. This is because the negative interpretation increases the associated distress and may result in the use of cognitive strategies in an attempt to control the memories e.g. avoidance and suppression. A cross-sectional study by Starr and Moulds (2006) also found a correlation between negative appraisals of intrusive memories and the maintenance of depressed mood, alongside psychological distress and cognitive avoidance. Such idiosyncratic appraisals of the intrusive memories may lead to a sense of on-going threat and distress. Other existing research has shown the role of attributional biases on psychological well-being (Abramson et al., 1978; Beck, 1967; Morris, 2007; Newby & Moulds, 2010).

Similarly, interpretive bias has also been shown to be a risk factor for depression, as previous research has shown a relationship between the tendency to impose more negative interpretations on ambiguous information and the onset and maintenance of depression (Gotlib & Joormann, 2010; Matthews & MacLeod, 2005). It is possible that an individual's pre-existing vulnerability, such as from previous trauma experience, is influenced by processing biases that the person possesses, such as attentional, memory and interpretive bias. CBT targeting intrusive memories should aim to explore the individuals' appraisal of the memories, encourage them to reflect on whether or not their appraisal may be biased in anyway, and aim to support them to change the meaning of distressing memories and put things into new perspectives. Also, considering negative memories are likely to make the individual feel threatened, CBT for the treatment of trauma memories should use creative imagery techniques can be used to reduce the sense of current threat by changing the image or memory and making it less threatening (Holmes & Matthews, 2010).

The research indicates that the interpretation of intrusive memories by the sufferer is often linked to the individual's core beliefs; this means that there are certain early experiences that have become valid representations of the person's view of themselves, others and the world. Young, Klosko, & Weishaar. (2003) proposed that our early experiences often shape our perception of reality in a way that we feel comfortable to see the world through that lens, and although these experiences may have been advantageous at a period of time, they tend to become maladaptive overtime. As reported by the therapists interviewed for this research, it appears that their clients tend to feel quite secure and comfortable with the familiarity of their entrenched maladaptive beliefs about themselves, therefore are likely to interpret the

presence of intrusive memories in a way that corresponds to their view of themselves, others and the world. For this reason, they are likely to interpret the intrusive memories as evidence of their defectiveness, filthiness, and need to be punished as reported to the therapists interviewed.

The findings of this research demonstrate that intrusive memories of trauma may pose a **threat to the sense of self**, and this in turn can become very distressing for the individual. Some participants reported that their client's experience of intrusive memories is threatening to their sense of self, perhaps because they were experiencing something that was novel to them, which in turn had an impact on their perception of themselves. Second, participants reported that some of their clients found the intrusive nature of the trauma memories resulted in them questioning their sense of agency, as they felt no control over the intrusive memories. The sense of agency has been referred to as a central aspect of human self-consciousness, where one experiences oneself as being the agent or in control of one's own actions (David, Newen, & Vogeley, 2008; Gallagher, 2000; Newen & Vogeley, 2003). In view of this, intrusive memories, especially when the individual is yet to identify the triggers, may result in them experiencing a lack of agency, which may contribute to feelings of powerlessness, hopelessness and helplessness.

It can be assumed that the threat intrusive memories pose to an individual's sense of self plays a fundamental role in the maintenance of psychological distress that is experienced. The therapists reported that their clients' sense of self may have been disturbed by the intrusive nature of the trauma memories. This finding appear to lend some support to the idea that

traumatic events may lead to disturbances in sense of self, interacting with the intrusive

memories, anxiety, depression, and under-regulation of feelings of anger and guilt (Horowitz,

2015). Intrusive images have been shown to represent the self, with a tendency to attach

meanings about the self from the original trauma event; for example, "I am powerless" "I am a

failure". All in all, this indicates that there may be a need for individuals experiencing intrusive

memories to begin to separate the self from the memories in order to limit the impact of the

memories on their sense of identity. Clinicians should aim to support clients to master

symptoms, improve emotional regulation and achieve post-traumatic growth in identity.

Furthermore, from the therapists' perspective the intrusive trauma memories are experienced

by their clients as **unwanted elements that actively intrude on their mind**, acting with the

purpose of distressing them, hence the therapists' description of the trauma memories as

"waiting to intrude" "constantly nipping". This uncontrollable "nipping" also contributes to the

damage to the sense of agency experienced by clients as reported by participants. To possess a

sense of agency requires an individual to feel that they have a good degree of control of the

body at the very least (Gallagher, 2011). The loss of a sense of control that is often experienced

by trauma survivors may compound what they tend to portray as a feeling of helplessness.

Similarly, it has also been shown that intrusive trauma memories may weaken our sense of

ownership (Ataria, 2013), a notion defined as "experiencing our body as our own"" (de

Vignemont, 2011., p 232). Sense of ownership is distinct from sense of agency as it relates to

experiencing our body as ours rather than simply being in control of our actions. In view of

these definitions the trauma memories may pose as a re-enactment of the lack of sense of

ownership they experience following the traumatic event.

The findings of the current study also demonstrate that **intrusive memories can be triggered by a variety of cues**, and as the therapists involved in the research described, some of their clients had reported that their senses were very powerful in recognition of these triggers. This may present a way in which the brain attempts to protect the individual by triggering an early-warning system that something bad is about to happen. The images relate to a threatening experience and contain the most traumatic aspects of the event, referred to as the "hotspots" (Holmes, Grey & Young, 2005) or stimuli present shortly before the greatest emotional impact which is akin to the "early warning signals" (Ehlers et al., 2002). Holmes, Grey & Young (2005) found that themes in intrusive images that are related to hotspots are connected to the sense of threat to one's physical integrity and sense of self. This supports the notion that intrusive memories may be of an anticipatory nature that encapsulate the fear of what might have happened or when the meaning of the event became more problematic (Hackmann et al., 2004).

The participants narrated that they found their clients' **"survival strategies" to be automatic and immediate**, which suggests an experience of being amid difficulties and with urgency discovering ways of coping, as opposed to using a well-thought-out approach. This category is supported by cognitive behavioural model of trauma and psycho-analytic models of trauma. One of the most noticeable strategies is by keeping busy, as a way of fending off the trauma memories. By keeping busy, they can probably hide from other people what may be going on for them on the inside and equally they do not have time for conscious reflection. It has been shown that trauma experiences tend to be internalised, taking place within the individual

(Arnold & Hawkes, 2008). In view of this, it is conceivable that many people experiencing intrusive memories look inwards for survival strategies when they begin to experience these trauma memories. The survival strategies adopted by clients vary and they include making efforts to avoid the intrusive memories and the emotions they contain; disconnecting from the bodily self, emotions and other people.

The findings of this study support the notion that **coming to terms with one's own traumatic experiences (acceptance)**, the feelings associated with them and their impact on ones' life is an important process for healing to begin. The therapists formulated that invalidating and denying the core experiences was distressing and made it more difficult for their clients to come to terms with the painful experiences. This is fair, as participants reported that clients were likely to spend a great deal of energy on avoidant coping strategies to escape their painful experiences or the cues related to the trauma to keep the trauma-related intrusive memories at bay. This can be perceived as a common coping mechanism by individuals who are yet to come to terms with their core experiences (Walser &Hayes, 2006). This therefore supports the aim of Acceptance and Commitment Therapy (ACT) which targets decreasing experiential avoidance, including unwanted memories, thoughts and feelings while instead increasing acceptance of these painful experiences to move to valued direction. This is based on the notion that it is the way in which we judge, evaluate and avoid pain that results in suffering as opposed to the suffering itself (Walser & Westrup, 2007).

4.2.2 Therapists' construction of the impact of trauma work

In relation to the therapists' construction of the impact of the therapeutic process on them, all the therapists who participated in the research interviews reported that it was possible for the clients' traumatic material to be transmitted onto them through countertransference process. Countertransference has been defined as the totality of unconscious reactions of the therapist to the client and to the clients' transference in therapy (Cavanagh et al, 2015). With this concept, focus is shifted from the clients onto the therapists and the powerful feelings that may arise from the therapeutic work. On the other hand, transference is the redirection of feelings and desires, especially those retained form childhood towards a new object (Loewald, 1986). Some of the participants reported experiencing a great deal of counter transference when working with trauma clients and learning to manage these reactions with experience. This finding is supported by Cushway's (1995) finding that younger therapists experience higher level of distress than their more experienced counterparts and may feel guilt and shame about their strong counter-transference reactions. These findings support the theoretical concepts of vicarious traumatisation which suggest that there are disrupted beliefs in relation to the self, others and the world from exposure to client trauma (Figley, 1995; Tripanny et al., 2004).

Some of the participants reported that they sometimes felt an **impact on their psychological well-being**, during therapy and sometimes long after therapy had ended. The difficult emotions they experienced ranged from anxiety, low mood and hopelessness to anger and frustration. There was a consensus that it was necessary for them to take steps to protect

themselves against their clients' trauma, and they reflected on coping strategies such as supervision, case discussion, professional education, and discussion with colleagues about difficult therapy sessions. Previous research has shown that therapists often find treating trauma survivors to be stressful due to the demand on their expertise and their emotions. The nature of therapeutic intervention with individuals who have experienced trauma such as childhood sexual abuse can be very stressful it involves detailed description and processing of the clients' very painful and often horrific events as. The findings of this research support the notion that vicarious traumatisation is unavoidable and is the natural consequence of being human, of the connection and care we have for our clients as we see the effect of traumatic experiences on their lives (Saakvitne et al., 2000).

Participants spoke about experiencing **connection with their clients**, which in turn increased their ability to empathise with them, making them vulnerable to being affected by their clients' trauma. Empathy has been shown to be critical to vicarious traumatisation as by definition it refers to the capacity to share other people's feelings, pain, joy, fear and other emotions (Hein & Singer, 2008). It is an essential feature of the therapeutic relationship, allowing the therapist to come to comprehend what the client may be experiencing (Canfield, 2005). When therapists emphatically engage with their clients and the repeated emotive narration of their traumatic experiences, they may experience the trauma content as if it were internally generated (Canfield, 2005). Other researchers have maintained that empathy can lead the individuals in close contact with trauma clients to experience their trauma symptoms as theirs (Woodward, Murrell, & Bettler, 2005). It is also possible that clients project the unmanageable

distressing feelings surrounding their traumatic experiences on the therapist, which results in them experiencing these as their own, feeling, thinking and acting in accordance with them. As such, it may become difficult for the therapist to identify what belongs to them.

The empathy shown by therapists towards their clients is supported by the core concepts of theory of mind which are based on beliefs, desires and intentions that are used to understand why an individual is likely to act in a particular way or to predict how they will act (Kloo, Perner, & Gritzer, 2010). Theory of mind involves understanding someone else's emotions, intentions, knowledge, and beliefs, whilst using that understanding to navigate social situations. One of the major theoretical positions with respect to theory of mind is the simulation theory. It is based on the idea that we have privileged access to our own mental contents, namely our own immediate thoughts, feelings and perception. Our ability to make sense of others relies heavily on our ability to place ourselves in their position through an imaginative simulation process. For example, we may be able to predict someone else response to an emotion-arousing stimulus by imagining ourselves in the same situation. We may also be inclined to imagine what would lead us to respond in such manner. In view of this it is assumed that the ability to carry out simulations is dependent on a capacity for imaginative pretence. It has been shown that such a capacity is evident from the early stages of development (Harris, 1992, 2009). The abilities tend to improve with development and are one basis for developmental changes in theory of mind. Hence, it is posited that the therapist's ability to understand and to an extent share their client's trauma-related intrusive memories has contributed to the experience of emotional distress for the therapist.

A few therapists talked about feeling a sense of bond with the client when they recognised familiar aspects of the trauma narrative that were somewhat related to them. There is a need for therapists working with trauma clients to be aware of their feelings, thoughts and beliefs in order to prevent collusion with their clients' inner experiences. In the therapeutic context, collusion refers to influencing and being influenced by the client without being aware of it (Petrigliari & Wood, 2003). Moreover, therapists are also more likely to efficiently assist their client if they can separate their inner experiences from those of their clients. Some of the participants alluded to experiencing counter-transference. It has been argued that the counter-transference responses are dependent on the therapist's resources to discriminate well between their feelings towards the client that were directly related to the client's projection or those that are independent to them. In this context, projection refers to a defence mechanism people unconsciously use to cope with difficult emotions by redirecting them to someone else (Baumeister, Dale & Sommer., 2002). The concepts of transference and countertransference were explained in section 4.2.2. Some of the participants reported automatic strategies that appear to be in the form of defence mechanisms. For example, some participants recognised that they used affective disconnection to numb themselves from the emotional aspects. Jade reported that she was "sceptical" about a client's narrative as her trauma experiences were very disturbing, in essence convincing herself that the client was exaggerating their trauma. Hence, it is important that therapists are self-aware, so they can recognise their emotional processing. It has been proposed that a therapist's self-awareness allows them to become self-conscious as objective observer of themselves, hence keeping them grounded (Pieterse, Lee, Ritmeester & Collins, 2013). Supervision may provide

opportunity to develop this ability as they reflect on their work with the supervisor, hence

learn to manage their own emotional processing and be genuine in their relationship with their

clients (Murphy & Joseph, 2013).

According to the findings the therapists initially struggled to cope with the emotional demands

of trauma work, however, overtime they **discovered useful coping strategies** to manage the

difficult demands of the work. The participants described a range of approaches they adopted

to manage the impact of trauma work on their psychological well-being. All the participants

recognised the importance of engaging in supervision as a way of managing the potential

impact of trauma work. For example, Sandra talked about using supervision as a medium of

understanding the counter transference-transference dynamic with a client as she realises that

some clients tend to bring out emotional responses that she recognises as not belonging to

her. Supervision is one of the most effective means for processing painful client materials,

especially when these are intertwined with personal emotions and thoughts that may impact

on the therapist's well-being and their ability to perform their psychological practice to the

best of their ability. Supervision was adopted by counseling psychology in the 1970s in the US,

and the emphasis of counselling psychology on the reflective practitioner model gave

supervision its credibility as it was identified as the reflection on practice aspect of the clinical

work (Carroll, 2007). Supervision therefore requires the review, questioning, consideration and

critical reflection upon practice.

In view of the emphasis placed on reflective practice within counselling psychology, it is fitting to consider the definition of supervision proposed by Ryan (2004) who defined the art and practice of supervision as "an inquiry into practice...a compassionate appreciative inquiry...In supervision we re-write the stories of our own practice...supervision interrupts practice. It wakes us up to what we are doing. When we are alive to what we are doing we wake up to what it is, instead of falling asleep in the comfort stories of our clinical routines" (p. 44). Therefore, it incorporates the benefits of applying reflective practice in the way they learn, see ourselves and the world (Baumgarter, 2001; Kolb, 1984), ensuring that we learn from experiences to allow cognitive and affective change. There are several models of supervision, which supervisors systematically adopt when supervising the therapeutic practice of their supervisees. Some models focus on the role of the supervisor such as discrimination model (Bernard & Goodyear, 1992) and supervisory alliance models (Bordin, 1983). Other models are theoretical orientation specific such as Psychoanalytic supervision and Rogerian supervision. While they are all very useful, in recent times one of the most widely recognised model of supervision is the seven-eyed model by Hawkins and Shohet (2012).

The seven-eyed model of supervision provides a comprehensive and systemic model for examining the process of supervision and appears to be the fitting to trauma work. It is proposed that at any time in supervision there are many levels operating and at a minimum all supervision situations would involve at least four elements, the supervisor, the therapist, the client and the wider context. However, of these four, the supervisor and the therapist are the only parties usually directly present in the supervision session, whilst the therapist and

supervisor hold the client and work context in the conscious and unconscious awareness. The

model acknowledges that despite this, the client and work context are carried into these

sessions in the conscious and unconscious awareness of the therapist, whilst also

acknowledging the power differentials that prevail within and between the systems.

Specifically, the one of the modes focuses on the wider context, which acknowledges that the

client-therapist-supervisory relationships exists within wider context which impinges upon the

processes within it. There are professional codes and ethics, organisational requirements and

constrictions, relationships with other involved agencies, gender, culture, country of origin,

client and therapist's profession and so on that are to be taken into consideration. Therefore,

the seven-eyed model is about looking at encouraging the supervisee to look at what and how

they're bringing the client to the supervision session and the materials that the client is

bringing into the therapeutic relationship; however, this is not just done at the dyadic level but

also in a holistic way.

Some participants expressed saviour fantasies that needed to be tempered in supervision. This

is very important as it is easy for a therapist to be pulled into an "extra empathy" stance that

draws the therapist to rescue the client, demanding more emotionally from the therapist

whilst also potentially repeating the pattern of disempowerment that the trauma client may

have previously experienced. Cunningham (2003) proposed that it is important that

supervisors create a safe and secure space for the therapist to disclose vicarious trauma

symptoms, and that supervision should encourage conversation about reactions to the trauma

client and contents, normalise and validate the therapist's feelings regarding the trauma

content, explore trauma-related thoughts and emotions, and appropriately deal with affective reactions without focusing too much on the therapist's personal life or the client's problem.

A few of the participants spoke about their experience of taking their client's troubles home with them, which highlights the importance of preventing, minimising or appropriately managing spill over when it occurs. This requires vigilance and energy, maintaining good physical health, good sleep and balanced nutrition are important, as alluded to by the therapists. Moreover, trauma contents tend to occupy the therapists' intra-psychic space; therefore, it is important that efforts are made to protect one's inner self from being invaded by the trauma content, in essence keeping it within clear boundaries. Strategies to achieve this may include avoiding exposure to unwanted trauma-related conversations with colleagues. On the other hand, it could also involve engaging with the trauma contents and the feelings they invoke by sharing them with colleagues in a boundaried manner. This would provide an opportunity to express feelings of frustrations, hopelessness, and dissatisfaction at the progress made, and so on. It has been argued that some characteristics of trauma work are best understood by other trauma therapists (Pearlman & Saakvitne, 1995), therefore conversations with work colleagues about trauma work can be just as essential as supervision.

Therapists involved in this research made reference to adopting other effective strategies to manage the impact of their client's trauma narratives as they became more experienced in trauma work. They reported the importance of their awareness of the possibility of being

traumatised, maintaining a healthy balance of work, rest and social life, whilst also

reconnecting with their emotions and experiences with clients through engagement with

supervision, personal therapy, emotional support from colleagues, journal writing, and so on.

There appears to be a correlation between the healthy strategies adopted by therapists and

the strategies for managing vicarious traumatisation that were suggested by Saakvitne et al.

(2000). These authors argued that there are three main components to managing the effect of

vicarious trauma. One of the core components is *anticipating vicarious trauma and protecting*

oneself from its impact by showing awareness through reflection, and maintaining a sense of

balance around work, rest, play and socialisation with friends and family. The participants in

this research seemed to suggest that doing whatever provides relaxation and pleasure and

enhances the meaning of life are important in their effort to contain, distance and counter-

balance the traumatic contents. They referred to engaging in sports and exercise, hobbies,

travelling, spending time with their children, going to the movies, and so on. Also important is

engaging in various forms of self-expression that assist their tolerance and help them to

connect with their clients' experiences and emotions, such as journal writing, drawing,

painting, and so on (Trippany, White-Kress, & Wilcoxon, 2004). The second component is

addressing vicarious traumatisation by engaging in strategies such as self-care, self-nurturing

and escape. The third component is *transforming the pain of vicarious traumatisation*, which

refers to the things the therapists can do to transform the impact of the work into a

connection with something positive, such as creating meaning, infusing meaning in current

activities, challenging negative beliefs and participating in community building.

Although therapists' exposure to their clients' trauma-related intrusive memories may have an impact on their psychological well-being, the findings of this study indicates that **trauma work also brings some rewards and privileges** as identified by the therapists interviewed for the research. Research on positive consequences of trauma work is relatively recent and has been regarded as vicarious resilience or vicarious post-traumatic growth. This notion encompasses the positive consequences of working with trauma survivors and bearing witness to their stories. It proposes that there is scope for therapists to experience personal strength, psychological growth, and empowerment because of their exposure to accounts of resilience perseverance and growth (Engstrom, Hernandez, & Gangsei, 2008; Puvimanasinghe, 2015). Some of the participants in this research emphasised the importance of establishing independence and empowerment in their clients to enable them to overcome their difficulties and grow through them. They described personal satisfaction when they observed clients becoming empowered, with this in turn empowering them as they witnessed the effectiveness of their interventions; it was generally perceived as rewarding. This finding reaffirms the reciprocal effects of therapy that was suggested by Engstrom, Hernandez, & Gangsei (2008). Participants recognised that they were inspired by their clients' admirable resilience and strength to be able to cope with their traumatic experiences and the accompanying intrusive memories. Some of the participants also reported establishing therapeutic relationships with clients and this was pivotal to empowering clients and building trust, while at the same time helping therapists to grow. These findings were supported by Puvimanasinghe (2015). Pearlman and Saakvitne (1995) made a statement that succinctly sums up some of the deeply enriching experiences that trauma therapy can provide: "Sharing joy and sorrow, laughter and

pain, wisdom and ideas with another person is at the heart of what it means to be human. The many moments of such connection in therapy deepen our own humanity" (p. 405).

4.3 The process mechanism for therapist-client trauma memories adaption

The process mechanism represents a conceptualisation of the therapists' construction of their clients' adaptation to experiences of trauma-related intrusive memories. It also represents the process therapists go through as they attempt to manage the impact of trauma work. Figure 3 is a diagrammatic representation of this process; it presents transitional phases that introduce psychological depth to the processes clients and therapists use to transition from the initial therapeutic contract to the end of therapy when reflection usually takes place.

The first phase comprises the shared understanding of the client's difficulties, with connection between the therapist and the client being shown to be important at this point. There is also a need to understand the clients coping mechanism prior to therapy so as to jointly identify the strategies that may need to be reviewed, changed or eradicated. This may include the client's use of avoidant strategies and defence mechanisms, maladaptive appraisal of intrusive memories, perception of intrusive memories as threatening to their sense of self, and so on.

At the next phase, the client's acceptance of their past traumatic experiences and the feelings and thoughts that surround it are shown to be important in this process. The therapist consequently begins to support the client to reappraise the meanings attached to their intrusive memories. The therapist also guides the client to adopt new and more functional

coping strategies. It is also important for the therapist to be aware of their client's trauma narratives on themselves and adopt appropriate coping strategies to manage their effect. As therapy progresses, the therapist begins to understand that the client's response to their trauma experiences is an unconscious strategy to survive within the mental health system.

As therapy reaches the latter stages, the clients become more aware of the triggers for their intrusive memories and are using new strategies to manage. The therapist also becomes aware of the limitations and boundaries of working within the mental health system. At the end of therapy, the therapist reflects on the therapeutic work, recognising the difference they have made to the lives of their clients. They also become more aware of how the work has changed them. Although, therapists reflect on the limitations of working under the mental system they also consider the rewards and privileges of trauma work.

Figure 3: Therapists' construction of their clients' processing of trauma memories

Initiating/ Contracting

*Connection with the client

*Intrusive memories vs. Client's activity

*Threat to sense of self

*Here and now quality of intrusive memories

*Anticipation of intrusive memories

*Maladaptive appraisal of intrusive memories

*Identifying client's survival strategies

Treatment

*Acceptance of past trauma

*Reappraisal of intrusive memories

*Client's awareness of triggers

*Therapist's awareness of boundaries & limitations

*Client discovering new coping strategies

*Survival within the mental health system

*Therapist discovering coping strategies

Endings

*Client's awareness of triggers

*Therapist's awareness of boundaries and limitations

*Client utilising new coping strategies

*Client recognise their growth through trauma

*Surviving within the mental health system

*Therapist utilising coping strategies

Reflections

*Recognising the difference made

*Therapist's awareness of how it changed them

*Recognising rewards & privileges of trauma work

*Reflection on the limitations of working within mental health system

Therapist's awareness of boundaries and limitations

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4.4 A model of therapists' construction of their clients' experience of trauma-related

intrusive memories

The proposed model is based on the proposition that there are three processes involved in the

therapists' construction of their clients' experience of trauma-related intrusive memories in

the context of psychological distress. On the one hand, there is an internal processing that

goes on within the therapists in relation to their clients' intrapersonal and interpersonal

experience of trauma-related intrusive memories. The process allows me and the reader to see

the clients through the eyes of the therapists, making sense of their journey through therapy.

The second process is an intrapersonal negotiation that goes on for the therapists where they

pay attention to the impact of their clients' trauma experiences on them and the synergetic

processes that were pertinent. The third process relates to the therapists' self-reflection on

their work with trauma clients, and how it has changed their own perspectives. The categories

are therefore, grouped under three distinct headings, as can be seen in Figure 4. One is

labelled 'Therapists making sense of clients' traumatic memories'. The second one is labelled

'Therapists' therapeutic process in therapy' and the third group is labelled 'Therapists

reflection on trauma work'.

Figure 4 is the schematic illustration of grounded theory of trauma-related intrusive memories

as reported from the perspective of therapists who have worked extensively with trauma

clients. The categories described in this analysis and the ways of grouping them present a

fluidly interconnected and mutually influencing process. The categories are grouped into three

processes which evokes interpersonal and/or intrapersonal negotiation. It is proposed that

these processes may either contribute to psychological distress for the client and therapists or

bring forth psychological growth. Experience of trauma-related intrusive memories is often

perceived as a threat to one's sense of self as one experience self as not having control. The

loss of sense of self as thinker and as an agent coupled with the here and now quality of the

trauma memories increases this perception of threat, therefore increasing the likelihood of

feeling distressed. The intrusiveness of these trauma memories contributes to a sense of

current threat as the sensory memories from the trauma may be experienced in the here and

now without the client realising that they are from a past event.

The interpretation and appraisal of these trauma memories are pivotal to how distressing they

are for the individual. For example, perceiving the intruding nature of the memories as

meaning one has lost control may contribute to feelings of hopelessness and helplessness,

which some of the participants suggested their clients reported. Similarly, a negative appraisal

of the trauma memories may in turn contribute to the sense of threat to self. Such responses

are likely to cause distress to the individuals. Also, there is interconnectedness between the

perception of intrusive memories as active and the anticipation of them, which may result in

the use of survival strategies such as avoidance, trauma amnesia, denial of past trauma and its

impact and so on.

The therapists seem to acknowledge and recognise changes that take place when they feel a

great connection with clients. This could be in the form of awareness of how related their

clients' experience may be to them, which induces more empathy, while for some it made it

difficult for them to continue the therapeutic work. The participants who ascribed to

psychanalytic theory of trauma also acknowledged the synergetic processes such as the

counter-transference dynamic which plays a significant role in their experiencing of the clients'

trauma, its impact on them and what they project onto the client. There is a link between the

connection they feel towards their clients and a desire to want to go beyond the limitations of

their work. For this reason some of the therapists interviewed reported that they found they

needed to be more boundaried with clients who they felt strong connections towards.

Figure 4: Schematic of a grounded theory of trauma-related intrusive memories and psychological distress/growth – Therapists' perspective

THERAPISTS MAKING SENSE OF CLIENTS' TRAUMA MEMORIES

THE THERAPISTS' THERAPEUTIC PROCESS IN THERAPY

THERAPISTS' REFLECTION ON TRAUMA WORK

THREAT TO SENSE OF SELF

Losing sense of self as thinker

Losing sense of agency

Here and now quality

APPRAISAL OF TRAUMA MEMORIES

Internalising self as defective

Initial response to trauma

Acceptance of past trauma experiences

'Out of the blue' nature of trauma memories

Anticipatory nature of trauma memories

DISCOVERING SURVIVAL STRATEGIES

Avoidance of predatory memories

Dissociation as a form of escape

Trauma amnesia

Denial of trauma event & its impact

Control as a way of coping

THERAPISTS' PROCESS IN THERAPY

Establishing human connection with clients

Value of empathy to trauma recovery

Sympathy disguising as empathy

Awareness of boundary & limitation

THERAPISTS CHANGING & REFLECTING ON TRAUMA WORK

Recognising recovery in clients

Therapist's self-reflection: Awareness of growth through trauma

Rewards & privileges of trauma work

Surviving within the mental health system

Bilateral distrust within the system

Trauma memories conceptualised as systemic issue

THERAPISTS DISCOVERING COPING STRATEGIES

Being mindful of the emotional content

Awareness and acceptance of the challenges of trauma work

Collective management of vulnerability

Supervision as a container

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The schematic diagrammatic representation of trauma-related intrusive memories indicates that therapists go through a process of self-reflection where they identified that acceptance of past experience is a key element for recovery in trauma clients, in that it allows the individual to come to terms with the experiences, whilst being able to process a more adaptive appraisal and adopt more functional coping strategies. There is a reflection of the growth that happens to the trauma clients and the therapist, something they explored in terms of change in perspective, show of strength and resilience. Also closely linked is the acknowledgement of the privilege and rewards of working with the client group and an appreciation of the clients' willingness to let them into their world despite having experienced very difficult life events. There is recognition that the clients' response to their trauma in most cases is an attempt to survive within the mental health system that they struggle to trust. It is suggested that this may be due to their previous experience of being abused by individuals they have trusted. However, this is often conceptualised as "manipulative" or "divisive". Simultaneously, the therapists also present themselves as having to survive within the system which they perceive to be labelling and presumptuous. Also relevant are the limitations to the nature of the work they may be able to do with clients due to the constraints of working under the current NHS system.

The model proposes that there are important consequences of the clients' experience of trauma-related intrusive memories to the client but also to the therapists due to their exposure to their client's trauma narrative. It is suggested that the therapists' engagement with the interpersonal and intrapersonal processes of their client's trauma-related intrusive memories may contribute to psychological distress or augment post-traumatic growth in them

and their clients. The participants who predominantly work with trauma clients using CBT tend to suggest that it is possible for clients to experience psychological distress due to the cumulative effect of experiencing trauma and adoption of maladaptive way of thinking or coping mechanism. It was constructed that trauma work has an impact on the psychological well-being of therapists a result of identifying with their clients' trauma stories, self-esteem, locus of control, sense of safety, memory systems, schemas and world views. On the other hand, some clients may become aware of their resilience and strength as a result of working through past trauma with their therapist. However, therapists may also experience psychological growth, personal strength and empowerment as a result of listening to clients' accounts of resilience, perseverance and growth.

4.5 Evaluation of the proposed model

The model indicates that therapists have constructed their clients' experience of trauma related intrusive memories as distinct. The analysis demonstrated that the research study was able to employ different stances from the therapists' perspective to understand how therapists construct and make sense of their clients' intrusive trauma memories in the context of the clients' psychological distress. For example, it allowed the reader to delve into the perspectives of the therapist looking at their client and making sense of their journey through therapy. It explored the process of the therapists looking within to make sense of how the clients' trauma experiences have impacted on them, in terms of synergetic process such as empathy and counter-transference. Through self-reflection, it also allowed the therapist to reflect on how their engagement with trauma work has change them. The construction of these stances from the therapists' perspective fits very well with the constructivist research

paradigm as the therapists were able to assign meanings to their clients' trauma narratives, and by that allowing me to make sense of their formulation of their client's trauma experiences. This is a novel way of working as it takes a multi-faceted view from the therapists' perspectives, allowing me to elicit multiple perspectives from the therapists involved in this research. Moreover, the research allows the readers to understand from the therapists' eyes what goes on in trauma work and the process of going through therapy, for the client and therapist.

The proposed model shares some resemblance to the Seven-eyed model (Hawkins & Shohet, 2012) which is used in the context of supervision. It provides a comprehensive and systemic model for examining the process of supervision. Hawkins & Shohet (2012) proposed that during supervision there are many levels operating, involving at least four elements, the supervisor, the therapist, the client and the wider context. However, of these four, the supervisor and the therapist are the only parties usually directly present in the supervision session, whilst the therapist and supervisor hold the client and wider context in mind. The model acknowledges the power differentials that prevail within the therapeutic dynamic and the system within which the client is receiving treatment. In view of this, the tentative model this research study proposes also delves into the experiences of other stances, perspectives and the wider context, with this provoking the therapist to consider these different positions.

Overall, this research has successfully explored different perspectives of trauma-related intrusive memories from the therapist. The recruitment of therapists for this research was highly important to this process as they have the training and experience of considering different positions in their clinical practice and are experienced in the practice of self-reflection and use of meta-skills. Psychological therapists are trained to be able to understand transference, counter-transference, multiple processes and other-perspectives, something I had hoped to achieve.

4.6 Evaluation of the research study

The evaluation of standards of quality, trustworthiness and credibility in qualitative research has always being contentious (Denzin, 2011). The quality of the presented research is informed by guidance from grounded theory researchers (Charmaz, 2006), counselling psychology researchers and other qualitative researchers (Elliott, Fischer & Rennie, 1999). To maintain good quality during the research process, it is paramount to own one's perspective; I was clear about my adopted theoretical orientation and personal values. Also important is clarifying how the research paradigm fits the research questions. To ensure compliance with this demand, I have engaged in personal, methodological and epistemological reflexive processes throughout the process of conducting and writing up this research. I have documented reflexive notes in this thesis where relevant and inserted some extracts in Appendix 12. I have found it important to acknowledge that it is impossible for my values and experiences to be fully separated from the construction of the analysis (Marecek, 2003).

With regard to the trustworthiness of the research, Elliott, Fischer & Rennie (1999) also emphasised the importance of providing clear information about the nature of the sample, facilitating credibility checks and acknowledging the limitations of the study. In the methodology chapter of the research, a sample description and participant contextualisation were provided. I discussed the approach to coding and engaged in the process with colleagues and experienced qualitative researchers during study groups, whilst also comparing the coding. Also, I provided information on the extensive coding and analytic process in the methodology chapter, with extracts of transcription, coding, memos and categorisation process provided in appendices 10 and 11. The thesis also includes participant quotes in the analysis and discussion chapters. Charmaz (2006) identified that profound engagement with the research topic and the grounded theory analytic approach is key to credibility of research. The limitations of the study are also discussed.

To ensure credibility of the research it is important to provide a coherent synthesis of the data without over-simplification or loss of value. There is a need to produce analysis that resonate and augment interest in the research topic, either through originality and novelty of the research topic and its methodology. Morrow (2005) emphasised the importance of bridging the gap between research and clinical practice. It must be highlighted that the research included a range of responses that were rich in information and added value to the research findings. The synthesis of data allowed the development of a tentative model, core connecting category and main categories via the communication of my data analysis and interpretation. This original contribution of the research is explored in the introduction and discussion

chapters, and information is provided on the potential for the findings of the research to be

applied to trauma clients, psychological therapists and clinical practice.

Finally, in the striving for credibility participants wellbeing was held with high priority

throughout the process of conducting and writing up this research. Kasket (2012) emphasised

the importance of prioritising participant well-being in research of this nature. The research

demonstrated this by obtaining ethics clearance and reporting this in the thesis, which

referred to obtaining informed consent, and ensuring that the briefing, interview and

debriefing processes were kind and without attempts to manipulate. The participants reported

that they enjoyed taking part in the research interview and found it worthwhile.

4.7 Limitations of research

As with much research, there were limitations to this research study. It is acknowledged that

the findings of this research represent one of several possible theories. As I've previously

mentioned, my personal experiences and perspectives have influenced the research topic,

methodology and findings. I have reflected on the idea that my experience of working with

trauma clients has encouraged me to pursue research in this area. However, I'd also mention

that this shared experience helped me to empathise with participants' difficulties during the

research interview and was pivotal in me reaching certain understanding. I was mindful of

ensuring I separated my personal experiences when interpreting data by writing a memo when

certain parts of the interview segment touched upon meaningful experiences that were

personal to me. This was then used to carefully check that assumptions were well grounded in

the data. I concede that the research could have benefitted from a follow-up focus group

interview with the participants to involve them more deeply in the analytic process and further

develop the model. The demands and deadline attached to my doctoral research has made it

impossible for me to carry out further field work. If the opportunity arises, I would invite these

participants and perhaps clients that have experienced trauma-related intrusive memories to

provide feedback on the therapists' perspectives, presented tentative model and to identify

areas for further development.

There are a number of limitations in relation to the sample and the recruitment process. Many

qualitative researchers acknowledge the lack of generalisability of their findings, and this is

also true for the current research (Marecek, 2003). All the participants in the study are

psychologists working for the NHS. It may have been just as important to recruit psychological

therapists from charities and those doing private work, as this might have allowed for an

exploration of their experience of working with trauma clients under a different system. It

may have been useful to recruit psychologists who adopt humanistic approaches in their work

with trauma clients. This is important as they conceptualise psychological distress differently,

in that they see it as important feelings supporting and motivating the processing of trauma-

related experiences, which may bring forth positive change (Tedeschi & Calhoun, 2004). Also, it

could be argued that the decision to exclude individuals who were receiving treatment for

trauma-related mental health problems from the sample may contribute to a selection bias of

the 'healthy worker effect' (McMichael, Spirtas, & Kupper, 1974, 1976). It may be suggested

that if only psychological therapists who are in good mental health are represented, this may

lead to an under-representation of therapists who may have actually experienced the more

severe impacts of trauma work. However, due to the sensitive nature of the research, there were concerns that talking about vicarious effect of trauma might be a trigger to a therapist who might still be receiving treatment.

The study may be considered an abbreviated version of grounded theory (Willig, 2008) as opposed to a fully-fledged theory of trauma-related intrusive memories in the context of psychological distress. The sample of nine psychologists may be considered to be relatively small; Mason (2011) proposed 21 participants to be the mean of the grounded theory PhDs he reviewed. My desire was to ensure richness of data that generated from quite long interviews with each participant as opposed to less rich data from greater number of participants. I view the breadth of this study as a major contribution to the field, but also understand the relatively small sample size may also be a limitation. The recruitment of more participants would likely provide us with more comprehensive explanations. It is my hope that the study has made a significant contribution by presenting a plausible account of how therapists construct and make sense of their clients' trauma-related intrusive memories, albeit with incomplete explanations.

I recognise that arguably these accounts could have suffered from self-reporting issues around memory; these include exaggerating and forgetting significant aspects of the experience. It is important to highlight that it is possible that some participants may have attempted to portray themselves and the nature of their therapeutic work in a positive light. However, this was

safeguarded against, as I made efforts to avoid asking direct questions regarding the effect of

trauma-related intrusive memories on their clients' trauma and on the impact of trauma work

as experienced by the therapists. The decision to adopt a semi-structured informal interview

strategy which allowed for prompts for elaboration and further discussion also mitigated this

concern. It would be useful for future research to attempt to recruit trauma clients post

treatment from other sources including private, charity, other NHS services and community

settings. It would be useful to consider including the narrative of significant others such as

partners, family members, close friends and carers. The relational components of trauma-

related intrusive memories should be explored.

4.8 Implications of the research study

There are many clinical implications of this research. Within clinical practice, counselling

psychologists should be encouraged to have an open-minded attitude which may allow clients

to find their own specific meanings, interpretations, ways of coping and recovery. Therefore, it

may be valuable for counselling psychologists to routinely ask their clients about experience of

trauma memories, their interpretation and the idiosyncratic cognitive strategies they adopt.

Also, considering that the study demonstrated the importance of coming to terms with

traumatic experiences to allow for psychological growth, treatment that focuses on helping

clients to shift from a position of avoidance to one of acceptance may help trauma survivors to

have better outcome with their trauma experiences. Whilst the recommended treatment for

complex trauma is Trauma focused-cognitive behavioural therapy (NICE Guideline 26 for

PTSD), it is proposed that the notion of post-traumatic growth presents person-centred

therapy as an alternative treatment especially as it aims to help clients to achieve personal growth and self-actualisation (Rogers, 1951).

The study also has implications for policy and practice, particularly the concept of post-traumatic growth can be integrated into clinical practice. Psychotherapy constitutes a good context to explore, support and encourage growth in the aftermath of a trauma experience within a trustful and intimate therapeutic relationship. Counselling psychologists can promote the active use of the growth paradigm in their clients' daily life by creating conditions that are likely to allow growth. The acknowledgement of the client's suffering enables them to explore positive changes as a result of their coping process. Also, the introduction of good practice guidelines for facilitating growth while working with trauma clients may help to prevent the stress that may accompany this nature of work and offers a containing framework, supporting therapists in this challenging work. Also, specialised training in the delivery and supervision of trauma-focused work during clinical training and in continuous professional development is likely to increase therapists' knowledge and confidence, helping them to promote growth in themselves and their clients.

Furthermore, at a practical level, in order to minimise experience of vicarious traumatisation it is important that therapists and their supervisors are able to recognize the signs and symptoms of its emergence. Therefore, it may be helpful for services to offer trainings to therapist, trainees, and other mental health practitioners about vicarious traumatisation. The

awareness of the factors can help therapists to monitor and possibly make quick recovery from vicarious traumatisation. Some of the signs identified by Catanese (2010) include exhaustion, increased irritability, chronic lateness, workaholism, depression, diminished sense of personal achievement. Also, the participants' report of rewards and privileges of trauma work may enhance the motivation of therapists and encourage other health care professionals to consider working with this client group. This focus is likely to minimise the negative consequences of trauma work and enhance the well-being of therapists and the quality of services being provided. It is important that training, supervision and educational programs promote strategies for coping with the effects of trauma work on both the clients and the therapists, whilst also raising awareness of the positive experience of the work.

The findings provide a framework for conceptualising the complex factors associated with trauma- memories that may contribute to post-traumatic growth and resilience. This concept may be of value to professionals working with trauma clients; moreover, it may give an awareness of how individuals with past traumatic and painful experiences transition from the initial phase of therapeutic contract, through acceptance of their experiences and to the adoption of more adaptive coping strategies and reflections. This understanding is highly important in working with clients' maladaptive coping strategies. It will enable practising therapists to identify more clearly where difficulties might exist, providing appropriate skills and knowledge applicable to the clients' needs, therefore improving care and client-centred services. Also, if it is assumed that growth occurs through exposure to the client's trauma and the ensuing distress, it can also be assumed that counter-transference plays a significant role.

With this highlighted, it may be beneficial to consider whether the contributory causal processes involved are the same as those that act as the cause of counter-transference. It would be worthwhile for future research to explore factors that can lead to post-traumatic growth in therapists who work with trauma clients.

In conclusion, this research provides a plausible account of how therapists construct and make sense of their clients' trauma memories in the context of the clients' psychological distress. Moreover, it demonstrates that a range of factors may contribute to the intensity of trauma-related intrusive memories as constructed by therapists, such as maladaptive appraisal of intrusions, denial of one's past trauma experiences and use of avoidance strategies. Simultaneously, the research also shows that whilst meaning well, the mental health system may also contribute to the suffering of trauma clients due to its limited resources and the use of labelling, contributing to the narrative of surviving within the system. To my knowledge, there are currently no existing theoretical models that provide an account of how psychological therapists construct their understanding of their clients' trauma memories. Also, this research was able to gain richer insight into the psychological well-being of practitioners who are consistently exposed to trauma narratives.

It is suggested that great challenges are posed in trauma psychotherapy, therefore making it important for trauma therapists to develop strong support systems both at work and outside of work, whilst also cultivating effective self-care strategies. The research found support for

the importance of self-care in doing trauma work. Allmark et al. (2009) highlighted the importance of on-going professional development and individual and group support for therapist working with trauma clients, emphasising its establishment in organisational policies and procedures. Finally, apart from the challenges that trauma therapy brings, there are several rewarding outcomes. These include the meaningfulness of helping individuals to restore their lives, and therapists' experience of personal growth and strength having been exposed to narration of difficult traumatic experiences. All in all, there is scope for the challenges of this nature of work to be transformed into opportunities for empathy, self-discovery, understanding, and personal and professional growth.

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APPENDICES

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APPENDIX 1: CITY UNIVERSITY OF LONDON

ETHICS APPLICATION FORM

Psychology Department Standard Ethics Application Form:

Undergraduate, Taught Masters and Professional Doctorate Students

This form should be completed in full. Please ensure you include the accompanying documentation listed in question 19.

Does your research involve any of the following? *For each item, please place a 'x' in the appropriate column*	Yes	No
Persons under the age of 18 *(If yes, please refer to the Working with Children guidelines and include a copy of your DBS)*		✓
Vulnerable adults (e.g. with psychological difficulties) *(If yes, please include a copy of your DBS where applicable)*		✓
Use of deception *(If yes, please refer to the Use of Deception guidelines)*		✓
Questions about potentially sensitive topics		✓
Potential for 'labelling' by the researcher or participant (e.g. 'I am stupid')		✓
Potential for psychological stress, anxiety, humiliation or pain		✓
Questions about illegal activities		✓
Invasive interventions that would not normally be encountered in everyday life (e.g. vigorous exercise, administration of drugs)		✓
Potential for adverse impact on employment or social standing		✓
The collection of human tissue, blood or other biological samples		✓
Access to potentially sensitive data via a third party (e.g. employee data)		✓
Access to personal records or confidential information		✓

Anything else that means it has more than a minimal risk of physical or psychological harm, discomfort or stress to participants.		✓

If you answered 'no' to <u>all</u> the above questions your application may be eligible for light touch review. You should send your application to your supervisor who will approve it and send it to a second reviewer. Once the second reviewer has approved your application they will submit it to psychology.ethics@city.ac.uk and you will be issued with an ethics approval code. <u>You cannot start your research until you have received this code.</u>

If you answered 'yes' to any of the questions, your application is NOT eligible for light touch review and will need to be reviewed at the next Psychology Department Research Ethics Committee meeting**.** You should send your application to your supervisor who will approve it and send it to psychology.ethics@city.ac.uk. The committee meetings take place on the first Wednesday of every month (with the exception of January and August). Your application should be submitted at least <u>2 weeks</u> in advance of the meeting you would like it considered at. We aim to send you a response within 7 days. Note that you may be asked to revise and resubmit your application so should ensure you allow for sufficient time when scheduling your research. Once your application has been approved you will be issued with an ethics approval code. <u>You cannot start your research until you have received this code.</u>

Which of the following describes the main applicant? *Please place a 'x' in the appropriate space*	
Undergraduate student	
Taught postgraduate student	
Professional doctorate student	X
Research student	
Staff (applying for own research)	
Staff (applying for research conducted as part of a lab class)	

1. Name of applicant(s).
Adebayo Idowu
2. Email(s).
██████████████████

3. Project title.
Investigating the presence of spontaneous memories of trauma in psychological distress - Perspective of therapists.

4. Provide a lay summary of the background and aims of the research. (No more than 400 words.)
Quantitative research has shown that individuals that report frequent and intrusive memories of traumatic events often experience psychological distress as a result. There is a need for researches with qualitative focus, which would allow for an understanding of how people make sense of intrusive trauma memories, more so providing an opportunity to explore how therapists construct and make sense of their clients' intrusive trauma memories in the context of the clients' psychological distress. The aim of the current study is to understand from the therapists' perspective, how trauma-related intrusive memories impacts on psychological distress in their clients. It will also explore therapists' understanding of the impact of trauma work on them. It is anticipated that 10 therapists will be recruited for this research and interviewed on their experience of working with trauma clients. The semi-structured interviews will be analysed using grounded theory (Charmaz, 2006), which will provide an in-depth understanding of the experience of intrusive trauma memories and psychological distress from the point of view of the therapist. It is expected that some categories will emerge from the analysis, which may result in the generation of a new theory. The study may provide qualitative evidence of the presence of intrusive memories in some mental health difficulties including depression, its form and characteristics, with particular focus on how people interpret the memories. This is a very important domain for the current research as previous studies have shown that the interpretation of intrusive memories has a role to play in depression.

5. Provide a summary of the design and methodology.
Qualitative research methodology will be employed for the current study. Data will be gathered through face to face semi-structured interviews. The interviews will be approximately 1 hour30 minutes long, it will be designed to explore the presence of intrusive trauma memories in psychological distress from the therapist's perspective. Also, participants will be asked to complete a demographic questionnaire, including items relating to age, ethnic group, marital status, length of therapeutic work and adopted therapeutic modality.
Grounded theory will be used to generate a theoretical explanation from the data which may be tested against data subsequently collected. In accordance with grounded theory an analytical approach whereby data collection and data analysis are closely related and conducted simultaneously will be employed. Therefore, allowing data collection and

participant selection to be shaped by ongoing analysis which will refine the emerging concepts, themes and theory.

6. Provide details of all the methods of data collection you will employ (e.g., questionnaires, reaction times, skin conductance, audio-recorded interviews).

The semi-structured interviews will be recorded with the aid of a voice recorder with the participant's consent.

7. Is there any possibility of a participant disclosing any issues of concern during the course of the research? (e.g. emotional, psychological, health or educational.) Is there any possibility of the researcher identifying such issues? If so, please describe the procedures that are in place for the appropriate referral of the participant.

No

8. Details of participants (e.g. age, gender, exclusion/inclusion criteria). Please justify any exclusion criteria.

It is anticipated that a sample of 10 therapists from various therapy/counselling services will be recruited for the current study, particularly those that have worked or currently working with clients that have experienced trauma and have intrusive memories of such trauma. This is irrespective of the therapeutic modality. Also, it may also include trainee clinical or trainee counselling psychologist. Participants must be fluent in English and at least 24 years of age; this is because therapists are usually above this age. Participants who are receiving or seeking treatment for mental health problems will be excluded from the sample, to protect them from the sensitive nature of the research area.

9. How will participants be selected and recruited? Who will select and recruit participants?

Participants will be recruited in London by personal contact, through advertising the study via internet and in places that provide counselling/therapeutic services to people, such as NHS, GP, universities and voluntary therapy services.

10. Will participants receive any incentives for taking part? (Please provide details of these and justify their type and amount.)

This is to be agreed with research supervisor

11. Will informed consent be obtained from all participants? If not, please provide a justification. (Note that a copy of your consent form should be included with your application, see question 19.)

Yes

12. How will you brief and debrief participants? (Note that copies of your information sheet and debrief should be included with your application, see question 19.)

Participants will be thanked for taking part in the research. They will be advised that their answers will be collated with that of other participants, and analysed as a whole. I will inform them that for this reason I will be unable to feedback any information to them about their individual responses. However, they can contact me if they would like to know the findings of the research. They will be advised that they are still fee to withdraw their data until a specific date (before analysis begin) and will be advised of the procedure for doing this. Finally, they will be informed of when the data will be destroyed.

13. Location of data collection. (Please describe exactly where data collection will take place.)

Data collection will take place in a room on campus.

13a. Is any part of your research taking place outside England/Wales?

No	X	
Yes		If 'yes', please describe how you have identified and complied with all local requirements concerning ethical approval and research governance.

13b. Is any part of your research taking place <u>outside</u> the University buildings?

No	X	
Yes		If 'yes', please submit a risk assessment with your application.

13c. Is any part of your research taking place <u>within</u> the University buildings?

No		
Yes	X	If 'yes', please ensure you have familiarised yourself with relevant risk assessments available on Moodle.

14. What potential risks to the participants do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.

There are no obvious risks to participants. Individuals who are receiving or seeking treatment for serious mental health difficulties will be excluded from the study, to limit the risk of re-traumatisation. Also, comprehensive information will be given to participants about the nature of the research, while also using precautionary measures to deal with potentially distressed participants by conducting the study under the guidance of an experienced counselling psychologist. The participants will be explicitly made aware of their right to withdraw from the research at any time, while also informing them that this is not affected by any form of compensation that has been offered or received by the participants.

15. What potential risks to the researchers do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.

None

16. What methods will you use to ensure participants' confidentiality and anonymity? (Please note that consent forms should always be kept in a separate folder to data and should NOT include participant numbers.)

Please place an 'X' in all appropriate spaces

Complete anonymity of participants (i.e. researchers will not meet, or know the identity of participants, as participants are a part of a random sample and are required to return responses with no form of personal identification.)	
Anonymised sample or data (i.e. an *irreversible* process whereby identifiers are removed from data and replaced by a code, with no record retained of how the code relates to the identifiers. It is then impossible to identify the individual to whom the sample of information relates.)	**X**
De-identified samples or data (i.e. a *reversible* process whereby identifiers are replaced by a code, to which the researcher retains the key, in a secure location.)	
Participants being referred to by pseudonym in any publication arising from the research	
Any other method of protecting the privacy of participants (e.g. use of direct quotes with specific permission only; use of real name with specific, written permission only.) *Please provide further details below.*	

17. Which of the following methods of data storage will you employ?

Data will be kept in a locked filing cabinet	
Data and identifiers will be kept in separate, locked filing cabinets	X
Access to computer files will be available by password only	X
Hard data storage at City University London	
Hard data storage at another site. *Please provide further details below*.	

18. Who will have access to the data?

Please place an 'X' in the appropriate space

Only researchers named in this application form	X
People other than those named in this application form. *Please provide further details below of who will have access and for what purpose.*	

19. Attachments checklist. *Please ensure you have referred to the Psychology Department templates when producing these items. These can be found in the Research Ethics page on Moodle.

Please place an 'X' in all appropriate spaces

	Attached	Not applicable
*Text for study advertisement	X	
*Participant information sheet	X	
*Participant consent form	X	

Questionnaires to be employed		
Debrief	X	
Copy of DBS		
Risk assessment		
Others (please specify, e.g. topic guide for interview, confirmation letter from external organisation)		

20. Information for insurance purposes.

(a) Please provide a <u>brief</u> abstract describing the project

Quantitative research has shown that individuals that report frequent and intrusive memories of traumatic events often experience psychological distress as a result. There is a need for researches with qualitative focus, which would allow for an understanding of how people make sense of intrusive trauma memories, more so to explore how therapists construct and make sense of their clients' intrusive trauma memories in the context of the clients' psychological distress. It will also explore how working with individuals with trauma-related intrusive memories impacts on therapists. It is anticipated that 10 therapists will be recruited for this research and interviewed on their experience of working with trauma clients. The semi-structured interviews will be analysed using grounded theory (Charmaz, 2006), which will provide an in-depth understanding of the experience of intrusive trauma memories and psychological distress from the point of view of the therapist. It is expected that some categories will emerge from the analysis, which may result in the generation of a new theory. The study may provide qualitative evidence of the presence of intrusive memories in some mental health difficulties including depression, its form and characteristics, with particular focus on how people interpret the memories. This is a very important domain for the current research as previous studies have shown that the interpretation of intrusive memories has a role to play in depression.

Please place an 'X' in all appropriate spaces

(b) Does the research involve any of the following:	Yes	No
Children under the age of 5 years?		X
Clinical trials / intervention testing?		X
Over 500 participants?		X
(c) Are you specifically recruiting pregnant women?		X
(d) Is any part of the research taking place outside of the UK?		X

If you have answered 'no' to all the above questions, please go to section 21.

If you have answered 'yes' to any of the above questions you will need to check that the university's insurance will cover your research. You should do this by submitting this application to ███████████████████, <u>before</u> applying for ethics approval. Please initial below to confirm that you have done this.

I have received confirmation that this research will be covered by the university's insurance.

Name ……………………………………………. Date……………………………

21. Information for reporting purposes.

Please place an 'X' in all appropriate spaces

(a) Does the research involve any of the following:	Yes	No
Persons under the age of 18 years?		X
Vulnerable adults?		X
Participant recruitment outside England and Wales?		X

(b) Has the research received external funding?		**X**

22. Declarations by applicant(s)		
Please confirm each of the statements below by placing an 'X' in the appropriate space		
I certify that to the best of my knowledge the information given above, together with accompanying information, is complete and correct.		**X**
I accept the responsibility for the conduct of the procedures set out in the attached application.		**X**
I have attempted to identify all risks related to the research that may arise in conducting the project.		**X**
I understand that **no** research work involving human participants or data can commence until ethical approval has been given.		**X**
	Signature (Please type name)	**Date**
Student(s)	Adebayo Idowu	03/09/2015
Supervisor		

APPENDIX 2: RECRUITMENT ADVERT

CITY UNIVERSITY LONDON

Department of Psychology
City University London

PARTICIPANTS NEEDED FOR
RESEARCH IN COUNSELLING PSYCHOLOGY

We are looking for Psychologists to take part in a study investigating the role of trauma-related intrusive memories in psychological distress and its impact on the therapist.

We are interested in interviewing Qualified Counselling or Clinical Psychologist on their experience with these client group.

Criteria to participate:

-   You are a Qualified Counselling or Clinical Psychologist
-   You are not receiving or currently seeking treatment for trauma-related mental health difficulties
-   You are able to understand English

You would be asked to: take part in an interview about your experience of working with clients who experience spontaneous memories of trauma.

Your participation would involve *1* session,
which is approximately *an hour long*.

For more information about this study, or to take part,
please contact:
Researcher - Adebayo Idowu ▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮

Supervisor - Dr Renata Pires-Yfantouda
Psychology Department
at
▮▮▮▮▮▮▮▮▮▮▮
Email: ▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮

This study has been reviewed by and received ethics clearance
through the Psychology Department Research Ethics Committee, City University London. Ethics code - [PSYETH (P/L) 15/16 39].

If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on ▮▮▮▮▮▮▮▮▮ or via email:
▮▮▮▮▮▮▮▮▮▮▮

APPENDIX 3: RECRUITMENT EMAIL

<u>Recruitment Email</u>

Dear ﹍﹍﹍﹍

I am a Trainee Counselling Psychologist at City University of London. I am in the process of carrying out my doctoral research and recruiting qualified counselling or clinical psychologists who have worked with trauma clients with intrusive trauma memories. The interview will be approximately an hour 30 minutes long and will explore the role of trauma memories on psychological distress as experienced by clients, from a therapists' perspective. It will also explore how clients' trauma memories may impact on the therapist.

The criteria to participate are as follow:

- You are a Qualified Counselling or Clinical Psychologist with experience of working with trauma clients
- You are not receiving or currently seeking treatment for trauma-related mental health difficulties
- You are able to communicate in English

Please read the attached participant information sheet for more details about the research.

Kindly send me an email if you have any questions or would be interested in taking part in this research. Thank you.

Best regards,

Adebayo Idowu

Trainee Counselling Psychologist (DPsych - Year 3)

City, University of London

██████████████

APPENDIX 4: PRE-INTERVIEW PARTICIPANT INFORMATION SHEET

CITY UNIVERSITY LONDON

Participant Information Sheet

Title of study: The role of trauma-related intrusive memories in psychological distress - From the therapist's perspective; and its impact on the therapist.

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The aim of this study is to gather information from psychological therapists about the how therapists construct and make sense of their clients' intrusive trauma memories in the context of the clients' psychological distress. The study will also explore the impact of trauma-related intrusive memories on therapists. Having a better knowledge will help in developing strategies to manage the spontaneous memories so as to minimise its effect therapists' mental well-being. The research is being conducted as a requirement of Professional Doctoral Programme in Counselling Psychology at City University London. The study will run for approximately 1 hour.

Why have I been invited?

The study will include approximately 10 participants. The individuals participating in the study must be Qualified Counselling or Clinical Psychologists who have experience of working with individuals with history of trauma and intrusive memories. They must be able to speak and understand English fluently. They have never sought treatment nor currently receiving treatment for a mental health problem.

Do I have to take part?
Participation is voluntary. You may withdraw at any stage of the research or avoid answering questions which are felt to be too personal or intrusive. You will not be penalized or disadvantaged in any way if you choose to withdraw. Taking part in the research will not affect their grades should be included.

It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw your data and without giving a reason.

What will happen if I take part?

Should you agree to take part in the study you will be required to engage in a semi-structured interview asking questions about your experience of working with clients that are suffering from psychological distress and spontaneous memories of trauma. The interview will be recorded on a voice recorder. You are assured that this will later be transferred into password protected computer file for transcription. You will also complete a short questionnaire about demographic details, such as age, ethnic group and so on. The whole research should not take longer than 1 hour. The research only involves one session.

What do I have to do?

You will be expected to come to the agreed place and at the agreed time for the research. You will interviewed by the researcher, the questions relate to your perspective on spontaneous memories of trauma within your clients. It may take about an hour of your time.

What are the possible disadvantages and risks of taking part?

The study will require your time in taking part in an interview. Also, as it involves talking about your client's traumatic life experiences and its effect on their mood if any, which you may find distressing. If you become distressed, you can withdraw at any time during the study. If you feel very distressed and would like to discuss this with someone, please contact your GP or the University Student and Mental Health Service on ▮▮▮▮▮▮▮▮▮

What are the possible benefits of taking part?

Your participation will contribute to our research on the role of spontaneous memories of trauma on psychological distress. This will be vital to everyone, especially in developing strategies to manage it.

What will happen when the research study stops?

If the project is stopped, all of your data will be destroyed, therefore it will not be analysed.

Will my taking part in the study be kept confidential?

If you consent to take part in the research the interview session will be transferred into a password protected file. It will be then be transcribed and analysed. All information, which is collected, about you during the course of the research will be kept strictly anonymous and confidential. The information will solely be for this research.

What will happen to the results of the research study?

The results of the research are likely to be discussed in the write up of the research project. It may also be published in a psychological journal. Your anonymity and confidentiality will be protected at all times. You can obtain a copy of the results by contacting the researcher on the email below.

What will happen if I don't want to carry on with the study?
You are free to withdraw from the research at any time. There are no punishments or disadvantages to you for withdrawing.

What if there is a problem?

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone █████████. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: Interpretation of spontaneous memories and effect on mood.

You could also write to the Secretary at:
Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square, London. EC1V 0HB.
Email: █████████████████████

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?

This study has been approved by City University London Psychology Department Research Ethics Committee, [PSYETH (P/L) 15/16 39].

Further information and contact details

If you have any queries about the research please feel free to contact the researcher or their supervisor via their University email accounts:

Adebayo Idowu (Researcher) Email:█████████████████████
Dr Renata Pires-Yfantouda (Supervisor) Email:█████████████████████████

Thank you for taking the time to read this information sheet.

APPENDIX 5: INFORMED CONSENT FORM

CITY UNIVERSITY LONDON

Title of Study: The role of trauma-related intrusive memories in psychological distress - From the therapist's perspective; and its impact on the therapist.

Please initial box

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve taking part in an interview about my experience with clients that presented with depression.	
2.	This information will be held and processed for the following purpose(s): To investigate the extent to which spontaneous memories of trauma are present in psychological distress. I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

_____   _____   _____

Name of Participant   Signature   Date

_____   _____   _____

Name of Researcher   Signature   Date

When completed, 1 copy for participant; 1 copy for researcher file.

Note to researcher: to ensure anonymity, consent forms should NOT include participant numbers and should be stored separately from data.

APPENDIX 6: POST INTERVIEW DEBRIEF

CITY UNIVERSITY LONDON

The role of trauma-related intrusive memories in psychological distress - From the therapist's perspective

DEBRIEF INFORMATION

Thank you for taking part in this study. Your answers will now be gathered together with the responses of other people participating in the research. The data will then be analysed as a whole rather than there being any examination of anybody's scores in isolation. For this reason we will be unable to feedback any information to you about your own responses.

If however you would like to know the findings of our overall research please contact the researcher (email: ⬛⬛⬛⬛⬛⬛⬛⬛⬛⬛) and you will be sent a summary of the findings.

If participation in this research has left you with any concerns related to mood or any other psychological health then please contact your GP or the University Student and Mental Health Service on ⬛⬛⬛⬛⬛⬛.

We hope you found the study interesting. If you have any other questions, please do not hesitate to contact us at the following:

Researcher - Adebayo Idowu - ⬛⬛⬛⬛⬛⬛⬛⬛⬛
Supervisor - Dr Renata Pires-Yfantouda - ⬛⬛⬛⬛⬛⬛⬛⬛⬛⬛⬛

Ethics approval code: [PSYETH (P/L) 15/16 39].

APPENDIX 7: INITIAL INTERVIEW SCHEDULE

Appendix 7: Initial Interview Schedule: Trauma-related intrusive memories -Perspective of therapists

1. People who have experienced some kind of trauma sometimes have memories of parts of the traumatic event pop into their mind when they do not want them to. Could you describe to your best knowledge of such intrusive memories as experienced by your client? (How they experience the intrusive memory, features, frequency, clarify & detailed?)

2. Does it affect their mood in any way? In what way does it affect their mood?

3. Do they attach any meaning to these memories? If so, can you tell me a little about this? (what the memory means to them)

4. Is there a sensory quality to this memory (e.g. hearing sounds, smells or taste, bodily sensations) and could you describe it? Did that make it more distressing and upsetting for them? If so in what way?

5. In your client's view, to what extent did it seem to be happening now instead of something from the past?

6. Which moment in the course of the event would your client say had the greatest emotional impact on them? Is there a reason for this?

7. How long would your client say they spend dwelling on the trauma event? And are there any consequences of dwelling on them?

8. Have your client tried not to think about, talk about or have feelings about the event? How did they find it?

9. Have your clients made effort to avoid activities, people and places that reminded them of the event? How did they find it?

10. Would you say your client is aware of anything that may trigger the memory?

11. Is there a particular and important part of the event that they tend to struggle to recollect?

12. How does your client manage the intrusive memories?

13. What is your experience of your client's trauma in the room with them? Would you say it has any effect on you during the session? Would you say this impact continued long after therapy or even after ending therapy with the client? Please tell me about these.

14. How do you manage the vicarious experience of your client's trauma?

APPENDIX 8: REVISED INTERVIEW SCHEDULE

Appendix 8: Revised Interview Schedule: Trauma-related intrusive memories -Perspective of therapists

1) People who have experienced some kind of trauma sometimes have memories of parts of the traumatic event pop into their mind when they do not want them to. Could you describe to your best knowledge of such intrusive memories as experienced by your client?

2) In what way did it affect their emotional and psychological well-being, if it did?

3) Do they attach any meaning to these memories? If so, can you tell me a little about this? (what the memory means to them)

4) Is there a sensory quality to this memory (e.g. hearing sounds, smells or taste, bodily sensations) and could you describe it? How did they find this and what impact did it have?

5) In your client's view, to what extent did it seem to be happening now instead of something from the past? Could you describe this?

6) How would you say your clients managed their trauma-related intrusive experiences over time? How effective were these strategies?

7) Would you say your client is aware of anything that may trigger the memory?

8) What decisions and choices would you say your clients made in relation to their relationships with others in view of these trauma memories?

9) What is it like to work with clients that experience trauma memories? How did professionals working with them experience them? What is the nature and dynamic of their relationship with the service?

10) What is your experience of your clients' trauma in the room with them? Would you say it has any effect on you during the session? Would you say this impact continued long after therapy or even after ending therapy with the client? Please tell me about these.

11) What decision have you made as part of managing yourself, your thoughts and your feelings, particularly when working with this client group?

12) Has there been any change from your initial experience with trauma work and now?

13) What sort of things have you learnt about working with trauma clients and coping with this nature of work?

14) Is there anything else you think would be useful for me to know?

APPENDIX 9: TRANSCRIPTION KEY

Appendix 9: Transcription key

The following forms of notation as used for the transcription of interviews were adapted from Gail Jefferson's version in Potter and Wetherell (1994). The interviewer is indicated by the letters AI and the participant is indicated by their pseudonym.

Brackets indicate an overlap by the other speaker between utterances e.g.: I: What do you k (of Women & Health) about Women and Health? =

An 'equals' sign at the end of a speaker's utterance indicates the absence of a discernible gap between speakers e.g.: I: Did you= A: Yes

Pauses longer than 5 seconds are indicated by number of seconds in brackets, e.g. a 7-second pause: (7)

Words which are underlined were spoken with emphasis. Words in uppercase were uttered noticeably louder than the surrounding words e.g.: A: I REALLY, REALLY don't like it. It makes me so unhappy.

A sigh or a loud intake of breath are indicated in the text by ..hh.

A colon indicates an extension of the preceding vowel sound, or phoneme, e.g.: A: Yeah:h, I see:

Words which could not be heard/understood during transcription are indicated by a lower case x per word e.g.: xx

An uppercase X indicates a name of a person or place which cannot be given for the sake of confidentiality. A description of the relationship of the person, or the type of place (e.g. country) is indicated in curly brackets e.g.: X {current male partner} said

Feelings such as anger, or a distinct tone of voice, are described in curly brackets, e.g. {sounded unhappy}

APPENDIX 10: SAMPLE OF CODING SYSTEMS AND CODING SEGMENTS

Sample of coding systems and coding segments

Code systems	Coded segments
Greatest emotional impact *Client felt unable to defend herself*	that sensory memory of being kind of attacked from the back, what she remembered then was that she was completed submitted to it because she thought there was no point fighting because he was much bigger and stronger than her, because there was no help, she had no chance so she just laid there and to her that was very traumatic (6) partly because of her own inaction because she just didn't, she didn't try to fight him erm there were some self-criticism Jason, 175 - 175 (0) Greatest emotional impact
Traumatic experience has affected her ability to trust people including professionals	I think probably the abusive teacher just because it seemed to impact on erm, very much her on her ability to trust other people, especially men as well erm and her ability to kind of function, this heightened anxiety about being close to people, just this kind of impacting on her, so yea she would be very kind of timid, or sort of hunched, overt lack of eye contact, I think just impacting on her ability to engage with people very well yea I think that had a major impact really Clara, 325 - 325 (0) Greatest emotional impact
Client no able to engage with services	it was because it affected our work and her kind of engagement with services, so for me I suppose it was the one I could see the direct link to how it might impact with her work with some professionals Clara, 329 - 329 (0) Greatest emotional impact one was when she was raped at the age of 13, and she went home and told her mum but her mum didn't believe her, that had a massive impact on her
Not being believed by her mother made the experience worse	Charlotte, 467 - 467 (0) Greatest emotional impact
Anticipation of an attack is critical to client's distress level	it was the image of the mother coming towards, it almost felt like it was the image of the mother charging towards him that was one aspect that was very intensely described, her just coming towards him with no kind of compassion maybe, just like this full on I'm ready to like physically abuse you in that sense, a bit of this out of control you know aspect of the mother, and another sense was, another feeling was the second he spoke about the sexual abuse, so the person that had been climbing behind the bed, er he got really upset with the thought of the person like actually putting himself in the other person's bed, in his bed, it was just a thought like how dare, how could he actually do that? Sandra, 597 - 597 (0) Greatest emotional impact
Client questions attackers behaviour	what this particular guy has described to me was that he would hide behind the sofa when his mum came down the stairs, so it's the vigilance of being ready for the attack, so he erm when he was young his mum stamped on his head, so that kind of real awful but it's not the pain and it's not even the erm it's the kind of threat of it happening again, so it's almost like the erm its the actual abuse but just the bit, just

Client needed to be vigilant to cope with abuse	before it happens the kind of now there's no way out of it anymore" so for example with him it would be "mum has seen me and i can see her looking at me and she's now going to attack me" that little moment, and the attack is really bad as well Kathleen, 887 - 887 (0) Greatest emotional impact something about the word "peak", the peak of it comes to my mind, which is what you're saying. For me my sense was erm I really, I think the common theme would be the part that symbolises the greatest level of vulnerability. So that's my interpretation of it Tara, 1198 - 1198 (0) Greatest emotional impact
The peak of the traumatic event is described as when they felt most vulnerable *Realising the extent of traumatic experience was unnerving* *Client is distressed by and questions visual images*	the chap in intensive care unit...the memory that he reported was waking up erm and being told he'd been unconscious for five weeks, so it wasn't the waking up, it was the finding out that he had been through this experience that he had no idea about. The other one was seeing other patients hanging erm in front of him so something that I think there, erm he knew he was a patient and he was seeing other patients hanging, so in other words "goodness me, this could be me, where am I, what are they doing with me?" and I think also the recognising that as a policeman he would have found, erm related to that image differently if it was a real thing, if it was really happening than erm how he related to it as a patient on the bed seeing other patients so erm seeing them in their hospital gowns, seeing them he was also in hospital gown. Tara, 1198 - 1198 (0) Greatest emotional

Trauma amnesia *Client convinced she had a good childhood* *Therapist slowly unpicked client's false experience of a good childhood*	the slightly less complex client really struggled to remember her childhood, a lot of her childhood I think to begin with she genuinely felt she had a good childhood, and when I first started to do the assessment process she really struggled to answer the questions, the general questions about her history, and had consistently I think but covered it up fine "oh it was fine, it was alright" but when we started to unpick it, and I had to use a lot of kind of circular questions from a more systemic model Jade, 77 - 77 (0) Trauma amnesia
Client returns to the here and now and is surprised by ongoing events *Flashback episode results in confusion* *She feels she has no control of her own mind*	when she comes back she recognises that something has happened but she has no memory of doing, like she suddenly comes round and finds herself wearing different clothes, she suddenly finds herself having cooked dinner, she finds herself in a different room, she can't remember going into the room, erm she had an incident at work where she and her colleague were doing a presentation today and she was adamant that the colleague didn't cover part of it and the colleague said that she did. Then my client concluded that she has no memories of being there, it's scary because she doesn't know what else she could have done so she's not in control of her mind, to others she looked perfectly fine so there was no sign of her not being there, she looks pretty normal and in her mind she's switched off Jason, 167 - 167 (0) Trauma amnesia
Client blocks out traumatic experiences as a way of coping	Often these kinds of things are coping mechanisms from childhood, she hasn't got anything organic going on as far as we know, amnesia is often related to severe childhood abuse and with her history it's not surprising Jason, 169 - 169 (0) Trauma amnesia
Client's memory of traumatic event is incomplete	she doesn't remember most of it, er there are like little bits here and there, she doesn't know exactly when it happened, she doesn't have any visual memory attached to it, she just has this sensations and flashes of something happening, an emotional memory, but there's no beginning and end, it's like just a random piece that's been taken out (6) so there's no particular context and that makes it, that makes working with it quite difficult Jason, 211 - 211 (0) Trauma amnesia
	I don't know if she couldn't recollect it or she didn't want to talk about it but it was I suppose exactly what happened to her in that cupboard with the teacher, so I don't know, she didn't talk about it, what she was made to do or what he did to her Clara, 384 - 384 (0) Trauma amnesia
Client may not want to talk about the trauma	I've had clients that erm have had black outs in the sense of er only remembering certain parts of the memory and not remembering others, you know and there's gaps, there's a lot of gaps in the memories, that sometimes come back and sometimes there's just ideas of what could have happened in those gaps, like not really knowing and

Client experiences gaps in memory	yea there's feeling of er, sometimes client's I've been remembering certain events that indicate you know sexual abuse that kind of things, but they remember little things they don't remember the abuse itself, they remember situations around the abuse, just after it happens, just before it happened do you know what I mean? just images of them
Client may have emotions about an experience without remembering it	being in the bathroom with their er you know what I mean their underwear on the floor, things like that but the actual event is what they're not remembering, so that's a pretty significant part of the memory itself that is being blanked out Jessica, 631 - 631 (0) Trauma amnesia
Clients does not remember the intimate details of the trauma	the first one, those images and very graphic images of the act being committed are seared into her brain, and she's very, they are definitely images of that, but I do agree and think other people maybe have coped
Important parts of trauma events may not be remembered	in very different ways and maybe have absented themselves or literally push it down afterwards in some way of dissociation with the memory and not going there, and could be this thing of shame where they don't want to tell a therapist. It's one of the things I quite like about EMDR, they can work with the images and process the memories without ever having to go into graphic detail with you, and quite often I find that they have enormous sense of relief knowing they don't have to say the worst of it even though I know they can remember it. I had a lady that said
A client that has images of the trauma event in their brain	"you mean I don't have to describe the position that they put me into" and I was like "No you don't you can visualise them, you can tell me if you want but it's not necessary" she was so relieved so it means she could see them and remember them but she didn't want to share them
She experiences vivid intrusive images of the sexual trauma	with me and report them, so there are two things there really aren't there? Jessica, 742 - 742 (0) Trauma amnesia
Shame as a barrier to talking about trauma	you can't recover them, you can't recollect the memory, but also I think it's interesting that it affects your mood and behaviours, so you'll be very depressed, very unstable, you'll be drinking and all these but you won't know why, because you have no memory of it and then later it starts to surface because of various reasons Jessica, 770 - 770 (0) Trauma amnesia
Client appreciates not having to share trauma experience	I know that people only know that something happened and suddenly they were somewhere else but that's the only memory that they have and the bit that's in the middle they can't remember, they can only
Client reluctant to share her traumatic experience	assume, they can make assumptions of some sort I don't know Kathleen, 941 - 941 (0) Trauma amnesia
The traumatic experience has an impact on mood and choices despite not having memory of it	I actually think the young woman at the psychosexual service for whom it was so much more acute whenever it happened and she didn't actually have a narrative around it, she didn't have a place in the timeline of her life to put it, so it felt like it was now, whenever she talked about it, it was now you know, erm whereas the other people
Clients' emotional well-being is affected despite	could all get to a place of "it happened and this is my memory of it, so I

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not recollecting the memory	can talk about the memory in a more observing way" and I guess they could feel it
	Tara, 1180 - 1180 (0) Trauma amnesia
Clients' awareness of an event but unable to recollect the event	
Client sometimes attempt to fill the missing gap	
Client has no narrative or time line of trauma event	
Surviving the mental health system	it's seen within the system as manipulative but of course it's survival isn't it? This is the strategies that these people needed to survive their complicated messed up childhood
	Jade, 29 - 29 (0) Surviving the MH system \Client surviving within the system
Therapist substitutes the label "manipulative" for survival strategy	
	It's the only one that's worked, and if we're honest we all do that don't we? or else it absolutely doesn't work we just do what we do, we have our ways of relating to people, but it's very easy when there are two separate services involved that those things get enacted re-enacted within the system
Clients sometimes unconsciously play out their experience within the system	Jade, 31 - 31 (0) Surviving the MH system \Client surviving within the system
Trauma memories conceptualised as systemic issue	working systemically can also be important, helping someone to see the way the trauma may fit, the memory may fit in the wider system and who else might be able to support them with it, so I'm kind of naming the fact that they needn't be alone with it, some of it might be private, some of it may not need to be shared, the kind of ripple effect, the implications of it, potentially things that others can support them with.
	Tara, 1234 - 1234 (0) Surviving the MH system \Client surviving within the system
Clients trauma-related issues to be shared	

Pressure within the political system means job roles are not as distinctive *Acknowledging the value of all professions within the system*	Absolutely absolutely and that is again in the wider system one of my fears and concerns as there is more pressure within the political system to have generic workers where social workers and nurses do pretty much the same things and OTs are drawn in to do pretty much the same things and it's all about care coordination, we lose something because all of that profession brings different focus and attention and it's that that's really effective for these people, and you know there's a pressure to move away from that Jade, 27 - 27 (0) Surviving the MH system \Service limitations & pressure on staff
Chaos as a form of control within the system *Good communication to counteract clients' manage survival strategies* *Survival strategies used to survive difficult childhood experiences*	the complex trauma clients invite and create unconsciously chaos around them in the system, and so it's really difficult to maintain the level of communication to ensure that the clients is not at some level playing mummy off against daddy within the system and I think again being rooted in the CMHT you know my CPN colleagues would come in and say "oh she said such and such" and I'd say "oh right this is the conversation we had" and then she would go "oh ok alright that's useful to know" and then we would decide on a united front ,and she would know we would speak about the other "oh I spoke to your CPN and your CPN said this" we made that really clear that this was a whole team approach in a way that erm those kind of erm, and it's seen within the system as manipulative but of course it's survival isn't it? This is the strategies that these people needed to survive their complicated messed up childhood Jade, 29 - 29 (0) Surviving the MH system\ Chaos as a form of control within the system
Labelling within MH system Client given a range of diagnoses Labelling inhibit service's acknowledgement of client experiences *Clients finds it difficult to engage with the team* *Client considered as "difficult" to be around*	she didn't respond to medication unsurprisingly and so then she collected all sort of different diagnosis, I wrote report and I think I found 15 different diagnosis, it was you know all the usual, err the anxiety, the depression, the PTSD, but also emotional unstable personality disorder, borderline personality disorder, you know all sort of different things that cropped up and then finally a dissociative disorder, erm and it was easy to forget and I think the same with this other woman who came to us started off with anxiety and depression but as soon as she got the diagnosis for borderline personality disorder Jade 21 - 21 (0) Surviving the MH system\Labelling within MH system she had really struggled to engage effectively with the team, there was a lot of reluctance to put her forward to see me because she was so difficult and they just thought she was annoying and she'd had a fight, and of course her story was her history had been fine, and there was no problem but she was difficult to be around Jade, 73 - 73 (0) Surviving the MH system \Labelling within MH system

Attachment problems may contribute to trauma clients'' distrust of services and professionals *The therapist must help them to feel safe* Therapist is able to make trauma clients feel safe *Therapist contains clients when they are triggered* *Client's inability to make sense of experience means therapist cannot make sense of it* *Some professionals were more interested in adopting the medical model* *The DSM-5 is criticised as limited* *Clients may be re-traumatised within the system*	if they've had attachment ruptures where they cannot trust people and believe people are dangerous unsafe you know, you need to keep you know gentle sensitive eye contact, I think I'm kind of lucky I have a friendly sort of looking face and erm and I think erm just those kind of non-verbal and everything, about being very, and you're teaching them as well about how to regulate their own affect systems "Ohh isn't that interesting" you know "tough or interesting", yea you know and I think that makes a huge difference for me certainly it sounds from the feedback it makes them feel safer, and I notice when they get triggered and they go off the eye contact stops and I try to always just bring them back, calm them down, bring them back to relax them and again just an awareness of those bodily non-verbal things that are really important Jessica, 794 - 794 (0) it was very hard to, because she had not made sense of it, it was very hard to make sense of it it was very hard to explain it to somebody else, and then she came across professionals who also didn't know much about trauma and were more interested in diagnosing and giving her medication and that kind of invalidated her more "Ohh you're just having mental health problems" and they just label it unstable. Jason, 139 - 139 (0) Surviving the MH system \Labelling within MH system I think the DSM-5 I think needs to be redone basically, I don't think it serves us well. I think there's a lot of trauma that comes up when we see people with just depression that actually at the moment currently is unrecognised, not worked with and not worked with properly and I think that we can end up re-traumatising people by getting them to talk about it and I sort have a lot of views about that, that I'm sort of trying to explore Jessica, 666 - 666 (0) Surviving the MH system \Labelling within MH system
Discovering survival strategies *Trauma memory is active* *Active avoidance of predatory memories* *Clients engages with the memories by working hard/keep at bay*	sometimes inside the therapeutic settings erm the other client had very frequent intrusive memories really whenever she stopped, as she soon as she slowed down immediately they would be **waiting to intrude** and that was what she found so difficult and she managed that by just being too busy to think or feel for a long time, as I said working, she worked full time, she had her first two children, when she had three she dropped down a bit, then when fourth child arrived and five she was still working, and you know being a mum, and doing tutoring and you know everything was spotless at home, it was that **real manic defence** and so when she couldn't maintain that and it all got too much all of

Diagnosing to simplify	those memories was just constantly **nipping** at her, there would be **some intrusion about anything and everything really**
Describes trauma memories as active Predatory (my term)	Jade, 33 - 33 (0) Discovering survival strategies \active avoidance of predatory memories
Therapist finds it difficult to understand - overwhelming	yea he couldn't handle it to be honest, when they started coming back he was not able to cope, he would come to the session very concerned with the memories, and would say I didn't want to open this door, there was a lot of concerns about him with coping with this kind of memories, you know he wasn't able to kind of shut them down at some point, it was very much you know intrusive like its being described, it's not something that he wanted to deal with
Intrusive memories are intolerable and uncontainable	Sandra, 569 - 569 (0) Discovering survival strategies \Intrusive memories are intolerable and uncontainable
The trauma memories are uncontainable - causing fear	he felt that things were getting too out of control in that sense, you know it was the fear of the memories themselves, you know what I mean, and er and I think he just thought he couldn't handle it, there was too much too much of that kind of stuff coming out at once
	Sandra, 581 - 581 (0) Trauma memories seen as active and predatory\Intrusive memories are intolerable and uncontainable
Cannot identify the triggers for the intrusive memories	the awareness of the triggers themselves could be a safety thing but when it seems like there's no triggers for the intrusive memories it feels so out of control, that's when it feels a bit very distressful to be honest in the way my client has been describing it
	Sandra, 623 - 623 (0) Discovering survival strategies \Intrusive memories are intolerable and uncontainable
It is out of control	I mean part of the older woman's despair and fear, sense of hopeless at the enormity of the task that she's facing is the fact that she gets triggered by any little thing that sometimes she can't even identify, that sometime makes her feel that she, it just feels like this marmot task where on earth does she begin? She gets no sense of control she can get triggered anytime by anything, MASSIVELY, it is exhausting, absolutely exhausting and terrifying
Intrusive memories are intolerable and uncontainable	Jessica, 758 - 758 (0) Discovering survival strategies \Intrusive memories are intolerable and uncontainable
Client experiences a lack of control or agency *Trauma memories pushing client to breaking point*	the intrusive memories can also have the form of intrusive thought or voices or visions, as some people call it, images, that they can't switch of and that's very distressing, you know they can get very angry, low in mood, erm yea very upset with themselves
	Kathleen, 836 - 836 (0) Discovering survival strategies \Intrusive memories are intolerable and uncontainable
Trauma memories experience in different modalities	

Intrusive memories can becomes distressing as they cannot be contained	
Unable to escape from intrusive memories *Trauma memory described as active* *There is no escaping the trauma memories*	the other client had very frequent intrusive memories really whenever she stopped, as she soon as she slowed down immediately they would be waiting to intrude and that was what she found so difficult...so when she couldn't maintain that and it all got too much all of those memories was just constantly nipping at her, there would be some intrusion about anything and everything really Jade, 33 - 33 (0) Trauma Discovering survival strategies \Unable to escape from intrusive memories so to an extreme for her at times although she wasn't doing that when she came to see me she had been able to get herself back out there, because it hadn't worked you know as she'd withdrawn, the trauma memories had just followed her into her safe place so uhmm Jade, 69 - 69 (0) Discovering survival strategies \Unable to escape from intrusive memories
Dissociation as a form of escape *Client's dissociation is witnessed by therapist* *Client becomes unaware of events that have taken place* *She has no memories of her experiences* *Sense of loss of control over mind* *Clients dissociates during therapy session*	And at times she would completely dissociate, he would have no awareness of her age or who she was in the room, it would be as if she was actually in that flashback experience erm so really powerful intrusive imagery, full blown flashbacks. Jade, 13 - 13 (0) Discovering survival strategies\Dissociation as a form of escape That's the thing she doesn't know, when she comes back she recognises that something has happened but she has no memory of doing, like she suddenly comes round and finds herself wearing different clothes, she suddenly finds herself having cooked dinner, she finds herself in a different room, she can't remember going into the room, erm she had an incident at work where she and her colleague were doing a presentation today and she was adamant that the colleague didn't cover part of it and the colleague said that she did. Then my client concluded that she has no memories of being there, it's scary because she doesn't know what else she could have done so she's not in control of her mind, to others she looked perfectly fine so there was no sign of her not being there, she looks pretty normal and in her mind she's switched off Jason, 167 - 167 (0) Discovering survival strategies\Dissociation as a form of escape in the sessions with her she would often dissociate and kind of flash back to these erm traumatic events, she would sort of be gone, be gone you know out of the room for maybe a couple of minute. This was my first experience of dissociation and flashback to that extent, I was kind of quite overwhelmed by it and was not really sure of what to do with that

Witnessing this is overwhelming *Clients dissociates to manage feelings of distress*	Clara, 275 - 275 (0) Discovering survival strategies\Dissociation as a form of escape erm very distressed when it happens, I think people, erm some people get very distressed and therefore they dissociate to cut off the distress because they feel so overwhelmed that they dissociate, because the feeling is so overwhelming that they can't face the experience, the emotional experience…coping in the moment but it's not a long term solution, so it's a survival mechanism in that moment Kathleen, 838 - 838 (0) Discovering survival strategies\Dissociation as a form of escape
Control as a way of coping *Client had experienced parents as controlling* *Suppression is an attempt to have some control* *Uncontainable trauma memories contributes to loss of control*	I think we talked a lot about control, in terms of erm her kind of gaining some control by not eating, as she always felt she had no control, mum and dad were very critical of her growing up and controlling as well, so that as her way of gaining it back, so I think that's what happened so we looked at it in that way, it wasn't really much more than that Clara, 345 - 345 (0) Client's coping mechanism\Control as a way of coping so in some way its controlling, whatever it is, suppression, whatever kind of coping mechanism he was using, when it felt out of control he felt out of control, he wasn't so you know, he didn't know what to do 583 - 583 (0)) Discovering survival strategies\Control as a way of coping
Internal interpretation of trauma memories *Becomes overwhelmed by the trauma* *Finds self to be unbearable*	all that shame, self-loathing,' I'm a bad person, I must be a bad person' gets internalised like a stick of rock and they just have a conviction that they're not worth it, defective and it runs through them true and true and I think it comes from those kind of experiences that were never repaired 700 - 7000 (0)) Internalising self as defective\appraisal of trauma memories it was an image of this really dirty toilet basically, really repulsive really disgusting so the meaning that came to her mind she would recoil and want to shut away and hide which interrupted her sex life…I think the meaning she attached to that was something about the filthiness of sex or of herself, she really disliked herself she found her body intolerably unacceptable 1162 - 1162 (0)) Internalising self as defective\appraisal of trauma memories

Memory is triggered *Unablke to control the triggers*	so if she sees somebody with similar shoes to her ex-husband then she will often have flashbacks to the time he attacked her and stamped on her, so things like shoes and bins closing on the ward, they have metal bins… so that again will take her back to her army days 427 - 427 (0)) Out of the blue nature of intrusive memories\appraisal of trauma memories
Client accepting trauma experience	she was able to acknowledge whatever she did feel as oppose to invalidate that and dismiss it as just her going potty 215 -215 (0)) Out of the blue nature of intrusive memories\appraisal of trauma memories

APPENDIX 11: SAMPLE MEMO

Sample of memo writing

Personal reflexivity on the interview

In the first couple of interviews there were moments when I felt awkward, especially as I was interviewing a female psychologist, I was nervous about asking them questions that related to the sexual content of the intrusive memories experienced by their clients. I was wary that it could be seen as me enjoying it, and for this reason noticed I refrained from asking them specifically what the intrusive memories contained of when it became obvious that the client had experienced sexual abuse. This social awkwardness was also apparent in the participants, when they struggled to get their words out, lowered their voice, laughed awkwardly.

Looking back at the transcript my awkwardness came across through my silence or sometimes lowered voice, whilst also refraining from speaking directly about the related topics. My identification as a man and worries about how I could be perceived meant I didn't feel free to speak freely about the sexual content of the intrusive memories. However, having noticed this issue I later began to ask the participants questions that were related to, I became more open to these discussions and encouraged participants to speak about topics if they were comfortable doing so, with the understanding that not all the participants would feel comfortable about it.

Research reflexivity during data analysis

My interest in this research topic dates back to my previous research into trauma-related memories, which I carried out using quantitative research methodology as a requirement of my master's degree. Although it augmented my interest into this current research, as I felt a need to look closely at the experience of trauma-memories, it was important for me to ensure that my analysis was not informed by my previous findings and other existing research, therefore ensuring that my analysis fell within the remit of the data.

In view of the above, when I noticed the participants making reference to a link between intrusive memories and psychological problems such as depression and anxiety; I looked at the data closely to ensure it was indeed generated from the transcript and not from a pre-existing knowledge. This is something I aim to do throughout the data analysis.

Trauma amnesia - Is it also experienced by therapists that worked with them?

The category 'Discovering survival strategies' merges with this memo

Related codes:

Actively defending against the trauma

She is convinced she had a good childhood

She blocks out traumatic experiences as a way of coping

Client experiences gaps in memory

Clients does not remember the intimate details of the trauma

Avoidance of trauma memories

Suppression of trauma memories

Although it was reported by the therapists involved in the research that trauma amnesia is one of the strategies trauma clients use to defend against their trauma-related intrusive memories, where in several cases they are unable to recollect the trauma event or parts of it, and in some of the cases they tend not to remember the most threatening r vulnerable part of it. I also wonder whether this amnesia was also sometimes shared by the therapists who worked with them. I observed that there were moments when participants seemed to struggle to recollect some of their clients' narration of their traumatic experiences. It was not always clear as to whether this was due to them not being able to remember or an unconscious repression process that had gone on after hearing about worrying aspects of these traumatic experiences. This meant not only delaying or choosing not to speak about certain parts of the trauma but also not owning their physical and emotional experiences, therefore in a sense avoiding disclosure.

Therapists' distrust of trauma clients' narratives: What may be going on?

The category 'Surviving the mental health system' merges with this memo

Related codes:

Therapist is sceptical about clients' trauma

Therapists' experience of client trauma

Response to client's trauma

There were instances where some participants expressed they were sometimes sceptical about the traumatic experiences shared by their clients, and in some cases these scepticism is shared by the team. I can also relate to this, as in my clinical practice I have sometimes felt some narrative by some trauma clients can appear far-fetched to me. I would sometimes wonder if this is really true. I wonder whether this has a lot to do with how they expressed the traumatic experience to me. I can imagine if there is a non-challant and unemotional approach it makes it more difficult for one to fully comprehend what is being shared or connect with it emotionally. At the same time, I also wonder whether it is a form of defence by myself and some of the psychologists involved in this research. If we can't fathom it, then it didn't happen which means we don't have to process it as we and can just pretend like it never occurred.

Labelling within the mental health system - is it not damaging to clients?

The category 'Surviving the mental health system' merges with this memo

Related codes:

Client characterised by diagnosis

Therapists' frustration with the system

Client's lack of trust for MH system

Client's self-blame and defectiveness

Client questioning self

I find it fascinating that even though a number of participants questioned the value of labelling within the mental health system they often characterised clients based on their diagnosis for example referring to some of their clients as "the client with personality disorder". This is intriguing as even though they seem to be of the opinion that it has an impact on public attitude towards mentally ill people, but more so, and has the potential to affect the client's perception of themselves, they have become intertwined with the labelling system that they do it unconsciously despite not wanting to buy into it .This resonates with me significantly as I find that the label given to trauma clients in most cases evokes mixed feelings, affecting social distance, and sometimes may mean mental health services cease to acknowledge their individual traumatic experiences as everyone with the label is grouped together, ignoring individual experiences, subtleties and variations. These views are largely shared by me as I

have in the past reflected on the idea that when clients are given diagnosis, the service and professionals working within it may ignore their trauma, something that has contributed largely to their mental health difficulties. However, I do understand that a lot of clients find a diagnosis as something helpful, particularly in terms of being able to identify what may be troubling them. I imagine in most of these cases we do find some clients begin to play the system for survival reasons, something which then results in them being labelled as "manipulative". I noticed that similar rhetoric was shared by a couple of the participants. One participant wondered whether the labelling promotes self-blame in clients and consider themselves as being the problem. In regards to participants characterising clients based on their diagnosis, I wonder if I do the same.

Trauma clients finding it difficult to trust professionals and system

The category 'Surviving the mental health system' merges with this memo

Related codes:

Service's lack of compassion

Client unable to engage with services

The fears of professionals

Clients' lack of trust for MH system

Client's history of abuse or trauma event

Punitive nature of MH system

The participants often reported a distrustful relationship between trauma clients and MH services, including the professionals involved in their treatment. There is a shared notion that in most cases it takes some time for clients to trust professionals and the service itself, and even in some cases this never really happens. On reflecting on this, it will be sensible that trauma clients would be more cautious when letting people into their world, having being let down and abused by people that are meant to care for them, as it is with discover with several trauma cases. I personally find this to be quite frustrating as I find the mental health system as not fully grasping of this. I imagine I would be the same if I had been at the end of the experiences some of my clients went through. I imagine it serves as a protective measure against further harm and abuse. With this in mind, it is important that psychologists and other professionals don't quickly label clients as "difficult", instead feedback to them our

understanding of their fears of trusting people, and allowing them the freedom to do that in their own time.

Value of MDT working when working with trauma

The category 'Discovering coping strategies' merges with this memo

Related codes:

Therapist working strategy

Effective MDT working

Service limitation and pressure on staff

Some of the participants made references to the importance of multi-disciplinary team working approach particularly when working with trauma clients It was reported that it is important to work in close knit with the other professionals involved in his care. Whilst this team working approach is beneficial the participants expressed that this is not always possible within the service especially the NHS which is quite limited with resources and it is not always possible for MDT to work cohesively. This is also something I can relate with through my clinical experience, as it is not always possible to see what other professionals are doing for example care coordinator. My placement at a CMHT was invaluable for this reason, as I was opportune to work closely with the other professionals involved in the care of my clients, and with this we were able to collaboratively come up with a care package that aided the recovery of the clients.

APPENDIX 12: EXCERPTS FROM RESEARCHER'S REFLEXIVE DIARY

Excerpts from researcher's reflexive diary

22nd October 2016

I recently began to conduct research interviews. I remember being quite anxious the morning of my first interview wondering whether the interviews questions I had prepared would work. It reminds me of the first time I did a psychological assessment, in that I was trying to come across as confident. The intensity was greater here as I would be interviewing qualified psychologists for the research, therefore this only added to my anxiety, with me knowing how experienced they are I was worried that they may be critical of my interview questions. When I met up with the first participant, she immediately shared her experience of doing her doctoral research; this helped to put me at ease. I wonder whether she could tell that I was anxious. Although, her experience of doing the doctoral research is of course not the focus of the interview, it helped me to relax knowing that she has shared similar experience. The interview began slowly, I would say I was trying to find my way and so was the participant.

As I continued to interview new participants, the theme of feeling privileged as a result of working with trauma clients began to emerge. A couple of the participants I have interviewed spoke about experiencing feelings of guilt for "feeling sorry for themselves" when they experienced some issues in their personal lives, albeit in comparison to the trauma clients they were working with. My own experience of feeling privilege in comparison with some of the individuals I have worked with probably comes to play here. I remember in the past I would often feel ridiculous for complaining about certain things in my life when I begin to think of some of the most heart-breaking and gut-wrenching traumatic experiences they have experienced. I find that over time I have had to constantly remind myself that my clients' experiences, does not and should not render my personal experiences as pathetic irrespective of how challenging and traumatic my clients' experiences may be considered. I have come to understand that everyone's experience is just as valid, remarkable and worth talking about, and that includes that of professionals.

12th December 2016

I have noticed so far with the clients that as interview progresses, in most cases they become emotionally charged. I have somewhat found this to be challenging as there is a tendency for me to want to want to "be with" the participant in that process and foster therapeutic connection, but I was conscious that in dong that I may breach the boundary of the researcher role. Nonetheless, I still ensured that I made attempts to bring him the core qualities of counselling psychology, namely empathy, warmth and positive regard. Some may argue that

this may blur the line between my role as a therapist and that of a researcher. However, considering counselling psychology as a discipline embodies the practitioner-researcher stance, it is only ethical that that there will be an overlap from time to time. I was conscious in ensuring that I do not become too much of a therapist during the interviews. With some of the participants I found that it was a struggle to stay within the scheduled time frame for the interview as they seem to take it as their one opportunity to share with someone that is ready to listen to them and understand their narrative of the joy and struggles of working with trauma clients, especially with the notion that themselves and the clients are only surviving under a system that is limited in a lot of ways. I am dreading having to transcribe some of the interview recordings as the dada generated is likely to be overwhelming, Nonetheless, I wanted to allow participants that time express themselves, and also I wanted to allow them considerable influence over the length of the interview and its direction. I am pleased to have been able to do this.

29th January 2017

The theme of survival with the mental health system began to emerge quite strongly in the data. This is fascinating as there was no question that directly focus enquired this. In tangent with the demands of grounded theory, I have made a decision to revise some of my interview questions. A couple of the questions will enquire about clients' relationship with the professionals involved in their treatment and the service at large. It will be interesting to see if these becomes a re-occurring them with the remaining interviews.

I have found with most of my interviews to date that as the interview continued it became more emotionally charged, especially when she began to speak about the re-traumatisation that goes on within the mental health system, especially under the NHS as several trauma clients often go through a revolving door system, where they received psychological treatment for a limited length of time even though the treatment is more likely to be effective if the therapy contract is longer. This resonated with me as I have experienced it with some of my clients and share in her frustration. I have in the past wondered whether I was contributing to their pain by seeing them even though I am of the awareness that the work we are likely to do will only scratch the surface. However, I must say from my experience that clients do appreciate the brief therapy and finds it worthwhile particularly when provided by a kind psychologist.

15th June 2017

On reflection I find it very helpful to have transcribed the data almost immediately after each interview. I have had to listen to the recording of the interviews again whilst doing my coding and I have finding several things I had not paid attention to previously. I have recently began to analyse the data, and noticed that I have sometimes being drawn towards the positivist position of finding the truth about trauma-related intrusive memories from the data. I have sometimes becomes overwhelmed by the importance of the research to me and wanted to make sure it is acceptable. There is still enormous pressure I have put on myself to try to do justice to what the participants have shared with me, whilst adding conceptual reading of the stories and ensuring I remained grounded in the data. I sometimes feel the idea of generating a theory is weighing on me as in essence theories are often based on concrete experimentation. I have also wondered about how my role in the research may be judged by others. Nonetheless, considering the different ways I would have constructed the data and the diverse ways other researchers may have constructed it, it is fair to say that this is an account of a way in which trauma-related intrusive memories are experienced.

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Section B: publishable article pages 289-376

Section B: Publishable Journal Article

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