Therapists' Construction of Trauma Work and Negotiating the Therapeutic Relationship

Danielle D'Mello

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City University London

Department of Psychology

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Acknowledgements

Declaration

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Section A: **Preface**

This portfolio consists of three sections: a client case study, a piece of empirical doctoral research and a publishable paper. Each part was completed as part of my doctoral training and is presented with the view of demonstrating my competence as a Counselling Psychologist.

The patterns that run through these pieces and unite them are the themes of trauma and the struggle to create an aligned relationship in therapeutic practice. The client case study reviews a piece of work with a client who sought help for severe anxiety, following the traumatic loss of her mother and home. The empirical research is a Foucauldian discourse analysis that explores how five therapists construct their work with clients presenting with trauma. The paper presents two of the discourses that emerged from the research, the discourses of vicarious trauma and posttraumatic growth, and how the therapists used them to construct their work with trauma.

I have been interested in trauma for several years. Prior to beginning my doctoral training, I worked offering therapeutic support to children and young people, many of who were struggling with trauma. I found the work stimulating and rewarding, but equally, discussing the work and the impact it had on us with colleagues fostered an interest in how trauma work is approached. Although I did not explicitly realise it at the time, we were drawing on many of the dominant discourses presented in this research.

In clinical placements I have continued to find working with trauma fulfilling and challenging and as a trainee eager to learn and prove myself, I found myself increasingly drawing on discourses that may be criticised for how they pathologise the client. This caused me to reflect on my practice but more so, my principles. I feel passionately about promoting inclusive practice and believe in seeking to empower clients. At the same time however, for

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much of this training I found balancing training with work and personal issues very challenging. I frequently felt totally overwhelmed and I have realised that often it is the times when I am learning that I feel the most stupid. Grappling with trying to make sense of the theoretical and practical aspects of being a Counselling Psychologist, I found that gaining access to specialist discourses that consist of 'expert' vocabulary and jargon felt good; I experienced locating myself within these discourses as an indication that I was becoming part of the institution of psychology.

As a researcher taking a critical stance towards the discourses we use, I have had to question how congruent I can be when seeking to critique psychological and psychotherapeutic discourses and the unequal power relationships created and maintained by them, when I am using this research to integrate myself further into the institution of psychology. The difficulty between challenging oppressive discourses and acknowledging that I am located within them and the use and privilege they afford is something that I believe has been and will continue to be key to my experience of being a counselling psychologist.

The case study is a discussion of a piece of work that was meaningful to me on many levels. In my third year of training I was placed in a secondary care mental health service. The whole experience of this placement was amazing, the service allowed the flexibility to tailor the therapeutic approach to suit the client's presentation, and I was able to learn a huge amount from the fantastic supervisor I had in this role. Despite the difficult organisational changes that were ongoing throughout my time there, which meant that the environment could be stressful at times, supervision was always a calm, supportive space that encouraged me to slow down, be reflective and make sense of the processes between my client and me. Always invaluable, this space was particularly appreciated in reflecting upon and evaluating my work with the client I present here.

The work is a piece of therapy with Mavis, a British woman in her mid-fifties, who accessed the service for support with severe anxiety. We contracted and completed 16 sessions together. She was the first client with who I used ACT, and I was eager to practice the interventions. However, I learnt that I could not to be too fixated on delivering protocols as Mavis' presentation required flexibility and patience. Mavis had a huge amount of emotional pain to process, which often required nothing more than the intensely difficult task of sitting with the emotion and feeling it together. The case study is a discussion of my struggle to navigate our therapeutic relationship, and the constant challenge of re-negotiating the way that both our relational styles tended to pull us into an unhelpful pattern, in order to try to achieve an aligned, collaborative relationship that would allow us to struggle through our first experience of using ACT together.

The reason I choose to include this piece of work in the portfolio is twofold. Firstly, the parallel processes between us offered a rich opportunity to consider how challenging it can be to navigate the therapeutic relationship, highlighting how the desire to offer care and make positive changes from the position of therapist can have undesirable consequences in disempowering and pathologising the client. Secondly, Mavis's story allows consideration of what we mean by 'trauma', and how subjective an experience it can be. Exploring the meaning that becomes attributed to the discursive object of 'trauma' is a key theme in this portfolio.

The empirical research uses a social constructionist stance to apply Foucauldian discourse analysis to the interviews collected from five therapeutic practitioners, with the view of exploring how they use available discourses to construct their work with clients presenting with trauma. The findings are divided into two key themes, which I name the 'pathologising' and 'non pathologising' discourses of trauma. I argue that the discourses in the latter theme offer a critique of the former; however, it is of note that from a social constructionist epistemology it is not appropriate to argue that any are any closer to the 'truth' than the

others. This caveat accepted, I suggest that taking a critical stance towards the discourses used to construct trauma work can be useful in challenging patterns of oppression and working towards more empowering practice. Analysis of the discourses enables consideration of their implications for the therapeutic relationship and the role of the body and emotion.

I use the findings to argue that despite our manifest (and often best) intentions, the discourses we draw on as practitioners can position ourselves and our client in ways that produce undesirable practice and subjectivity. I wanted to critically explore the discourses that the participants have drawn on to construct trauma, and this approach has allowed me to do this. The result is a piece of research that I hope has meaningful implications for counselling psychology, but that has certainly allowed me to reflect on my own work and develop myself as a practitioner in ways that I would not have been able to do otherwise.

In the paper I present two of the discourses that emerged from the research. Firstly, the discourse of vicarious trauma, which I argue is the dominant discourse used to construct therapists' experience of trauma work. I also present the discourse of posttraumatic growth, which I have used to critique the vicarious trauma discourse. I argue that currently there is very little literature available, if any, that does not position the therapist that works with trauma as vulnerable to negative changes that occur as the result of the taxing nature of the work. I argue that this this is a pathalogising discourse that locates trauma within the therapist and the client, positioning them both as (potential) victims to the work.

Literature located within the wider discourse of 'positive psychology' that seeks to focus on the therapist's potential for growth through their work, constructs the growth alongside the negative effects of the work, often with the action orientation of arguing that indices of growth can provide a counterbalance to the cost of the work. I critique this discourse for enforcing the positioning of the therapist as damaged by their work with trauma. I hope that the

findings presented in this paper, which depict the way practitioners may actively resist these discourses, will begin to address the gap in the literature and allow useful reflection of how practitioners construct their work with trauma.

I hope that this portfolio allows the assessment of my skills in practice and research. Moreover, I hope it offers the reader a sense of how I have struggled, and continued to do so, with how to navigate theoretical and practical issues in an attempt to be a reflexive practitioner, who is willing to continually re-navigate the therapeutic process in order to be alongside the client.

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Section C: Empirical Research: Exploring how therapists construct their experience of trauma work: A discourse analysis

C.1   Abstract

This study aims to critically explore the discourses therapists use to construct trauma. Five therapists (two counselling psychologists, one clinical psychologist, one gestalt therapist and one psychotherapist), who self-identified as working with trauma, were interviewed. The transcripts were analysed using Foucauldian discourse analysis. The results were divided into 'pathologising' and 'non-pathologising' discourses of trauma. The 'pathologising' theme includes the discourses of 'psychiatry', 'cognitive behavioural therapy', 'vicarious trauma' and 'developmental trauma and resilience'. The 'non-pathologising' discourses are 'posttraumatic growth', 'embodiment' and 'feminism'. The findings are used to argue that the 'pathologising' discourses of trauma exacerbate power imbalance in the therapeutic relationship through the way the therapist and client are positioned, and that a more fluid, aligned relationship may be allowed from the 'non-pathologising' discourses. The way the 'pathologising' discourses construct emotion in binary terms of positive and negative is critiqued, as the 'non-pathologising' discourses allow difficult emotions to be constructed as a potentially enriching experience rather than a symptom to be alleviated. It is suggested that the 'pathologising' discourses neglect the body or construct it as a site for the experience of symptoms, and the 'non-pathologising' discourses may allow the embodied experiences of trauma to be constructed as useful in the process of recovery. These results were considered in the context of existing literature and recommendations for future practice and research are presented.

C.2　　　　　Literature Review

C.2.1　　　　Introduction

In this chapter I will critically explore how trauma and working with trauma are constructed in discourse. As this research uses a social constructionist epistemology, I would like to contextualise current discourses by presenting a genealogy of trauma, discussing 'hysteria', 'war neuroses' and 'feminism'. I then present the current discourses of trauma of psychiatry, feminism, biology, vicarious trauma (VT), posttraumatic growth (PTG) and lay discourse. Psychological and psychotherapeutic approaches to working with trauma follow: cognitive behavioural therapy (CBT), cognitive processing therapy (CPT), prolonged exposure therapy (PET), eye movement desensitisation and reprocessing (EMDR), dual representation theory and psychodynamic therapy. I offer a critical review of the existing empirical research into therapists' account of working with trauma. Finally, I will outline the aims of this study and research questions.

C.2.2　　　　Genealogy of Trauma

C.2.2.1　　Hysteria

'Hysteria' is reported to have undergone various definitions and explanations prior to becoming constructed as an outmoded term in dominant discourses (van der Kolk, 2007). Some texts suggest that a version of the diagnosis has been in use since Ancient Egyptian times and it is suggested that it has predominantly been assigned to women (Tasca, Rapetti, Carta & Fadda, 2012). As this genealogy will detail, the dominant conceptualisation of the disorder shifted from a physical to mental illness at the beginning of the 19th century.

'Hysteria' was formally 'defined' by Charcot (Charcot, 1877). Constructing 'hysteria' as a diagnosis reflects the socio-historical culture in the West at that time, in which scientific discourses were overtaking religious discourses as the most accepted form of 'truth' (Szasz, 1960) and giving way to the "scientific psychiatry of the nineteenth century" (Foucault, 1965, p.158). Positioned within scientific discourses as a neurologist, Charcot adopted a

methodological approach in his research (Herman, 1992) and argued that 'symptoms', including fits, retention of urine and paralysis and contraction of body parts, did not have a physical cause (Charcot, 1877).

The works into hysteria of Janet and Freud, both students of Charcot, have been credited as major contributors to current conceptualizations of trauma (Herman, 1992; van der Kolk, 2007). Janet (1920) emphasised the experience of the traumatic event when constructing the aetiology of 'hysteria' in his patients, illustrated in the following description:

> "[She had been] beat and abused in every way [and] fell into crises of delirium during which she acted over again the scenes she had lived through"
> (Janet, 1920, p. 63)

However, he constructed the development of the disorder as the result of 'internal' processes, suggesting that being able to reflect on one's present and past was integral to good psychological health. Janet has been credited with providing the first comprehensive account of 'dissociation' in trauma (van der Hart & Horst, 1989), as he argued that the traumatised subject pathologically dissociates the traumatic memories, due to the extreme stress they experienced during an event that is incompatible with their belief system (Janet, 1920).

The theories Freud argued earlier in his career are suggested to be the most in line with current constructions of the cause of trauma (Masson, 1984). Freud wrote *Studies on Hysteria* with Breuer (1893-1895), based on their work with clients who disclosed traumas (usually sexual abuse) that they could not talk about when not in a 'hypnoid' state. It is interesting to note that in this work the authors emphasised their patients' intelligence and good character, apparently positioning themselves against the discourses that locate an innate weakness in subjects positioned as 'hysterical' (Breuer & Freud, 1893-1895).

Freud later revoked his ideas. In *Beyond the Pleasure Principle* he argued that the traumatic

events described by the patient were fantasies rather than genuine memories (Freud, 1920).

It is suggested that Freud may have denied the validity of his patients' traumatic memories in

order to avoid being ostracised from his professional community, who apparently found

Freud's ideas unacceptable (Herman, 1992). The suggestion that patients may produce

'false memories' is reported to have dominated psychoanalytic approaches to trauma for the

next hundred years, and has been criticised for causing the subject's traumatic experiences

to be denied and dismissed (Masson, 1984).

C.2.2.2 War neuroses

The physical and psychological impacts of experiencing warfare have been reported at

various junctures in history. The term 'shell-shock' is reported to have first been used in

medical literature during world war one (WWI) in 1915 by British psychologist Myers (Jones,

2010). He eschewed the explanation of a physical problem caused by extremely loud noise,

arguing that as the hearing appeared to be the only sense unaffected, it was more likely that

the phenomenon observed was similar to 'hysteria' (Myers, 1915). Myers emphasised the

highly distressing situations the men had experienced (Myers, 1915) and advocated

psychotherapeutic interventions (Jones, 2010). This is reported to have been considered an

infeasible solution for the number of men affected. Texts suggest that constructing 'shell

shock' as a physical disorder enabled the more economically viable option of treatment that

consisted of a short rest, and once the symptoms had abated the men were returned to duty.

The government and army denied the legitimacy of the problem by arguing that adequate

training and leadership should prevent it (Bogacz, 1989).

A further factor that may have contributed to the bias towards constructing 'shell shock' as a

physical problem may have been an effort to resist positioning the subject as having

feminine traits and weak character, which may have been very shaming (Herman, 1992).

Whether the motivation was economic or social cost (Phillips, Lawrence & Hardy, 2004),

texts report that the psychological construction of 'shell shock' was actively supressed by the government, forbidding the publication of papers concerning the topic (Sloggett, 1916).

The work of Kardiner is credited as significantly contributing to the construction of a psychological disorder (Herman, 1992), as his work with WWI soldiers led him to propose that 'combat neuroses' were a disorder similar to 'hysteria' (Kardiner, 1941). However, Kardiner criticised the label for being stigmatising in the way it constructed the problem as a fault of the sufferer through their weak will or an attempt for preferential treatment. He located the problem in the subject's 'mind', writing "the symptom contains the idea 'I am still living in the traumatic situation'" (Kardiner, 1941, p.82) and argued that the disorder arose from external factors that challenged the subject's coping strategies, causing subconscious defences to be triggered (Kardiner, 1941; Kardiner & Spiegel, 1947).

Following WWII, those who had been detained as prisoners of war and in concentration camps were positioned as having a physical condition before the term 'concentration camp syndrome' was developed at the end of the 1950s (Weisaeth, 2014). However, it is reported that research into holocaust survivors was scarce as it was widely considered that such atrocities were unlikely to happen again (Weisaeth, 2014). This opinion that may have been constructed through 'structural oppression' (Brown, 2001), as it has been suggested that both allied nations and Germany sought to suppress public knowledge of what had happened to the Jewish people (Felman & Laub, 1992).

The construction of warfare and soldiers' experiences shifted when 'Vietnam Veterans Against the War' was founded in 1967 in opposition to US participation in the Vietnam War (Hunt, 1999). In the context of a 'radical' political climate in the West (Hunt, 1999), veterans actively resisted the positioning of 'hero' through action that included public demonstrations and the return of their medals (Herman, 1992). A paper by Shatan (1973) reported how veterans set up 'rap groups' as a way of providing mutual psychological support for 'post-

Vietnam syndrome'. It is suggested that not only did the veterans position themselves as psychologically impacted by their experiences, but in doing so they were able to challenge the stigmatisation of being diagnosed with 'war neuroses', through their insistence that they had the right to be distressed (Herman, 1992). Texts also report that the high incidence of antisocial and criminal behaviour associated with former veterans prompted psychiatric investigation, which concluded that their behaviour was due to 'massive trauma' (Shatan, 1973). As a result, the construction of 'posttraumatic stress disorder' (PTSD) entered The Diagnostic and Statistical Manual of Mental Disorder, third edition (DSM III) in 1980.

C.2.2.3   Feminism

Feminist discourses, which challenge the dominant discourses that construct 'natural' roles for men and women and position women beneath men's intellect and power, began to be more widely accessible in the 1960s and 1970s (Herman, 1992). Located within and facilitated by the discourse of feminism, research into the experiences of women and children began in the 1970s. Herman (1992) argued that once the construct of 'PTSD' had been legitimised by war veterans, the 'syndromes' reported in the following research gradually became constructed as the same phenomenon as that experienced by those who had experienced war fare.

Burgess and Holmstrom (1974) used the data collected from the interviews of women admitted to a hospital's emergency ward for rape to construct 'rape trauma syndrome'. The authors advocated the use of 'crisis intervention counselling' for women who have been raped and the need for in depth, informed professional help (Burgess & Holmstrom, 1974). In 1975, The National Institute of Mental Health created a centre for research on rape, through which female researchers conducted in depth interviews with women. The results were used to position women as frequently experiencing abuse (Largen, 1976). Russel (1983) led research into sexual abuse on a random sample of 930 women in San Francisco. The interviews, conducted entirely by women, sought to identify the frequency and severity

of abuse experienced, constructing traumatic experiences in a range of severity from 'very serious' (e.g. forcible penetration) to 'less serious' (e.g. sexual touching of body parts and forced kissing), and categorising the 'type' of perpetrator in a range from strangers to close family members. The authors reported that 38% had experienced at least one incident of sexual abuse before the age of 18 and 28% before the age of 14 (Russel, 1983).

The authors of the research presented here appear to have challenged the construction of sexual and childhood abuse as rare occurrences, and used the discourse to argue that these events lead to the development of significant trauma (Herman, 1992). However, the dominant discourse of trauma in mental health may still have constructed gendered violence as peripheral or inconsequential: in the 1980s leading psychiatric guidelines claimed that incest occurred in less than one in one million women and that its impact was not especially damaging (van der Kolk, 2007), and it is of note that marital rape was not criminalised in England and Wales until 1991 (Isaac, 2014).

C.2.3 Current discourses of trauma

C.2.3.1 Psychiatric discourse

This is the discourse utilised and produced by the institution of psychiatry. It is sometimes referred to as 'medical' discourse, but I shall be using the term 'psychiatric' discourse throughout this research. I suggest that psychiatric discourse is the dominant discourse of trauma. The discourse is used to construct 'posttraumatic stress disorder' (PTSD), positioning the subject as having had an abnormal or pathological reaction to a traumatic event.

The tenth edition of the International Classification of Diseases (ICD-10; World Health Organization (WHO), 1992) and fifth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM 5; American Psychiatric Association (APA), 2013) are tools within this discourse. Both offer a description of the 'symptoms' that can be used to 'identify'

pathological trauma in the subject: the presence of a triggering traumatic event, persistently

re-experiencing the event, numbing and avoidance. There are some distinct differences in

the definitions between the DSM 5 (APA, 2013) and ICD 10 (WHO, 1992), which are

presented below.

'PTSD' has had continuous revisions since it entered the DSM III in 1980 (Zoellner, Bedard-

Gilliab, Jun, Marks & Garcia, 2013). In the release of the most recent edition, the DSM 5

(APA, 2013), 'PTSD' was moved from 'anxiety disorders' to a new category of 'traumatic and

stressor-related disorders'. The title of the new category emphasises the role of the 'stressor',

or (potentially) traumatic event, as does the requirement of exposure to a traumatic event

listed under criterion A. The practical implication of this is that a subject must be identified as

having experienced a clinically relevant event in order to be aligned with the diagnosis of

'PTSD' (Zoellner et al., 2013).

There is an ongoing discussion in the literature regarding what constitutes an event that is

clinically meaningful to the diagnosis of 'PTSD', and what would be constructed as a trigger

for other disorders, including depression and social anxiety (Zoellner et al., 2013). Debated

experiences include sexual harassment (Avina & O'Donohue, 2002), complicated childbirth

(Olde, van der Hart, Kleber & van Son, 2006) and chronic illness (Eglinton & Chung, 2011).

Adding to the conflict, the ICD 10 continues to construct the traumatic event as something

outside of usual experience that is "likely to cause pervasive distress in almost anyone"

(WHO, 1992, p.147). This stipulation was removed from the DSM's fourth edition in

response to feminist research that argued that stressors may be commonplace for some and

that the impact of an event is subjective (Herman, 1992). The DSM 5 constructs risk or

threat of death, serious injury or sexual abuse as qualifying events (APA, 2013). The

exposure may be direct or indirect, which allows family members and professionals involved

with the directly-traumatised subject to be diagnosed with 'PTSD'. Those who have

witnessed the event through electronic media, such as the television, are explicitly excluded (APA, 2013).

The DSM 5 has removed the requirement that the subject reacts to the traumatic event with fear, helplessness and horror (APA, 2013). It has been suggested that this may be useful in obtaining a diagnosis for those who either did not feel an emotional reaction to the event or cannot remember it, given that the response to extreme trauma can be constructed in terms of the symptoms of 'amnesia' and 'emotional numbing' (Brown, 2006). However, 'avoidance' symptoms are constructed in terms of fear (Zoellner et al., 2013), which suggests that the emotion of fear is still significant in how psychiatric discourse constructs trauma.

The DSM 5 included a new cluster of symptoms constructed in terms of 'cognitive and mood disturbances', such as persistent negative beliefs and expectations about oneself or the world (APA, 2013). This construction seems to draw on the discourse of cognitive behavioural therapy (CBT; Beck, 1964), presented in section C.2.4.1 of this chapter. This may reflect not only that CBT is the dominant psychotherapeutic discourse for working with trauma, but also how constructions from other discourses may become integrated into a dominant discourse.

In the ICD 10 (WHO, 1992), 'PTSD' is presented under the category of 'reaction to severe stress, and adjustment disorders', which is a subsection under 'neurotic, stress-related and somatoform disorders'. The definition uses the constructs of 'predisposing factors', including a 'history of neurotic illnesses' and 'personality traits' such as 'compulsivity', to position those who were apparently triggered by less magnitudinous events.

Psychiatric discourse is located within wider scientific discourses, based on positivist epistemologies that seek to identify distinct psychological phenomenon (Mehta, 2011). This includes defining disorders and the symptoms that comprise them. The DSM 5 (APA, 2013)

and ICD 10 (WHO, 1992) serve to allow symptoms to be mapped in a constellation that then leads to a specific diagnosis. Research located within this discourse seeks to develop the 'validity' of diagnostic criteria by increasing the heterogeneity of the disorder; in other words, reducing the variation in presentation in those diagnosed. However, the same symptom may be listed under several disorders and studies have suggested that the majority of those diagnosed with 'PTSD' have comorbidities (Lockwood & Forbes, 2014), which is used to criticise the validity of the disorder and diagnostic tools in general. Although psychiatric discourse is used to suggest that 'PTSD' is one disorder, amalgamating the discourses presented in the genealogy, there are still bodies of research and literature that seek to explore how trauma within specific populations, such as war veterans (Shay, 2014) or those who have experienced childhood abuse (Mehta et al., 2013), may produce unique or distinct disorders.

C.2.3.2 Feminist discourse

As discussed above, feminist discourse has contributed significantly to current constructions of trauma. Feminist authors have argued that, far from being 'outside usual experience', the patriarchal society we are situated in means that for those who are not in the hegemonic position of the white, middle class, able-bodied, heterosexual man, trauma can be an 'everyday' occurrence (Burstow, 2003; Root, 1992). Feminist discourse has been used to criticise psychiatric discourse for locating the 'problem' within the subject rather than the society or perpetrator who caused the trauma (Burstow, 2003). The discourse can be used to challenge diagnoses that are disproportionately attributed to women (Tseris, 2013), of which 'PTSD' is an example (Sherin & Nemeroff, 2011).

Feminist discourse has been integrated with psychiatric discourse to argue that trauma is a relatively desirable, less pathologising diagnosis. Seeley (2008) argued that diagnosing a client with 'PTSD' emphasises their position as victim, undermining the blame of the traumatised subject for what happened to them and the subsequent pathological outcome.

This construction of trauma has been used to argue that it would be more useful and less pathologising to use trauma-based diagnoses instead of other disorders that are usually aligned to women and which often construct trauma as part of their aetiology, such as 'borderline/emotionally unstable personality' disorder (Herman, 1992; Tseris, 2013).

C.2.3.3   Biological discourse

The term 'biological', 'neurobiological', 'psychobiological' and 'neuropsychological' are often used interchangeably in literature. I shall use the term 'biological' throughout this research. This discourse is used in texts to construct a biological profile for 'PTSD', seeking to 'prove' or 'disprove' the validity of the construct. The discourse constructs trauma in terms of disordered physiological changes associated with stress (McEwan, 2004) and differentiates it from 'normal' functioning, which is the ability to return to homeostasis (i.e. a 'normal', non-stressed state) through physiological and behavioural responses (Kolb & Whishaw, 2001). The literature reports biological differences between controls and those diagnosed with 'PTSD' in the prefrontal cortex, amygdala and hippocampus of the brain and the hypothalamic-pituitary-adrenal (HPA) axis of the nervous system. These findings are summarised below.

The prefrontal cortex, associated with complex thought, memory storage and the personal experience of emotionally salient experiences (Makinson & Young, 2011), is reported to show decreased activity in those diagnosed with 'PTSD' (Milad et al., 2009).

The amygdala is suggested to be part of the system that alerts us to threats and helps activate protective systems (Makinson & Young, 2011). Subjects with 'PTSD' are said to experience amygdala hyperactivity in response to emotional stimuli, both 'happy' and 'fearful' (Shin et al., 2005), and stimuli associated with the original trauma (Liberzon et al., 1999). Subjects diagnosed with 'PTSD' have been reported to have decreased left amygdala volume compared to controls (Kolassa & Elbert, 2007). Amygdala hyperactivity is

linked with symptoms such as hyperarousal, and is associated with the maintenance of the disorder (Antunes-Alves & Comeau, 2014).

The hippocampus is implicated in memory formation and emotion regulation. Subjects diagnosed with 'PTSD' have been reported to have reduced hippocampal activity and volume, which has been linked to memory problems and reduced ability to perceive safety (Kolassa & Elbert, 2007).

Hormones including cortisol, epinephrine and norepinephrine are argued to be released at times of stress, as part of the HPA axis of the nervous system. Chronic exposure to stress is reported to changes how the HPA axis responds to acute and prolonged stress, permanently altering how the subject interacts with their environment and their ability to cope with subsequent stress (Brenner, 2011). A meta-analysis conducted by Meewisse, Reitsma, de Vries, Gersons & Olff (2007) explored the pre and post trauma plasma levels of cortisol in subjects diagnosed with 'PTSD' compared to controls. They suggested that women with 'PTSD' had lower cortisol levels than female controls but men with 'PTSD' showed no difference to male controls, and that those with histories of sexual or physical abuse showed lower cortisol levels than controls, but war veterans and refugees did not. These findings may be linked, as the different sexes are associated with different potentially traumatising events: women are reportedly more likely to be sexually abused and men more likely to experience direct warfare (Tolin & Foa, 2006).

Biological discourse is used in research seeking to explore whether these characteristics predate the traumatic experience, which positions the subject as having a predisposition to developing 'PTSD'. Biological discourse locates trauma within the body, including the physical brain. This may offer insight into why biological research has been criticised for not translating findings into meaningful positive changes in clinical practice (Brenner, 2011), as most psychological and psychotherapeutic discourses locate trauma in the 'mind' and

construct positive therapeutic change in terms of cognitive and emotional shifts, also located within the 'mind' (see discussions of psychotherapeutic approaches to trauma in section C.2.4).

Like the majority of psychological and psychotherapeutic discourses, recovery is constructed as a return to normality. In biological discourse this means seeking to change the subject's 'biological profile' to resemble a non-traumatised subject, which facilitates the practice of pharmacological interventions (Antunes-Alves & Comeau, 2014). Some authors suggest that it would be useful to conduct early screening of those who have encountered (potentially) traumatic events for the biological indicators of 'PTSD' or a predisposition to develop 'PTSD', advocating that pharmacology during the acute stage of trauma would benefit prognosis (Vaiva et al., 2003).

A therapeutic approach that is facilitated by constructing trauma in the body is somatic or body psychotherapy (I use the two terms interchangeably). Within this modality, the therapist guides the client to learn skills that allow them to experience the physical sensations that are evoked by their memories of the trauma, whilst being able to cognitively recognise that they are currently safe and that the traumatic event is not reoccurring (Rothschild, 2000).

C.2.3.4 The discourse of vicarious trauma

This discourse constructs trauma as something that is harmful to the therapist, causing them to be become 'traumatised' themselves. Within this discourse, I include 'vicarious trauma' (VT; McCann & Pearlman, 1990), 'secondary traumatic stress' (STS; Figley, 1995), 'compassion fatigue' (CF; Figley, 1995) and 'burnout' (Maslach, 1982).

VT discourse is used to construct trauma as something that can significantly affect subjects indirectly exposed to it. The term was 'defined' by McCann and Pearlman (1990) as "a theoretical conceptualisation of the profound psychological impact of working with trauma

victims" (p.143). 'VT' is constructed as changes to cognitive schemas about oneself and the world, including safety, trust, esteem, intimacy and control. It is typically measured using the Trauma and Attachment Belief Scale (TABS; Pearlman, 2003), formerly the Traumatic Stress Institute Belief Scale (TSI; Pearlman, 1996; Pearlman & Mac Ian, 1995). This discourse is used to locate trauma within the therapist, and to argue that even without overt symptoms, the practitioner may be permanently altered as a result their work (Pearlman & Saakvitne, 1995).

Figley (1995) suggested that 'STS' and 'CF' may be used interchangeably to conceptualise the "natural, consequent behaviours and emotions resulting from knowledge about a traumatising event experienced by a significant other" (p. 10). He argued that these 'natural' effects of working with trauma can be differentiated from 'secondary traumatic stress disorder' (STSD), which has the same symptoms as 'PTSD'. However, subsequent literature does not appear to differentiate between 'STS'/'CF' and 'STSD'. Texts construct 'CF' and 'STS' in terms of re-experiencing the traumatic event, exhaustion, avoidance and persistent hyperarousal (Arnold, Calhoun, Tedeschi & Cann, 2005). 'CF' is typically measured using the Professional Quality of Life Scale (ProQOL; Stamm, 2010), which measures the dual components of 'CF' and 'compassion satisfaction' (CS), discussed in the following section, the discourse of posttraumatic growth (section C.2.3.5.). 'STS' is measured by the Secondary Traumatic Stress Scale (STSS; Bride, Robinson, Yegidis & Figley, 2004). Like 'VT', the constructs 'STS'/'CF' are usually used in texts to position mental health practitioners, including nurses (Beck, 2011; Duffy, Avalos & Dowling, 2015), therapists (Canfield, 2005) and social workers (Bride, 2004) as likely to be, if not inevitably, affected by trauma work.

'Burnout' is arguably the most distinct of these terms, as it is used to position workers outside of 'caring' professions. Freudenberger (1974) argued that 'burnout' is the frustration or fatigue that results from the failure to gain expected professional results, rather than the

result of engaging empathically with clients (Arnold et al., 2005). A further difference between 'burnout' and the other terms is that 'burnout' is constructed to be caused by cumulative experience, whereas 'VT' and 'STS'/'CF' can reportedly develop suddenly (Beck, 2011). 'Burnout' was (re)defined by Maslach (1982) as a syndrome identified by emotional exhaustion, depersonalisation and reduced personal accomplishment, and is measured using 'The Maslach Burnout Inventory' (MBI; Maslach & Jackson, 1981).

These quantitative measures have been criticised for the overlap in symptoms (Kadambi & Truscot, 2004; Deighton, Gurris & Traue, 2007) and studies that have used multiple tools with the same participants have noted a correlation in results. As a result, some authors argue that the syndromes do not have meaningful differences (Deighton et al., 2007), whereas others argue that these results simply mean the measures need developing (Jenkins & Baird, 2002). In terms of how they are used to construct trauma, I argue that they are all part of wider discourse that constructs trauma as (potentially) harmful to engage with, positioning the therapist at risk. Throughout this research I will refer to this discourse as VT discourse.

This construction of trauma seems to have been integrated into the dominant discourse of psychiatry. I suggest this is illustrated in the DSM 5 inclusion of 'indirect' exposure to the traumatic event in criterion A (APA, 2013). Psychiatric discourse does not differentiate between the 'disorder' caused by indirect or direct exposure, constructing both as 'posttraumatic stress disorder' (PTSD), which seems to enforce the action orientation of VT discourse that working with trauma can lead to serious, damaging consequences for the practitioner.

C.2.3.5   Posttraumatic growth discourse

This discourse is part of the wider discourse of 'positive psychology'. Positive psychology discourses are used to explore and promote the enhancement of wellbeing, and to criticise

other psychological discourses for using a 'disease model' of mental health, which constructs 'health' in terms of an absence of abnormality or dysfunction (Seligman, 2005). There is a growing body of research that constructs trauma in terms of a potential to enrich lives and facilitate development (Joseph & Linley, 2007). In this section I present 'compassion satisfaction' (CS; Stamm, 2005), 'posttraumatic growth' (PTG; Tedeschi & Calhoun, 1996), 'vicarious PTG' (VPTG; Arnold et al., 2005) and 'vicarious resilience' (VR; Hernandez, Gansei & Engstrom, 2007).

'CS' is constructed as a phenomenon that arises as the practitioner compassionately engages with the client (Stamm, 2005). There is little research into 'CS' and the existing literature tends to construct it in terms of its relationship with 'CF' and 'burnout' (Ray, Wong, White & Heaslip, 2013). 'CS' is measured alongside CF using the 'The Professional Quality of Life' (ProQOL; Stamm, 2010).

'PTG' was first used by Tedeschi and Calhoun (1996). The authors developed 'The Posttraumatic Growth Inventory' (PTGI), which positions the subject as able to engage with coping strategies and meaning-making in order to achieve measurable beneficial changes, including changes in priorities, emotional growth, sense of relationships with others and life philosophy. Texts that use this discourse locate the cause of the trauma externally to the subject, but the ability, and therefore, responsibility, to achieve 'benefits' are located within the subject (Tedeschi & Calhoun, 1996). Authors used the discourse to link the potential for growth with the intensity of 'PTSD' symptoms (Merecz, Waskowska & Wezyk, 2012), and to challenge interventions that focus on symptom reduction, especially pharmacology, for inhibiting the subject's potential for growth (Antunes-Alves & Comeau, 2014).

Arnold et al. (2005) argued that 'VPTG' is a way of recognising the "important work related benefits" that arise from trauma work (p. 242). They constructed the 'benefits' in terms of desirable personality traits, including empathy and compassion; increased appreciation of

human resilience; the satisfaction of seeing and being part of their client's recovery; better appreciation of interpersonal relationships and increased spirituality (Arnold et al., 2005). The majority of texts construct 'VPTG' as 'PTG' located within the therapist, constructing trauma as something that can lead to growth in the therapist in the same way it can for the directly-traumatised subject (Barrington & Shakespeare-Finch, 2013). However, some authors argued that they are distinct phenomenon (Arnold et al., 2005; Hyatt-Burkart, 2014).

Hernandez et al. (2007) developed 'VR', based on research into therapists' work with clients who have experienced torture. The authors suggested that it could "offer a counterbalance to the negative effects of trauma work on therapists" (p.240), arguing that an awareness of 'VR' can benefit clinical work by reducing the fear of being adversely affected, improving therapists' motivation and self-care, and allowing the therapist to apply what they have learnt from clients in their own times of crisis.

The discourse presented in this section is used to construct trauma as something that offers growth through the process of engaging with it, and to argue that these benefits are largely ignored (Tedeschi & Calhoun, 1996). This discourse is not used to invalidate or deny the negative effects of trauma in the directly or indirectly-traumatised subject. In fact, the authors seemed to be emphasising the presence of the negative impacts of trauma, arguing that the positives can occur alongside or after the negatives effects (Hernandez-Wolfe, Killian, Engstrom & Gangsei, 2014).

C.2.3.6   Lay discourse

A review of the literature available online suggested that much of the information seems orientated towards defining and identifying trauma, as indicated by news articles arguing that trauma may be misdiagnosed as other disorders (Ruiz, 2014). Another theme was discussion around the kinds of events that can be considered relevant. This is suggested in the example given by the Google definition (the death of a child), and articles advocating

that 'domestic abuse' be recognised as leading to 'PTSD' (Edwards, 2016). Reflecting psychological and psychotherapeutic discourses, such as psychiatric discourse, the texts suggest a conflict between the definition of trauma as something that results from an event (Ruiz, 2014), locating the 'source' of the trauma externally to the subject and as the result of a subjective propensity or vulnerability, locating the trauma within the subject. It appears that 'trauma' is constructed in psychological and psychotherapeutic terms even when for a 'lay' audience.

When the primary topic of discussion is something other than trauma, the discursive object of trauma appears to be more able to be constructed by non-psychological and psychotherapeutic discourses. In an example from an online newspaper article, the author positioned subjects concerned about redundancy as traumatised in a colloquial, non-clinically relevant sense when he wrote "I addressed the staff, who had the demeanour of the traumatised victims of psychological warfare" (Kelner, 2016). From the limited review of lay discourse I conducted, I suggest that perhaps a key difference between the way trauma is constructed psychologically and colloquially is in the types of events that used to position the subject as traumatised.

C.2.4   Psychotherapeutic approaches to trauma

NICE guidelines recommend trauma-focused cognitive behavioural therapy to those who meet the diagnosis of 'PTSD', and that those who show limited or no improvement should be given an alternative form of trauma-focused psychological treatment, or the combination of psychological and pharmacological treatment (NICE, 2005). NICE uses evidence collected from randomised control trials (RTCs) to develop recommendations. Trauma-focused psychotherapies with convincing evidence bases are cognitive behavioural therapy (CBT; Sherman, 1998; Van Etten & Taylor, 1998); cognitive processing therapy (CPT; Resick & Schnicke, 1992); prolonged exposure therapy (PET; Foa et al., 2005; Powers, Halpern, Ferenschak, Gillihan & Foa, 2010); eye movement desensitization reprocessing (EMDR;

Van Etten & Taylor, 1998); and dual representation theory (Brewin, Dalgleish & Joseph, 1996), all of which I present in the following section.

I also include psychodynamic therapy. Although it is reported to have a weaker evidence base than the 'trauma-focused' therapies presented above (Levi, Bar-Haim, Kreiss & Fruchter, 2015), it is one of the core therapeutic discourses and a common treatment for 'PTSD' (Schottenbauer, Glass, Arnkoff & Hafter Gray, 2008). It is of note that whilst the trauma-focused therapies tend to focus on symptom reduction, psychodynamic therapy may construct a treatment aim as the enriched personal understanding of the trauma (Foa, Keane, Friedman & Cohen, 2009), which may contribute to the lack of empirical support. Furthermore if psychodynamic therapies are conducted over long time periods, they cannot be appropriately tested by RCTs (Leichsenring, 2005).

C.2.4.1   Cognitive behavioural therapy (CBT)

The dominant CBT model for working with 'PTSD' was developed by Ehlers and Clark (2000), which suggests that a pathological reaction occurs when the subject's negative appraisals during and after the traumatic event cause them to experience a sense of constant current threat. The appraisals tend to be global and non-time specific, consisting of assessments about the world e.g. 'the world is a dangerous place' or themselves e.g. 'I am weak and cannot cope'. The subject is positioned as having 'inaccurate' cognitions that cause them to judge situations to be more dangerous than they really are or exaggerate the possibility of the traumatic event happening again. The discourse suggests that these thoughts evoke fear, leading to a cycle of fear and avoidance. The discourse also constructs pathological trauma as the result of the subject's 'unhelpful' cognitions about their 'normal' reactions immediately after the traumatic event, such as reacting to emotional numbing or intrusive thoughts with the thought 'I will never be the same again' (Ehlers & Clark, 2000).

CBT seeks to identify and modify the 'unhelpful' cognitions that contribute to the sense of constant threat. Treatment usually involves psychoeducation to normalise the client's response to the trauma and its sequelae. The therapist is positioned as directing the client to understand how their behavioural coping strategies, such as hypervigilance and avoidance, maintain the disorder by directly triggering 'PTSD' symptoms and preventing changes in the nature of the traumatic memory and the unhelpful appraisals. The client is encouraged to make contact with the memories of the event and a key part of the therapy may be supporting them to integrate their fragmented memories into a coherent narrative, with the view that this will reduce involuntary recollections (Ehlers & Clark, 2000).

CBT has the strongest evidence base for reducing 'PTSD' symptomology (Cukor, Olden, Lee & Difede, 2010). However, it has been criticised for pathologising the client by locating the source of the trauma 'within' the client, by constructing trauma in terms of faulty cognitions (Gilbert, 2009). In addition, texts utilising psychodynamic discourse have criticised CBT for neglecting the relationship and interpersonal dynamics (Persons, Gross, Etkin & Madan, 1996).

C.2.4.2 Cognitive processing therapy

Cognitive processing therapy (CPT; Resick & Schnicke, 1992) is a type of CBT. It constructs trauma in terms of avoidance behaviours and faulty appraisals (Schyder & Cloitre, 2015). The treatment was originally developed to treat the symptoms of 'PTSD' in rape victims, and predominantly consists of cognitive reworking, psychoeducation and exposure work (Resick & Schnicke, 1992). The therapist may direct the client to write about the traumatic event then read it with the therapist and at home, with the view that this will facilitate emotional processing when combined with identifying and correcting the client's beliefs about the event (Resick et al., 2008).

Studies that have compared CPT with PET (see below, section C.2.4.3) indicate that both are highly effective in treating 'PTSD' and comorbid depression (Resick, Nishith, Weaver, Austin & Feuer, 2002). An RCT study reported that following CPT, 40% of clients no longer met the diagnosis of 'PTSD' and 50% had continued to improve a month after finishing treatment (Monson et al., 2006).

C.2.4.3   Prolonged exposure based therapy

Prolonged exposure therapy (PET) was developed specifically for 'PTSD' by Foa et al. (2005). 'Emotional processing theory', which underpins PET, constructs trauma in terms of emotions, especially fear, as cognitive representations of the stimuli, the emotional response and their meaning (Foa & Kozak, 1986). The discourse positions the subject as having these representations located in their 'mind', which are activated when the subject is confronted by information that correlates with part of that representation. The discourse uses the constructions of 'normal' and 'abnormal' responses to position the subject as non-traumatised or traumatised. The non-traumatised subject is positioned as having the normal representations that correspond with reality, whereas the traumatised subjects do not and this causes the erroneous perception of danger (Schnyder & Cloitre, 2015).

The discourse constructs recovery, both 'natural' (i.e. that which means pathological trauma does not develop) and as the result of therapy, as the faulty representations being broken down, as everyday life and the exposure to reminders of the trauma 'prove' to the subject that these experiences do not result in actual harm (Foa & Cahill, 2001). The authors suggested that avoidance prevents this from happening, and therefore PET seeks to overcome avoidance. The treatment involves the therapist guiding the client to make contact with the traumatic memories, through imaginal and in vivo exposure (Schnyder & Cloitre, 2015).

PET is reported to have a strong RCT evidence base, citing rapid reduction of symptoms and maintenance of recovery (Foa et al., 2005) and effectiveness with comorbidities (Foa et al., 2013), although some studies suggest the improvements are not significantly different to those reported in other trauma-focused treatments, such as CBT and EMDR (Powers et al., 2010). As this discourse constructs recovery as a process of experiencing a fearful reaction followed by the realisation of safety, this discourse prohibits the use of pharmacological treatments that reduce affect, such as benzodiazepine (Schnyder & Cloitre, 2015).

C.2.4.4   Eye movement desensitisation and reprocessing

Eye movement desensitisation and reprocessing (EMDR) was developed for 'PTSD' by Shapiro (1995). Texts report that Shapiro observed how her own disturbing thoughts became less distressing when accompanied by eye movements (Shapiro, 1995). She then developed the underlying theory 'adaptive information processing' (Shapiro, 2001). The theory constructs a physiological information processing system located within the subject's 'mind', which normally integrates new information with stored memories, allowing learning, relief from distress and the availability of the information for future use. She suggested that 'PTSD' develops when a subject is physically and emotionally overwhelmed by an event, causing the traumatic material to be processed improperly and the initial perceptions of the event to be stored as if they are current input (Shapiro & Maxfield, 2002).

EMDR treatment seeks to emotionally desensitise traumatic memories and alter their negative self-assessments. The therapist directs the client to identify distressing visual memories of the trauma and an accompanying 'unhelpful' cognition, e.g. 'I am helpless' then hold the two in mind whilst following the therapist's finger with their eyes, creating rhythmic, saccadic eye movements (Shapiro, 1989). The client is asked to note bodily sensations and rate their distress throughout treatment (Wolpe, 1982). As such, the body is constructed as holding the 'dysfunctional' material. Treatment is reported to be complete

when the client can think about the memory without feeling any bodily tension (Shapiro & Maxfield, 2002).

EDMR has collected a positive evidence base. Some RCTs have reported that EMDR is as effective as exposure based CBT (Seidler & Wagner, 2006), although some have reported it to be less so (Bisson et al., 2007). The role of the saccadic eye movements in EMDR has been criticised, with some texts suggesting that it is likely to be the exposure element of the therapy that brings results (Cukor et al., 2010).

C.2.4.5   Dual representation theory

This discourse constructs trauma in terms of memory (Brewin, Dalgleish & Joseph, 1996). Texts construct pathological trauma as the result of abnormal memory processing causing the subject to oscillate between avoiding and re-experiencing trauma-related memories. The theory constructs traumatic memory as a dual representation of failed association between 'C-reps', which are abstract, flexible and contextualised representations that can be verbalised, and 'S-reps', inflexible, sensory bound representations, which can be triggered in the form of flashbacks when the subject is exposed to internal or external trauma-related stimuli (Brewin, Gregory, Lipton & Burgess, 2010). Whilst a healthy subject is positioned as able to integrate their memories into normal autobiographical long-term memory, the traumatised subject is positioned as unable to, due to the high levels of affect they experienced during the traumatic event (Schnyder & Cloitre, 2015). The experience of flashbacks and specific trauma-related dreams are constructed as the result of S-reps memory (Brewin, 2001).

The model can be used to challenge other cognitive models of trauma that assume that traumatic memory is similar to normal memory (Brewin et al., 2010). This discourse facilitates the practice of CBT, by constructing the process of making contact with the content of the memories as allowing the traumatised subject to access both C-reps and S-

reps, enabling re-encoding to occur and strengthening the connection between the two types of memories, which leads to symptom reduction (Schnyder & Cloitre, 2015).

C.2.4.6   **Psychodynamic discourse of trauma**

The terms 'psychodynamic' and 'psychoanalytic' are often used interchangeably. For the purpose of this research, I shall use the term 'psychodynamic' when referring to contemporary literature and approaches.

Freud's early work around trauma with Breuer (1842-1925) constructed trauma as memories that could not be 'abreacted' or expressed, resulting in the continual repetition of the trauma. They suggested that this inability to express the trauma was the result of the circumstances of the event, such as social constraints, repression, or the subject being in a 'dissociative' or 'hypnoid' state at the time (Breuer & Freud, 1842-1925).

Since the time of Freud, multiple models of trauma have been developed and I present the key themes of these approaches. Psychodynamic discourse constructs trauma as a subjective experience rather than an event. The subject is positioned as having an 'internal' representation of themselves and the world, constructed as personality and layers of consciousness and unconsciousness. The therapist is positioned as guiding the client to explore the subjective meaning of the event in terms of the subject's values, previous and current life experiences and circumstances (Schnyder & Cloitre, 2015).

A further theme in psychodynamic discourse is that trauma is constructed relationally (Schnyder & Cloitre, 2015). 'Healthy' subjects are positioned as having the expectation of 'going on being', maintained through self-other fantasies and the confident belief or trust that others will be available to provide the reciprocal experiences needed to allow the maintenance of selfhoods (Brothers, 2009). Experiences are constructed as traumatic when the subject perceives information that profoundly contradicts their existing representations of

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themselves and their relationship with the world. The subject is positioned as having their trust in their world violated (Spermon, Darlington & Gibney, 2010) and their internal representations are shattered, resulting in the experience of annihilation, or fragmentation, of the self (Brothers, 2009).

'Dissociation' is a key construct in psychodynamic discourses of trauma (Breuer & Freud, 1842-1925; Bromberg, 1998). Psychodynamic discourses position the healthy subject as having a 'healthy' illusion of a 'unified self', whilst actually having numerous internal 'states' that are able to communicate with each other. Authors suggest that pathological dissociation occurs in order to protect the illusion of unity in the face of information that cannot be processed. The states are unable to communicate, meaning that the subject is unable to self-reflect (Bromberg, 1998).

Psychodynamic discourse constructs recovery in terms of bringing conflicts into conscious awareness through the use of the therapeutic relationship. The therapist is positioned as able to analyse defences and explore intra and interpersonal themes relating to the trauma (Schottenbauer, Glass, Arnkoff & Gray, 2008). The therapeutic relationship is constructed as allowing the client's different states of self to be expressed, recognised, and reflected upon, therefore supporting the states to become integrated into the client's sense of self and re-establishing the healthy illusion of unity (Bromberg, 1998).

Psychodynamic discourse constructs 'transference' and 'counter transference' as a central part of the therapeutic work. The discourse constructs trauma as something that evokes particularly powerful transference dynamics. This can mean that the therapist is positioned as vulnerable to subjective distress (Herman, 1992) or to acting in unhelpful, inappropriate ways (Spermon et al., 2010).

C.2.5   Empirical research constructing the therapist's perspective

I will now present a review of the quantitative and qualitative research that constructs the

therapist's perspective of trauma work. I argue that all of the research is located within a

discourse of vicarious trauma (VT), although some used posttraumatic growth (PTG)

discourse concurrently. I divide the quantitative research into the following themes: research

that attempts to identify and measure the way working with trauma changes the therapist,

and secondly, research concerned with identifying factors that affect how the therapist is

impacted. The qualitative research is divided into that which seeks to explore the therapist

experience of working with trauma, and research that seeks to identify how therapists cope

with working with trauma.

C.2.5.1   Quantitative research

C.2.5.1.1   Identifying and measuring changes in the therapist

This theme describes how the research constructs trauma as something that changes the

therapist. The changes are located 'within' the therapist, constructing them mostly in terms of

cognitions, and also affect and behaviour. A key study is that of Pearlman and Mac Ian

(1995), who trialled the Traumatic Stress Institute belief scale (TSI; Pearlman & Mac Ian,

1995). The scale was designed to measure disrupted cognitive schemas in areas

hypothesised to be 'sensitive' to trauma and indicate 'VT'. 188 self-identified trauma

therapists completed a version with 79 items using a six point Likert scale. Participants also

completed the Impact of Events Scale (IES; Horowitz, Wilner & Alvarez, 1979), a 15 item

scale with a four point Likert scale designed to assess the avoidant and intrusive symptoms

of 'PTSD'; the Symptom Checklist-90 (SCL-90-R; Derogatis, 1977), which uses 90 four point

Likert scale questions to measure general distress; the Marlowe-Crowne Social Desirability

Scale (Marlowe-Crowne; Crowne & Marlowe, 1964), used to assess how the participants

might be tailoring their answers to meet the assumed desired response; and finally, an

independent measures assessment regarding the nature of participants' work with trauma

and their personal histories and demographics. The research used VT discourse to argue

that working with trauma is (potentially) dangerous for the therapist and construct trauma in terms of cognitive changes. The IES (Horowitz et al., 1979) draws upon the discourse of psychiatry to locate 'avoidant and intrusive symptoms' within the therapist. This study was unable to remark on how unique these 'phenomena' are to trauma therapists as no comparison was conducted, and as the study was cross-sectional rather than longitudinal, authors could not use the results to infer causality. This use of the discourse was replicated in the following pieces of research.

Pinsley (2000) assessed 163 therapists who treat adult survivors of rape and incest with the TSI (Pearlman & Mac Ian, 1995), IES (Horowitz et al., 1979) and Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981) with the view of measuring the impact of listening to traumatic narratives. Marmaras et al. (2003) used the TSI (Pearlman & Mac Ian, 1995) and IES (Horowitz et al., 1979) to assess 375 female therapists working with adult outpatient trauma survivors. Van der Water (1996) tested 130 female and 35 male therapists with the 'Trauma Work Impact Scale', which she developed with the aim of specifically measuring the impact of trauma work on the aspects of therapists' lives that were identified in the literature she reviewed. She divided the impact on the therapist into eight categories: personal identity, preoccupation with safety issues, therapeutic relationships, professional relationships with colleagues, personal relationships with friends and family, and preoccupation with trauma work resulting in psychological and behavioural change, sensory imagery disruptions and alterations in world view. Therefore she is not only locating the impact of the work within the therapist, but also interpersonally, which I suggest could lead to the therapist's friends, family and clients being positioned as affected by 'VT'.

Brady, Guy, Poelstra and Brokaw (1999) and Kadambi and Truscott (2004) conducted similar studies to those presented above but did not find significant results. Brady et al. (1999) conducted the widest scale research presented here, analysing the results of 1000 female psychotherapists working with sexual abuse survivors, who had completed the TSI

(Pearlman & Mac Ian, 1995), IES (Horowitz et al., 1979) and the Spiritual Well-Being Scale (Ellison, 1983). Kadambi and Truscott (2004), who compared the incidence of 'VT' in 221 therapists working with cancer, sexual violence and general practice using the TSI (Pearlman & Mac Ian, 1995), IES (Horowitz et al., 1979) and MBI (Maslach & Jackson, 1981), seemed to be resisting the construction of trauma as particularly difficult to work with found in VT discourse, by arguing that there is little evidence that 'VT' is a unique hazard to working with trauma.

C.2.5.1.2   Factors that affect how the therapist is impacted

This theme concerns how the research sought to identify factors that influence how trauma impacts the therapist. I have divided these into factors that are 'internal' and 'external' to the therapist.

Factors located 'within' the therapist seem to be constructed using personality psychology discourse, positioning the subject in terms of 'traits' and 'context-specific tendencies' (McAdams, 1995). The therapist's emotional reactivity was constructed as a moderator of being negatively affected by trauma work by Rzeszutek, Partyka and Golab (2015), who tested 21 male and 59 female trauma therapists (selected on the criteria of having a master's degree in clinical psychology and a professional licence in trauma therapy) with the PTSD Questionnaire: Factorial Version (PTSD-F; Strelau, Zawadzki, Oniszczenko, & Sobolewski, 2002). Rzeszutek et al. (2015) argued that practitioners who are more emotionally reactive and less sensitive to stimuli are more likely to experience negative impacts. Weaks (2000), assessed 95 therapists with the Ways of Coping Questionnaire (WCQ; Folkman & Lazarus, 1988), IES (Horowitz et al., 1979), TSI (Pearlman & Mac Ian, 1995) and demographic forms, and argued that therapist 'coping styles' influences the extent of negative effects.

Research by Brockhouse, Msetfi, Cohen and Jospeh (2011) and Linley and Joseph (2007) used PTG discourse to position the therapist as more able to experience growth when identified with specific variables. Brockhouse et al. (2011) assessed 118 participants, contacted through UK therapists' registers who confirmed that they worked with trauma. The authors assessed 'VT' by measuring duration of therapy career, hours per week with clients, exposure to 'PTSD' clients and percentage of 'VT' over the last month. Participants were also tested with the Jefferson Scale of Physician Empathy (JSPE; Hojat et al., 2002); Sense of Coherence Scale (SOC; Antonovsky, 1987); the Perceived Organisational Support Scale (Eisenberger, Stinglhamber, Vandenberghe, Sucharski & Rhodes, 2002) and the Post Traumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996). Brockhouse et al. (2011) used the results to link empathy and coherence with greater growth. Linley and Joseph (2007) used the Crisis Support Scale (Joseph, Andrews, Williams, & Yule, 1992); JSPE (Hojat et al., 2002); SOC (Antonovsky, 1987); Working Alliance Inventory, Form T–Bond subscale (WAI–Bond; Horvath & Greenberg, 1989) and The Professional Quality of Life (ProQOL; Stamm, 2010) to explore the relationship between therapists' work and wellbeing in 156 therapists and also linked greater growth to sense of coherence.

Therapists' ability was constructed as a protective factor. Deighton, Gurris and Traue (2007) measured how much 1 unspecified, 34 male, 65 female therapists advocated and practiced 'working through' of traumatic memories with clients, using the MBI (Maslach & Jackson, 1981), ProQOL (Stamm, 2010), a set of questions adapted from a study designed to measure distress in therapists working with torture survivors, and questions aimed to determine how much they advocate and practice working through. They used the results to position therapists whose work matched their ideals as being more resilient to the negative impact of working with trauma, and those who advocated but did not practice working through as the most likely to be affected. Craig and Sprang (2010) tested the impact of using evidence based practices on 'burnout', 'CF' and 'CS' on 532 social workers and clinical psychologists identified as working directly with trauma with the ProQOL (Stamm, 2005) and

the Trauma Practices Questionnaire (TPQ; Craig & Sprang, 2009). Craig and Sprang (2010) argued that therapist knowledge and confidence, which they determined depending on the extent to which the therapist used evidence based practice, moderate the effects of 'burnout', 'CF' and 'CS'. Having practiced for a greater length of time, which arguably may be constructed as indicating ability, was also linked to lower negative impacts (Pearlman & Mac Ian, 1995).

Therapists' life experience was constructed as a mediating factor. This is interesting as it illustrates how something happening in the therapist's life is constructed as an 'external' factor if it is a current experience, but as an 'internal' factor if it is located in the past. Pinsley (2000) constructed 'current life stress' as a cause external to the therapist that can lead to them being positioned within a discourse of VT. However, attachment style (Brandon, 2000; Marmaras et al., 2003) and personal history of trauma (Pearlman & Mac Ian, 1995; van der Water, 1996) were used to locate the cause within the therapist.

Brandon (2000) compared attachment styles between mental health professionals and psychology students using the TSI (Pearlman & Mac Ian, 1995) and the Relationships Questionnaire, Revised (Bartholomew & Horowitz, 1991) with the view that this would indicate whether working in mental health disrupts attachment styles and allow analysis of the relationship among work experience, personal history and 'VT' in mental health workers. The results indicated a significant difference in 'VT' and adult attachment style, with securely attached subjects experiencing fewer disruptions, and no significant relationship among 'VT', time spent as a trauma worker or personal history of trauma. Studies by Pinsley (2000) and Weaks (2000) did not find significant support of their hypotheses that personal trauma history increased vulnerability. Linley and Joseph (2007) linked personal trauma history with therapists' increased potential for personal growth (Linley & Joseph, 2007).

Factors located externally to the therapist included personal therapy (Brockhouse et al., 2011; Linely & Joseph, 2007) and clinical supervision (Linely & Joseph, 2007), which were all constructed as facilitating personal growth. A higher percentage of trauma in case load was constructed as exacerbating the negative impact of working with trauma (Brady et al., 1999; Craig & Sprang, 2010; Pearlman & Mac Ian, 1995). Higher income and training were constructed as protective factors against negative impacts (Craig & Sprang, 2010; van der Water, 1996).

The way a discourse locates the 'reason' that a subject is affected by 'VT' or 'PTG' internally or externally to the subject may have implications for the subjective experience and practice enabled from that subject position. Locating the 'reason' within the subject may allow them more power to act as opposed to an external factor that they may have less control over, but also potentially compounds any subjective experience of shame a subject feels from being positioned in a particular way.

C.2.5.2   Qualitative research

C.2.5.2.1   Explorations of the experience of working with trauma

The following pieces of research used constructions of cognitive changes to position their participants within VT discourse, locating the trauma within the therapist.

Iliffe and Steed (2000) conducted a phenomenological analysis of semi structured interviews taken from 18 therapists (selected as their therapeutic caseloads were at least 50% perpetrators or survivors of domestic violence), with the aim of offering insight into the professional and personal impact of working with domestic violence. Iliffe and Steed (2000) used an interview schedule based McCann and Pearlman (1990)'s discussion of 'VT', which is likely to explain why the results were constructed in terms of the negative changes presented in VT discourse.

Some texts constructed these negative effects as a 'natural' part of working with trauma. These included the work of Arnold et al. (2005); Bennet-Baker (1999); Hernandez-Wolfe et al. (2014); and Iliffe and Steed (2000). Bennet-Baker (1999) used a heuristic methodology to explore resilience as a protective factor to 'VT' in 13 psychotherapists, constructing 'VT' as personal and professional change in the therapist and as a normal part of working with trauma. These pieces of research seemed to position the therapist as a victim to the work. At the same time however, and often within the same article, therapists were positioned as able or with the responsibility to control or escape these effects, which I will explore below.

Research by Arnold et al. (2005) and Hernandez-Wolfe et al. (2014) sought to explore the benefits of working with trauma, developing the constructs of 'PTG' and 'vicarious resilience' (VR) respectively. Both papers explore the 'negatives' and 'positives' of working with trauma together, constructing trauma as something that is challenging and potentially damaging to work with, but that can lead to growth as well. Arnold et al.'s (2005) phenomenologically based study analysed data collected from 'naturalistic interviews' with 21 psychotherapists who self-reported as working with trauma ("i.e. events that were disruptive enough to challenge or overwhelm clients' ability to cope"; p. 244) using Lincoln and Guba's (1985) constant-comparison method to identify major themes in 'VPTG'. The questions used in interviews were described as neutral and open ended, giving the example "How have you been affected by your work with clients who have experienced traumatic events" (p.245). This question appears to orient the participant to constructing trauma as something that has affected them, minimising their ability to draw on discourses that may offer a different construction. This bias is acknowledged in the authors' explicit intent to 'define' how trauma work can affect the therapist in positive ways as well as negative.

Hernandez-Wolfe, Killian, Engstrom and Gansei (2014) used modified grounded theory, rooted in feminist principles (Charmaz, 2006), to explore the coexistence of 'VR' and 'VT' and the role of intersectionality on data collected from semi structured interviews with one

male and 12 female therapists working with survivors of torture in the US. The authors argued that 'VR' and 'VT' coexist in the therapist in the same way the positive and negative effects of trauma coexist in the directly-traumatised subject, and that "privilege and lack thereof" (p. 13) may impact how the effects of trauma may manifest in the subject. As Hernandez-Wolfe et al. (2014) constructed trauma as the result of experiencing torture, the authors were unable to discuss whether these 'phenomena' may be found in those who work with other presentations.

C.2.5.2.2 Explorations of the experience of coping with working with trauma

Pierce (2000) conducted a narrative study into how 10 psychotherapists describe coping with the impact of working with Vietnam veterans diagnosed with 'PTSD'. He linked effective working with the ability to reduce the effect of the work on oneself and suggested that not monitoring one's own experience may lead to negative changes in world view. Bennet-Baker (1999) argued that therapists can learn to change the negative effects of working with trauma into healing for themselves and their clients. Iliffe and Steed (2000) suggested that therapists can 'cope' with the negative effects of the work by making use of debriefing, monitoring case load, peer support and engaging in political activism, positioning the therapist with the 'internal' ability and responsibility to make use of 'external' resources. Harrison and Westwood (2009) positioned the therapist with 'internal' resources to mediate negative effects, including developing mindful self-awareness and consciously embracing complexity. Harris and Westwood (2009) used results collected from applying narrative analysis to three phases of interviews collected from 6 therapists who work with trauma, with the aim of determining how therapists engage in protective practices that mitigate the risks of 'VT'. They constructed coping in terms 'interpersonal' strategies, which are located both inside the therapist and within the therapeutic relationship, such as maintaining clear boundaries and developing 'exquisite empathy' with clients.

C.2.5.3   Summary and critique of empirical research

All of the empirical research reviewed here has used the discourse of VT to construct the

therapist's experience of working with trauma, and some used VT discourse and PTG

discourse together. The homogeneity in the findings of the quantitative research is likely to

reflect the use of the same psychometric tools, especially the TSI (Pearlman & Mac Ian,

1995) and IES (Horowitz et al., 1979). All of the qualitative research seemed to construct

trauma as something that will lead to changes located within the therapist; research with the

manifest intention of 'identifying' positive changes also identified 'difficulties' and negative

changes. This is partly explained by the methodologies used in these pieces of research; I

was unable to find any literature taking a critical approach to the construct of 'VT'.

It is customary to outline methodological limitations in empirical texts. In the research

reviewed, most authors cautioned the reader against making inappropriate generalisations

based on the findings, and warned that cause and effect cannot be inferred. At the same

time, the texts are drawing on discourses that constructs trauma as something that will

cause changes in the therapist through the process of therapeutic engagement. I am not

advocating that authors should not be transparent about the limitations of their

methodological approaches; however, considering these texts from a discursive perspective,

I suggest that the use of 'limitations' acts as a disclaimer, facilitating the action orientation of

the text to position the therapist as vulnerable to changes that result from trauma work.

The key variables among the studies were the number of participants used and how the

researchers defined trauma in order to position their participants as trauma therapists.

Pearlman & Mac Ian (1995) argue that 'VT' is based on 'constructivist' principles and

therefore advocate that participants should self-define as trauma therapists, a directive that

seems to have been followed in both quantitative (Brockhouse et al., 2011) and qualitative

research (Arnold et al., 2005). It is interesting to note the type of traumatising event that

researchers have used to define trauma: the most common client experience used to

position the therapist as working with trauma was sexual violence, used in quantitative studies conducted by Pinsley (2000), Brady et al. (1999) and Kadambi and Truscott (2004). The latter two papers do not explain this choice. However, Pinsley (2000) reports her reasoning as twofold. Firstly, that sexual violence can be particularly challenging to work with, which presumably puts the therapist more at risk of 'VT'. Secondly, that sexual violence is a common experience that clients may seek therapy for and therefore is useful to research. Pinsley's (2000) text could indicate that 'sexual violence' is relatively firmly entrenched in the 'definition' of a potentially traumatising event offered by available discourses. The argument offered by feminist discourse that sexual violence is common place may also mean that researchers identified this as a relatively easy specification to recruit, by the inference that a high proportion of therapists may have worked with clients who have experienced sexual violence.

C.2.6   Conclusion

In this chapter I have presented a genealogy of trauma, tracing how the discourses of hysteria, war neuroses and feminism have contributed to how trauma is constructed today. I discussed the discourses available to practitioners today, including psychological and psychotherapeutic approaches to working with trauma. I then presented the empirical research concerned with therapist's experience of working with trauma, arguing that all of the research is located within the discourse of VT. This highlights a gap in the literature that I hope this research will at least begin to address. Furthermore, I hope that challenging this dominant discourse will be useful in developing a critical perspective towards training and practice for trauma work.

The aim of this research is to critically explore how therapists construct their work with trauma, using the following research questions as guidance:

- How do psychologists and psychotherapists use discourse to construct their work with clients presenting with trauma?
- What is the action orientation of these discourses?
- What subject positions are available in these discourses?
- What subjectivity and practice is facilitated and disabled by the discourses?

C.3   Methodology

C.3.1   Introduction

In this chapter I will introduce the ontology and underlying epistemology of this research and seek to justify why I felt they were the most appropriate for the questions I hope to address. I will then present the methods employed and the details of the analytic approach. I include a section on methodological reflexivity and finally, a summary of the chapter.

C.3.2   Reminder of research aims

This study aims to explore how therapeutic practitioners construct their work with trauma, by applying Foucauldian Discourse Analysis (FDA) to the discourse collected from semi-structured interviews with five therapists who self-identified as working with trauma. Please note that I use the terms 'therapist' and 'practitioner' interchangeably. Following the literature review in the previous chapter, I identified the following research questions:

- How do psychologists and psychotherapists use discourse to construct their work with clients presenting with trauma?

- What is the action orientation of these discourses?

- What subject positions are available in these discourses?

- What subjectivity and practice are facilitated and disabled by the discourses?

C.3.3   Rationale for a qualitative approach

Qualitative research is concerned with how individuals make sense of their world (Willig, 2013). Rather than the researcher deciding the parameters of meaning by laying out variables, as in a quantitative approach, I wanted to place the focus on the individual by using a bottom up approach that would allow the participants to generate the meaning, a characteristic of an effective qualitative design (Willig, 2013). I chose a qualitative design that I hoped would allow me to engage with the richness of a person's individual construction and allow a deeper understanding of the way in which practitioners construct their experiences.

The research to date seems to be offering the assumption that working with trauma will impact the practitioner and result in them becoming traumatised (McCann & Pearlman, 1990). In the very early stages of this research, I considered other research methods. To offer an example, I considered interpretive phenomenological analysis (IPA; Smith, 1996). This methodology seeks to explore the lived experience of an identified phenomenon. The approach suggests that the researcher is unable to directly access the participant's experience and therefore the analysis is the researcher's interpretation of what has been expressed (Willig, 2013). I believe that this approach could have been useful to me, but it would have produced a very different piece of research, based around a different research question, to the one I wanted to produce. Using IPA would have required me to identify a phenomenon, possibly 'trauma', or a phenomenon that arises from working with trauma, and I was reluctant to guide the participant's construction of their experience in this way. I wanted to take a critical stance to how trauma and the experience of working with it are constructed, and I felt that a phenomenological approach would reinforce the assumptions that I wanted to question.

I also rejected the possibility of using discursive psychology, as opposed to FDA. A discursive psychological approach would have allowed me to explore how therapists use discourse within social interactions to achieve personal goals (Potter & Wetherell, 1987). However, when I considered the wider applications of the two branches of discourse analysis, I decided I wanted to consider the subjective and practical effects of the discourses, which entails an FDA approach, rather than the performative aspects revealed from a discursive psychological approach (Willig, 2013). I believe that no other qualitative approach would have been appropriate for the questions I wanted to answer. I hope that a social constructionist epistemology, which I will introduce in the next section, will allow me to do this.

C.3.4 Theory of knowledge: Introducing social constructionism

Western science has traditionally taken a positivist position to research, which assumes that the world contains phenomena that can be investigated to reveal their true nature (Willig, 2013). The term was first used by Comte (1974), as he emphasised the importance of scientific learning based on the methods of the natural sciences to create a system of knowledge. Due to the focus on cause and effect, positivism can be seen as the underpinning epistemology to many quantitative approaches (Cruickshank, 2011).

Social constructionism, a term used primarily by psychologists (Burr, 1995), emerged as a post positivist position and has been constructed from sociological discourses (Cruickshank, 2011). The approach acts to challenge the assumption that something can have a true nature and suggests that the way a phenomenon is perceived depends on the context. Within this epistemology, the subject can never be objective, as that would require them to be free from their past life experiences; their culture, history and individual differences, all of which orientate them to see things from a perspective which is inherently biased (Burr, 1995). As such, social constructionism is fundamentally critical of 'taken for granted' knowledge and can be used alongside feminist and transcultural theory to argue that the 'norm' set by positivist science is actually the specific hegemonic perspective of the white middle-class heterosexual male (Burstow, 2003).

Texts utilising a social constructionist epistemology argue that knowledge is created socially as subjects engage with one another, and that language is a form of social action (Potter & Wetherell, 1987). The emphasis on 'constructionism' suggests that when the subject gains knowledge, they are not merely perceiving and receiving information. Whether struggling to produce a new theory or just sitting back to take it in, the subject plays an active role in creating a representation of what they perceive, with the constructs of what they already know acting as building blocks.

Psychological discourses have traditionally used the constructs of biology and cognition to 'explain' phenomenon (Locke, 2011). Social constructionism proposes a radical departure from this approach, which has led to the approach being critiqued by some authors for missing the individual (Burr, 1995). Franks (2014) argued that social constructionism places too much emphasis on contingents and is too quick to reject the possibility of innate human conditions. However, social constructionist approaches do not necessarily deny the possibility of 'innate human conditions' and some authors caution against getting caught in endless back and forth discussions about the constructs of 'internal' phenomenon (Potter & Wetherell, 1987). Rather, the approach seeks to be critical of 'taken for granted' knowledge and to treat the text the researcher wishes to analyse as a context-specific expression of cultural and historical factors (Locke, 2011).

A further criticism of social construction approaches is made by feminist writers such as Hollway (1984), who argues that this position ignores embodiment, the role of the body and what it is like to be a person living in their reality, and that this separation of subjectivity from the social processes is artificial and less useful than an approach that allows consideration of subjective experiences. I accept these criticisms and try to recognize the limitations of the approach as I analyse and discuss this research. However, as I will go on to explore in the following section, I believe that the discourse analytic approach I use does allow some exploration of subjectivity, with the acknowledgement that this methodology cannot make phenomenological claims about experiences.

C.3.5 Discourse analysis

Discourse analysis is a broad term for research looking at language in a social and cognitive context (Potter & Wetherell, 1987). It is a method of analysis grounded in a social constructionist epistemology and takes the position that knowledge is constructed from verbal structures. Discourse analysis is often reported to be divided into discursive psychology, which looks at how language is used, and Foucauldian discourse analysis

(FDA), which is concerned with what kinds of objects, subjects and ways of being are constructed by language and available to people (Willig, 2013). This research employs a Foucauldian approach, which I shall now introduce and present my rationale for using it.

FDA evolved from the work of Michel Foucault, who argued that discourse is a system of representation that constructs how knowledge about something is depicted. He argued that discourse has productive, rather than merely performative qualities and that instead of focusing on what people do with it, the researcher should consider the implications of the discursive resources available (Kantor, 2006). Foucault suggested that by looking specifically at how language has been used, the researcher can assess the limits of the discourse to which it belongs, consider the way it correlates with other statements it may be connected with, and what forms of statement it excludes (Foucault, 1972). FDA adopts an 'aerial view' of discourse, considering how discourse acts on a macro level. The researcher can look at the action orientation of the discourse, what it is trying to do (Willig, 2013) and how the piece of discourse interacts and draws from other available discourse.

Foucault argued that nothing meaningful lies outside discourse (Foucault, 1972). As such, FDA assumes that anything with any significance to society or the individual must be able to be constructed in discourse. For example, physical things, actions and concepts become objects in discourse and it is discourse around an object, not the object itself, which produces knowledge (Hall, 1997). Thus, when exploring the objects that appear in discourse, the researcher is not looking at the phenomenon itself but at how it is constructed linguistically.

Foucault suggested that discourse can reveal the power relations that operate in our culture (Foucault, 1976). He suggested that power originates from institutions; the language used by the institutions gives those that can use that language power, and those that cannot are shut out. It is argued that knowledge is a form of power and what we consider to be 'true' is

merely the construction that holds sufficient authority to make itself be seen as true but only in that specific historical context. This argument has been criticised for placing too much emphasis on the significance of discourse and neglecting the influence of material, economic and structural factors (Hall, 1997).

In *The Archaeology of Knowledge*, Foucault (1972) suggested that the researcher should weigh the value of the statements in the discourse. Value is not considered to be truth, but what characterises the statement's place, use and possibility of transformation. Foucault's method implies that we should know why the statement was produced as it was and why it could not have been another. However, Foucault also said that the producer may not be aware of all the relations among statements, but that even if two producers of discourse have never heard of each other or what is said, those relations are established, forming large groups of statements or discourses, such as medicine, economics or grammar (Foucault, 1972). He suggested that it is not enough to consider what is said, but what is also left out:

> "The manifest discourse, therefore, is really no more than the repressive presence of what it does not say; and this 'not said' is a hollow that undermines from within all that is said"
>
> (Foucault, 1972, p.25)

In addition, Foucault argued that it is not enough to recognise that texts are not neutral, but the researcher should ask, what the texts are, what biases lie within them, how they are defined or limited, what distinct types of law they obey, what they articulate, what subgroups lie within them and what specific phenomena do they reveal (Foucault, 1972).

Derrida (1967) criticised this suggestion. He likened discourse to signs, and suggested that in order to access the latent meaning in the sign (or piece of discourse) the researcher first

has to be sure of the manifest. Therefore, he argued, surely it is necessary that the analyst speak the same language as the producer in order to fully understand the sign. Reflecting on this argument, I feel that it is a shortfall of the FDA approach to assume it is possible to fully assess the discourses that are being drawn on and those that are being left out. As I interviewed therapists, it seems reasonable to assume that I will speak 'the same language' as them and thus be able to access the discourse. However, I question whether I would know whether there are discourses excluded if they are not in my awareness. To give an example based on my research, one of my participants is a Gestalt therapist, which is a discipline I have little knowledge of. It is possible that they could draw on discourses that are inaccessible to me, potentially leading me to misattribute it or miss it altogether. Foucault's suggestion that a discourse impacts on another even if the user has never heard of it seems valid, as it seems compelling to assume that our discourse is shaped by powers and institutions in discourse that may be inaccessible or outside our awareness. However, in practical terms I wonder how this can be considered, other than making explicit the limitations of the researcher's reach.

It seems that FDA introduced a new way of conceptualising the subject, as FDA suggests that it is the discourse and not the person who produced it that creates the knowledge. Therefore, the subject is produced within the discourse and shaped by it. Under this approach discourse may produce a subject in two ways. Firstly, a subject appearing in discourse is constructed and positioned within it. They may seem to personify a particular piece of knowledge as they are perceived as possessing certain characteristics. Secondly, the user is subjected to the discourse through the process of engaging with it in order to derive meaning (Hall, 1997). Foucault suggested that identity is formed relationally, through a "myriad of power relationships" (Sawicki, 1991). Therefore, where we can vary the way we can construct our identity, we can manipulate power. The amount of power the subject has depends on their ability to participate in society's different discourses (Kantor, 2006). Subjects subjugate themselves as they are constantly evaluated and compared to social

norms (Burr, 1995). Therefore, Foucault saw the user (speaker, listener, reader, etc.) not as an autonomous, strategic agent, but as a subject constructed and positioned by historically grounded discourses (Willig, 2013).

Whereas discursive psychological approaches consider the 'psychological' reasons why a subject may use the available discourse in the way they do, FDA focuses on 'macro' level issues and has thus been criticised for ignoring or dismissing the subject as an individual and failing to consider the role of agency (Parker, 1999). The matter of 'agency' may be one that serves to highlight how discussions of epistemology are socially and historically located themselves. In the West, which is often termed an 'individualistic' society, the subject is often manifestly positioned as possessing agency and (limited) free will. Texts also consider the construct of agency in terms of 'the state', and how social hierarchies of power and governance may determine the amount of agency the subject is afforded (Meyer & Jepperson, 2000). This links with Foucault's (1991) argument of governmentality, where subjects act to self-enforce the limits and directions imposed upon them from top-down power dynamics, meaning that overt action to enforce these patterns becomes largely unnecessary. FDA allows exploration of how specific discourses facilitate and prevent certain practices and subjectivities (Willig, 2013). Therefore, perhaps the approach can be considered to allow exploration of the limits of agency.

Foucault has been criticised for giving insufficient reflection onto himself and the subject positions he takes, ignoring feminist perspectives and failing to consider his own position of privilege adequately (Hollway 1984). I was concerned about the way in which FDA can be seen to positon the analyst as 'above' the text, and have used careful reflexivity to help me acknowledge my own position and how I co-constructed the text with the participant during the interview and through my subsequent role as analyst. I have sought to be explicit about this bias by including a methodological reflexivity section at the end of this chapter.

When embarking on this research, I initially considered that naturally occurring speech, say between colleagues in the office, could provide very interesting and rich data. However, to do so may have incurred many ethical and practical considerations and perhaps rendered this approach unviable. As I wanted to literally access people's voice, I decided to use interviews. Using interviews as a source of data collection has been critiqued for its methodological validity by authors such as Potter and Hepburn (2005), who report that researchers frequently fail to view the interview as interactive, deleting or insufficiently recognising the role of the interviewer in producing the text. I hope that using an FDA approach, which views the texts as co-constructed and can be used to emphasise the role of the researcher will help me to overcome some of these limitations (Parker, 1999).

I would now like to introduce the pilot study, which I conducted to inform the development of this research and test the validity of my research design. A colleague who self-identified as having worked with trauma agreed to participate in the pilot. We met for a semi structured interview (see appendix I for interview questions). I transcribed the interview then used Willig's (2013) six stages of FDA to help me to review the data. I did not conduct a full analysis owing to time constraints.

Reviewing the interview process and the data gathered, I noted that my question "how do you think working with trauma affects you" seemed to orientate us towards negative impacts, as perhaps the word 'affected' was constructed in negative terms, so I changed the wording to "how working with trauma changes you". I felt that I asked too many questions, making the discourse seem stilted, so I removed the final question and planned to be more fluid in the way I spoke in order to facilitate a more 'natural' seeming dialogue. I noticed that we focused on the work place when constructing how the work affected them, which meant that only professional discourses were used. I felt that this may be due to a combination of the participant's choice to speak only of the work-place but also the structure of the questions and a lack of opportunity to move towards other topics. I wanted to allow more space in the

subsequent interviews for participants and me to be flexible about how we construct their work with trauma, whilst at the same time being respectful that they may not want to talk about certain things.

Reflecting on the pilot study, I felt that the way in which we knew each other was impacting on the discourse we were producing. From class room discussion, my participant had some pre-existing knowledge about my research, and it seemed that at the beginning of the interview these ideas were influencing them to draw on more extreme examples of their experience of working with trauma, orientating their constructions to meet their expectation of what I was looking for. In addition, the discourse indicated an awareness of our continued relationship outside the interview, which may have influenced how much information they felt comfortable sharing. This highlighted the importance of reflexivity to acknowledge my role in co-constructing the discourse, and recognising how a subject's positioning can be specific to that instance (Harré & van Langenhove, 1991).

FDA is a method of social psychology, which concerns itself with the study of collective activity rather than internal processes (Billig, 1997). Therefore, it can be suggested that a limitation of this approach is that it does not include psyche or intrapsychic dynamics. As a trainee psychologist, I usually position the subject as containing an internal world. I suggest that a limitation of discourse analysis is that it can seem counter-intuitive or unnatural as I suggest that the dominant discourses of how we communicate with each other construct language as something that codes for our internal experiences. This seems particularly poignant for therapists, as I suggest the majority of psychological and psychotherapeutic approaches facilitate the assumption that the therapist can access the client's internal world through talking to them, at least to some extent.

These ideas seem at odds with the underpinnings of discourse analysis, and thus the ethics of using discourse analysis as a research tool has been criticised by Hamersley (2014).

Hammersley (2014) argued that by conducting a discourse analysis of the data, the researcher violates the trust and assumptions of the participant, who may 'reasonably' assume that the researcher is interested in what they say, rather than how they say it. He warned that the solution may not be to be more explicit about using discourse analysis prior to the interview, as this could lead the participant to try to amend their speech.

It is important to acknowledge that the subject participating in any qualitative research, even non-critical approaches that do purport to be interested in 'what' the participant says, may still lack knowledge of the analytic procedure and the type of knowledge being created. Taylor and Smith (2014) countered Hammersley's (2013) argument by reporting that generally, participants will be told what the research is about in brief and that the participant is likely to have expectations of what is being asked of them that may or may not be correct. Furthermore, Taylor and Smith (2014) argued that most participants are recruited because they are identified as a member of the 'group' that the research is interested in - in this case, therapists that work with clients presenting with trauma. Therefore, the supposition that the research is interested in them as an individual may not be genuine regardless of the analytic approach.

C.3.6   Method

C.3.6.1   Research design

This research used FDA to analyse the data collected from 5 semi-structured interviews with practitioners who work therapeutically with trauma, with the view of exploring how they construct their experiences.

C.3.6.2   Recruitment and participants

I was interested in interviewing practitioners who had at least 6 months experience of working therapeutically with trauma. It was important to me that I include psychologists in this, as this is a piece of psychological research, but I wanted to be inclusive of other

therapists. The practical reason of wanting to make use of some of the connections I had in recruiting my participants was a factor, but more, I felt this decision fit with my philosophical standing. Rather than draw distinctions among different professions (for example, counselling or clinical psychologists or psychotherapists) I have positioned subjects belonging to these professions as able to draw on psychological and psychotherapeutic discourses, in addition to others. Moreover, I positioned the subject as possessing individual differences that may be at least as likely to influence the way they construct their work as the distinctions among the professions they belong to. I decided against stipulating what modality the therapist practices, as I felt that to do so would potentially orient potential participants to a particular construction of trauma and I wanted to allow more flexibility. I also thought that this would make recruitment more difficult (by making the inclusion criteria more stringent), that it would mean that certain services may be included or excluded as a result or mean that participants would feel they could only draw on some of their work and exclude work where they deviated from their usual practice. I wanted to be able to discuss such things, if they arose.

I hoped to access a broad range of experience by accessing different health care settings. I chose not to recruit from the NHS for the following reasons: I wanted to make use of connections I had with non-NHS services; the time frame of applying for NHS ethics discouraged me from doing so; and finally, I wondered if doing so may limit the type of work my participants had experienced. I chose to recruit using 'snowballing', where "one subject gives the researcher the name of another subject, who in turn provides the name of a third, and so on" (Vogt, 1999, p. 301). I had hoped this would be useful to me in allowing me to directly approach therapists working with trauma, and for making use of the contacts I had through work. I also conducted a web-search of organisations and individual therapists that work with trauma, then telephoned and/or sent emails of the research flier (see appendix II) to those services I was able to identify as offering therapy for people affected by trauma. I was able to recruit one participant in this way.

Snowballing has been criticized for giving biased data as the participants have been subjectively chosen, which can result in the cohesiveness of the results being over-emphasised (Griffiths, Gossop, Powis & Strang, 1993). In the case of my research, this recruitment method meant that the pre-existing relationship between the participant and me varied. I chose not to interview people I knew well, but there was variation in as much as one participant and I had never had any contact at all until he answered an unsolicited email from me, compared to others who I contacted via mutual acquaintances and those whom I had previously met in a professional capacity. I was mindful of these factors when analysing the data.

When planning recruitment, I considered diversity issues. Authors have raised concerns over the lack of research with participant diversity that is representative of the general population (Allmark, 2004). In addition, psychological and psychotherapeutic practitioners are predominantly white, middle class women (Grapin, Bocanegra, Green & Jaafar, 2016). These factors indicated that not only might trying to recruit participants who's diversity was representative of the general population be practically difficult, to do so may entail targeting and rejecting specific participants based on 'protected' characteristics, which I was not comfortable with. Instead, I hoped that constructing my inclusion criteria in minimal terms (simply, that they self identify with having worked therapeutically with trauma for a minimum of six months) would allow those of varied backgrounds and characteristics feel able to participate. My inability to offer the interview in a language other than English is a limitation of this.

I chose to recruit five participants. As this is a piece of qualitative research, it does not strive for generalizability, which refers to the extent to which the findings can be applied from the study sample to the rest of the population (Polit & Hungler, 1991). Authors recommend a 'single figure' sample size may be suitable for a detailed qualitative study (Marshall, 1996). I discussed sample size with my supervisor. Bearing in mind the restraints on time and

resources, it seemed to be a choice between having a larger sample size and a relatively less 'deep' analysis, and a smaller sample size with a 'deeper' analysis. I hoped that analysing the data collected from the interviews with five practitioners would allow me to conduct a more thorough analysis.

Once a potential participant had consented to being contacted, I sent them the information sheet (appendix III), then spoke to them, either by email or over the phone, to answer any questions they might have before taking part and to agree the location, date and time of the interview.

In the recruitment material and when talking about my research with a view to recruit, I used the word 'trauma' but did not provide a definition, because I wanted to allow potential participants to decide whether they felt they had worked specifically with trauma and were able to take part in the research. I hoped that this would allow room to explore with my participants what trauma means to them and how they view their work. It is possible that participants' construction of the material they received may have influenced their motivation for participating and so it may have been useful to have asked about this in the interview and allow the opportunity to acknowledge and explore their preconceptions and reasons for taking part. On receiving the information, one of the participants asked questions about what I meant by trauma and this meant that I explicitly explained these reasons to them prior to agreeing that they would take part. It is possible that this may have orientated the discourse we produced together in the interview. In retrospect, I could have declined to answer their questions, perhaps explaining that this was something we could talk about in the interview itself and reminding them that they have opportunity to decline from taking part should they wish.

I offered to travel to my participants, allowing them to choose where we met and in all cases I went to their place of work, which in the case of two of my participants, was their home. I

hoped that travelling to them and being 'on their turf' would help the participants to feel more able to participate and more comfortable in the interview process.

Participants' demographics are as follows. I have used pseudonyms to protect participant anonymity.

- Deborah is a white, British born female counselling psychologist. Her current work is a mix of practice in a health-care environment and private practice.
- Tom is a white, British born male clinical psychologist. His current work is split between a health-care environment and an academic post.
- Bianca is a white, female counselling psychologist from Europe. She currently works in a health-care environment.
- Dave is a white, British born male Gestalt therapist. He works predominantly in private practice.
- Urszula is a white, female psychotherapist from Europe. Her current work is split between private and charity-based therapeutic practice.

Participants' ages ranged from their thirties to fifties.

C.3.6.3   Ethical considerations

Participants were asked to consider their experiences of working with trauma and the way in which they feel affected and changed by this. The concept of trauma can be emotionally difficult, and it seemed possible that participants would be talking about emotionally engaging with another person's distress and reflecting on how this resonated with them. For this reason, I offered participants an optional debrief following the interview.

As the participants are practitioners, it was assumed that they would all be regularly attending supervision and this should minimise the chance of a participant being significantly impacted, such as suffering emotional distress that impedes their ability to function in their

day to day life. I assumed that any such issues would have already been picked up through the practitioner's supervision and professional reflection, although it was considered possible that this could happen. An additional consideration was that a participant may disclose something that indicated risk or inappropriate professional conduct. When asking participants to agree to take part I explained verbally and in writing the limits of the confidentiality and how they could contact my supervisor and university if they wished. I also explained that they would be given pseudonyms and all identifying information would be removed from the interview in order to protect the confidentiality of the participants, their colleagues and clients. See appendix IV for ethics form.

C.3.6.4 The interview process

I reviewed the consent form (see appendix V) with participants to ensure that full consent was obtained before beginning the one to one semi structured interview (see appendix VI). In most cases we were pressed for time as we were meeting during the participants' working day, but I tried to allow some space for building rapport.

I collected my data in a six week period and did not start transcribing until after I had interviewed my final participant, as I did not want observations and hypotheses that I may form whilst transcribing to influence my other interviews. Although I tried to be consistent in the way I approached the interviews, it is likely that previous interviews will have influenced ones that followed.

C.3.6.5 Recording and transcribing

I recorded the interviews with a VN-6800PC digital voice recorder, placing it somewhere between the participant and me so that both our voices could be clearly picked up.

I transcribed the interviews using the guidelines from Parker (1992, pp. 124-125), see below. Parker's approach allows for some description of the speakers' behaviour (e.g. an intake of

breath before the a word) but I found my participants were doing more than these guidelines allowed for, such as laughing over certain words or holding their breath. I wanted to depict such things as I felt it influenced the manifest meaning, an integral step of FDA so that one can consider the latent meaning and the meaning that is absent. Thus, I added some transcriptions steps that seemed to fit my data. See below for a description of these.

Parker (1992, pp. 124-125)

1. When there are doubts about accuracy of material: put in round brackets (like this)*;

2. When material has been omitted from the transcript, put empty square brackets [];

3. To clarify, put it in square brackets [to help the reader];

4. Put noises, words of assent and so on in slashes /hmm/, like this/yes/;

5. Indicate the lack of gap between one speaker and another with = marks at the end of one and the beginning of the next utterance;

6. Indicate pauses in round brackets (2) and a full stop for pauses less than one second (.)

7. Indicate extended sound with colon marks, ye::s;

8. Indicate emphasis in speech by underlining;

9. Indicate intake of breath before a word by putting a full stop before it, .aah.

To this list I have added the following steps:

10. An intake of breath followed by a pause is depicted by a full stop then the length of the pause in brackets .(3);

11. A question mark indicates a rising intonation during the utterance (rather than being used because of the grammatical structure of what has been said);

12. Non-verbal sounds are put in square brackets [laughs] like this and when they are not made by the person speaking at that time this will be done within slashes like this /[coughs]/

13. Information purposely excluded to protect confidentiality was documented like this [identifying information]. Participant's names have been replaced with their pseudonym.

14. Finally, I numbered the lines of each interview, with the view that this would allow me to produce a transparent, comprehensible paper trail and clearly show the origins of the extracts I would use to illustrate the analysis chapter.

C.3.6.6   Analytic procedure

Texts offering guidelines for FDA emphasise that there is no concrete method. However, different authors have suggested frameworks of considerations that can be used to structure analysis. I used Willig's six steps for FDA: identifying discursive constructions, discourses, action orientation, positionings, practice and subjectivity (2013, pp. 131-133). These steps and how I carried them out are now addressed in detail.

Prior to beginning analysis I read each interview individually. I read and reread each interview transcript many times during this process, but as an initial stage I made no notes and tried to read it as I would read a text that I was not planning to analyse. Once I had read a transcript completely, I spent some time reflecting on how I had read it, what feelings I was left with and what I felt it was saying. I then made notes on my feelings and reflections on this in a reflexivity journal (Lincoln & Guba, 1985) before moving on to the next interview.

Stage 1:   Discursive Constructions

My primary research aim was to identify the discourses that are used to construct trauma. As a first stage of coding, I went through the interviews and noted on the transcripts where the discursive object of trauma is being constructed. I was mindful that the discursive object may be being constructed without being named (Willig, 2013).

Stage 2:   Discourses

This stage involved going back through the pieces of discourse identified as constructing

trauma and determining the different discourses, or "networks of meaning" being used (Willig,

2013, p.137). To help me do this, I asked 'what discourses are being drawn upon?' and 'how

do they relate to each other?' (Willig, 2013). I found this a lengthy and difficult process, as

the discourses were predominantly psychological and psychotherapeutic and overlapped

with each other. The interview transcripts were annotated with notes identifying these

findings. See appendix VII for an extract of an annotated transcript.

Once I had identified the different discourses, I decided to copy and paste the sections into

tables. As part of this stage, I chose what to name each discourse. For example, I created a

table called 'psychiatric discourse' and added the pieces of discourse with the participant's

pseudonym and the transcript line numbers, which I felt belonged to psychiatry. I did this

because I felt it helped me to separate the different discourses and once I had done so, I

went through each discourse individually for the following stages of analysis. I frequently

looked back to the original transcript to make sure I was appreciating the context (i.e. what

discourse preluded and preceded the identified piece) of the discourse. See appendix VIII for

an extract of an analysis table.

Stage 3:   Action Orientation

For this stage I looked at how the discourse constructs 'trauma', asking myself what kind of

discursive object is being created, the function this serves, how it relates to other discourses

and what is gained from constructing trauma in this way.

Stage 4:   Subject Positions

I looked at how each discourse of trauma positions the subject, considering what patterns of

meaning could be taken up from these positions. Specifically, I looked at the position of

therapist, client and traumatised subject. Identifying these positions are indicative of how I

constructed meaning from the interviews, and my agenda and goals for the research. I explored this in the reflexivity section of the analysis. To enhance my analysis, I used 'positioning theory' (Harré & van Langenhove, 1991; Harré & Moghaddam, 2003). As the participants were all psychologists or therapists belonging to psychological and psychotherapeutic governing bodies (such as the Health and Care Professions Council; HCPC) I wanted to consider how this may be influencing how the subjects were positioned. To do so, I looked at the 'moral order', or discursively located role offered to the subject by the discourse (Harré & van Langenhove, 1991).

Stage 5:   Practice

This stage involved considering how the discourse facilitates and prevents opportunities for action, with the view that discourses legitimise certain behaviours, which in turn reinforce the discourse. To inform my analysis, I asked what can be done as a result of the discourse, and what is prevented or limited.

Stage 6:   Subjectivity

For this stage I examined what specific "ways-of-being" and "ways-of-seeing" the world are made available by each discourse (Willig, 2013, p.133). I asked what subjective experiences can be felt from the positionings available.

Once I had completed these stages of analysis, I went through the tables and identified the themes that had emerged from the analysis. For example, in the 'psychiatric' discourse table, I looked at all the ways the therapist may be positioned, identifying the patterns and the anomalies that emerged. I recorded these by annotating and highlighting the tables. Following this process, I determined that the discourses I had identified could be divided into two themes, which I chose to call 'pathologising' and non-pathologising' discourses of trauma. I used this as the basis for structuring my analysis.

C.3.6.7 Research validity

As this is a piece of qualitative research, it does not strive for objectivity, reliability or generalisability (Yardley, 2008). Yardley (2008) suggested that reliability (the reproduction of the study to produce similar results) and generalisability (the extent to which the results can be assumed to apply outside the study) are not appropriate measures for this type of qualitative research. However, if discourses were available to the participants that took part in this research, it seems reasonable to suggest that they are available to other practitioners too. This research hopes to explore how the participants and researcher influenced and constructed the discourse in the interviews and the analysis that were produced, with the view that this will raise questions and suggestions for future psychological practice and research. Rather than objectivity, I hope careful reflexivity will make my biases clear to the reader and allow transparency in the research.

By way of enhancing research validity, the extent to which it may be considered to be sound, legitimate and authoritative, I considered the procedures identified by Yardley (2008). After reflecting on their appropriateness for this study, I ensured the validity of the analysis on the basis of disconfirming case analysis, paper trail, sensitivity to context, commitment and rigour, coherence and transparency and finally, impact and importance. I have explored these considerations and how they have been applied to this research in detail in the discussion chapter of this thesis (C.5).

Reflexivity is important to method and I wanted to explicitly consider the active role I have played as the researcher in constructing the discourse during the interview, transcription and analysis. To help me to see how I may do this, prior to interviewing any of my participants, I interviewed myself and continued to make notes in a reflexivity journal throughout the research process, as recommended by Ortlipp (2008).

C.3.7 Methodological reflexivity

The guidelines for psychological research offered by the British Psychological Society (BPS) advocate that a person serving as a "data source" in the research should be referred to as a 'participant' (BPS, 2014, p.5). The guideline goes on to explain:

> "This recognises their active role and replaces the term 'subject' which has been
> viewed as portraying people as passive recipients rather than active agents"
> (BPS, 2014, pp. 5-6)

I suggest that this guideline may create a tension with the FDA approach, which argues that individuals become 'subjects' located within discourse (Willig, 2013). Under this approach, it is interesting to note that the use of 'active agents' by the BPS appears to be utilising the dominant Western positioning of the autonomous subject. In an attempt to navigate this whilst still recognising the guideline, I use both terms: 'participant' when talking about the individual person, and 'subject' when considering how the person becomes situated in the discourse and in order to facilitate consideration of how this influences the practice and subjectivity afforded from the subject positions available within the discourses. This approach has limitations, perhaps most apparently and suggested in the excerpt above taken from the BPS guideline, the way that 'subject' may appear to position the person as a 'passive agent', and therefore creating a significant power differential between the participants and me. I agree that this is problematic, but suggest that it is a short fall of the FDA approach in general. I hope that recognising my use of the words 'participants' and 'subjects' makes this transparent and, arguably, more honest.

As a social agent positioned by discourse, the research I produce is positioned and constructed by the discourses available. My positioning as a trainee psychologist is likely to have orientated me toward psychological discourses and resulted in how I constructed the meaning of the text accordingly when I was reading and analysing the transcripts. The

process of reflexivity has allowed me to acknowledge how dominant discourses of trauma, most notably psychiatric and vicarious trauma (VT), have influenced my interpretation of the discourse. An example of this is that I used the term 'traumatised subject' in order to explore how the discourses of trauma positioned the subjects and provided the basis for much of how I analysed the data. This term is located within psychiatric discourse, which constructs trauma as a binary position and can reduce subjects' experiences to diagnostic categories in psychiatric discourse (Georgaca, 2013).

Looking back over the course of my research, I can see that when I was in the initial stages I was located within VT discourse and structured my early work using the construction of trauma as something that affects the practitioner, at least transiently. Following the pilot interview, I replaced the question *"how has working with trauma impacted you"* to *"how has working with trauma changed you"*, as I felt that the use of the word 'impact' orientated the discourse towards the 'negative' effects of the work and I hoped that using 'changed' would allow the construction of positive and negative impacts. As a final question, I asked participants for their reaction to the following terms: 'vicarious trauma', 'posttraumatic growth', 'vicarious resilience', 'secondary traumatic stress' and 'burn out'. As my research has progressed I have found myself taking a position against the dominant discourse of VT and seeking to problematize the assumption that working with trauma is necessarily damaging for the practitioner. On reflection, I regret the use of the above interview questions as I believe they orientated the discourse I was co-constructing with the participant towards the discourse of VT.

The discourse I collected suggests that the dominant discourse of how working with trauma affects the practitioner is one of VT, and indeed this is supported by the literature reviewed. However, some research indicates that constructions of discursive objects found in literature are not necessarily the same as those found in verbal accounts and discursive objects are constructed differently depending on context (Wetherell, 1998). Therefore, I suggest that it

would be interesting to conduct further research that has a less structured interview format, which may allow participants greater freedom and choice in the discourses used to construct their experience of working with trauma.

Maybin (2001) suggested that in order to understand the way a piece of discourse has been constructed, one should consider what the producer of the text was anticipating. The preliminary information I sent to the participants explained that I was interested in therapeutic practitioners' experience of working with trauma. If VT is the dominant discourse of working with trauma and it is currently 'common sense' that working with trauma negatively effects the practitioner, then it is likely that this will be the discourse participants have access to when constructing meaning from what was being asked of them in the interview (Willig, 2013).

As my research has developed, the discourses I have called 'non-pathologising' became more apparent and available to me. I believe that the process of this analysis has made me more conscious of some of the ways I use psychological and psychotherapeutic discourse, such as the way I constructed the 'traumatised subject' and the split between negative and positive emotions, which may benefit my therapeutic practice and allow me to try to co-construct a more collaborative way of working.

Reflexivity has revealed the way that I am likely to have used psychiatric discourse to elevate my position and allow my research to 'belong' in the field. This raises questions regarding how genuine a criticism of the imbalances of power and the elitism produced by institutions that strive to elevate some and exclude others can be, when the subject aligned with the criticism is part of, or desires to be part of, that institution. The struggle between wanting and needing the authority that psychiatric discourse affords me, and wanting to position myself as a practitioner who challenges the power-hierarchy is one that I strongly identify with.

During the process of analysis I noticed that some of my pre-existing constructions of trauma were influencing the way I interpreted the themes. An example of this is the discourse of embodiment. It was only after I had identified the discourse and began to review how it constructed trauma in a way that positioned the subject holistically that I noticed that up until that point I had been interpreting and constructing the meaning of the discourses using the assumption that 'emotions' are held in the mind and can be separated from physical feelings located in the body.

I was able to reflect on how the Cartesian split had seemed like 'common sense' to me, so dominant a construction that I had taken it for granted and not noticed it until I was confronted with an alternative construction. It is of note that my most recent therapeutic practice has been in CBT and third wave CBT modalities, and as identified in the summary of 'pathologising' discourses (section C.4.3.6), the discourse of CBT does separate physical sensations and emotions. Whilst I argue that the Cartesian split of mind and body found in the 'pathologising' discourses is the dominant construction, it seems likely that my current theoretical orientation influenced the way I was constructing the discourses and may have made it harder for me to notice this bias.

In the earlier stages of the analysis, I considered resilience as an independent discourse (as mentioned at the beginning of this chapter, the data could have been analysed in many ways and therefore I believe that 'resilience' could have been identified as an independent discourse and a valid argument presented for doing so) and assumed, probably because I had thought of the discourse of resilience as part of the wider discourse of 'positive psychology', that the discourse of resilience would position the subject favourably in terms of challenging pathological constructions. However, as I analysed the discourse I found that my preconceived assumption that 'resilience' was positive was challenged. It also raises the issue of how ideas and theoretical constructs in discourse may subtly pathologise or

disempower the subject despite our good intentions. I have presented this discourse at the end of the 'pathologising' section to represent the way I argue it offers a 'beneficial' and 'pathologising' position.

Finally, I wanted to acknowledge the way in which I have structured this analysis, dividing the discourses into 'pathologising' and 'non-pathologising'. This may appear to offer the 'pathologising' discourses as negative and 'non-pathologising' as positive, and indeed this may reflect how I constructed them at times. This may be the result of my attempts to come to grips with what felt at times like an overwhelmingly complex and intertwined array of possible analytic themes. However, I feel it is important to emphasise that although I have sought to problematize how the 'pathologising' discourses of trauma appear to the dominant ones, and I have used the 'non-pathologising' discourses to critique them, I am not suggesting that the 'non-pathologising' discourses are more useful and would not produce problems and issues of their own. As Parker (1999) warned, the goal of FDA is not to try to produce an ideal way of talking about something. Instead, the process can be used to make hidden and taken for granted power imbalances explicit, with the hope that by becoming aware of these patterns, we can try to challenge them.

C.3.8   Summary

In this chapter I have sought to explain and justify my choice of methodology, and why I believe FDA is the most useful approach for exploring how therapists construct their experience of working with trauma. In addition to offering my understanding of FDA, I have sought to explore the underlying social constructionist epistemology. I have presented the pilot study and how this shaped the development of the research, particularly in influencing the interview questions. I have described my analytic strategy and how I reviewed the research for validity. Finally in this chapter, I included a section of methodological reflexivity.

C.4 **Analysis**

C.4.1 **Reminder of research aims and methodology**

This research explores how therapists construct their work with trauma. I hope to identify what discourses are used to construct trauma, the subject positions made available in these discourses, and what subjective experiences and practices are possible from them.

I used Foucauldian Discourse Analysis (FDA) to analyse the data collected from individual interviews with five therapeutic practitioners who self-identified as working with trauma. I identified the discourses used to construct the discursive object 'trauma' before ascertaining the action orientation of each discourse, and the subject positions, practice and subjectivity that are made possible by them (Willig, 2013). See 'analytic procedure' section 3.6.6 in the methods section of the previous chapter for the full details of how this was done.

C.4.2 **Structure**

Perhaps as one might expect, the discourses used by practitioners to construct their experience of working therapeutically with trauma are predominantly psychological and psychotherapeutic (a finding that I explore in more detail in the discussion), which all offer the subject position of practitioner or therapist (I use the terms interchangeably) and client.

I have divided the discourses into two themes, which I have called 'pathologising' and 'non-pathologising'. I believe this structure offers coherence, which is suggested to support usefulness of the analysis (Wetherell & Potter, 1992). I would like to acknowledge that the approach to structuring this analysis is in some ways artificial. The social constructionist epistemology of this research suggests that there is no 'truth' to be discovered in the data. This analysis is one of many possible analyses and I do not attempt to be objective. Instead, I have used reflexivity in an attempt to make my interests, context and goals for the research explicit and allow me to be held accountable for the analysis (Harper, 2003).

Direct quotes from interviews are in italics and quotation marks, with the lines of the interview that the quote has been taken in brackets, e.g. (12-15). To see the details of my original transcription style, refer to the methods section of this thesis, section 3.6.5. For the purposes of this chapter, I have edited the included extracts to make them easier to read, adding basic punctuation and removing the pauses, non-verbal sounds, fillers and minor words such as 'hm' and 'yeah' that intersperse the speakers' turns. Words added to give context are enclosed in square brackets. I shall now introduce the discourses in these themes.

Within the 'pathologising' discourses of trauma, I identify the discourses of psychiatry, cognitive behavioural therapy (CBT), vicarious trauma (VT) and developmental trauma and resilience. Psychiatric discourse refers to the highly specialised discourse produced and utilised by psychiatric institutions, and constructs trauma in terms of a collection of symptoms that allows diagnosis and the differentiation of 'pathological' and 'normal' reactions to clinically relevant events, with the action orientation of excluding non-clinically relevant reactions. This discourse creates an 'expert' position for the therapist, which seems to be replicated in the other 'pathologising' discourses. The discourse of CBT constructs trauma as the result of a combination of internal and external factors: the interaction of the client's thoughts, emotions, physical feelings, behaviour and external triggers, with an emphasis on thoughts. The CBT discourse facilitates targeted trauma work. Participants seemed to use this discourse to construct trauma as an 'understandable' response to what had happened to the traumatised subject, whilst simultaneously locating the trauma within the client. The discourse of VT is used to position the therapist as a (potential) victim, locating trauma within the therapist in addition to the client and constructing indirect exposure to an experience as trauma. The action orientation of the VT discourse is to position the therapist at risk. Participants used the discourse of VT and also actively positioned themselves against it. The discourse of developmental trauma and resilience constructs events that occur in infancy, childhood and adolescence as critical to the subject's

subsequent development, and traumatic experiences in these years is constructed as a barrier to developing resilience to subsequent traumas. The discourse is used to offer a 'reason' why some people become pathologically traumatised by certain events and others may not.

The discourses described above are identified as 'pathologising' due to the way they construct trauma as an abnormal (pathological) reaction located within the subject. These discourses construct the 'reason' for the trauma as the result of the client's 'internal' processes, whilst simultaneously emphasising the role of the triggering event. Within these discourses, the position of traumatised subject seems synonymous with the position of the client, and incompatible with the position of therapist. The result of this appears to be that the therapeutic relationship is extremely unequal, magnifying the power differential between the therapist who is positioned as in control and 'expert', and the helpless, traumatised client.

Within the second theme, the 'non-pathologising' discourses of trauma, I include the discourses of posttraumatic growth (PTG), embodiment and feminism. The discourse of PTG offers the construction of trauma as a process that can lead to positive changes in the traumatised subject, allowing the subject positions of victim and survivor. The PTG discourse constructs trauma as something that can benefit the therapist through their engagement with it. The discourse of embodiment constructs trauma as a 'felt sense', something that affects the whole of the person, 'mind' and body. The embodiment discourse allows the trauma to be observed and experienced by the therapist in ways that differ from the verbal exchange facilitated in other discourses, allowing the therapist and client to use their bodies as tools for therapy. The embodiment discourse positions the therapist and client as experiencing a shared connection through trauma therapy, allowing an aligned therapeutic relationship. The discourse of feminism constructs trauma as an everyday experience for subjects who are not in a hegemonic position. The action orientation is to challenge dominant discourses for locating the trauma within the subject, by locating the responsibility, blame and problem in

the subject or society that caused the trauma. The feminist discourse allows the subject positions of victim, survivor, perpetrator and activist in addition to the positions of therapist and client.

The 'non-pathologising' discourses offer more fluid subject positions and seem to enable the participants to move in and out of the 'traumatised' position. The 'non-pathologising' discourses are used to critique the pathologising discourses and are argued to offer the potential for a more aligned therapeutic relationship and a mutually shared experience.

C.4.3   The 'pathologising' discourse of trauma

As I will go on to argue, these discourses all appear to be deeply pathologising for the subject positioned as traumatised. I will begin by introducing each discourse and then go on to present their shared qualities and the implications of these for practice and subjectivity.

C.4.3.1   The discourse of psychiatry

The psychiatric discourse constructs trauma as a pathological reaction that can be identified based on the following 'symptoms': re-experiencing of the event, avoidance and psychological arousal following an identifiable traumatic event (APA, 2013; WHO, 1992). All participants describe these symptoms, using the psychiatric discourse to construct trauma as posttraumatic stress disorder (PTSD). This extract offers an example:

> Dave: *"Trauma is something that is the result of something that has*
> *happened to somebody at some point in their life, which, for whatever reason,*
> *they cannot or have not let go of and thus get flashbacks or get mood*
> *disturbances, memory disturbances, personality disturbances because of*
> *what has happened to them"*
> (18-22)

Dave uses the psychiatric discourse to construct trauma as a clinical diagnosis distinguished by the subject exhibiting specific symptoms of '*flashbacks', 'mood disturbances', 'memory disturbances'* and *'personality disturbances'*. The discourse constructs trauma as a 'real' phenomenon. Participants use the discursive objects of 'symptoms' to evidence the presence of trauma; failure on the part of the practitioner and client to identify these symptoms in a subject would presumably prevent the client from being aligned with the label of trauma.

The psychiatric discourse locates the problem within the traumatised subject; constructing trauma as something that occurs due to the person being unable to 'let go' of what happened to them and therefore suggesting an abnormality in the person that resulted in the development of the symptoms. More specifically, the trauma is located in the subjects 'mind'. The body is constructed as a separate entity, a secondary aspect to the person that provides the site where 'symptoms' can be experienced and observed from the position of client and therapist respectively.

The diagnostic process has been criticised by social constructionist theorists for reducing the experience of the client to fit with the symptoms presented in diagnostic tools. In this way the client is argued to become an 'object' in the discourse, used to evidence the validity of a specific diagnosis (Georgaca, 2013; Hak, 1989). During the process of the interviews (and the preceding exchanges that led to participation in this research) the way in which the participants and I co-constructed an understanding of their experience of trauma according to the diagnostic framework provided by psychiatric discourse suggests that at times the traumatised subject did become an object in the psychiatric discourse. The psychiatric discourse seems to create a significant power differential between the therapist and client, and I wonder how this is magnified by the client being positioned as an object, and what the possible ramifications are for this in terms of client care. It seems possible that the 'object

position' acts as a barrier to clients being involved in developing their own treatment plan and being positioned as an autonomous subject, facilitating top down interventions.

An action orientation of psychiatric discourse is to exclude non-clinically relevant experiences from the construction of trauma. This is demonstrated in the following extract of Tom's interview, where he draws on psychiatric discourse to construct trauma as a clinically significant issue and to distance himself from colloquial interpretations of trauma.

> Danielle: *"How do you define trauma yourself as a practitioner?"*

> Tom: *"I would stick quite fairly, I've gotta say quite sort of fairly tight to diagnostic definitions of this because you- the word trauma is used colloquially and incredibly loosely so you can have a traumatic relationship break up or you know there was a kind of… traumatic phone call, having flashbacks of that meeting so the language around when people have kind of like a problem following a traumatic experiences is appropriated in just common, you know, just common life"*
> (23-28)

The emotional distress and psychological problems of subjects whose experience can be constructed to fit the clinical diagnosis of trauma are legitimised, as being aligned with a diagnosis makes their problems 'official'. This could mean that those whose experiences are not easily aligned to the diagnostic framework have their problems dismissed or undermined, as they are constructed as less important or meaningful. The implications for practice are that if psychiatric discourse allows the provision of services for those who are positioned as clinically traumatised, it can bar access to those who have been traumatised in a clinically irrelevant way. Psychiatric discourse facilitates the provision of specialist services and the allocation of limited resources for subjects identified as traumatised by constructing trauma

as a serious problem, and simultaneously undermines the justification of those services being extended to people who do not meet the remit. This may offer a practical example of the power afforded to the therapist over those positioned as (potential) clients.

Participants seem to be navigating this exclusion by critiquing the construct of diagnoses, drawing on psychiatric discourse to argue that clients may still have meaningful needs despite not meeting specific PTSD diagnoses, as demonstrated in the following extracts:

> Tom: *"Even if they don't formally meet the criteria for PTSD they are in some way re-experiencing it in the present, either in the form of intrusive memories, formal flashbacks, dissociative flashbacks or sort of bad dreams that feel as though they are happening again"*
> (37-39)

> Deborah: *"I think lots of clients are traumatised without meeting lots of clinical criteria"*
> (86-87)

I chose to include these extracts as they illustrate how participants are able to take up a dual position, locating themselves within the discourse, as they use it to describe and formulate their clients, and against it as they construct trauma as something that can be significant and clinically meaningful despite not meeting 'formal' diagnosis.

FDA advocates considering both the manifest and latent meaning of a piece of discourse (Foucault, 1972). In these extracts, the manifest meaning is a criticism of the diagnostic model, positioning the speaker against psychiatric discourse, but the latent purpose seems to be to emphasise the speaker's position of possessing psychiatric knowledge and the ability to use formal clinical discourse. Taking the position against psychiatry could suggest

that the subject is drawing on an 'antipsychiatric' discourse, which developed subversively to the dominant discourse of psychiatry (Szasz, 1961). Antipsychiatry discourse can be used to position therapeutic practitioners as critical and client-orientated, producing a desirable subject position.

The dual positioning of 'inside and against' psychiatric discourse may allow the practitioner to demonstrate that they are able to understand and can make use of psychiatric discourse, which affords them membership of the institutions and access to the affiliated power and respect from colleagues and clients, whilst simultaneously positioning themselves as aware of the limitations of psychiatric practice. Criticism of psychiatric discourse seems to act as a disclaimer. In other words, acknowledging the limitations of the psychiatric model allows the practitioner to continue to construct trauma in a way that is pathologising, whilst preventing criticism for being pathologising and disallowing other discourses that could produce more empowered client positions.

C.4.3.2   The discourse of cognitive behavioural therapy (CBT)

Deborah, Tom and Dave use the CBT discourse to construct their work with trauma, aligning themselves with the discourse. CBT, or cognitive therapy, was developed by Aaron Beck in the early 1960s. It was devised as a structured, short term form of therapy, which focuses on identifying and modifying the client's 'dysfunctional', inaccurate or unhelpful thinking and behaviour in order to target specific problems (Beck, 1964). CBT tends to be the model of therapy advocated by institutions such as the National Health Service (NHS) and National Institute for Health and Clinical Excellence (NICE; Guy, Thomas, Stephenson & Loewenthal, 2011), and is the recommended treatment for PTSD (NICE, 2005).

CBT discourse constructs trauma as the effect of the interaction of a subject's thoughts, emotions, physical sensations and behaviour, in their environment. The discourse can be

used to 'explain' trauma as the result of a combination of internal and external factors but with an emphasis on the role of thoughts, as demonstrated in the following extract:

> Deborah: "She has never been able to get past the idea that people are unsafe and are out to harm you, quite rationally when you think about what happened to her every day, that still twenty years on as an adult she can't integrate what happened to her into any kind of broader framework. Do you know what I mean? Really, it's like there's that… there's those particular experiences then start to cloud everything else and then they live their lives trying to avoid or deal with or to adjust to that thing that's"
>
> Danielle: "So it's impacted their whole lives hasn't it over their"
>
> Deborah: "Yeah the way they think and the way they feel, the way they see themselves"
>
> (60-68)

Deborah uses CBT discourse to construct trauma in terms of thoughts that are an understandable response to a traumatic event that become overgeneralised and applied to everyday life in an irrational or unhelpful way, which results in a sense of constant threat (Ehlers & Clark, 2000). CBT discourse positions the client as stuck: *"she can't integrate what happened to her into any kind of broader framework"*.

Deborah's use of "*they live their lives trying to avoid or deal with or to adjust*" positions the subject as behaving and thinking in the problematic way because they are trying to help themselves get better, albeit in a way that, according to the discourse of CBT , actually exacerbates the problem. This, and constructing the problematic thoughts as a 'rational' response at the time of the event, draw on a discourse of 'third wave' CBT, which positions the 'disordered' subject as 'doing the best they can' (Gilbert, 2009). Since the 1980s, Western CBT practice has seen the development of 'third wave' CBT discourses, which

criticise 'traditional' CBT for pathologising the client's thought processes and compounding their subjective sense of shame at being mentally unwell (Gilbert, 2009). This locates the discourse socially and historically and reflects the wider movement of psychological and psychosocial discourses that have sought to emphasise the adaptive function of disordered behaviour.

Despite this, the construction of irrational or unhelpful thoughts, evidenced in this extract as "*the way they feel, the way they see themselves",* serves to locate the trauma within the client, thus positioning them as irrational and allowing the assumption that the way the client perceives themselves and the world is inaccurate. As the therapist's role is constructed as helping the client to change these views, the therapist is positioned as rational. This serves to create a significant power imbalance between the rational therapist and irrational client.

The discourse facilitates the use of psychoeducation to normalise the client's response to the trauma and hopefully allows the traumatised subject the sense of relief from shame, combined with a mode of treatment that is directed at modifying the targetted behaviour. Simultaneously, however, the sense of shame is maintained; the subject continues to be pathologised owing to how their thoughts, discursively located within the subject's 'mind', are constructed as responsible for the trauma.

The therapist is positioned as able to identify the thoughts, feelings and behaviour that comprise the trauma and practice in a way that amends or eliminates them. As a result, the discourse of CBT allows exposure-based therapeutic protocols, as illustrated when Tom says "*I'm not blasé but I know that's [the traumatic memories] where the action is*" (lines 152-154) and challenges discourses that suggest that exposure to traumatic material can be dangerous and (re)traumatising for the client and therapist.

Tom positions himself opposite therapists who are not able to do this when he says "*I know […] that people can be quite wary or afraid- therapists- and of hearing stories and of doing the trauma focused work*" (lines 154-156). He seems to be actively positioning himself as competent enough to recognise the benefit of practicing in this way and bear the difficulties that may arise. This is a powerful position, and juxtapose to that of the practitioner who does not work in this way. Tom takes a judgmental yet understanding position, by constructing the 'other' way of working as the result of fear or wariness, as opposed to other possible explanations for not working in this way such as a lack of caring, or a different idea of the best way to work. Within this discourse the 'other' practitioner is less powerful and becomes the object of sympathy as they presumably struggle with the content of the work.

C.4.3.4   The discourse of vicarious trauma (VT)

The VT discourse builds on the psychological and psychotherapeutic discourses that position the subject as vulnerable to (re)traumatisation through engagement with traumatic material in therapy. The VT discourse constructs trauma as something that changes the therapist, impacting upon the way they see themselves and the world, and creating observable, measurable change in therapists' schemata (Pearlman & Mac Ian, 1995). Within this discourse these changes are constructed as 'evidence' of trauma located in the therapist. At the same time, the discourse constructs trauma as something that can reside in the therapist without overt symptomology (Pearlman & Saakvitne, 1995). This creates an expectation that trauma will impact upon the therapist, whether it is noticeable or not. The therapist is positioned as a victim in the therapy, from which the subjective experience of being overwhelmed and deskilled by the magnitude of what the client brings to the therapeutic encounter can be felt.

The position of 'victim' within the discourse of VT is interesting because of the circular, reciprocal pattern that emerges: the therapist is a victim to the client's presentation and

becomes 'vicariously traumatised', and the effect of the 'VT' is that the therapist then behaves in a way that victimises the client, as illustrated in the following extract:

> Tom: "I think there's a role for both informal supervision and then of course definitely for formal supervision, and as part of formal supervision you've got to have on the agenda your emotional reaction to hearing stories 'cause all these things, you know, 'you don't have emotions when you hear these stories', you do, it's what you then do with them. They then go on to affect your work otherwise […] so if you're hearing something and you're feeling awful and you don't want to hear any more, you know, you are more likely to get your client to shut up…that may not be the most helpful thing for them"
> (312-324)

The action orientation of the discourse of VT is to construct trauma as a phenomenon that is especially challenging to work with and that negatively affects the therapist. This discourse can be useful to therapists as it can be used to argue that therapists working with trauma need greater professional support and a higher level of skills to cope with the extremely challenging nature of the work, potentially facilitating the development of training and supervision for those working with trauma, and organisational structure that enables peer support and perhaps discourages lone working and caseloads with a high percentage of trauma.

The discourse may allow relief for therapists by normalising their subjective experience of feeling overwhelmed and deskilled, and perhaps usefully undermine the legitimacy of negative self-appraisals concerning ability, skilfulness and so on. This allows therapists to use the discourse of VT to express feelings of inadequacy or exhaustion and distance themselves from these assertions, allowing the 'reason' for these feelings to be the nature of the work, rather than the therapists' shortcomings. However, within this discourse of VT, this

is contradicted as the therapist is positioned as responsible for 'taking care' of themselves, and taking the appropriate steps, described by participants as eating, sleeping, exercising (Deborah and Tom), engaging in supervision (all participants) and actively seeking out pleasure, relaxation and appreciation of life (Urszula and Bianca) as ways to counterbalance the fatiguing effects of 'VT'. This positioning allows the therapist to be proactive and empowered, and supports the practice of self-care on an individual and organisational level.

Positioning the therapist with the responsibility to navigate and mediate the effects of 'VT' could mean that the therapist who does go through subjective experiences discursively located within VT discourse, such as intrusive thoughts or nightmares, or feeling exhausted or deskilled, may feel a sense of shame and failure at their inability to adequately 'take care of themselves' and avoid these experiences. Furthermore, positioning the therapist within the VT discourse as able to harm the client (demonstrated in the extract taken from Tom's interview above) could be very distressing and act as a barrier to seeking help if the therapist fears recrimination or being shamed.

Constructing trauma as something that requires a higher level of skill from the therapist means that the therapist can be positioned as either sufficiently or insufficiently skilled to do the work. This creates a tension with locating thoughts of inadequacy within a discourse of VT and explaining them as the 'deskilling' nature of trauma work rather than a genuine reflection of a lack of skill.

Bianca, Tom and Dave actively positioned themselves against the discourse of VT, illustrated in the following extract from Tom's interview:

>   Danielle: "Since doing this work what changes have you noticed in yourself from
>   working with trauma?"

Tom: "I think it's very difficult to disentangle what changes are to do with the

work one does, to do with getting older more generally, different work

circumstances and that kind of thing. What can be put down to working with

people that have experienced traumatic events? I'm genuinely not sure I can

say"

(62-67)

My question asks Tom to make an assessment of himself and in doing so forcibly positions

him within a discourse of VT (Harré & van Langenhove, 1991). Tom actively resists this

discourse and repositions himself as a practitioner who has not been specifically impacted

by his work, whilst maintaining the ongoing cooperative social interaction of the interview

(Harré & Moghaddam, 2003). At other times in the interview, Tom, like other participants,

constructs trauma as something that can traumatise the therapist, and Tom described an

example of how his behaviour had changed as a result of his work. Tom's movement

between subject positions of 'vicariously traumatised' and 'non-vicariously traumatised'

suggests that he is drawing on a wider construction of trauma as something that can but

does not necessarily traumatise the practitioner and positions them as having control over

the effects of the work.

I have sought to explore why participants may resist the discourse of VT using the following

extract from Bianca:

"It's just about really about being with someone and being with them through that

experience and just sitting there, sitting there with that experience and allowing…

allowing those emotions and allowing what's coming out to come up and for them to

be safe enough in the room with you so you can engage with what's going on as

opposed to avoiding it or pushing it or feeling like it's so scary that you can't even go

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there and you can't allow those feelings to come, which is very natural and a lot of

people do"

(80-86)

Within this extract two positions appear available to the therapist: those who can bear the emotions of working with trauma and those who cannot. The latter seems to be an undesirable position, from which the therapist can be identified as being 'vicariously traumatised' and therefore trying to avoid their feelings. Bianca takes the position of practitioner who can recognise 'VT' in others, which allows her to be perceived as possessing the knowledge of this discourse. This position allows her to challenge or support colleagues who she identifies as being affected in this way; constructing 'VT' as something that can negatively affect clients (by preventing the emergence of feelings within the therapeutic relationship) allows the criticism of other's practice to be constructed as responsible, proactive behaviour.

Resisting the discourse of VT seems to allow participants a subjective experience of pride and achievement through being able to do the work well and enjoy it despite the warnings, which seems to facilitate their work. In this way, the position of defying the dominant discourse appeared to allow participants a subversive strength.

C.4.3.4   The discourse of developmental trauma and resilience

This discourse is located within the wider discourse of developmental psychology, which positions the subject according to the stage of life they are in, and uses the construction of a particular 'stage', such as infancy, to explain and contextualise the subject's experience (Upton, 2011). Early research into 'developmental psychology' focused on the early years of infancy and early childhood, but the field has since expanded to include the entire life span (Upton, 2011). However, research into 'developmental trauma' does focus on early life, constructing events that happen in those years as critical for determining the subject's

subsequent development (Burman, 1994) and uses the experiences of childhood abuse or neglect to construct the aetiology of psychopathology (van der Kolk, 2005). 'Resilience', defined by Yates and Masten (2004) as the ability to flourish despite adversity, seems to be part of the developmental trauma discourse. The discourse of developmental trauma and resilience constructs a 'non-traumatic' childhood as facilitating the development of resilience, whereas childhood trauma is a barrier (Crittenden, 1985).

Participants use the discourse of developmental trauma and resilience to construct trauma in two ways. The first uses the discourse to construct trauma as the experience of 'negative' events in infancy and childhood, such as sexual, emotional or physical abuse, or a lack of affection and care (Schimmenti, 2012). Within developmental trauma discourse, subjects identified as developmentally traumatised are positioned as psychologically vulnerable. Thus, the second use of this discourse is to offer these early life experiences as a 'reason' why some people lack resilience and therefore become pathologically traumatised in response to a subsequent traumatic event when others may not.

These points shall be explored now in the following extract from Deborah, who uses the discourse of developmental trauma and resilience to position the subject according to their early experiences:

> Deborah: "Having a non-traumatic childhood and upbringing meant - means that there is a resilience I guess that perhaps I wouldn't have had if I'd had a very- perhaps I couldn't do what I'm doing [working with trauma] if I hadn't, you know? But it's hard to feel guilty because… to be a child and not to have anyone ever hug you, you know? That kind of real basic stuff. And to not ever feel that your parents smiled at you. You think God, really, that basic you know"

> Danielle: "So kind of the things you take for granted until you hear something like that, isn't it"
>
> Deborah: "Totally. And to not have parents that do anything for you, that tend to harm you"
>
> (410-418)

The discourse offers an additional construction of trauma to that found in the other pathological discourses that use the discursive construct of a 'major' traumatic event, or something that actively happened to the traumatised subject to explain the development of pathology. The discourse of developmental trauma and resilience allows this, but simultaneously offers the construction of trauma as the result of a lack of or a failure to be provided with something that can be considered a normal experience or what one should be able to expect, such as being hugged or smiled at as a child. The discourse positions the subject according to a spectrum of needs and together, Deborah and I construct trauma as the lack of the very 'basic' care that a subject needs.

Deborah aligns herself with the resilient position due to her 'non-traumatic childhood', and uses this to explain how she is able to cope with trauma work. If the discourse of developmental trauma and resilience positions therapists identified as having 'non traumatic childhoods' resilient enough to work with trauma, it raises questions for how a therapist who may have experienced a 'traumatic childhood' would be positioned. I wonder if this discourse could position therapists who identify as having experienced trauma in their early years within a discourse of VT, due to their inferred vulnerability.

Reflecting on the subjectivity that can be experienced from being positioned within this discourse, I wonder if using childhood experiences to explain trauma enables the responsibility for being traumatised to be distanced from the traumatised subject. It seems that it may be easier to accept that events and experiences were not a person's fault if they

happened in infancy, and I wonder if the discourse can be used to counter subjective experiences of shame and blame located with the traumatised subject. At the same time, however, by distancing the traumatised subject from responsibility, their 'victim' position and associated helplessness and powerlessness may be enforced.

I found that to be identified as resilient seems a beneficial position, one from which one could feel hopeful regarding recovery and one's future. However, within this discourse the non-resilient subject position seems to be extremely pathologising:

> Urszula: *"Some people especially the trauma during the developmental time are more intense and longer if people may never have the chance to develop resilience and strength"*
> *(49-51)*

The discourse offers a more complex positioning than merely 'traumatised and non-resilient' and 'non-traumatised and resilient', as those positioned as traumatised can be identified as 'resilient' in addition to 'non-resilient'. This variation in how the traumatised client could be positioned seems to affect how the therapist is positioned. I will explore this using the following extract from Deborah:

> *"Even if a client has had a significant trauma or difficulties experiences which are very, very challenging, when you can feel there's that sort of resilience there underneath you can go slowly and work together to sort of unpack, revisit, make sense of what's happened to them and I don't think that you really feel that with these clients; that actually sometimes going near it can make it worse, reliving can make it worse."*
> *(109-114)*

'Resilience' seems to affect the construction of the therapeutic work and its expected outcome. The position of 'traumatised yet resilient' seems to be aligned with hope for recovery, potentially allowing trust in the relationship and therapeutic process to be felt from the position of therapist and client. This allows the therapist to take a more directive role and encourage the client to make contact with the traumatic material with the view that the client can cope with doing so. Potentially, this positioning may facilitate the therapist using challenging therapeutic interventions, such as time-limited or exposure-based therapies.

The positioning of 'traumatised and non-resilient' client and the therapist who works with them appears to be very different. The words "*reliving can make it worse*" constructs therapy as potentially re-traumatising, allowing fear and validating the act of avoiding talking about the traumatic event. The traumatised subject is positioned as too vulnerable to cope with the distress evoked from confronting the traumatic material in therapy. The therapist is positioned with the responsibility for the client's potential re-traumatisation, perhaps making it difficult for the therapist to use interventions effectively and encouraging the therapist's subjective experience of feeling deskilled and disempowered.

I suggest that this discourse is problematic as to be positioned as 'traumatised and non-resilient' seems very disempowering. A client positioned in this way seems to be entirely helpless, lacking the psychological resources to help themselves and struggling to benefit from therapy. I wonder if a possible benefit of this discourse for therapists may be that it can offer an explanation for unsuccessful therapy. Tentatively, I suggest that the discourse may be used to allow the therapist to feel frustration and a sense of failure, whilst attributing the cause of these feelings to the client's lack of resilience, thus allowing the therapist's position to be distanced from the responsibility of the client's recovery.

C.4.3.6   Summary and shared qualities of the 'pathologising' discourses

The discourses presented above all construct psychological wellbeing according to the 'disease model', which constructs disease as a deviation from the norm and health as the absence of disease (Hart, 1985). This suggests that the medical discourse that dominates health care, and of which psychiatric discourse is part of, has influenced and shaped the discourses the participants use to construct trauma.

Further reflecting dominant Western discourses of the last century, the discourses position the subject in terms of a mind-body split, known as 'Cartesian dualism' (Mehta, 2011). This is illustrated in how the psychological and psychotherapeutic discourses presented above locate the trauma in a way that constructs the subject as containing a 'mind' where trauma is located, and a separate physical body. The 'mind' is an interesting construction as it presumably located in the brain, and yet at the same time is something different, as the physical brain is part of the body. Although present in all the 'pathologising' discourses, this is clearly illustrated in CBT discourse, which explicitly separates emotions from physical sensations, suggesting that emotions are held in the 'mind' (Damasio, 1994).

The discourses position the subject as a distinct entity, influenced but separate from its surrounding environment. The discourses construct trauma as an abnormal, pathological reaction, allowing subjects to be positioned in one of two binary ways: 'not traumatised' or 'normal', and 'traumatised'. A shared action orientation of these discourses is to locate the problem within the traumatised person, as trauma is constructed as the internal result of a combination of internal and external events. Locating the trauma within the individual facilitates Western therapeutic practice, which constructs positive change for the traumatised person in terms of individualistic goals. Hopefully, these interventions can be useful in allowing the traumatised subject to experience a subjective shift following explanations as to why they may be feeling a certain way, potentially reducing fear and shame (which arguably

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originates from the problem being located in the traumatised subject) through normalising and understanding the experience.

The subjective experiences of the trauma are constructed in terms of symptoms. Recovery from trauma is constructed as internal changes in the subject that alleviate or remove 'symptoms', returning the subject to normativity. With this goal, psychological and psychotherapeutic interventions and pharmacology can be utilised together as they have the shared orientation of changing the parts of the subject that are identified as part of the pathology, either by removing them (such as is the case for the symptom of flashbacks) or bringing them in line with normal standards (such as heart rate). This may reflect current health care institutional emphasis on time limited approaches to trauma and other mental health issues, whereby a rapid change in the client's presentation is desirable and can be achieved through a combination of psychological and pharmacological intervention (Tseris, 2013).

The client is placed in a powerless position, whereas the practitioner position is one of control and an objective assessor of the client, e.g. Deborah: "*I think that was when I realised she had a lot of unprocessed stuff*" (line 20). This allows the practitioner to feel able to judge whether the traumatised person is traumatised in a clinically significant way and allows the allocation of trauma-focused treatment. Participants take up this position actively when they describe their clients' presentations and symptoms, selecting the clients that they deem appropriate for an interview that asks them to speak about their experiences of working with trauma. The language utilised in psychiatric and psychological discourse is specialised, excluding those who are not able to understand and use it. The effect of this is to increase the power differential and maintain the 'expert' position of the therapist in the therapeutic dyad.

These discourses emphasise the role of the 'potentially traumatic event' (Tolin & Foa, 2006) and how deeply trauma affects the individual. As a result, the traumatic event can be used to provide the 'reason' they are having problems. This action is reinforced by the psychiatric construction of the traumatising event being outside the range of normal experience, which remains in the ICD-10 definition of PTSD despite being absent from the DSM since it was removed in the forth edition (see literature review for more details; APA, 2013; WHO, 1992).

The explanations of trauma being caused by psychological abnormalities (internal to the subject) and by a potentially traumatic event (external) are used alongside each other, with the traumatised subject able to be simultaneously positioned as traumatised because of internal and external reasons. I wonder if the construction of trauma as the result of a traumatic event can be used to navigate the discomfort of the construction of the psychologically vulnerable subject, and allow the practitioner to feel that they are able to mediate the potentially pathologising effects of using the discourses presented in this section.

C.4.4   The 'non-pathologising' discourses of trauma

Under this heading I explore the discourses of posttraumatic growth (PTG), embodiment and feminism. These discourses have been grouped as 'non-pathologising' due to how they construct trauma, especially in terms of the therapeutic relationship, body and role of affect and emotion. I present these discourses individually before discussing how they can be used to critique and challenge the 'pathologising' discourses.

C.4.4.1   The discourse of posttraumatic growth (PTG)

The PTG discourse is part of the wider discourse of 'positive psychology'. The action orientation of positive psychology discourse is to challenge the 'disease model' of traditional psychological discourses by focusing on flourishing and strengths (Seligman & Csikszentmihalyi, 2000). The PTG discourse constructs trauma as a phenomenon that can lead to positive changes in the subject, through the adaptive coping mechanisms they

develop as the result of their traumatic experience. The discourse positions the subject as able to achieve meaning-making from their trauma, which can lead to emotional growth and a different perspective on one's priorities, philosophy of life and relationships with others (Tedeschi & Calhoun, 1996). The discourse can be used to emphasise the importance of exploring the subjective meaning of the trauma, and argue that merely addressing symptomology may hinder the traumatised subject's ability to achieve 'PTG' (Antunes-Alves & Comeau, 2014; van der Kolk & McFarlane, 2007).

Deborah, Bianca, Tom and Urszula drew upon this discourse. Bianca utilises this construction of trauma in the following extract:

> *"[The work should facilitate] understanding of what's going on and allowing those feelings, that energy to pass through and I don't mean pass through in the sense that it ever leaves you or goes away completely, but in the sense that it gets, that it becomes a part of you that doesn't stop you from living, that can be assimilated into your existence and that then allows you to continue to engage with life and as I said to relearn how to live"*
> *(36-41)*

Bianca uses the PTG discourse to construct trauma as an irreversible process with potentially positive outcomes that allows the subject to "*continue to engage with life*" through a process of integration and acceptance. The construction of trauma and recovery as a process means the subject is not in one of the fixed, binary positions of either traumatised or non-traumatised. The discourse challenges the 'pathologising' psychological and psychotherapeutic discourses, which construct the desirable goal of trauma recovery as the removal of symptoms to resume normative function. The PTG discourse offers the construction of moving forward with the trauma. Bianca appears to actively align herself with this construction when she emphasises "*I don't mean […] that it ever leaves or goes away*

completely". The action orientation of PTG discourse is to suggest that a person can experience benefits alongside the distress following trauma and challenge the dominant discourse that constructs trauma as purely negative or harmful.

The subject positions and subjective experiences facilitated by this discourse are explored using the following extract from Deborah:

> "*She is the evidence that stuff can change, because I mean if she, it couldn't have been a harder childhood, I don't think. I don't think I could imagine much more, and adolescence, so a real kind of faith inducing… that the process can work and if you get the right relationship it can really do, you know, great things and even if […] horrendous things happen to them, with the right context and support things really can change*"
> (379-384)

The PTG discourse offers the traumatised subject the position of 'victim' and 'survivor'. These positions can be occupied simultaneously, as demonstrated in Deborah's extract whereby her client, the traumatised subject, is positioned as a victim through her childhood experiences (a position also found in 'pathologising discourse') and a survivor through her engagement with therapy and her ability to change and achieve "*great things*". The therapist is positioned as a potential part of the "*context and support*", which can facilitate the client to flourish. This aligns the positions and allows the experience of a more collaborative therapeutic alliance. Constructing recovery in terms of shifted perceptions of one's self, relationships and world (Tedeschi and Calhoun, 1996) may facilitate therapeutic practice focused on the client's individual assessments of what is important to them, rather than the 'top down' goal of returning to medically determined normativity.

Foucault (1972) argued that what was missing from discourse can be as telling as what is included. Within the discourse it is interesting to note that participants tended to talk about clients who they positioned as having benefited from therapy. In a discourse that offers victim and survivor as simultaneous positions, it seems that to be positioned as survivor requires one to be positioned as a victim but the reverse is not so, as presumably one could be positioned as a victim who has not survived.

The participants did not appear to use this discourse to position themselves or their clients as subjects who have not (yet) recovered from trauma. Therefore I have not been able to examine how this could have occurred and what it may mean for how subjects are positioned. However, I suggest that the reason for the absence of non-recovery here may be that within the discourse of PTG it is difficult to position oneself as a therapist who has not found positives from the work or experienced clients developing and thriving despite their trauma. It is possible that to do so would utilise incompatible discourses of failure and irreparable damage, which may be undesirable for the therapist.

This construction of trauma seems to facilitate the subjective experience of hope from both the therapist and client position, as there is a sense of strength and a feeling of being able to endure the difficulties of the trauma. The discourse could be used to construct a lack of progress or the experience of an increase in 'negative' affect as part of a (difficult) process that can be continued. This allows the construction of some emotions as positive and some as negative to be challenged, as the discourse can be used to encourage the subject to engage with the range of emotions as part of the process of trauma and recovery. This could enable those positioned as traumatised to access and continue to make use of therapy and allow the therapist to construct their experience in a way that resists the discourse of VT and the 'common sense' assumption that trauma is damaging. The hope that can be felt from this discourse allows services, professionals and the traumatised person to keep trying to work towards recovery despite difficulties, and may facilitate the discourse of embodiment.

When Deborah says "*with the right context and support*", this discourse seems to be attributing the positive change to wider social factors beyond the client and therapist dyad. Thus, in addition to the view of the therapeutic relationship found in the 'pathologising' psychological and psychotherapeutic discourses that positions the therapist as central to the client's recovery, this discourse simultaneously allows the relationship to be only a part in a system which can facilitate recovery. This could be used to allow discourses that would support changes to be made within the person's social, familial or societal environment, possibly discourses of social work or community psychology.

C.4.4.2 The discourse of embodiment

This discourse focuses on the body and how it interacts with the environment (Meier, Schnall, Schwarz & Bargh, 2012). It overlaps with biological discourse, as both have been utilised to construct subjective embodied states (Neidenthal, Barsalou, Winkielman, Krauth-Gruber & Ric, 2005). For the purposes of this analysis I have constructed the embodiment discourse to be that which allows us to talk about the bodily experiences we can feel and observe using only our senses. I excluded extracts of the discourse that could be considered to be purely biological and did not construct biological changes in terms of how they feel to the subject. To summarise, the embodiment discourse can be used to construct the self through the body (Young, 1992), and ask "what is it like to have a body?" (Longo, Schuur, Kammers, Tsakiris & Haggard, 2008). The discourse constructs trauma in terms of subjective perceptions and experiences located in body (Clarke & Griffin, 2008). I use the words feelings, emotions and affect interchangeably.

The following extracts illustrate the way the discourse was used to construct trauma as an embodied experience:

> Deborah: "She [the client] would describe it like somebody had just poured something in her, you know? She would just feel this disgusting sense of wanting to get rid of something"
>
> (323-325)

> Dave: "As a result he was, I guess, viscerally affected. You know, he was able to keep that in his body for years before realising that he was starting to drink more and more and more to cope with the nightmares and the stress he was getting at work and so on and so forth"
>
> (67-70)

These extracts describe the therapist's observations of the embodiment of trauma in another, their client. The action orientation of this discourse is to construct trauma as something that affects the whole person, mind, body and all the senses in a very powerful way. Trauma becomes something that can be observed and experienced by the practitioner in ways other than the verbal exchange facilitated in traditional therapies:

> Urszula: "If I see that the client is becoming really distressed I may ask the client to help to ground them, so I may just explore different techniques for them to ground themselves and maybe then if they already know how to ground themselves I may have to remind them and then they may ground themselves"
>
> (18-21)

The discourse of embodiment constructs optimal well-being and recovery from trauma as being able to subjectively experience the feelings and emotions within oneself whilst cognitively recognising one's physical surroundings and current safety (Rothschild, 2000). It can be used to encourage body psychotherapy and criticise the use of purely word-based

practice, which constructs the trauma and recovery process in terms of the client and therapist exchanging dialogue. As Urszula describes using skills from trauma-focused body psychotherapy, the responsibility for the client's welfare is aligned with the therapist, allowing the therapist to take control of the therapeutic process. The control and power afforded to the therapist position within the discourse of embodiment seems similar to that of the 'pathologising' psychological and psychotherapeutic discourses.

The discourse of embodiment uses the construct of body psychotherapy to construct a dynamic process with the potential of becoming more 'in touch' with one's own embodied experience. The discourse allows the therapist to occupy the position of observing the client, as demonstrated in the extracts above (taken from Deborah and Dave's interviews), which is available in the other psychological and psychotherapeutic discourses presented. Embodiment discourse also facilitates the position of the therapist feeling and experiencing the trauma with the client. At times, this seems to facilitate a discourse of VT, as participants position themselves as experiencing difficult physical sensations constructed as symptoms of trauma, such as when Urszula says *"I can almost feel this [her client's trauma] in my stomach"* (lines 360-361).

Participants also use the discourse of embodiment to construct the feelings they experienced in their body when working with trauma as tools for the work, describing how they used their experience of their senses to develop skills in trauma work, enhance their own wellbeing, engage in self-care practices and help their client:

> Dave: *"I rely on myself and my body and my senses and my feelings to help*
>   *me understand what's going on in the room with me [and] with my client"*
>   (205-206)

> Urszula: "We use smells and different things to close the sessions so I do try to
> use this as well, and maybe having my own kinds of spiritual techniques, you
> know, all little things that I can kind of- visualisations of things that I can kind
> of use to close the sessions [and] to ground myself"
> (397-399)

The discourse does not require the subject to be positioned as traumatised in order to be eligible for the benefits of the therapy. The 'pathologising' discourses aim to position the subject as either traumatised or non-traumatised and accordingly offer or withhold treatment. In contrast, this discourse allows any subject to be positioned as being able to appropriately use and benefit from these skills. This is demonstrated when Urszula and Bianca position themselves as subjects who have become more 'in touch' and 'grounded'. Furthermore, the discourse is used to construct trauma work that is not limited to addressing the trauma. This facilitates practice that works with the traumatised subject as a whole, rather than identifying trauma symptoms and targeting them in the work. Thus, the discourse could be used to challenge the 'pathologising' discourses and the symptom-focused practice that they may be used to endorse.

Whilst the discourses presented in the 'pathologising' section construct the self as a 'mind', which is able to reflect on itself, the outside world and the physical body, employing a Cartesian dualism (Damasio, 1994), the discourse of embodiment does not construct a separation of mind and body. Instead, the discourse offers the construction of a whole self in which powerful emotions are felt holistically, and are constructed as contributing to the subjective experience of trauma. This discourse is interesting because by utilising the construction of a unified self, it highlights how the 'pathologising' discourses treat the body as an object, simultaneously the self (subject) and not-self.

The discourse acts to expand the discursive location of trauma from the mind to include the body. In turn this leads to a shift in what it means to 'understand' trauma, as this discourse encourages the therapist to incorporate their body and senses into their construction of trauma.

Trauma is constructed as a felt sense, and Deborah, Bianca and Urszula use this discourse to construct trauma as something that "*can't be verbalised*" (Bianca, line 35). In this construction of trauma, a space is created where the therapist and client feel the trauma together. This means that whilst the embodiment discourse locates trauma in the subject it also allows it to be located outside the subject, in the shared, felt connection between therapist and client. This is demonstrated in the following extract taken from Bianca:

> "*I think that when you are working closely with someone that has been through that trauma, even though we work, you know, at the relationship, a lot of times it's based on the conversation and based in words, there is a lot of it that is unspoken and there is a level of connection that you reach when you really feeling that with the client that is… that can't be verbalised. I think a part, a really huge part, of working with trauma is not spoken, is in the felt sense of that relationship*"
>
> (30-35)

The embodiment discourse seems to allow the subjective experience of empowerment and a sense of regaining control over one's sense of self, whilst allowing the experience of difficult, overwhelming feelings without explicitly positioning the subject as 'traumatised' or 'non traumatised'. Deborah, Urszula and Bianca use the discourse of embodiment to construct the subjective experience of traumatic feelings as states rather than a fixed position of 'traumatised'. They use the discourse to position themselves and their clients as experiencing these feelings, suggesting that they construct the feelings relationally, shared with and dependent on the other. This construction of emotion differs from that offered in the

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'pathologising' discourses, which locates the emotion in the 'mind'. Instead, the discourse of embodiment allows emotion to be located in the mind and body of the 'self', but also in a tertiary space between the therapist and client.

Perhaps constructing trauma as a fluid process facilitates the alignment of the therapist and client, as to be positioned as traumatised is constructed as an occurrence in an ongoing flow of subjective experience, rather than a fixed position from which one is helpless, out of control and in need of another to assist them to move towards a normative state.

The discourse of embodiment facilitates the discourse of PTG, as it allows trauma to be constructed as something that can lead to personal development and enhanced wellbeing. An action orientation of the discourse of embodiment is to construct the experiencing of powerful emotions as desirable. The subjectivity evoked from this construction of trauma may be the experience of permission to feel these emotions, subsequently allowing relief from a possible perceived expectation to 'be okay' on the part of both therapist and client. This may enable those in the therapist position to speak about their feelings in a way that does not necessarily position them within a discourse of VT. Therapists may then feel able to access support and make meaning of their experiences without the shame and fear that can be felt from the position of VT.

The discourse potentially positions those who do not have this experience unfavourably. Bianca, Tom and Dave criticised a lack of a strong emotional reaction in the therapist position, constructing this in terms of 'desensitisation'. This suggests that therapists who cannot be positioned favourably within the discourse of embodiment may be positioned as experiencing 'burnout', aligning the therapist with symptoms such as desensitisation and depersonalisation (Maslach, 1982).

C.4.4.3   The feminist discourse

This discourse offers a critique of psychological and psychotherapeutic discourses. Feminist discourse constructs society as 'insidiously' traumatic to those who are not privileged through their hegemonic position (Root, 1992). The action orientation of the feminist discourse is to argue that the prejudice, subjugation and vulnerability to abuse caused by being positioned as female, lesbian, gay, bisexual, transgender, disabled or a person of colour are instances of trauma. Therefore, trauma is constructed as a daily occurrence for many people. The discourse not only opposes the definition of trauma offered by the discourses in the 'pathologising' theme (i.e. as something outside of normal experience), but could also be used to challenge 'pathologising' discourse that constructs the perception of current danger as a symptom of pathological trauma by arguing that for many, the perception of current threat may be accurate.

Feminist discourse has influenced the construction of trauma to include the after-effects of experiencing domestic, sexual and childhood abuse. Within these interviews, all participants construct trauma as the outcome of experiences of abuse in childhood. In addition, Deborah and Dave cited domestic violence and Urszula referred to gendered violence. The action orientation of the feminist discourse of trauma is to challenge the way 'pathologising' discourse and in particular, psychiatric discourse, locate the 'problem' in the traumatised subject, seeking to relocate the blame and shame of what happened with the 'perpetrator'.

Feminist discourse offers the positions of 'victim', 'survivor', 'activist' and 'perpetrator'. The following extract illustrates the positioning of victim, survivor and perpetrator.

> Bianca: *"She's very functioning, in her late twenties, and decided- realised it was time to work on this sexual abuse that happened when she was eleven. It's had a lot of influence on her life obviously, she was a virgin when it happened so it was a rape"*

(208-211)

This extract does not explicitly name a perpetrator, but by explaining that her client was traumatised by rape, a victim-perpetrator positioning is present. The victim-perpetrator polarity allows feminist discourse to be utilised in a moral way, adding a further action orientation of the discourse: to label specific behaviours as 'wrong'. The perpetrator position, found in Deborah, Bianca, Dave and Urszula's interviews, functions in the feminist discourse to undermine the shame that can be felt from the traumatised subject's position by allowing reassurance that the traumatic experience was wrong and not the victim's fault. This discourse is frequently utilised in therapeutic practice with subjects who have experienced abuse. The victim position can be problematic as it may position the victim as powerless. Additionally, constructing society as insidiously traumatic could lead to a sense of hopelessness and helplessness to change. However, the discourse simultaneously allows the victim to be positioned as a survivor, as demonstrated by Bianca's use of *"she's very functioning",* and by constructing her client's engagement with therapy as an empowered choice through the use of *"decided- realised it was time to work on this".* The survivor position allows a subjective experience of strength and pride.

The feminist discourse positions the subject as having the responsibility to act and to challenge traumatising behaviour, allowing a position I have called the 'activist' position to be taken up. The feminist discourse positions therapist's as potential activists as they have the opportunity to recognise and name trauma. The position of activist enables the therapist to adopt a feminist way of practice, which supports the client to acknowledge society's inequalities (Evans, Kincade & Seem, 2010) and feel anger, which can lead to empowerment (Baker Miller & Surrey, 1997).

The position of activist could be problematic. I wonder if being positioned as an activist may evoke feelings of responsibility that could lead to a therapist being pulled into the 'rescuer'

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position (Spermon, Darlington & Gibney, 2010), reinforcing the traumatised subject's victim position and magnifying an unhelpful power differential in the therapeutic relationship. Furthermore, the feminist discourse can be used to argue that rather than pathologise the traumatised subject, discourse should pathologise the abuser and the society that condones it (Burstow, 2005). Therefore, those who do not acknowledge trauma or take up the activist position are positioned as perpetrators through their lack of action. This constructs a moral duty to help those traumatised and oppose traumatising situations, which Deborah utilises in the following extract:

> *"I think then just seeing the volume of calls that were around this sort of stuff, I think especially childhood abuse or rape [...] once you hear it's then quite hard to say 'oh well that's not for me, that's too hard for me'"*
> (194-199)

This may position therapists in a way that leads to feeling obligated to take on work, potentially at the expense of their own limits and locate them in a discourse of VT (Brady, Guy, Poelstra & Brokaw, 1999).

A tension arises in feminist discourse when the subject is positioned as both victim and perpetrator, as indicated in the following extract:

> Bianca: *"He had different traumatic experiences in his younger life, he was… he was a young boy when he was raped by a stranger in an elevator. He had traumatic upbringing, a violent father, wasn't given any support […] in his teenage years [he] ended up in a gay relationship [and] had a fight with this person and the other boy that he was in a fight with died"*
> (449-453)

Bianca uses the feminist discourse to construct trauma as a lack of support, a violent parent and rape, positioning her client as a victim. She also uses the construct of trauma to explain his behaviour. She goes on to resist positioning the client as a perpetrator when she says:

"To the world he's a monster, to the world he's a murderer and non-deserving of anything good, non-deserving of happiness"
(465-466)

I chose to include this extract as it suggests the difficulty that can be faced in positioning a subject in ways that are constructed to be contradictory. As part of the therapist-client positioning within this discourse, Bianca has aligned herself with her client and appears to have taken the activist position as she challenges the 'world's' view. The 'world' could be the perspective allowed from common sense, layperson's discourses that condemn specific behaviours such as murder, and could also include criminal and legal discourses. It is interesting to note that although she explicitly acknowledges the traumatised subject's behaviour, he is positioned as a victim rather than perpetrator. This highlights the possible use of being positioned as a victim (and therefore vulnerable) as punitively-orientated discourses are challenged and prevention-orientated discourses are enabled. This could allow the allocation of resources to pre-emptive services that offer support to those identified as vulnerable.

C.4.5 Conclusion

My research asks what discourses therapists use to construct trauma, how these position the subject and what subjectivity and practice are made possible. Participants drew on the discourses of psychiatry, cognitive behavioural therapy (CBT), vicarious trauma (VT), developmental trauma and resilience, posttraumatic growth (PTG), embodiment and feminism to construct trauma. In order to effectively summarise the way these discourses position the subject, and the subjectivity and practice they facilitate, I have divided the

findings into the following themes: the therapeutic relationship, the body and the role of affect/emotion in trauma. I argue that the discourses identified as 'non-pathologising', can be used to critique and challenge the way the 'pathologising' discourses construct trauma.

The 'non-pathologising' discourses challenge the juxtaposed, binary positions of traumatised and non-traumatised available in the 'pathologising' discourses by constructing trauma as a fluid state, which allow the subject to be positioned as experiencing certain feelings (such as helplessness or sadness) without necessarily being positioned as the traumatised subject. The result of this appears to be that participants feel more able to position themselves as the therapist and simultaneously with 'traumatic' feelings, constructing the trauma as something to be shared and experienced with the client. This aligned positioning of shared, mutual experience is difficult in the 'pathologising' discourses, which position the client as helpless and the therapist as knowledgeable and in control. The alternative positioning offered in the 'non-pathologising' discourses could be used to challenge or reduce the power differential between therapist and client in the traditional discourses and support a collaborative, equal therapeutic relationship.

In the 'pathologising' discourses, being positioned as traumatised is to be positioned as helpless. This is potentially incompatible, or at least undesirable, for the position of therapist for whom taking control is constructed as the appropriate behaviour. It seems that it could be very shaming for a therapist to be discursively identified as experiencing feelings constructed as trauma. It is interesting to note that only Urszula positions herself as having a personal history of trauma and although all participants use the VT discourse to construct their work, only Urszula explicitly identifies herself as having experienced 'VT'. As explored above, the feminist discourse, which Urszula draws on heavily and locates herself within, positions any non-hegemonic subject as the victim of trauma. This could mean that the positon of being traumatised is normalised and perceived as less shaming, and the subject may choose to position themselves as traumatised (both directly and vicariously) because the feminist

discourse allows this position to be held, whilst simultaneously allowing the subject to occupy the position of competent practitioner.

Both 'pathological' and 'non-pathological' discourses empathise the role of emotion in the construction of trauma. However, whereas the 'pathologising' discourse construct trauma in terms of negative (meaning difficult or unpleasant) emotions, the 'non-pathologising' discourses construct trauma as the experience of powerful, potentially enriching emotions and resist the construction of certain emotions as negative and positive. The 'non-pathologising' discourses do not deny the difficulty of experiencing the emotions constructed as traumatic, but construct it as something to be experienced in order to reach the potential for growth, development and new perspective. Thus, the 'non-pathologising' discourses offer a critique of the 'pathologising' discourses for constructing the difficult emotional experience of trauma as 'symptoms' to be alleviated and barring the opportunity for acceptance and growth.

The 'non-pathologising' discourses emphasise the role of the body as the vehicle for experiencing trauma, offering a construction of trauma as a sense felt holistically in the self. This challenges the construction of a separate 'mind' and body found in the 'pathologising' discourses, which locate the traumatic emotion and thoughts in the mind and physical symptoms in the body. Given this construction and the extent of the literature on how trauma is held in the body (Herman, 1992; Rothschild, 2000; van der Kolk, 2014), body therapy seems scarce in the discourse obtained in the interviews. However, this may be the consequence of how our health care system is structured; many clients access psychological services through their GP or via a process entailing a period of waiting before they can access therapy. Although NICE guidelines recommend that those diagnosed with PTSD try therapy before receiving medication (NICE, 2005), in practice, the client may receive pharmacological interventions prior to accessing therapy with the aim of stabilising their presentation in the interim and making therapy more tolerable (Marshall & Cloitre,

2000). It makes sense therefore to suppose that many clients accessing psychological services may already be experiencing a reduction in physical symptoms by the time they begin therapy, resulting in therapy that focuses on cognitive, verbal interventions, as the 'body' has been taken care of through pharmacology.

C.5   Discussion

C.5.1   Introduction and reminder of research aims

The aim of this research is to explore how therapists construct their experience of working with clients presenting with trauma, using Foucauldian discourse analysis (FDA; Willig, 2013). In this chapter I summarise the analytic themes presented in the analysis chapter (C.4) and consider them in relation to the literature reviewed in chapter 2. Additional literature is integrated in order to allow discussion of the fuller context of the discourses that the participants appeared to use. I consider implications for practice and relevance to counselling psychology; the validity, strengths and limitations of this research; avenues for further research and finally, include a section on reflexivity.

Following the structure of the analysis chapter, I present the discourses under the headings of the 'pathologising' and 'non-pathologising' discourses of trauma. The 'pathologising' discourses include the discourses of psychiatry, cognitive behavioural therapy (CBT), vicarious trauma (VT) and developmental trauma and resilience. The psychiatric discourse constructs trauma as a clinical diagnosis, and is the discourse used and produced by the institution of psychiatry. The discourse positions the therapist as an 'expert', which is replicated in the other 'pathologising' discourses. The discourse of CBT seems to simultaneously position the traumatised subject as having had an abnormal and 'understandable' response to the traumatic event, constructing trauma as the result of factors internal and external to the subject. The discourse of VT constructs trauma as something that can be dangerous for the therapist to engage with, potentially resulting in harm to the therapist and client. The discourse of developmental trauma and resilience is used in the construction of developmental trauma to explain why a subject may or may not become pathologically traumatised after experiencing a traumatic event, positioning the subject as vulnerable to subsequent traumas owing to being identified as having experienced trauma in their 'developmental' years, or resilient. These discourses all

construct trauma as a pathological reaction to a traumatic event, locating the trauma, or 'problem', within the subject. Within these discourses the position of traumatised subject is always aligned with the client, and seems incompatible with positioning of the therapist. The result of this seems to be an amplified power imbalance between the powerful 'expert' therapist and the helpless, traumatised client.

The 'non-pathologising' theme includes the discourses of posttraumatic growth (PTG), embodiment and feminism. The PTG discourse constructs trauma as something that can lead to positive changes in the subject, both client and therapist, through the process of engaging with the trauma. The embodiment discourse constructs trauma as a 'felt sense', which is used to position the therapist and client alongside each other, sharing the emotional experience of the trauma. The discourse of feminism constructs trauma as the commonplace, everyday experiences for those who are oppressed in a patriarchal society. As such, the discourse can be used to challenge the 'pathologising' discourses, which construct trauma as unusual experience. Within these discourses the subject is able to move in and out of the position of 'traumatised'. These discourses offer a critique of the 'pathologising' discourses and the potential for a more equal power dynamic in the therapeutic relationship.

C.5.2 The 'pathologising' discourses

C.5.2.1 The discourse of psychiatry

The psychiatric discourse is a specialised discourse utilised and produced by the institution of psychiatry. Participants use it to construct trauma as a mental health phenomenon that consists of specific symptoms. This allows it to be observed and identified, resulting in diagnosis. This discourse is used to locate trauma in the subject's 'mind'. The 'mind' is presumably located within the subject's brain, but is also not the brain, for the physical brain is constructed as part of the body (Bentall, 2003). Thus, the 'mind' and body are constructed as distinct entities. Within psychiatric discourse, the body is constructed as secondary:

merely the site where the effects of the trauma may be felt or observed in the form of 'symptoms'.

The action orientation of the psychiatric discourse is to 'define' what is clinically relevant, or in other words, what is pathological. As such, diagnosis, and the descriptions of 'symptoms' presented in tools, such as the ICD 10 and DSM 5, offer a discursive map that allows events and client presentations to be constructed as clinically relevant to the diagnosis of pathological trauma (APA, 2013; WHO, 1992). The discourse allows subjects to be aligned with the diagnosis or not, creating polar positions of (clinically significantly) traumatised or non-traumatised.

Within this discourse, the therapist is consistently positioned as 'non-traumatised', and presumably 'sane'. The therapist is therefore able to take the position of objective observer who is able to identify trauma located within the client. This was actively demonstrated in the interview process as the position of therapist allowed the participants to choose which of their clients were relevant to this research i.e. 'meaningfully' traumatised. Using the discourse to describe their observation of the client and the implied correlation between their observations and diagnostic criteria constructs the therapist's experience in cognitive terms. This locates the discourse in a 'modernist' socio-historical context, as the current dominant 'scientific' discourses in the West construct thought as 'rational', more relevant and important to the practitioner's work than emotion (Ahmed, 2004). Thus, by positioning the client using diagnostic criteria, the practitioner is also positioned, taking the position of operating based on cognition, rationality and objectivity.

The findings of this research are consistent with existing social constructionist literature that problematizes the use of diagnostic criteria for reducing client's experiences to match the symptoms that compile a specific illness. Georgaca (2013) argued that psychiatric discourse is used to transform subjective experiences into psychiatric terms, reducing the client to an

object in the discourse. This research seems to indicate a similar pattern, as the participants use the discourse to 'evidence' the presence of trauma in their work with clients. Participants use the discourse to describe their clients' experiences in terms of a list of symptoms, such as when Dave constructs trauma as something that can be identified in clients due to "*flashbacks […] mood disturbances, memory disturbances, personality disturbances*" (lines 20-21). As suggested in a study by McCabe, Heath, Burns and Priebe (2002), who applied conversational analysis to the interactions between psychiatrists and patients, the discourse does not seem to facilitate an expansion of what these 'symptoms' actually consist of or mean to the client, such as, for example, how the client feels about their flashbacks or the content of them.

Georgaca (2013) argued that practitioners construct diagnostic criteria as "an objective process of identifying symptoms in a way that is consistent with scientific-medical understanding" (p.59). This is consistent with how participants positioned themselves as being able to objectively observe the presence of the 'symptoms' in the client and assess whether the client's experience was clinically relevant. Participants positioned themselves against psychiatric discourse at times, constructing the use of diagnosis as problematic or insufficiently encompassing. The way in which practitioners take these dual positions reflects the findings of a study by Harper (1995), who used discourse analysis based on the ten step method suggested by Potter & Wetherell (1987) to analyse data he collected from interviews with psychiatrists. He reported that psychiatrists constructed diagnosis as 'useful' and 'not useful', and argued that this might allow the user to be positioned as liberal and critical, whilst still allowing them to carry out the role required of them by the institutions to which they belong. I suggest that the participants in this research seem to be utilising the discourse in a similar way, holding the dual position of being within and against psychiatric discourse.

So far, the exploration has been critical, focused on the disempowerment the client may experience from being positioned in psychiatric discourse. I would also like to consider the

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benefits of psychiatric discourse. Szasz (1960) made the point that the more something 'happened to' a subject, as opposed to something the subject made happen, the more they are absolved from responsibility. Szasz goes on to argue that this raises questions of who then pays for the treatment, the subject or the state, and discusses the implications of this in different political environments. These arguments can be considered in the context of health care in the UK currently. Putting aside political debate regarding government plans for the National Health Service (NHS), at present there is therapeutic support available through the NHS but with limits. I argue that a practice that results from the psychiatric discourse is that it allows or bars access to services depending on whether the subject is positioned as meaningfully traumatised. The subject who meets diagnostic criteria for pathological trauma may be eligible for greater support than the subject who does not. This seems particularly pertinent in the current economic and political climate in which mental health care and funding has experienced financial cuts, leading to the triaging of service-users into services to become more stringent. A potential benefit to diagnosis is that it allows help, and hopefully enables the practitioner to decide on the best course of treatment, constructed in psychiatric discourse as that which leads to the desirable outcome of clinical improvement and increased personal functioning and quality of life for the client and their family (Alarcón, 2009). The powerless positioning of the client in this discourse facilitates help being given to them, rather than creating an expectation that the traumatised subject take care of themselves (Szasz, 1960).

More specifically, a function of being positioned within the diagnosis of PTSD may be that of all the mental health diagnoses, 'PTSD' is the most 'blameless' (Seeley, 2008). The discourse emphasises the traumatising event in the construction of trauma. This creates a tension in definition between locating the trauma within the subject, with locating the 'reason' the person is traumatised in the 'event'. This dichotomy reflects that of the discourses presented in the 'genealogy of trauma' in the literature review (C.2), such as when Janet

(1920) used the discourse to construct his client's presentation in terms of the hardship they had suffered when he wrote:

> "[she had been] beat and abused in every way [and] fell into crises of delirium during which she acted over again the scenes she had lived through"
>
> (Janet, 1920, p.63).

I suggest that this allows the practitioner to be positioned as sympathetic to the client's past experiences, whilst making observations from the position of 'clinical objectivity'. As I shall go on to argue under the discourse of CBT, this dual positioning seems to have permeated the other 'pathologising' discourses of trauma.

Seeley (2008) suggested that to be diagnosed with 'PTSD' aligns the subject with a construction of unprovoked assault, and with deserved and legitimate victimhood. She argued that by giving the diagnosis, the practitioner is supporting the client and asserting their innocence in causing what happened to them. This argument seems to be consistent with the way the participants use the psychiatric discourse as a way of emphasising the extent to which their clients had endured. Furthermore, the way feminists have criticised diagnoses such as a borderline/emotionally unstable personality disorder and argued that trauma based diagnoses would be more appropriate and useful, suggests that 'trauma' is constructed as a less pathologising and more empathic diagnosis (Herman, 1992; Tseris, 2013).

Trauma may be a favourable diagnosis, but I suggest that it should be recognised that the 'favourable' and 'unfavourable' diagnoses are all discursive constructions within the wider discourse of psychiatry. I argue that when a subject position is available to some and not others, it is as important to consider the implications for the subject who cannot be positioned in this way as it is for the former. I wonder whether the availability of the

discursive position of 'pathologically traumatised' actually serves to increase the pathology located in those aligned to other diagnoses that are constructed as more stigmatising, such as borderline/emotionally unstable personality disorder. Does this mean that they are positioned as either not having had an experience that sufficiently 'counts' for a trauma diagnosis, or that their reaction was somehow more pathological, as rather than resulting in the 'understandable' symptoms of trauma, their presentation is discursively located with another diagnosis. Both these positions serve to locate the responsibility entirely within the subject, denying them the 'excuse' offered by diagnoses of pathological trauma that the person has experienced something beyond the realms of what a person can cope with and remain 'normal'.

C.5.2.2 The discourse of cognitive behavioural therapy (CBT)

The CBT discourse constructs trauma as the result of the interaction of the subject's thoughts, emotions, physical sensations and behaviour in their environment. Emphasis is placed on the role of thoughts, reflecting how the discourse has developed from the work of Aaron Beck, who argued that psychopathology is the result of distorted thinking and reasoning (Beck, 1964). I argue that the discourse is used to manifestly position the therapist as understanding and collaborating with the client, whilst maintaining a significant power differential in the therapeutic relationship. The discourse may be used to advocate exposure based practice and seems to offer the practitioner a position of resistance against the discourse of VT.

Participants use the discourse in a way that appeared in line with the dominant model of CBT for trauma, which was developed by Ehlers and Clark (2000). The authors constructed a theory of trauma that emphasised how the subject's 'normal' reactions that immediately follow a traumatic event may become problematic as they become generalised into non-traumatic environments, producing a persistent, current sense of threat in the subject (Ehlers & Clark, 2000). The therapist is positioned as empathic, non-judgmental and understanding

of the client's 'trauma'. The client is positioned as irrational through their positioning of having a mental health problem that needs treating. The therapist takes the position of rational helper with the role of correcting the client's faulty thinking and aligning it with the 'rational' perspective.

Research and literature usually manifestly constructs CBT as a collaborative therapy. Dattilio and Hanna (2012) suggested that the relationship should be based on 'collaborative empiricism', the systematic process of the therapist and client working together to establish common goals, and argue that this allows the validity of cognitions to be explored together. However, I wonder how the discourse can allow a mutual process of discovery when the discourse frames one subject's perspective as accurate and rational and the other's as faulty.

The model of CBT has been criticised for locating the source of the problem within the client through the way in which the discourse constructs their thinking as faulty or distorted and potentially adding to their subjective sense of shame (Gilbert & Procter, 2006). I support this argument, as I suggest that the discourse locates the trauma in the subject. Simultaneously, the discourse seems to be used to allow the therapist to be positioned as understanding and empathic to the client. It seems that this action orientation is similar to that found in the psychiatric discourse, when participants were able to manifestly resist the discourse and allow themselves a more favourable position, whilst still using a discourse that pathologises the subject identified as traumatised.

There does not appear to be much in existing literature specifically regarding discursive construction of trauma in CBT discourse. However, the model of CBT has been strongly influenced by the psychiatric model of diagnosis and treatment, focusing on 'treating' specific problems in psychopathology (Bannink, 2012). For that reason, I suggest many of the criticisms of the psychiatric discourse as presented above seem to apply to the discourse of CBT. Specifically, the substantial power differential of the therapeutic relationship and the

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positioning of the therapist as rational and objective, compared to the client position of irrationality that is present in the discourse, despite the manifest action of constructing the therapeutic process as a collaborative process. However, CBT is a rapidly expanding mode of practice, with many variations. Perhaps the most obvious is the distinction between 'classic' (Beck, 1964) and 'third wave' modalities, including acceptance and commitment therapy (ACT; Hayes, Strosahl & Wilson, 1999) and compassion focused therapy (CFT; Gilbert, 2009). These approaches are constructed as challenging the pathologising nature of traditional psychotherapies (Gilbert & Procter, 2006; Hayes, et a, 1999) and it would be useful to have discursively based research to better understand how these modalities position the subject and the limitations of this for practice and subjectivity.

A further finding in this research was that CBT discourse seems to facilitate the practice of exposure-based therapy. Tom positions himself in favour of exposure-based interventions when he says "*I'm not blasé but I know that's [the traumatic memories] where the action is*" (lines 152-154). I argue that by identifying himself as a therapist who works in this way, he is positioning himself as capable of bearing the client's distress and in the juxtapose position to those therapists he positions as being "*quite wary or afraid […] of hearing stories and of doing the trauma focused work*" (lines 155-156).

Tom's use of the discourse echoes that of an article by Zoellner et al. (2011), who constructed confronting the client's traumatic memories as potentially frightening and intimidating for the therapist, but an important and necessary part of the work. The paper positions the therapist as fearing that the client will not be able to tolerate their distress; that the work will be too didactic and lack rapport; and that the therapist themselves will be overwhelmed and lead to 'VT', constructing these fears as 'common' clinical misconceptions. The paper urged therapists to confront the traumatic memories, which they call 'the elephant in the room', be more directive and actively respond to the client's distress.

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Tom, like Zoellner et al. (2011), seems to use CBT discourse to construct the effectiveness of his work and resist the possibility of being located within a discourse of VT, perhaps suggesting that aligning oneself with the position of therapist that practices in this way allows a sense of defiance against the warnings of VT discourse. I suggest that this use of the discourse may indicate that this discourse locates those therapists who do not work in this way within a discourse of VT, positioning them as fearful and wary to explain their lack of exposure focused work.

Considering the wider context of the social and historical position that the participants are located within, the interviews were collected in London, England, during a period of Tory-led austerity. Locating the problem of trauma within the individual may be considered to be a function of the wider discourse of neoliberalism, which I argue is especially apparent in the discourse of CBT. From a Foucauldian perspective, neoliberalism is constructed as a political rationality that seeks to promote government ambitions and positions the subject as a rational, active individual who is able to make choices in order to benefit themselves and their family (Teghtsoonian, 2009). In this wider discourse, which I argue CBT discourse is located within, both individuals and collectives (e.g families and organisations) become responsible for navigating and avoiding 'risks', which in other discourses can be constructed as social risks that the government should protect the subject from (Lemke, 2001).

The discourse of CBT and the practice of CBT can be used to construct psychological trauma as a risk that the subject has the responsibility of navigating, by being taught how to correct their faulty cognitions and thus avoid needing further support, positioning the subject as 'empowered' (Teghtsoonian, 2009). Furthermore, constructing good care in terms of 'evidence based practice', which is often synonymous with CBT (Teghtsoonian, 2009), has disallowed other discourses that would facilitate the practice of therapies that may offer different constructions of trauma and locate the responsibility outside the traumatised subject. The discourse of CBT, which constructs CBT as a the most practical and financially viable

option has allowed the practice of CBT on a broad level, evidenced by the introduction of Improving Access to Psychological Therapies (IAPT), which aims to enhance access to CBT (Clark, Layard & Smithies, 2008).

IAPT and the uniform delivery of CBT has been criticised for being part of the neoliberal orientation of the government of moving people from social assistance to the work force and for failing to address the negative impact of government policies on people's welfare and well being (Teghtsoonian, 2009). This action orientation is facilitated through the location of the problem within the traumatised subject, and the way that a function of CBT, the practice that is facilitated by the discourse of CBT, is to equip the subject with skills that they can use on outside of therapy and on and ongoing basis to independently manage their mental health, thus relieving the burden on social care inline with austerity.

C.5.2.3 The discourse of vicarious trauma (VT)

The discourse of VT constructs trauma as an extremely distressing psychological phenomenon, which endangers the therapist through their engagement with it. As indicated in the literature review, the majority of research concerned with the therapist's perspective of working with trauma seems to be located within a discourse of VT, within which I have included the constructs of compassion fatigue (CF; Figley, 1995), secondary traumatic stress (STS; Figley, 1995) and burnout (Maslach, 1982). In this research, the discourse was used to position both therapist and client as victims. The discourse constructs the impact of the work in terms of feeling overwhelmed and deskilled, the function of which is that it allows this subjective experience from the position of therapist to be attributed to the effect of working with trauma, rather than a genuine reflection of the therapist's lack of ability. In constructing trauma as particularly challenging, the discourse facilitates the allocation of services in the form of extra training and supervision to trauma practitioners. The discourse was used to simultaneously position the therapist as inevitably impacted, and with the responsibility to take care of themselves and navigate the effects. I argue that this seemed to allow

practitioners who positioned themselves as able to cope with the work a sense of strength, but might lead to shaming of practitioners who do feel themselves to be located within VT discourse for their failure to cope.

McCann and Pearlman (1990) suggested that the practitioner must have support in working through the "painful emotional experiences" (p. 144) of working with trauma else they may begin to feel "numb or emotionally distant, thus unable to maintain a warm, empathic, and responsive stance with clients" (p. 144). McCann and Pearlman (1990) positioned the therapist as a helpless victim who is unwillingly changed by the trauma work leading to a decreased ability to work effectively and appropriately. Jenkins and Baird (2002) also argued that working with trauma can lead to an inability to provide services.

The literature constructs the therapist's impairment in terms of trauma 'symptoms' experienced by the therapist themselves, emphasising 'numbing' (McCann & Pearlman, 1990), 'avoidance' (Dreighton, Gurris & Traue, 2007) and 'fearful avoidance' (Dreighton et al, 2007) as a barrier to effective therapeutic practice. Bianca and Tom use the discourse to position the therapist as fearful and avoidant. This locates the reasons for the ineffective practice within the therapist, but aligning them with symptoms provides a discursive tool to disallow other discourses that would construct the therapist as responsible for their failure, perhaps by identifying them as lazy or malicious. In other words, the therapist is positioned as working ineffectually but not purposely so, as they have lost control of the therapy. This raises the following question: if the majority of discourses used to construct trauma position the therapist as in control and the client as helpless, who is then positioned as having the control if the therapist becomes located within the VT discourse? The discourse seems to suggest that the power becomes located in the organisation or service that the practitioner works in, a suggestion I shall now explore.

The discourse utilised by participants and in the literature review indicates how the VT discourse can be used to urge services and employers to safeguard against the risk by offering specialist training (Craig & Sprang, 2010; van der Water, 1996), peer support (Ilfe & Speed, 2000), supervision (Pinsley, 2000; all the participants), the potential for more balanced caseloads i.e. a mix of trauma and non-trauma work (Craig & Sprang, 2010; Ilfe & Speed, 2000; Pinsley, 2000; van der Water, 1996) and promote the importance of practitioners taking breaks (participants Bianca and Deborah). These recommendations are potentially useful in providing support for the therapist and in turn facilitating 'good' practice. Furthermore, should a therapist become located within the VT discourse, the 'reason' for this could be constructed as the organisation's failure to meet these recommendations, perhaps providing a buffer against blame and shame being located within the therapist. The therapist is protected, but to achieve this they are positioned as helpless and in need of someone or something (the organisation) to take control, which re-enforces the action orientation of this discourse, which is to argue that the therapist is endangered by working with trauma.

Simultaneously however, participants use the discourse to position the therapist as having the ability and responsibility to mediate and navigate the negative effects of working with trauma by engaging in appropriate behaviours. This is reflected in the literature, as studies linked lowered levels of 'VT' with effective working (Craig & Sprang, 2010; Dreighton et al., 2007), active engagement with self-care (Harrison & Westwood, 2009), and accessing training and support (Craig & Sprang, 2010; Iliffe & Steed, 2000), and engaging in 'positive' activities both inside and outside work such as exercise (participants Deborah and Tom) and actively seeking out pleasure, relaxation and appreciation of life (Harrison & Westwood, 2009, and participants Urszula and Bianca). The result of this is that trauma becomes constructed as something that can, but does not necessarily have to, negatively impact the therapist, but with a tension as to whose responsibility it is to mitigate the associated effects. It is interesting to note the way that participants Tom and Bianca describe how practitioners can be located within the VT discourse but do not position themselves this way. I suggest

that this could reflect the undesirability of being situated within this discourse, positioning the subject with failed responsibility or insufficient ability.

In the analysis (C.4) I question whether a practitioner would be located within the VT discourse if they are identified as having had a traumatic childhood, as they may then be positioned as 'non-resilient'. The literature presented in the review indicates that the discourse of VT does position therapists as vulnerable if they have 'personal histories of trauma', although studies yielded mixed results as to support of their hypotheses (Linley & Joseph, 2007; Pearlman & Mac Ian, 1995; Pinsley, 2000; van der Water, 1996; and Weaks, 2000). It should be noted that these studies generally have not explained what is meant by personal trauma history, so it is possible that the 'history of trauma' may have occurred in adulthood and therefore not be indicative of 'developmental trauma'. However, the literature presented in the review also includes studies that identified the therapist's attachment style as a 'variable' in developing 'VT', and the authors found support of their hypotheses that those with insecure attachment styles are more likely to be affected by 'VT' (Brandon, 2000; Marmaras et al., 2003). I argue that these studies suggest that the discourse of VT can be used to position those with past trauma as more vulnerable, and therefore that those identified as having experienced developmental trauma would be positioned in this way too. The interlinking of the discourse of developmental trauma and resilience with the VT discourse seems to compound the potentially powerless positioning of therapists if they are identified as having developmental trauma or past trauma, as they become positioned as 'traumatised and non-resilient'.

Although all the participants use the discourse of VT, they also seem to actively resist it. They use the discourse as a way of pitting their own experience against it, as if creating a contrast by which to demonstrate how they enjoy and find satisfaction in this work. I suggest that there seems to be a subversive strength to be felt in using the discourse this way, positioning themselves as strong enough to do the work and to continue doing the work

despite the warnings found in this discourse. This position seems unrepresented in the literature. Research that positions the practitioner as finding their work enjoyable and satisfying tend to do so using the discourse of posttraumatic growth (PTG; Tedeschi & Calhoun, 1996), which constructs the benefits as phenomenon that arise as the result of engaging with the difficulty of the work, and constructs the 'growth' as occurring alongside the 'VT'. It is important to recognise that this is not the position the participants in this research took in the instances being discussed here: rather than positioning themselves as being benefitted as well as damaged by the work, they used the discourse to position themselves as not finding the work damaging.

The subject's active positioning of themselves against the dominant discourse of working with trauma seems, in some ways, comparable to Wetherell and Edley's (1999) 'rebellious positions'. In their paper *Negotiating Hegemonic Masculinity*, the authors suggested that taking the rebellious position allows the subject to be positioned as possessing the personality trait of unconventionality, which the authors argue leads to the subjective sense of feeling good about oneself and *"so well integrated as a human being that one is not afraid to act in terms of personal preferences"* (p. 350). I wonder if there are some similarities with the identity that the subject can construct for themselves by positioning themselves against hegemonic masculinity, and with what I argue to be the hegemonic construction of the experience of working with trauma. Wetherell and Edley (1999) went on to warn against constructing the hegemonic position in overly simplistic terms, suggesting that perhaps it is the 'non-hegemonic' position that is hegemonic. I argue that it would be useful for future research to continue to explore how practitioners position themselves in terms of VT discourse.

I wonder if the lack of literature reflecting the position taken by the participants in this study is partly explained by the lack of critical research around 'VT', as all of the research I reviewed seemed to assume the validity of the phenomenon. In terms of the existing literature, I

wonder if a possible reason that the position of practitioner who is not negatively impacted by the work seems to be absent may be because the discourse constructs trauma as something which affects the practitioner even if there is no overt symptomology (Pearlman & Saakvitne, 1995). If something is supposed to be impacting and influencing the subject even if there are no observable or visible signs, it becomes very hard to 'disprove'. As such, I argue that the discourse of VT disallows discourses that could undermine it. I suggest that this highlights the importance for further research underpinned by critical epistemologies, which do not assume that 'VT' is a phenomenon.

C.5.2.4 The discourse of developmental trauma and resilience

The discourse of developmental trauma and resilience constructs trauma in two ways. The first is to construct trauma as something that occurs in the early years of life, which affects subsequent development. As such, the discourse offered an additional construction of trauma to that found in the other 'pathologising' discourses, of something happening to the subject, whether it was an isolated, ongoing or repeated event, as in this discourse trauma could also be a lack of something happening to the subject: more specifically, a lack of adequate care and attention. This reflects literature such as that by Cloitre et al. (2009) who argued that childhood traumas are comprised not only as acts of commission (such as sexual assault) but of acts of omission as well (such as neglect or abandonment).

The experience of trauma in the early years is used by participants to position the subject as vulnerable to subsequent traumas, whereas those with 'non-traumatic' childhoods are positioned as resilient. This allows the discourse to be used to explain why some may become pathologically traumatised following an event when others may not. To be positioned as resilient seems to be desirable, and allows the subject to be attributed strength and useful adaptive behaviours. However, I argue that the discourse of developmental trauma and resilience is pathologising because of the availability of the opposite position, of

being non-resilient. In this position, the subject is attributed psychological vulnerability, allowing a subjective sense of hopelessness and helplessness.

For the therapist, it appeared that to be positioned as having had a 'non traumatic' childhood could be used to 'explain' how they had the resilience to cope with working with trauma. None of the participants used this discourse to position themselves as non-resilient, which may be because to do so would be incompatible with the role of therapist. I suggest that being positioned as non-resilient may locate the therapist undesirably within the discourse vicarious trauma (VT) and I have discussed this in the section exploring the discourse of VT.

Using the discourse of developmental trauma and resilience to frame and explain the development of pathological trauma following an event in later life is consistent with the literature reviewed. 'Attachment style' is used to explain client's reactions to potentially traumatising events, linking 'insecure attachment' with higher levels of distress and 'PTSD symptoms' (Declercq & Willemsen, 2006). Furthermore, 'resilience' explained by 'attachment security' has been used to position clients as less likely to develop 'PTSD' and more able to recover (Benoit, Bouthillier, Moss, Rousseau & Brunet, 2010), suggesting that as in this research, the discourse can be used to position subjects as resilient or non-resilient.

Participants seem to use the discourse to position the subject (both therapist and client) as resilient in a static way, suggesting that one is either resilient or not, with little room for manoeuvre and to move away from the positioning of non-resilient having once been identified as such. The discourse can be used to argue that there is a critical age when one can develop resilience, after which that ability declines or goes completely. My argument that the discourse offers rigid subject positions that can inhibit those positioned unfavourably in the pathologising 'non-resilient' position is reflected in some critical literature. Shaikh and Kauppi (2010) argued that research in this area, which is grounded in a positivist epistemology that frequently positions the subject in terms of 'personality traits', usually

suggests that some 'possess' resilience and some do not. Luthar, Cicchetti and Becker (2000) critically evaluated how 'resilience' is constructed in literature and argued that even when users manifestly describe resilience as a dynamic process, they use fixed subject positions, such as 'resilient children', which construct resilience as a constant characteristic.

Marecek (2002) argued that by constructing 'resilience' as a static trait, the discourse can be used to imply that those who are not resilient in the face of trauma (i.e. that become traumatised by a potentially traumatic event) are somehow responsible for their suffering. However, in this research it seems that participants use the construction of a lack of resilience to resist their clients being positioned as responsible. Although I assert that the discourse can be used to locate the 'reason' the subject has become traumatised (or not) within them, which is pathologising, I argue that the discourse is used by participants to mitigate blame and responsibility being assigned to their clients, and that this function is enabled by the discursive object of 'childhood', which is part of the discourse.

Current, dominant discourses of the child in the West construct childhood as a "time of play, an asexual and peaceful existence within the protective bosom of the family" (Kitzinger, 1988). This reflects the construction of the child found in the work of Rousseau, of a neutral being in need of nurture and education (Rousseau, 1762, in Burman, 1994). The child becomes an object in the discourse, not a subject in its own right but a blank canvas unto which the environments imparts its impact and this leads to the adult subject's subsequent weakness and foibles (Burman, 1994). The developmental trauma and resilience discourse offers a construction of trauma as something that has violated this construction of childhood. As such, the discourse uses 'childhood' to construct the subject's innocence and helplessness (Kitzinger, 1988), making it difficult for the subject to be aligned with blame or responsibility for the traumatic event and the effect that it had on them. The result of this is that the discourse can be used to facilitate therapeutic interventions that seek to undermine shame that the client may be feeling, by allowing the argument that it is not the traumatised

subject's fault that they are not resilient to trauma, whilst simultaneously 'explaining' the development of pathological trauma with the construction of an 'internal' defectiveness and vulnerability.

Further to the positions of resilient and non-resilient, the discourse offers 'traumatised yet resilient' and 'traumatised and non-resilient' subject positions, indicating that the discourse also offers the construction of trauma as the result of an extremely difficult event that can be used simultaneously. I argue that positioning the subject as 'traumatised yet resilient' allows feelings of confidence in the therapeutic process and hope of recovery from both the therapist and client. Conversely, 'traumatised and non-resilient' subjects are positioned in a hopeless way and the client is positioned as less likely to recover. The participants' use of the discourse is consistent with how it is utilised in texts that argue attachment style should be used to inform treatment plans for those with 'PTSD' (Dieperink, Leskela, Thuras & Engdahl, 2001; Forbes, Parslow, Fletcher, McHugh & Creamer, 2010).

Participants use the distinction between resilient and non-resilient traumatised subject positions to suggest different practice depending on how the client is positioned. Deborah uses the developmental trauma and resilience discourse to suggest that the usual way of working might only be effective with 'traumatised yet resilient' subjects. Deborah constructs usual therapeutic practice with her description of *"unpack, revisit, make sense of what happened to them"* and asserts that with non-resilient clients, this can make their trauma worse. This suggests that trauma is being constructed as something that is different to the 'usual' problems and presentations dealt with in therapy, which requires greater care to work with and perhaps a different therapeutic approach. This allows client-led, personally tailored practice and therefore discredits the assumption that one standardised way of working with subjects aligned to the 'traumatised' position can be effective. The discourse potentially undermines protocol-based services and the construction of service standardisation found in recommendations like NICE guidelines, which recommend trauma focused cognitive

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behavioural therapy (TF-CBT) or eye movement desensitisation and reprocessing (EMDR) for all those diagnosed with 'PTSD', and only suggests deviating to other therapeutic approaches and pharmacology after no or limited improvement following TF-CBT/EMDR (NICE, 2005).

C.5.2   The 'non-pathologising' discourses

C.5.2.1   The discourse of posttraumatic growth (PTG)

'PTG' was a term developed by Tedeschi and Calhoun (1996), which can be located in the wider discourse of 'positive psychology'. Positive psychology is constructed as acting to challenge the 'disease model' found in medicine, psychiatry and 'traditional' psychology, instead constructing 'mental health' as a spectrum of functioning. Authors of positive psychology texts argue that the 'movement' can be used to focus on enhancing psychological wellbeing rather than merely seeking to treat the abnormal (Joseph & Linley, 2008). As such, the PTG discourse constructs trauma as a process through which the traumatised subject can achieve greater insight, appreciation of life and wellbeing.

I suggest that this discourse allows the subjective experience of hope to be felt from both therapist and client, and thus allow both to engage with the difficult aspects of the work. The discourse allows the subject position of survivor in addition to the victim position found in the 'pathologising' discourses. Furthermore, the discourse is used to resist the construction of emotions as either positive or negative and to suggest that all emotions are important and potentially enriching. Participants use the PTG discourse to construct trauma and recovery as a process, positioning the subject as able to move forward with the trauma towards wellbeing by integrating the trauma, rather than alleviating or removing symptoms as in the 'pathologising' discourses. The discourse offers more fluid positioning than the juxtaposed traumatised and non-traumatised positions found in the 'pathologising' discourses.

This is a relatively new discourse, and there is substantially less research and literature than into the 'negative' effects of trauma and working with it. A study by Arnold et al. (2005) used grounded theory to 'identify' the major themes in 'PTG' experienced by therapists working with trauma. They called this 'vicarious PTG' (VPTG), which they 'defined' in terms of perceived psychological growth as the result of working with trauma and made the comment that this growth is "strikingly similar" to that reported by directly-traumatised subjects (p.240). The authors noted that many of the changes 'identified' in the participants could not be described as positive or negative, as often the effects of the work had a mix of qualities. The discourse used in Arnold et al.'s (2005) article seems to construct emotions in a more complex way than either positive or negative, which is reflected in the way participants in this research use the discourse.

Brockhouse et al. (2011) used the results of their quantitative study, which measured the relationship between empathy and cohesion to 'VPTG' to argue that it was the process of being affected by the work, constructed in this paper in terms of feeling 'empathy' and 'the interruption of cognitive schemas', which facilitates the potential for growth. Like the participants of Brockhouse et al.'s study, the participants in this research use the PTG discourse to advocate that the therapist and client actively engage with feeling the trauma during the therapeutic process. This constructs trauma as something that it is useful and life-enhancing, although difficult, to experience and this offers a challenge to the construction found in the VT discourse of trauma as something that is dangerous to engage with.

Reviewing the literature, it appears that the authors construct 'PTG' as something that can occur in the therapist alongside 'VT' (Hernandez, Gangsei & Engstrom, 2007). Hernandez et al. (2007) used the term 'vicarious resilience' (VR) to locate the 'growth' in the therapist and argue that the term can be used as a tool to counteract the fatiguing effects of working with trauma. The authors seem to be using the discourses of VT and PTG alongside each other, and in constructing a need for such a 'tool' they seem to be enforcing the assumption that

working with trauma will result in 'VT'. It is interesting then that the participants of this study seem to use the discourse to relocate experiences that could be located within a discourse of VT. In other words, rather than constructing feelings or behaviours as 'symptoms of VT', the PTG discourse can be used to construct them as part of the PTG process. The result of this is that trauma is not constructed as something that will 'inevitably' negatively affect the therapist, as seemed to appear in the majority of the literature (Figley, 1995; McCann & Pearlman, 1990). I suggest that the use of the discourse found in this research has significant implications for practice.

Considering first the position of the therapist, constructing trauma as something that is challenging to engage with but that can lead to positive changes within oneself may facilitate the therapist entering the field and taking a proactive approach to training and self-care, by locating these activities in a discourse that constructs them as behaviours that will do more than merely ward off damage (as in a discourse of VT) but lead to growth. Locating the 'effects' of working with trauma within in the discourse of PTG may allow the practitioner to be more able to continue working and actively engage with 'difficult' impacts by constructing them as part of a changeable, workable process rather than being positioned as someone who cannot cope with the stresses of the work. From the perspective of the client, locating their experiences within a PTG discourse may allow hope that things can improve, potentially allowing them to continue with engaging with therapy, in what may be a very difficult and emotional process.

The literature review indicated that PTG discourse and biological discourse have been used in tandem to argue that 'treating' trauma with psychopharmaceuticals may prevent or inhibit the ability of those who have experienced trauma being able to experience 'PTG' (Antunes-Alves & Comeau, 2014). Furthermore, some research has linked 'intensity of PTSD symptoms' with greater 'PTG' (Merecz, Waskowska & Wezzyk, 2012), suggesting that the discourse can be used to argue that the greater the extent of the trauma, the greater the

potential for growth. This literature suggests how the PTG discourse can be used to challenge discourses of trauma that construct the optimal outcome of treatment to be the removal of symptoms and rapid return to the non-traumatised state, arguing that this prevents the opportunity for growth. This has implications for practice, as it offers a powerful critique of offering pychopharmaceuticals to those identified as traumatised. However, this is a reason that the discourse of PTG may be resisted by services that are under pressure to provide evidence of client 'improvement' constructed in terms of symptom reduction.

C.5.2.6 The discourse of embodiment

The discourse of embodiment constructs trauma as a 'felt sense'. Participants use the discourse to construct trauma as something that affects the whole of the person, including their body. As a result, the discourse facilitates the discourse and practice of 'body' or 'somatic' psychotherapy (note I use the two terms interchangeably), with which participants Dave, Urszula and Bianca construct their body as a 'tool' for therapy.

Willig (2013) argued that despite the presence of dominant discourses, other subversive discourses can and do emerge. I argue that the discourse of embodiment is an example of this, offering a holistic construction of the person as an 'alternative' to the separation of mind and body found in the 'pathologising' discourses. Such separation, referred to as a Cartesian split, has dominated Western health care discourse since the 'modernist' rejection of the 'religious' in favour of a 'scientific' construction of the body (Mehta, 2011). Within these discourses, the body can be constructed as something that has become "out of control" (Paulson & Willig, 2008). Despite the growing body of literature that argues for a more holistic positioning of the subject, these texts continued to be framed as 'alternatives' to the dominant discourse (Damasio, 1994).

Within the discourse of embodiment, trauma is constructed as a felt sense, emphasising the role of emotion (I shall use the words affect, emotion and feelings interchangeably). Both

the therapist's and client's body are constructed as offering valuable information and potential in terms of understanding and learning to manage the effects of trauma. The discourse facilitates somatic psychotherapy, in which the client learns to accept the experience of their traumatic memories, whilst cognitively recognising that the traumatic event is not actually happening at that moment and they are safe. The therapeutic approach suggests that this can allow the client to experience less distress and learn techniques that include the mind and body to cope with the effects of their trauma (Rothschild, 2000).

The embodiment discourse allows the therapist to take the position of responsibility and power over the therapeutic process, but also allows a more aligned therapeutic dyad as the client is positioned as able to learn skills to manage their bodily responses to the trauma. The positioning of the therapist and client as cooperative is reflected in a paper by Rothschild (2010), who used the discourse of embodiment to argue that both client and therapist need to feel confident that the client knows how to control the memories and emotions that can be evoked in trauma work.

Reviewing the literature around somatic psychotherapy and embodiment, it is interesting to note that the discourse can be used to position both therapist and client as appropriate users and benefactors of the suggested practices (Conger, 1994; Rothschild, 2010). Similarly, participants use the discourse of embodiment to construct an experience of profiting from their work through the development of 'grounding' exercises and becoming more 'in touch' with one's self and one's body. They position themselves and their client in this way, suggesting that a subject does not need to be positioned as 'traumatised' to benefit from the work. The discourse seemed to facilitate the discourse of PTG by constructing trauma as a process through which one can grow.

Participants use this discourse to describe how they witnessed their client being profoundly affected by their trauma, and to construct their own experience of feeling the trauma with

their client. This construction seems to draw on somatic psychotherapy theory, such as Levine (1997), who suggested that rather than theorists and practitioners focusing on how to 'define' trauma, which the 'pathologising' discourses can be argued to do, it is more useful to try to attain an "experiential sense of how it [trauma] feels" (p.24). Likewise, participants in this research seem to use the discourse to construct trauma as a deeply individual experience and suggest the importance of trying to understand how it feels for the client.

Constructing the client's trauma as something that could be felt in the therapist's body was reflected in literature around the experience of the 'embodied therapist'. Shaw (2004), who used phenomenology to explore the therapist's body as the source of perception, positioned the therapist as having an experience that mirrors the client's. He used the discourse of embodiment to argue that the more emotionally involved the therapist is with the client, the more significant the bodily phenomenon. Similarly, the participants in the current research use the discourse of embodiment to construct a deep connection with their client, at times seeming to construct trauma relationally, through the emphasis of 'emotion'. The participants describe feeling the trauma 'with' their client, constructing the sensations within their bodies as phenomena that are produced through the act of sitting with the client in the therapy room and experiencing the feelings that are evoked through that process. Thus, the feelings were located within their (the therapist's) body, in the client's body, and in a mutual, shared space between them, offering the construction of an embodied sense of connection experienced by the therapist.

This use of the discourse seems to echo some of the critical literature around emotion that argues emotion is not an 'object', but a relationship to others (Burkitt, 2014). Ahmed (2004) argued that emotions are relational processes that are directed at an object or subject, and that the affective responses we experience create the border between the self and others, and 'give' others meaning and value. She constructed emotions as what connects and

separates individuals, arguing that "it is not about the inside getting out or the outside getting in, but that they 'affect' the very distinction of inside and outside in the first place" (p. 28).

Participants seem to use the discourse to construct their experience of feeling as something that allows them to identify what is 'self' and what is 'not self', and therefore construct a shift in interpersonal boundaries, allowing the therapist to '*feel with the client*' (Bianca, line 34). I suggest that perhaps constructing trauma in terms of emotions that can be felt as a shared experience allows the relationship to feel closer and more collaborative, facilitating the more aligned therapeutic relationship that participants seem able to construct using this discourse. The way participants use the discourse of embodiment could suggest that in the therapeutic relationship, the boundaries between what they position as self and other are changed through the construction of a shared emotional experience, allowing the positioning of a third space of shared emotion that the self and other share, and that could not exist without the presence of them both.

At times, the embodiment discourse seems to facilitate the discourse of VT, such as when Urszula says *"I can almost feel this [her client's trauma] in my stomach"* (lines 360-361), constructing her embodied experience as the experience of her client's trauma. This is reflected in the literature around the embodiment of trauma. Rothschild (2006) used the discourse of embodiment to argue that the felt sense of empathy can be exhausting to the therapist. In the section discussing the discourse of VT (C.5.2.3), I suggest that there seems to be a tension between how the VT discourse positions the therapist as inescapably affected by working with trauma, and with the responsibility to mitigate those effects and maintain fitness to practice. I wonder if the discourse of embodiment provides a way of discursively navigating this tension, as this discourse offers the construction of the felt sense of trauma as a way of being mindful to the effects of the work.

Rothschild (2006) argued that the therapist can learn to observe the physiological changes in one's own body (such as tension, sweating and position of the body) to become aware of how one feels empathy and the general way in which one's body and self are impacted by the work, and thus allow the therapist to know when to start and stop a therapeutic process. This indicates that whilst the embodiment discourse can locate the therapist in the discourse of VT, it can also be used to challenge such positioning. In other words, by constructing the physiological changes the therapist may experience as allowing them to be aware of and protect their boundaries, and know when to engage in self-care. This seems to be constructed in the discourse in the way that the participants use the discourse to position them as having a shared experience with the client, rather than positioning the client as traumatised and them, the therapist, as not traumatised.

C.5.2.7   The discourse of feminism

The discourse of feminism constructs trauma as the 'everyday' experiences for non-hegemonically positioned subjects (Root, 1992). Participants use the discourse to construct trauma as the outcome of experiencing abuse. The discourse constructs certain behaviours, such as abuse of others, as wrong and offers the subject positions of victim, survivor, perpetrator and activist. Victim and survivor are distinct positions that can be mutually inhabited or occupied singularly. Participants use the position of victim to emphasise the subject's lack of responsibility for what happened to them, and therefore navigate blame and shame that the subject may feel. I suggest that this may be problematic as it could increase the subjective sense of disempowerment and helplessness that can be felt from this position, which I will explore now.

The positions of victim and survivor have received significant exploration in feminist literature. The terms can be used to orientate the discourse socially and historically: a genealogy of the word 'survivor' conducted by Orgad (2009) suggested that discourses of the holocaust; psychotherapy; feminism and sexual and childhood abuse; reality television and health and

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fitness all contribute to the current positioning of 'survivor'. Pre-1970s, literature and research around those who had experienced events that can be located within discourses of abuse acted to locate responsibility in the 'victim' and 'victimiser', and it was the feminist movement during the 1970s that challenged this and led to the position of 'innocent victim' (Dunn, 2005). Dunn (2005) suggested that this position might have been useful in evoking sympathy for those positioned as victims and challenging the dominant discourses of the time, which were criticised for being 'victim blaming' by feminists.

The position of victim allows navigation of blame for subsequent behaviour, in addition to that of the trauma. Bianca describes a client who had killed his sexual partner when they were both teenagers and uses the discourse to construct the difficulties and disadvantages he had experienced to position as a victim and survivor and resist discourses that could be used to judge or condemn him (lines 449-466).

Bianca's use of the discourse is reminiscent of feminist literature that uses the discursive label of trauma (or PTSD) to explain the subject's behaviours that could be constructed as 'deviant' in other discourses. An example is a paper by Amaro et al. (2007), which recommended integrating trauma treatment with substance abuse treatment for women in urban settings. The action-orientation of this article is to challenge the construction of illegal drug use as a deviant behaviour, and promote an integrated therapeutic response to help the women. The women are positioned as victims through their exposure to traumatic events and this is compounded by giving them an 'urban' identity, which aligns the women with an experience of impoverishment, marginalisation and reduced choice to navigate trauma or cope in more 'useful' ways than drug abuse. The discourse utilised by both Bianca and Amaro et al. (2007) is able to undermine shame and blame that could potentially be attributed to the subject; facilitate empathy and care-giving; and challenge other, potentially more punitive discourses.

From the 1990s, new strands of feminist discourse criticised earlier discourses for the position of 'victim' as being helpless, passive and invoking a sense that the subject has 'given up' (Dunn, 2005). This lead to the position of 'survivor' being taken up in feminist discourse, which was reflected in the way participants use the discourse to position their clients, emphasising the subject's choice and constructing their behaviour in terms of an 'active strategy of survival' (Dunn, 2005, p.2).

The position of 'survivor' has been criticised for being problematic too. Dunn (2005) argued that positioning those who have experienced oppression or abuse as survivors may align attention and responsibility with that subject, rather than with the subject or 'social forces' that caused the event. I wonder if this could have implications for practice, as positioning the subject as a survivors with power and agency may reduce the allocation of resources and support that could help them. Orgad (2009) argued that the desirability of the position of 'survivor' may silence those who are not able to position themselves in this way, and reduce societal attention to traumas that do not produce survivors, only victims.

The majority of the literature critiquing victim and survivor positions seems to construct a dichotomy and suggest the two positions are contradictory. However, the participant's use of the discourse suggested that they positioned their clients as victims and survivors simultaneously. I suggest that this may be useful as it permits help to be offered to the 'victim' and the position of survivor allows the subjective sense of hope to be felt from both therapist and client that the trauma can be overcome. This dual positioning also may allow actions such as drug use or violence to be constructed as the 'survival' behaviour (survivor) of someone with very few choices (victim). However, I make this argument tentatively, as I feel that further critical research is needed to explore these positions and how subjects may be able to taken up by these dual positions themselves, rather than being allocated them, as is predominantly the case in my research.

Feminist discourse positions the subject as having a moral responsibility to act in a way that challenges the way patriarchal society oppresses those in non-hegemonic positions (Burstow, 1992). Therefore, the perpetrator position can be aligned to those who have failed to do so, in addition to positioning those who directly committed the traumatising action. This creates a moral obligation to 'take a stand' against trauma, which I suggest could lead the therapist to feel unable to 'say no' to working with trauma and locate them within VT discourse. The literature suggests that therapists identified as having high proportions of trauma work in their caseload locates them within a discourse of VT (Craig & Sprang, 2010; Iliffe & Steed, 2000; Pearlman & Mac Ian, 1995; Pinsley, 2000). At the same time however, greater amounts of work with trauma, constructed in terms of percentage of case load and the number of years worked were also used to position therapists within a discourse of PTG (Brockhouse et al., 2011; Craig & Sprang, 2010; Linley & Joseph, 2007).

The feminist discourse facilitates the practice of feminist therapy. 'Feminist' therapy is not a specific modality of therapy, but rather, the practice of therapy that integrates and promotes feminist ideals (Burstow, 1992). A key part of this is to 'politicize' the client's presentation; in other words, constructing the client's experiences and problems as part of a larger system of oppression. This may mean considering how a perpetrator may have experienced oppression, without denying the perpetrator's responsibility or suggesting that they should be 'forgiven' (Burstow, 1992). In addition, therapy based on feminist principles promotes the strengthening of the bonds among the client and other subjects who share their oppressive positioning; working with the body; encouraging the client to identify, feel and express their anger and strength; and respecting the client's boundaries of what they do and do not want to talk about. Burstow (1992) argued that many common therapeutic practices may be incompatible with feminist ideals, such as those that seek to make domestic situations more peaceful and bearable by (perhaps inadvertently) colluding with patriarchal systems of oppression.

In the analysis, it is noted that only Urszula actively positioned herself as having experienced trauma. I suggest that this positioning may have been allowed by her use of feminist discourse, which she drew on heavily. Perhaps by constructing trauma as a common experience for those in oppressed positions (which in feminist discourse, as a woman, she is), positioning oneself in this way is normalised and less shaming and stigmatising than it might be within 'pathologising' discourse. This argument seems to be reflected in feminist literature. Burstow (1992) argued that women therapists should aim to forge connection and solidarity with women clients that are based on 'shared oppression'. This suggests feminist practitioners should actively position themselves as having experienced trauma, offering a very different subject position to that of the neutral, objective practitioner position available in the 'pathologising' discourses. This may be further allowed by the way in which this discourse challenges the way the pathologising discourses align the position of being traumatised with being the 'problem'.

The feminist discourse allows a critique of the 'pathologising' discourses that construct trauma as an unusual or rare occurrence, which in turns raises questions for therapeutic practice. The 'pathologising' discourses presented in this thesis all construct a sense of current threat as a symptom of pathology. Feminist discourse can be used to challenge this by arguing that for many, that sense might be an accurate representation of the danger they face. Currently, the 'pathologising' discourses make a distinction among the types of events that can and cannot be constructed as a basis for developing pathological trauma. This is demonstrated when Tom uses the psychiatric discourse to construct experiences including phone calls, meetings and relationship break ups, as 'colloquial' uses of the word trauma and not clinically relevant experiences (lines 25-28).

Feminist theory and activism encouraged dominant discourses of trauma to include the experience of childhood and sexual abuse in the construction of what can cause trauma (Herman, 1992). I suggest that if feminist discourse was to become further integrated into

dominant discourses of trauma, and experiences such as those recorded in the website 'everydaysexism.com' (Bates, 2012) were to be constructed as clinically relevant experiences of sexual abuse, the construction of recovery in psychological and psychotherapeutic discourses would have to change in order to reflect a construction of society as genuinely constantly threatening for some.

The construction of abuse and what constitutes trauma has ramifications wider than psychological and psychotherapeutic practice. Currently, aligning a subject with the experience (be it victim or perpetrator) of abuse locates them within a legal discourse, and potentially discourses of government responsibility, raising questions as to what action should be taken to prevent and remedy abuse. This line of reasoning suggests possible institutional motivation for disallowing feminist discourse.

C.5.3   Implications for practice and relevance to Counselling Psychology

Conducting research using discourse analysis leaves the researcher in a conundrum: the social constructionist epistemology defies the positivist supposition that there are any 'truths' that we can know, which means making recommendations based on the findings problematic. On the other hand, for the research to be useful the practical applications of the findings must be considered. I structure these suggestions using the headings of the therapeutic relationship, the body and emotion.

C.5.3.1   The therapeutic relationship

In order to contextualise the recommendations I am about to make, I would like to explore some of the current literature constructing the therapeutic relationship. The majority of research into psychological and psychotherapeutic relationships has been phenomenologically based, seeking to identify what is helpful to a 'successful' alliance and 'positive' outcome. Research into the 'common factors' that facilitate successful therapy suggest that the quality of therapeutic alliance is one of the most relevant (Lambert & Barley,

2001; Tschacher, Junghan & Pfammatter, 2014). Although these studies do not always qualify what is meant by the 'quality' of the therapeutic relationship, there is an adjacent body of literature discussing the impact of 'power'. Furthermore, a phenomenological exploration of 30 child abuse survivors' experience of therapy six months after a six-week inpatient trauma treatment program conducted by Harper, Stalker, Palmer and Gadbois (2008) reported that the participants constructed the following therapeutic experiences as helpful: when the therapist facilitated them sharing control and decision making; when the therapist gave them choices; and when the therapist acknowledged that they have useful insights and ideas about how they can cope. These factors are constructed as indicators of the power balance in the therapeutic relationship, which the authors use as 'evidence' to argue that a more balanced therapeutic relationship is more useful to the client.

Churvin (1996) argued that the power imbalance in therapy is 'unavoidable'. Furthermore, Larner (1995) argued that the act of trying to 'deconstruct' the power in the relationship requires the therapist to take a directive stance towards this end, therefore reinforcing the therapist's powerful position and ability to influence the course of the therapy. Some authors suggest that in order to challenge the power differential therapists should be accepting of the power they possess but seek to give it away (Gibney, 1996) and try to take the position of 'not knowing' (Larner, 1995). This literature seems to construct power in 'all or nothing' terms, and I suggest that constructing the therapist's ability to influence the course of therapy as something negative may be unhelpful, as surely it is a central function of the role of therapist to be able to do this. Brown (2006) criticised the therapist taking the position of 'not knowing' and argued that this can lead therapists to feel ethically obligated to deny their knowledge and this renders them unable to challenge oppressive discourses. She suggested that the optimum positioning is one of 'partial knowing', which the therapist and client can both take up, and advocated that the therapist should actively reject the dominant positioning of the therapist as an objective subject by explicitly acknowledging their view-point.

I hope that one of the key uses of this research is that it highlights and makes apparent the deeply unequal power differential in the dominant discourses of trauma. The 'pathologising' discourses seem to position the therapist as powerful and objective, from where they are able to take control of the therapeutic process. The client, within whom the trauma is located, is positioned as the traumatised subject and helpless victim. Conversely, the 'non-pathologising' discourses offer more fluid positions, with 'trauma' constructed as a process rather than a fixed position. As a result, both therapist and client seem able to move in and out of the position of 'traumatised subject' and adopt more aligned, equally powerful positions in the therapeutic relationship. I suggest that a more mindful use of the dominant, 'pathologising' discourses of trauma may enable the practitioner to acknowledge the power being attributed to them, and actively seek to explore this with their client. As part of this, I suggest that considering the role of the body and emotion will be useful, which I discuss in the subsequent sections.

C.5.3.2 The body

I argue that many trauma focused therapies may inherently pathologise the client despite their manifest intentions, and I argue that the 'non-pathologising' discourse of embodiment offers the construction of the self as a whole, challenging the mind-body split found in the 'pathologising' discourses. I argue that in constructing such a split, the body becomes reduced to the site of symptoms, and something of which the subject has lost control. I believe an implication of this research is to promote the use of body work in therapy. The participants' use of the discourse suggests that this may allow the body to be constructed as a space for experience and understanding that facilitates healing and the navigation of 'trauma' from the position of both client and therapist.

The integration of the discourse of body therapy indicates that this discourse enhances wellbeing, a benefit that the subject does not need to be positioned as traumatised to experience, and that the therapist and client can share, potentially creating a more aligned

therapeutic relationship. The way in which the participants use the discourses suggest that bringing the body into the discursive terrain of the therapy session allows a more fluid construction of trauma, from which one can be located within the discourse of PTG, which allows the subjective experiences of growth or strength, rather than constructing the post-trauma ideal as a return to 'normal', or the pre-traumatised way of being.

I argue that as Counselling Psychologists, it may be useful to try to actively consider how we construct the subject when working therapeutically and contributing to literature, and allow a holistic construction of experience that permits the integration of body therapy and the construction of one's body as a tool for pleasure, knowledge and empowerment, rather than the site of symptoms.

C.5.3.3 The construction of emotion

I suggest that being more mindful of how we construct emotion may be useful in encouraging less pathologising practice. The 'pathologising' discourses seem to construct emotions in relatively simplistic terms, polarising them into good and bad, or acceptable, normal emotions versus evidence of pathological trauma. The 'non-pathologising' discourses seem to offer a different construction, acknowledging the intense difficulty of some subjective states but allowing them to be viewed as equally important and necessary. The discourse of PTG constructs the 'difficult' emotions as something that can lead to growth, and the feminist discourse particularly focuses on 'anger' as something that can be evoked to lead to empowerment. The discourse of embodiment constructs emotions not only as a process for the individual subject, but as a shared experience that can be constructed relationally as existing between the therapist and client, the result of which seems to be that the participants are able to construct a more aligned therapeutic relationship. I suggest that many practitioners would say that a full spectrum of emotion is 'normal' and 'healthy', but this research suggests that many of the discourses we draw on to construct trauma may latently construct a different message.

A useful implication for training could be to make trainees aware of discourses that construct trauma as a fluid process in addition to the construction of trauma as a fixed positioned. I discussed how this may benefit the client by creating a more aligned therapeutic relationship but I suggest that this could be beneficial for the therapist's wellbeing too. The findings of this research suggest that constructing trauma as a process may enable the therapist to feel able to accept and even embrace some of the 'difficult' impacts of working with trauma. I suggest that this may allow trainees to identify themselves as being traumatised at various points, without pathologising them and positioning them as 'non-resilient' and/or within a discourse of VT. This could allow trainees and practitioners to feel more able to talk about their experiences and potentially ask for help (perhaps in the form of supervision, training, or an assessment of the amount of trauma in their case load).

As a result of these findings, I recommend that practitioners be mindful of how dominant discourses can pathologise emotions and treat them as 'symptoms' to be removed. The 'non-pathologising' discourses seem to offer an alternative view of 'recovery', if indeed 'recovery' is the right word. The 'pathologising' discourses construct the client being able to be positioned with normative behaviour as the optimum outcome of therapy, with the implicit assumption that the subject should become as if the trauma had not happened. I wonder if both therapist and client can mutually benefit from challenging this assumption together. However, this may be challenging to implement in practice as public resources are allocated based on outcome measures that focus on recovery constructed in terms of symptom reduction.

C.5.4   Evaluating this research: validity, strengths and limitations

I used the guidelines offered by Yardley (2008) to check the validity of this research. Yardley (Yardley, 2008) suggested the following procedures: triangulation; comparing researchers' coding; participant feedback; disconfirming case analysis; paper trail; sensitivity to context;

commitment and rigour; coherence and transparency; and finally, impact and importance. After some consideration, I decided that the first three procedures, triangulation, comparing researchers' coding and participant feedback were inappropriate for this research for the following reasons. Triangulation in qualitative research refers to using evidence external to the data to confirm the analysis (Elliot, Fischer & Rennie, 1999). In other words, different methodologies may be employed, or different researchers used, to test and confirm the findings. I felt that using a Foucauldian Discourse Analysis (FDA) was the most appropriate for this research question, which denied the first avenue of triangulation, and as I am the sole researcher, the second avenue, the opportunity for comparing researchers' coding, was denied also. Furthermore, a discourse analytic approach assumes that participants may not be aware of the discourses they draw on, nor the available subject positions, action orientation and the subjectivity and practice made possible from these discourses (Elliot et al., 1999).Therefore, I felt that gaining participants' feedback on the analytic themes would not be appropriate or useful. I have employed the processes of disconfirming case analysis; paper trail; sensitivity to context; commitment and rigour; coherence and transparency; and impact and importance, which I present now.

Disconfirming case analysis refers to the process that follows the identification of themes and patterns in the data, whereby one seeks to find patterns or cases that do not fit (Yardley, 2008). Yardley (2008) suggested that this is useful in challenging the assumptions formed in the early stages of research and analysis. During the analysis, I sought to identify consistency in the data as I tried to understand how the discourses identified constructed trauma. I hope that the analysis has demonstrated not only the patterns I constructed from the data but also the variance and contradictions that were offered by the discourses in constructing the discursive object 'trauma', and the positions that were offered to subjects. The process of struggling with the data and trying to construct meaningful themes from it allowed me to challenge and re-construct many of my early assumptions, which I explore in detail in the methodological reflexivity section (C.3.7).

Creating a paper trail essentially allows readers to understand and potentially replicate the analytic procedure (Henwood & Pigeon, 1992; Yardley, 2008). The steps of analysis are described in detail in the methodology chapter of this thesis (C.3.6.6). The process of analysis was conducted over several months, and evolved over that time. I found that thoroughly annotating the transcripts and compiling tables of analytic themes allowed me to keep track of my previous analysis and go back in the process to replicate a process I had developed later on, and thus ensure that all the discourses were analysed in a similar way. As I developed new ideas or questions that I applied to the data to inform my analysis, I recorded notes in a reflexivity journal, as recommended by Lincoln and Guba (1985). I have explored some of the more salient points in the reflexivity sections of this thesis (C.3.7 and C.5.6).

Sensitivity to context involves considering the impact of the researcher on the participants, and how factors such as their relationship and their different roles may impact on the data collected (Yardley, 2008). These factors were considered during the designing of the research, and have been discussed under the 'recruitment and participants' section of the method. As this is a piece of qualitative research, it does not strive to be objective. Instead, I have endeavoured to be transparent and explicit about the agenda I bring to the research, and how I co-constructed the discourse produced in the interviews and analysed the data. I used open ended questions when collecting the data, as recommended by Yardley (2008). I hoped that the semi-structured format would allow the participants flexibility in drawing on different discourses. However, the majority of the discourses drawn on were psychological and psychotherapeutic. This may not be surprising, if we accept that subjects are positioned according to roles to which they are ascribed, with the result that specific discursive behaviours are constructed as appropriate and expected (Harré & van Langenhove, 1991). In retrospect, it might have been useful to allow more flexibility in the content of the interviews, which could have been facilitated with using fewer questions.

A further point to be made with regards to sensitivity to context is that of acknowledging one's own perspective. This is a point for validation raised by Elliot et al. (1999), which I feel links with context, who suggested that the researcher should explicitly state their own position, including personal, theoretical and methodological orientation, in order to make explicit the researcher's socio-cultural context. Theoretical and methodical orientation are described and explained in the methodological chapter, in which I present the social constructionist epistemology of this research and the FDA I would be employing.

I am aware that although I feel that I have shared personal thoughts and feelings that I deemed relevant and useful throughout this thesis, especially in the reflexivity sections, there is a part of me that is reluctant to orient myself socio-culturally, not least because it seems to involve attaching labels to myself, and I find myself wondering how valuable this is. On reflection, I suggest that this perspective may have been the influence of dominant discourses that construct 'real' research as that produced by the objective researcher, and possibly my own reluctance to identify myself as a minority (mixed race Asian and White, lesbian) and acknowledge my own privilege (able bodied, middle class and educated) and consider how this may have influenced the research. It is a limitation of this research that only basic demographic information about participants was collected: sex, approximate age and occupation. Participants were not asked how they identify in other capacities, such as sexual and gender identity, and therefore the implications of these variables and how they may serve to situate the discourses produced socially and historically cannot be fully explored. I suggest that it is too easy to ignore these variables as inconsequential, or perhaps as I did, avoid asking because it feels uncomfortable to do so. Questions regarding demographics are often crude; reducing what may be complex, multifaceted positionings to a gratuitous construction of identity. However, feminist researchers believe that explicitly naming and labelling these facets of identity, and thus actively positioning oneself, can be useful in challenging the positivist approach that promotes the hegemonic position (Reinharz,

1983). Certainly, I suggest that explicitly positioning myself in this way may serve to orientate the reader to the feminist discourses I have drawn on when writing these concluding arguments.

Commitment and rigour refers to conducting a study of sufficient depth to address the aims of the research (Yardley, 2008). In addition to careful analytic procedure, I tried to actively engage with the research object, reflecting upon how the participants and I had constructed trauma and how I continued to do so in the writing of this research. Furthermore, I hope that the extracts I have included in the analysis chapter clearly demonstrate the themes identified, and allow the reader to act as 'auditors' (Elliot et al., 1999).

Coherence and transparency refers to the "extent to which it [the research] makes sense as a consistent whole" (Yardley, 2008, p.267). I have sought to represent my findings so that they offer a coherent and integrated view, whilst recognising and preserving the nuances of the data (Elliot et al., 1999). I have tried to maintain a social constructionist, critical approach throughout the writing, with the view that this will support consistency between the research questions and the presentation of the research (Yardley, 2008). I hope to demonstrate transparency through presenting my analytic strategy and findings in the methodology and analysis chapters respectively. In the analysis, I aim to offer comprehensive definitions of each discourse I present, with the view that this allows the reader to see why the discourses are labelled as they are, and make the discourses' relevance to the research questions recognisable (Henwood & Pidgeon, 1992). The reflexivity sections (C.3.7 and C.5.6) promote transparency by describing the changing processes of the research and offering insight to my changing perspectives and subsequent analytic decisions.

Impact and importance refers to the implications of the research, both for practice and for future research (Yardley, 2008). I have explored these issues in the other sections of this chapter. I would like to address the issue of transferability (Henwood & Pidgeon, 1992). As a

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piece of FDA research, I am making the assumption that the discourses identified in this research are part of the social environment, and that if one person can draw on them, they are potentially available to others. I have used this premise to inform the analysis and tentatively suggest how the action orientations, subject positions, subjectivity and practice are made available in these discourses. Henwood and Pidgeon (1992, p. 108) warn that researchers must "guard against naïve empiricism", and certainly the results of this research cannot show how widely they may apply in different settings. However, as the aim of discourse analysis is to produce 'macrosocial' findings, they may tentatively illustrate the possibilities of language use and social practices (Talija, 1999).

In this research, which has used a Foucauldian approach, I have suggested that participants have positioned themselves both within and against the discourses. This calls into question the agency that is attributed to the subject; the FDA and discursive psychological approach make different assumptions about the person in terms of the agency afforded to them. Whereas FDA suggests that the subject is positioned by the discourse (see the methodology chapter for a more in depth discussion), discursive psychology asks how people use language to manage social interactions in order to achieve interpersonal objectives, thus conceptualising the user as an active agent (Willig, 2013). In my analysis, there have been times when the agency my approach ascribed to the subject meant that I moved towards a more discursive psychological perspective, such as when I argue that at times participants seemed to actively pit themselves against the position of vicariously traumatised therapist. I suggest that integrating the two divergent strands of discourse analysis, as recommended by Wetherell (1998), may be useful for future research to consider how participants navigate the available discourses, and allow more consideration of the role of agency in taking or resisting specific positions. This could facilitate exploration of the way in which the participant may be attempting to construct their responses based on the way they have understood the research goals, and factors that may have influenced their decision to take part in the research.

A premise of qualitative research is to position the researcher as a biased subject, resisting the 'neutral' position found in traditional, positivist research (Burr, 1995). Furthermore, I have used the outcomes of the analysis to argue that it would be useful for psychologists and therapeutic practitioners to acknowledge the way that a discourse may be positioning them as 'objective', and seek to question and unpack these inherent assumptions. As the FDA approach positions the researcher 'above' the data, able to draw macro-level inferences from the data (Hollway, 1984), I suggest that this methodology positions the researcher in a way that is comparable to the way the therapist is positioned in the 'pathologising' discourses. Although I have tried to treat the discourse as co-constructed by both participant and me, I suggest that integrating discursive psychology into further research may be useful in taking a more critical stance towards this positioning, and also allow an in-depth consideration of the dynamics between the participant and researcher.

Psychology is often criticised for insufficiently acknowledging the body through the focus on cognitive processes discursively located in the mind (Cromby, 2011). It is interesting, therefore, that one of the key discourses used to construct trauma that is identified in this research is that of embodiment, and that the role of the body and emotion have been discussed. Furthermore, discursive approaches to research are criticised for ignoring embodiment (Wetherell, 2012), and some research into affect draws a distinction between discourse and affect (Massumi, 1996). However, as Wetherell (2012) argues, surely even that which is constructed as 'not' words is still constructed using them, and when Bianca says that "*a really huge part of working with trauma is not spoken, is in the felt sense",* she constructs this 'unspokenness' using speech. Participants use discourse to construct trauma as an embodied phenomenon, and the body as both something that can become 'out of control' and the site of symptoms through the experience of trauma, and as a tool for growth and therapeutic connection. I am not making phenomenological claims about the experiences participants describe. I am, however, suggesting that the FDA approach of this

research has allowed the analytic lens to consider how trauma is constructed in the body and as a felt sense using available discourses, which I would like to suggest is a strength of this research.

More recently, discursive researchers and theorists have argued that discursive methodologies can be used to consider how embodiment and emotional experiences are constructed. Wetherell, McCreanor, McConville and Le Grice (2015) proposed that a psychodiscursive approach can be used to explore how subjects are positioned in discourse through their affect (such as self-righteousness, indignation), either through being the speaker and positioning oneself by identifying as 'having' an affect, or positioning another by attributing an affect to them. Indeed, it can be argued that separating discursive approaches and the consideration of affect and embodiment performs the same Cartesian dualism: the assumption that the felt senses in the body and the cognitive constructions of discourse are distinct (Wetherell, 2012). It is therefore a limitation of this study that the scope of how language constructs affect is restrained by the employed methodology.

A limitation of this study could be considered to be the variation of practitioners used. Of the five participants, three were psychologists and two were psychotherapists, and my reasons for this decision are discussed in the methodology chapter (C.3). Given their varied backgrounds it may be reasonable to assume that they may have been exposed to and utilised different discourses through their training and career development. Perhaps it would have given more insight into the discourses available to psychologists if the sample had been homogenously psychologists. However, I suggest that the training among doctoral psychology courses also varies, and of course the backgrounds, subsequent careers and a plethora of other 'life' factors would surely mean that assuming psychologists' training experiences are unvarying would be naïve.

The majority of discourses drawn upon are psychological and psychotherapeutic. I consider how the participants might have been discursively orientated towards using these discourses by the social context of the interviews in the methodological reflexivity section (C.3.7). I consider this to be a limitation of the research. A further limitation is the number of participants, as a larger number may have meant that a more diverse range of discourses could have been accessed. However, I cannot help but wonder how likely it would be for participants to not primarily use psychological and psychotherapeutic discourses. I include a section that reviews the lay constructions of trauma (C.2.3.6) in which I suggest that psychological discourses, or at least 'pop' psychological discourses are accessible to individuals who would not be identified as psychological/therapeutic practitioners. Perhaps the range of discourses presented here can be used as an indication of how psychological and psychotherapeutic discourses are the dominant discourses used to construct trauma outside of the field as well as in it. If so, this goes back to the points addressed under the discussion of the psychiatric discourse, of how the way that practitioners use the dominant discourse of psychiatry can lead to those in other positions taking on the language and potentially reducing their experiences to match the constructions available in that discourse (Georgaca, 2012).

C.5.5 Further research

As discussed above, this research suggests that the discourse of embodiment is a significant discourse drawn on by practitioners working with trauma. Perhaps a useful avenue of further research would be to apply a discursive analytic procedure, such as that suggested by Wetherell et al. (2015), to the way practitioners construct their work with trauma, which allows further reflection on how affect and embodied states position the subjects located within the discourses. This would allow a richer appreciation of these aspects than the current methodology allowed. In addition, the integration of discursive and phenomenological methods, as used by Willig (2011), may allow, as she argues, a rich and in-depth consideration of the experience facilitated through being located in particular

discourses. It could be useful to apply this methodology to data collected from 'clients' identified as traumatised, as this could provide us with further information to inform practice seeking to deconstruct pathologising discourses.

I argue that one of the issues this research has highlighted is how little literature exists that is critical of 'VT', which I identify as the dominant discourse used to construct working with trauma. Of the literature I reviewed, only one study seemed critical of the 'phenomenon' of 'VT': a piece of quantitative research conducted by Kadambi and Truscott (2004), who concluded that there was "little evidence to support vicarious trauma as an occupational hazard unique to therapists working with trauma survivors" (p.260). Furthermore, I argue that the research seeking to identify the 'positive' effects of working with trauma, which includes those exploring 'PTG' in therapists, all construct the experience as damaging or tiring, with the common action orientation of arguing that *alongside* 'VT' the therapist may experience growth.

My argument is not to dispute the validity of the 'phenomenon' of 'VT'. Rather, I wish to be critical of the 'common sense' assumption that results in therapists working with trauma being automatically located within VT discourse. I suggest that further research that deconstructs the positioning of the trauma therapist would be useful in allowing the subject a more empowered subjectivity. In addition, I suggest that resisting the discourse of VT may allow the subject a subversive strength through positioning themselves as able to enjoy and cope with the work despite the warnings, and further research exploring this may highlight positions from which strength can be felt.

I criticise psychology for its individualistic approach. Although the methodology of this research could indicate that it is located within the wider discourses of social psychology (Burr, 2015), the focus of this research enforces this individualistic approach, as I interviewed practitioners who spoke about their individual work with trauma. An avenue for

further research could be to consider discourses obtained from different sources, including the client but also moving away from the client-therapist dyad and considering community psychology settings.

C.5.6   Reflexivity

This research explores how practitioners construct their experience of working with trauma, with the view that this will be useful in informing practice and further research into working with clients identified as traumatised. However, as the research progressed I found that this very premise has been challenged. Through the process of analysis and reflecting on my findings, I realised that I had been employing dominant psychological and psychotherapeutic discourses to locate the subject in the fixed position of 'traumatised'. Although I had always positioned myself as critical of 'pathologising' discourses, especially psychiatric discourse, the process of this research has offered me a different perspective of my position at the beginning of the research, and I suggest that one of the key benefits for me as a practitioner has allowed me to reflect on how deeply the dominant discourse of psychiatry has influenced the way that I construct trauma, and for that matter, 'mental health' in general.

I suggest that as Counselling Psychologists, we often position ourselves as critical of psychiatry. As someone who has actively taken up that position, I was somewhat appalled to consider how the discourses that I use to position clients, both with them and removed from them, are positioning the client and myself and constructing the work in the very way that I manifestly profess myself to be critical of. I feel that the process of engaging with my participants' discourse has enabled me to become more aware and insightful in my practice. I believe that this is beneficial to me and my work, but that does not mean that this is easy. Ignorance is bliss, as they say, and an enhanced perception of how the discourses I use - and do not feel able to not use- can pathologise my clients frustrates me and at times makes me feel helpless due to my inability to navigate these issues.

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When working in time limited services, sometimes with prescribed methods of working, it can be difficult to acknowledge how the client and I are being positioned in the discourse we are using. Reflecting on my practice and the services I have been in during the course of this research has lead me to acknowledge that one of the reasons that 'symptoms' are used is because they offer a fast and easy way of talking about the client's experience. The very reason that the use of them is problematic, in the way they reduce the subject's experience to a unit of psychiatric currency, is the very reason they are useful. In the same way, deconstructing 'recovery' as the return to normativity is potentially multifaceted, time consuming and challenging. My ongoing struggle with how to cope with these complexities in practice and in theory are, I hope, part of the process of 'being' a reflexive, reflective practitioner.

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Appendices

Appendix I   Pilot study interview questions

- Can you begin by telling me a little about your current work in trauma?

- What led you to this work?

- Would you be able to tell me a bit about how you feel your work affects you? (Prompts: physically; relating to others; different aspects of life; sense of identity).

- What do you think influenced you in seeing things this way?

- Research has looked at the way in which the worker is affected by working with trauma, some of which focuses on the challenges and come on the positive growth. These terms include vicarious trauma, vicarious resilience, secondary traumatic stress, burn out and posttraumatic grow. What is your reaction to these phrases in terms of your own experiences?

- One way I have summarised these ideas in my own thinking is "costs" and "gains". How do you feel about that? If you feel comfortable with these words, or would like to choose other ones, how do you feel the "costs" and "gains" interact with each other in shaping your overall experience?

- If you were to go back and speak to yourself when you were about to embark on our career, what advice would you give relating to working with traumatic material?

Appendix II   Research flyer

Department of Psychology

City University London

Dear

My name is Danielle D'Mello and I am a Counselling Psychology doctoral student at City University. I am looking for participants for a piece of qualitative research into the way in which working with trauma affects therapists. I believe your experience and perspective will be really valuable for my research and would like to invite you to take part in my research and attend one semi structured interview which will last about 90 minutes.

This study has been reviewed by, and received ethics clearance through the Psychology Department Research Ethics Committee, City University London. Ethics approval number [insert approval number]. Please see the attached information sheet for more details of the study.

If you know any other therapists with experience of working with trauma who may be interested in taking part in this study, I would very much like to hear from them. You can contact me by email at Danielle.dmello.1@city.c.uk or on 07507799548. I look forward to hearing from you.

Yours Sincerely,

Danielle D'Mello

Appendix III   Information sheet

Title of study: How Psychologists Construct Their Experience of Working with Trauma?

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?

This research is being conducted as part of a 3-year Counselling Psychology Doctorate at City University. I hope to gather data using semi structured interviews which will last approximately 90 minutes, then there will be an optional debrief (I have allocated a further 30 minutes in my own timetable but you are by no means obliged to have it). The interview will be transcribed and analyzed using discourse analysis, which I hope will provide insight into how you and other psychologists construct your work with trauma and how it impacts you.

Why have I been invited?

You have been invited as I believe your professional experience and personal take on it may be very useful to my research. I have chosen to interview Practitioner Psychologists who work directly with clients in trauma services, and who have done so for a minimum of 6months. I want this work to be useful to the field of psychologists in terms of understanding what may be helpful in coping with the emotionally taxing nature of the work and developing our resilience. This is not to devalue the work of other professionals (psychotherapists, social workers etc) but

research indicates that the organizational setting, supervision etc impact on the way we experience our work and the way we talk about it, thus I felt they should not be included in this piece of work.

I am seeking to interview about 5 Practitioner Psychologists. I am using a snowballing technique to approach people who I believe have relevant work experience, by means of networking through colleagues.

Do I have to take part?

The participation in this study is voluntary. Should you decide to participate, you may withdraw at any stage and choose not to answer any questions you like without being asked to give reasons for this. You will not be penalized or disadvantaged in any way if you choose to withdraw or decline from giving information.

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen if I take part?

- We will agree on a mutually convenient time and place to meet. I am expecting that it may suit you best if I come to your place of work, but if you don't feel comfortable with this, we can use a room at City University.
- The meeting will last approximately 90 minutes
- The interview will be audio recorded and afterwards the researcher will transcribe,   anonymize and then analyze the interview's content using

discourse analysis and a social constructionist approach.

Expenses and Payments (if applicable)

- If you choose to come to City University, travel expenses will be reimbursed up to £20 in cash on the day

What do I have to do?

In taking part in the study the researcher is asking that you feel able to discuss your experiences of working with trauma and how you feel this has affected you in an open and honest way.

What are the possible disadvantages and risks of taking part?

In being asked to talk about your work with trauma, some of the content be reflecting emotionally difficult times and issues related to your personal identity (race, gender etc). As stated previously, please remember that you are more than welcome to decline to provide information at any stage of this process.

What are the possible benefits of taking part?

Taking part in this research will hopefully provide you with a new space to reflect on your experiences of working with trauma, possibly considering deeper meanings and understanding into your personal growth and resilience.

There may also be indirect benefits, as I hope this study will be useful to the field of psychologists and possibly anyone who works closely with trauma, in terms of understanding how we construct our experiences and how this affects the worker.

What will happen when the research study stops?

Data not included in the final piece of research will be deleted. Should the study be abandoned before completion, the data will be deleted.

Will my taking part in the study be kept confidential?

- Only the key researcher will have access to the data before it is anonymized.

- During the interview, you are invited to discuss your work as you wish but ask that you refrain from using clients' names or identifying information including the name of clinical setting.

- Audio recordings will be stored without personally identifying material and will be encrypted for protection.

- Your personal details and information will not be used for anything other than this study and will not be passed elsewhere.

- Data will not be archived or shared.

- Your confidentiality will be maintained at all times, the only exception to this may be if I believe you or someone else is at risk or where I am obliged to report violence, abuse, self- inflicted harm, harm to others, criminal activity.

- The records will be stored securely when the study is complete, they will be deleted/destroyed.

What will happen to the results of the research study?

This study will be submitted as part of a doctorate in Counselling Psychology at City University. Any future publications will maintain confidentiality.

What will happen if I don't want to carry on with the study?

You are free to withdraw from the study at any time without explanation or penalty.

What if there is a problem?

If you would like to complain about any aspect of the study, City University London has established a complaints procedure via the Secretary to the University's Senate Research Ethics Committee. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is "How Psychologists Construct Their Experience of Working With Trauma"

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: ███████████████████

Who has reviewed the study?

This study has been approved by City University London Psychology Department Research Ethics Committee

Further information and contact details

Any queries can be answered by the researcher, Danielle D'Mello at

███████████████████

You can also speak to the research supervisor, Julianna Challenor

███████████████████

Thank you for taking the time to read this information sheet.

Appendix IV   Ethics Form

Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, together with their research proposal clearly stating aims and methodology, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) <u>Guidelines for minimum standards of ethical approval in psychological research</u> (BPS: Leicester) should be referred to when planning your research.
- Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc   M.Phil   M.Sc   <u>D.Psych</u>   n/a

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

How Psychologists Construct Their Experiences of Working with Trauma

2. Name of student researcher (please include contact address and telephone number)

Danielle D'Mello. 43d Hornsey Rise Gardens, N19 3PS.

3. Name of research supervisor

Julianna Challenor

4. Is a research proposal appended to this ethics release form?

Yes   No

5. Does the research involve the use of human subjects/participants?

Yes   No

If yes,

5

a. Approximately how many are planned to be involved?

b. How will you recruit them?

I plan to use snowballing to find participants. I will ask permission to contact them

and then send them an invitation with an information sheet attached.

c. What are your recruitment criteria?

(Please append your recruitment material/advertisement/flyer)

That the participant be a practitioner psychologist who are working in trauma

services (trauma being defined as "an experience that is emotionally painful,

distressful, or shocking, which often results in lasting mental

and physical effects") for at least 6 months.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent?

Yes   No

d1. If yes, will signed parental/carer consent be obtained?   Yes

No

d2. If yes, has a CRB check been obtained?   Yes   No
(Please append a copy of your CRB check)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? (If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).

Each participant will be asked to take part in a single, one to one, semi structured

interview which will last about 90 minutes.

7. Is there any risk of physical or psychological harm to the participants

Yes   No

If yes,

a. Please detail the possible harm?

No risk of physical harm. There is a slight to moderate risk of psychological harm as the participants will be asked to talk about how they feel impacted by their work with trauma. The BACP stipulates sensitive topics as including the experience of violence. It is unlikely the participants would talk about first hand experiences but may discuss their exposure to violent material and what this was like for them. I will be asking the participant to reflect on their sense of identity, which may include gender, sexuality, ethnic status and other sensitive topics. As practitioner psychologists, the participants should be engaging in supervision to gain support with the psychological impact of their work, maintain fitness to practice and have robust enough self care for the type of questions in this interview, thus helping to safe guard them from psychological harm.

b. How can this be justified?

I hope the interview will provide participants with an opportunity for deeper reflection into how their work impacts them, how their strength and resilience has developed through their practice and what facilitated this. I hope that by working respectfully and being transparent with my goals, the participants will appreciate that their contribution is valued and contributing to what I hope will be positive development in psychology and perhaps wider work with emotionally taxing material.

c. What precautions are you taking to address the risks posed?

On balance I consider this to be a low risk study: the participants are likely to be highly functioning with adequate self care and psychological support as they are practitioner

to report this to my supervisor. In this case the transcript of the interview may not be

used in the research, depending on supervisor advice. In this case I would inform the

participant of this.

8. Will all subjects /participants and /or their parents /carers receive an

12. What provision will there be for the safe-keeping of these records?

The recordings will be stored on an encrypted memory stick. They will be

transcribed and anonymised prior to analysis. Computer files will be password

protected and the anonymised paper files will be stored in secure files.

13. What will happen to the records at the end of the project?

They will be deleted from the computer files completely and all paper notes will

be confidentially shredded. *They will be stored securer*

removed r deleted once identifying information has

r confidentially shredded (in the case of pape

permanently (in the case of e

14. How will you protect the anonymity of the participants?

Names and identifying information will be removed from the transcripts when they

occur. Participants will be asked to speak about their experiences and whilst they

may speak of specific pieces of work, I will ask they do not mention names or other

personal details which may identify clients, colleagues or work places.

15. What provision for post research de-brief or psychological support w be available should subjects/participants require?

As the participants will be practitioner psychologists, I feel a debrief at the end is

unnecessary, however I will allow extra time in my own timetable should the

participant wish to speak to me. I hope that as this will minimize the time asked of

from participants, individuals will feel more able to participate

(Please append any de-brief information sheets or resource lists detailing possible support options)

If you have circled an item in <u>**underlined bold**</u> print or wish to provide additional details of the research please provide further explanation here:

1. Is there any risk of physical or psychological harm to yourself?   Yes
No
If yes,

a. Please detail possible harm?

> I plan to travel to my participant's place of work to interview them. There should
> be health and safety measures in place in these services so the chance of risk is
> small. It is possible that listening to the accounts of psychologists being affected
> or impacted by their work will be emotive or thought provoking for me, but I feel it
> is very unlikely I will at risk of psychological harm.

Sig

S

b. How can this be justified?

CH
oth

> On balance I consider this work will allow me to access deeper meaning in my
> understanding of working with trauma as a psychologist and have positive

Res
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> ramifications for my own self care, professional growth, supervision and personal
> development.

Co
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c. What precautions are to be taken to address the risks posed?

Se

> When visiting the location of my participants I shall make sure I am aware of
> health and safety regulations and the relevant safety procedures of the service.
> I will make sure I am generally looking after myself around the time of research:
> enough sleep, rest and recreational activities. Should I feel I may be at risk of
> psychological harm, I can seek support through personal therapy or liaison with
> my supervisor.

Appendix V   Consent form

CITY UNIVERSITY
LONDON

Title of Study: *How Psychologists Construct Their Experiences of Working with Trauma*
Ethics approval number: *[Insert approval number here]*

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 · being interviewed by the researcher · allowing the interview to be audiotaped	
2.	This information will be held and processed for the purposes of a doctoral level piece of research. 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 Researcher   Signature   Date

_____   _____   _____
Name of Participant   Signature   Date

When completed, 1 copy for participant; 1 copy for researcher file.

Appendix VI   Interview questions

- Firstly, can you begin by telling me a little about your
  current work in trauma?

- What led you to this work?

- Would you be able to tell me a bit about how you feel your work has changed you?

  (Prompts: physically; relating to others; different aspects of life; sense of identity).

- Research has looked at the way in which the worker is affected by working with
  trauma, some of which focuses on the challenges and come on the positive growth.
  These terms include vicarious trauma, vicarious resilience, secondary traumatic
  stress, burn out and posttraumatic grow. What is your reaction to these phrases in
  terms of your own experiences?

- One way I have summarised these ideas in my own thinking is "costs" and
  "gains". How do you feel about that? If you feel comfortable with these words, or
  would like to choose other ones, how do you feel the "costs" and "gains" interact
  with each other in shaping your overall experience?

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Appendix   Submission guidelines for publishable piece

Retrieved from: https://uk.sagepub.com/en-gb/eur/journal/health#submission-guidelines

Health: is a broad ranging interdisciplinary journal related to health and the social sciences.

Focusing on the changing place of health matters in modern society, the journal continues to

provide an international forum for original articles and review essays from around the world. It

offers the breadth of outlook required by sociologists, psychologists, anthropologists, and cultural

theorists who are addressing problems that cross disciplinary boundaries.

[…]

Manuscript style

9.1 File types
Only electronic files conforming to the journal's guidelines will be accepted. Preferred formats for
the text and tables of your manuscript are Word DOC, RTF, XLS. LaTeX files are also accepted.
Please also refer to additional guideline on submitting artwork [and supplemental files] below.

9.2 Journal Style
Health: conforms to the SAGE house style. Click hereto review guidelines on SAGE UK House
Style

9.3 Reference Style
Health: adheres to the SAGE Harvard reference style.Click here to review the guidelines on
SAGE Harvard to ensure your manuscript conforms to this reference style.

If you use EndNote to manage references, download the SAGE Harvard output style by
following this linkand save to the appropriate folder (normally for Windows C:\Program
Files\EndNote\Styles and for Mac OS X Harddrive:Applications:EndNote:Styles). Once you've
done this, open EndNote and choose "Select Another Style..." from the dropdown menu in the
menu bar; locate and choose this new style from the following screen.

Manuscript Preparation
The text should be double-spaced throughout and with a minimum of 3cm for left and right hand
margins and 5cm at head and foot. Text should be standard 10 or 12 point.

9.4.1 Your Title, Keywords and Abstracts: Helping readers find your article online
The title, keywords and abstract are key to ensuring that readers find your article online through

online search engines such as Google. Please refer to the information and guidance on how best to title your article, write your abstract and select your keywords by visiting SAGE's Journal Author Gateway Guidelines on <u>How to Help Readers Find Your Article Online</u>.

9.4.2 Corresponding Author Contact details

Provide full contact details for the corresponding author including email, mailing address and telephone numbers. Academic affiliations are required for all co-authors. These details should be presented separately to the main text of the article to facilitate anonymous peer review.