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Exploring Experiences of using Trauma-Focused CBT and EMDR Therapy to Treat PTSD

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Dedication

For Jesse.

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Abbreviations

APA   American Psychiatric Association

BPS   British Psychological Society

CBT   Cognitive Behaviour Therapy

CF   Compassion Fatigue

CFT   Compassion Focused Therapy

CS   Compassion Satisfaction

DSM-5   Diagnostic and Statistical Manual of Mental Disorders, 5th edition

             (APA, 2013)

EMDR   Eye Movement Desensitization and Reprocessing

ICD-10   International Statistical Classification of Diseases, 10th revision

             5th edition (WHO, 2016)

IE   Imaginal Exposure

IPA   Interpretative Phenomenological Analysis

NET   Narrative Exposure Therapy

NHS   National Health Service

NICE   National Institute for Health and Care Excellence

PE   Prolonged Exposure

PTSD   Post-Traumatic Stress Disorder

RCT   Randomised Controlled Trial

REM   Rapid Eye Movement

STS   Secondary Traumatic Stress

STSD   Secondary Traumatic Stress Disorder

TF-CBT   Trauma-Focused Cognitive Behaviour Therapy

TSC	Traumatic Stress Clinic
UKPTS	United Kingdom Psychological Trauma Society
VPTG	Vicarious post-traumatic growth
VT	Vicarious Traumatisation
WHO	World Health Organisation

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THE FOLLOWING PARTS OF THIS THESIS HAVE BEEN REDACTED FOR DATA PROTECTION REASONS:

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Glossary of terms

Clinician

Unless otherwise specified in this study, the term 'clinician' will be used as a shorthand to refer to both clinical and counselling psychologists, whether trainee or fully qualified. A clinician will have taken a first degree in psychology, be a graduate member of the British Psychological Society, and either be HCPC registered, or on a clinical or counselling psychology post-graduate training programme that includes HCPC registration as part of the final qualification.

Therapist

The term 'therapist' will be used in the text as a generic term to encompass the many types of mental health treatment providers examined in reviewed studies. This term therefore potentially includes clinical and counselling psychologists, psychotherapists, counsellors, psychiatrists, psychiatric nurses, social workers, some occupational therapists, and other mental health professionals who may have trained in, and are qualified to practice, EMDR Therapy or TF-CBT.

Burnout

Burnout (Maslach, 1982) has been linked to compassion fatigue, which is also often used interchangeably with secondary traumatic stress disorder (Figley, 2002) and sometimes with vicarious traumatisation (McCann & Pearlman, 1990). There is often considerable overlap and resultant confusion in the literature, so it is worth clarifying the exact terminology of these constructs for the purposes of this study before critically examining the literature in this area.

Burnout can be defined as "a state of physical, emotional and mental exhaustion caused by long term involvement in emotionally demanding situations" (Pines & Aronson, 1988, p.9). The most widely used measure of burnout is the Maslach Burnout Inventory (Maslach & Jackson, 1981) which measures three key factors - emotional exhaustion, feelings of disconnection and loss of sense of accomplishment. Burnout is a relatively non-specific construct, however, which can occur in any profession as a result of factors such as job-related stress, workload and interpersonal conflict with colleagues (Maslach & Leiter, 1997). It is not specific to professionals working with trauma survivors and therefore the term will be referred to in this study only in its general occupational context (Maslach, 1982).

Vicarious Traumatisation

Vicarious traumatisation (VT) is a specific psychoanalytic and social cognitive developmental concept (see McCann & Pearlman, 1990). It refers to a therapist's cumulative reactions to working with trauma survivors which results in increasingly profound and negative shifts in the therapists' beliefs about "safety, power, independence, esteem, intimacy, and/or frame of reference" (Elwood, Mott, Lohr, & Galovski, 2011, p.26). The concept emphasizes cognitive changes as a defining characteristic, although it is assumed the therapist may also develop PTSD-like symptoms and behavioural changes over time as a result.

Secondary Traumatic Stress Disorder

Figley (2015) suggests secondary traumatic stress disorder (STSD) affects individuals who care for people diagnosed with what he would prefer to be termed primary (rather than post-) traumatic stress disorder, or PTSD. STSD refers to the development of PTSD-like symptoms and trauma-related interpersonal and cognitive changes in individuals close to a trauma survivor, such as family members, friends, caregivers and trauma workers, who have

not experienced the traumatic events themselves. Rather, the stressor involves second-hand exposure to distressing material as the trauma survivor describes their traumatic experience in detail (Figley, 2015). Thus, he suggests that symptom criteria of both PTSD and STSD are identical, except for Criterion A. which must distinguish between those individuals who have directly experienced traumatic events, and those who care for survivors and experience the events at one remove. The term 'secondary traumatic stress' (STS) is also referred to in the research and refers to a temporary and short-lived response rather than the more chronic and problematic development of the disorder, STSD.

Compassion Fatigue

The term compassion fatigue (CF) is often used interchangeably with STSD (e.g. Figley, 2002) and VT (McCann & Pearlman, 1990) and is also linked to burnout (Maslach, 1982). There are believed to be subtle differences in the use of each construct; however, there also appears to be considerable overlaps, and therefore confusion, in the literature.

CF has been defined as "the natural behaviours and emotions that arise from knowing about a traumatising event experienced by a significant other" (Figley, 2015, p.xiv). CF differs from burnout in several ways: it can occur with rapid rather than gradual onset and may have a potentially faster recovery rate. CF also involves a sense of isolation from a worker's support systems, and, unlike burnout, Figley (2015) believes CF is

"… identical to secondary traumatic stress disorder [STSD] and is the equivalent of PTSD" (p.xv).

However, he also suggests that, whereas STSD can be used with any profession, CF should be reserved to describe individuals in the helping professions, including clinicians, paramedics and social workers (Elwood et al., 2011). Figley (2015) argues the term CF is more readily accepted by therapists because it highlights the loss of empathic relating associated with

the "cost of caring" (p.9) for those in emotional pain; it is also this group which has been the main focus of research (Adams, Boscarino & Figley, 2006; Bride, 2007; Elwood et al., 2011).

As Figley (2015) proposes that CF and STSD are essentially identical concepts, particularly when referring to clinicians, they will be referred to interchangeably in this study. Crucially for this study, regarding research into traumatic stress, Figley (2015) points out

"…nearly all the attention has been directed to people in harm's way, and little to those who care for and worry about them… it is time to consider the least studied and least understood aspect of traumatic stress: secondary traumatic stress… It is important to know how these supporters become upset or traumatized as a result of their exposure to victims. By understanding this process, we not only can prevent additional, subsequent traumatic stress among supporters, but we can also increase the quality of care for victims by helping their supporters" (p.6-7).

Compassion Satisfaction

Compassion satisfaction (CS) refers to the pleasure derived from being able to do one's therapeutic work effectively (Stamm, 2002; 2010). Research into negative impacts of trauma work recently shifted to an increasing recognition of the more positive impacts such as CS. Recent research has shown that trauma therapists receiving specialised trauma training (Sprang, Clark, & Whitt-Woosley, 2007), and personal therapy and supervision (Linley & Joseph, 2007), reported significant increases in CS and decreases in CF and burnout.

Post-Traumatic Growth

Over the past decade or so it has been increasingly acknowledged that traumatic experiences do not necessarily have overwhelmingly negative impacts.   A systematic review by Linley & Joseph (2004) reported positive change is commonly found in 30-70% of survivors of a

wide range of traumatic experiences, including natural disasters, transportation accidents interpersonal assaults and other negative life events. Post-traumatic growth (PTG) can be characterised as positive cognitive, emotional, interpersonal and spiritual consequences that one may experience following a traumatic event (Tedeschi & Calhoun, 1995; 2004). Joseph (2011) recognised three domains of PTG: improved interpersonal relationships, positive changes in values and beliefs, and improved sense of self and self-worth. Similar positive gains have been observed following vicarious exposure to trauma in a wide range of relationships, both personal and professional (Brockhouse, Msetfi, Cohen, & Joseph, 2011). 'Vicarious PTG' (VPTG) refers to positive changes experienced by therapists engaged in trauma work with PTSD clients, and has been defined as "psychological growth following vicarious brushes with trauma" (Arnold, Calhoun, Tedeschi, & Cann, 2005, p.243).

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Preface

Overview of portfolio

This preface provides an overview of the three parts of this portfolio, comprising an original piece of qualitative research, a publishable paper for a peer-reviewed academic journal and a clinical case study. These three elements together represent examples of my research and clinical practice undertaken during the professional doctoral programme in counselling psychology. All three pieces of work are linked through the theme of trauma and the experiences provided from a variety of perspectives of working with the two currently NICE-recommended (2015) psychological treatments for post-traumatic stress disorder (PTSD): trauma-focused cognitive behavioural therapy (TF-CBT) (Ehlers & Clark, 2000) and eye movement desensitisation and reprocessing therapy (EMDR Therapy; Shapiro, 2001).

Part A: Research

Part A comprises a qualitative research study that explores clinicians' experiences of delivering TF-CBT and EMDR Therapy with clients diagnosed with PTSD. As a counselling psychologist wishing to specialise in trauma, and having trained in these two treatment approaches, I was interested to have the opportunity to carry out a piece of original research in this area. My motivation, which has driven this theme from its inception, has been a growing awareness of the stigma surrounding acknowledgment of the impact of trauma work on practitioners, trainee or experienced alike. The focus entirely on patient outcomes when evaluating treatment guidelines for PTSD has omitted until now any recognition of the potentially differential impacts of treatment approaches on the therapists who deliver them. Research on the impact of trauma work on therapists has tended by and large to use large scale quantitative

surveys aimed at investigating organisational, personal and client factors hypothesised as

potentially being associated with negative impacts such as vicarious traumatisation (VT),

secondary traumatic stress (STS) and burnout (Figley, 2015), or the more positive outcomes

which are increasingly being recognised, such as vicarious post- traumatic growth (VPTG)

(Bartoskova, 2015; Manning-Jones, de Terte & Stephens (2015). This study used a qualitative

approach instead, in order to privilege the lived experiences of clinicians engaged in this work. I

chose Interpretative Phenomenological Analysis (IPA) owing to its phenomenological and

hermeneutic foundations, which recognise the embodied and inter-subjective relationship that

clinicians have with their work and their clients, as well as my reciprocal relations as a research

explorer engaging with them (Smith, Flowers & Larkin, 2009).

This study used semi-structured interviews to explore the experiences of four

counselling and five clinical psychologists, asking them the question: 'How do you experience

delivering TF-CBT and EMDR Therapy?' Transcripts of the interviews were analysed using

IPA, from which three interconnected themes emerged. The first theme concerned clinicians'

experiences of all trauma work, notwithstanding choice of modality, as providing both immense

rewards, including the intense therapeutic connections they described enjoying with their clients,

as well as awareness of cumulative costs; clinicians also described coping strategies they

experienced as helpful to them in continuing their work. The second theme explored issues

regarding the containing and constraining aspects clinicians experienced of delivering TF-CBT.

The third theme acknowledged participants' experiences of the profound physical connection

engendered by the EMDR process between themselves and their clients, and their

understanding that, if they could manage anxiety and find confidence to "trust the process",

working with EMDR seemed to offer them an enormous sense of reward in terms of what they

described as more rapid and complete client transformation and healing. The implications of

these subjective experiences for the well-being of both clinicians, and potentially their clients,

are discussed, in particular with a view to responding to counselling psychologist Iqbal's (2015) concerns regarding the lack of training in awareness of the specific risk factors and symptoms of STS. Consequently, Iqbal (2015) cautioned that trauma therapists, including counselling psychologists, may inadvertently be putting themselves and their clients at risk, despite BPS and HCPC codes of conduct, performance and ethics (BPS, 2009; HCPC, 2012) which outline our full commitment to preventing client harm.

Part B: Journal Article

Part B is a publishable paper prepared for submission to the *Counselling Psychology Quarterly* journal, which focuses on one of the three themes which emerged from the research conducted in Part A., entitled "Trust the process". This theme focuses largely on counselling and clinical psychologist participants' experiences of delivering EMDR Therapy. In particular, this exploration highlights the positive experiences inherent in the process of EMDR, which seem to become more apparent once clinicians described overcoming their anxieties and ambivalence in order to adopt this different mode of treatment. This paper is intended as a challenge, therefore, to the current "*dominant discourse*" as one of my participants described it, which still seems to privilege CBT modes of treatment, despite the randomised controlled trials, reviews and meta-analyses which show that EMDR Therapy is at least as effective and more efficacious than TF-CBT in terms of patient outcomes (Power, et al., 2002; Shapiro, 2014; van Etten & Taylor, 1998). Although the more physically demanding nature of EMDR Therapy is recognised, including the risk of repetitive strain injury, I feel that the intense therapeutic connections, 'free association' nature of the work, and the rewarding outcomes available to clinicians, and their clients, deserve recognition as potential factors which may help reduce likelihood of STS and burnout, and increase the possibility of developing therapist resilience and VPTG. It is hoped, therefore, that these preliminary findings may be disseminated to a wider

audience through publication, not only to encourage further research investigation of this area, but also to provide information to trauma practitioners – current and potential - regarding the risks and rewards they may experience in different forms of trauma work so they are able to make more informed choices.

Part C: Case Study

Part C. is a case study based on a clinical piece of work I carried out during the final year of my counselling psychology training. It describes the therapeutic process of working with a veteran, given here the pseudonym 'Jack' to protect his identity, who was referred to my placement clinic with a diagnosis of PTSD following childhood sexual abuse, and subsequent traumatic events experienced as an adult, during active combat whilst in military Service and subsequently, in civilian life. This case study highlights my attempts to integrate different therapeutic models, principally compassion-focused therapy (CFT) (Gilbert, 2013), cognitive analytic therapy (CAT) (Ryle & Kerr, 2002), TF-CBT and EMDR Therapy, into a coherent and effective treatment plan, structured using Herman's (1992) 3-phase trauma treatment model as recommended by the recent UKPTS guideline for treating complex trauma (McFetridge et al., 2017). Despite my scepticism regarding the current hegemony of TF-CBT in trauma treatment, I chose to use a CBT cognitive restructuring technique, the 'Responsibility Pie' (Greenberger & Padesky, 1995), in order to reduce Jack's overwhelming sense of shame and guilt regarding his sexual abuse and perceived failures to protect vulnerable others from harm. I understand that, when following the EMDR Therapy protocol, cognitive interweaves are considered sufficient to address these complex long-held schemas (Shapiro, 2001). However, holding the tension between the lack of an evidence-base for or against the use of a 'Responsibility Pie' as preparation for EMDR Therapy, and some practice-based evidence to support it, with the encouragement of my supervisor I decided it would be appropriate to integrate this technique as

preparatory work before commencing EMDR processing with Jack. The remainder of the study details the therapeutic journey and evaluates the limitations of my clinical practice and how I engaged with supervision and reflection to work on these issues. In evaluating my client's outcome from this therapy, my sense is that the cognitive restructuring not only achieved its intended purpose by reducing shame and guilt and facilitating subsequent EMDR processing, but also it accomplished the additional benefit of deepening our collaborative and therapeutic alliance. As a scientist-practitioner in training I would be interested in future to test my hypothesis that cognitive restructuring through the use of a 'Responsibility Pie' in complex trauma cases involving overwhelming guilt and shame may reduce the likelihood of therapy sabotage and drop out, and facilitate subsequent EMDR processing. It is hoped this case study demonstrates a balanced attempt at evaluating how elements from both evidence-based trauma treatment approaches might be combined, always in pursuit of the client's best interests, in order to provide a theoretically coherent, integrated and effective treatment package.

The theme of treating trauma with the two NICE-recommended (2015) psychological approaches wends its way through this thesis, hopefully to provide the reader with an open and balanced view of certain aspects of what, from my own and my participants' diverse experiences, may be beneficial elements of both recommended treatment modalities, and what may be some of the drawbacks, for clinicians, and perhaps inadvertently for clients too. In opening up the discourse around trauma treatment to include more detailed exploration of both positive and negative aspects of the work I hope to play a small part in reducing the stigma which still seems to surround discussion of trauma therapist well-being, and providing more informed choice for those contemplating entering the field.

Personal reflections

Since enrolling on the doctorate in counselling psychology at City, University of London, my journey has been always challenging, at times stressful, occasionally traumatic in the very broadest sense of the word - but ultimately has resulted in personal and professional growth and development of a magnitude I had absolutely not anticipated at the start. Part of this journey has involved wrestling with what it means to be a counselling psychologist and how my professional and personal identities have merged and shifted in response to that steep learning curve. This research portfolio forms a significant part of that process. Through my own journey of development as a clinician with a particular interest in working with trauma, I came to see that in privileging the therapeutic relationship with our clients, we also owed a duty of care towards ourselves, if our use of 'self' is to be truly instrumental in healing. When carrying out the interviews for this research I have been equal parts humbled, inspired and concerned by the overwhelming focus of attention these dedicated clinician interviewees all placed on the well-being of their clients, and the difficulty many of us seem to have in allowing ourselves to care for ourselves. 'Caring for the carers' seemed almost a taboo subject and yet nurturing personal and professional well-being has been a vital part of my learning curve, and I now recognise it is essential in order for us to enjoy a long, hopefully effective, and ultimately rewarding career in this profession.

My choice of case study for inclusion in this portfolio also reflects in part my wish to acknowledge personal experiences, limitations and difficulties I have had of working with, sometimes almost unbearable, accounts of traumatic experiences; this case is an account of childhood sexual abuse, combat-related trauma and torture, that happened to an individual I have come to respect for his honesty, admire for his courage, and care about deeply through working with him therapeutically. I found this case study an interesting, hopefully integrated, mix of TF-CBT and EMDR work, united under the umbrella of Herman's (1992) 3-phase

structure and CFT (Gilbert, 2013). CFT has proved so helpful to me, and hopefully to my

client(s), in understanding, exploring, and overcoming the dark cloud of trauma to reveal the

reward: the silver lining of post-traumatic growth. I hope we, as trauma therapists, can also

mindfully employ compassion to extend to ourselves the care we also offer – and try to model,

however imperfectly - for our clients.

My final aim in carrying out this research is to disseminate any findings of relevance to

counselling psychologists, and to other trauma practitioners, through publication as a journal

article and presentation of the data at conferences. Raising awareness of our ethical duty, and

compassionate wish, to 'care for the carers' and protect them (ourselves) from the personal and

professional costs associated with compassion fatigue, forms part of expanding and developing

our professional best practice as counselling psychologists. This research, inevitably, has

limitations, but I hope in illuminating the impact of choice of trauma treatment on the therapists

who deliver it, this explorative study may pave the way for more extensive research, ultimately,

to further the aim of all counselling psychologists: to help each other to help others, to the best

of our abilities.

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Part A: Research

Caring for the Carers: Exploring Clinicians' Experiences

of using Trauma-Focused CBT and EMDR Therapy

to Treat PTSD

Words: 44,789

Abstract

WHO (2013), NICE (2015) and UKPTS (McFetridge et al., 2017) guidelines equally recommend trauma-focused cognitive behavioural therapy (TF-CBT) and eye movement desensitization and reprocessing therapy (EMDR Therapy) as the psychological therapies of choice for post-traumatic stress disorder (PTSD) in terms of patient outcomes. However, although trauma treatments such as these are generally acknowledged to present a risk of compassion fatigue and burnout for the therapists who carry them out, (Figley, 1995) no research to date has distinguished between TF-CBT and EMDR Therapy in terms of their impact on the clinicians who deliver them.

This study employed a qualitative design to explore clinicians' own experiences of administering EMDR Therapy and TF-CBT, both during treatment sessions and cumulatively over time, when treating clients referred with PTSD. Nine counselling and clinical psychologists working in an NHS Traumatic Stress Clinic setting, qualified in both treatment approaches, and with experience of working with at least one client in each modality, were each invited to participate in a semi-structured audio-recorded interview. Transcripts were analysed using Interpretative Phenomenological Analysis.

The first of three main themes to emerge arose from the experience common to all participants that *"It's not about the modalities, really"*. Rather, trauma work in general was experienced as having both negative and positive impacts for clinicians; these formed four sub-themes, '*Compensatory rewards', 'Connection with clients', 'Cumulative costs'* and '*Coping strategies'*. However, a more complex and nuanced account emerged as two further themes. Many participants identified their original training in TF-CBT as *"My comfort zone";* sub-themes differentiated this as either *'Containing'* of both their own and their clients' anxieties, enabling clinicians to feel competent, confident and in control, or *'Constraining'*, where clinicians felt

frustrated by the "clunky" and more confrontational aspects of this modality. The final theme acknowledged that learning to *"Trust the process"* of EMDR Therapy, in particular sub-themes regarding *'Intense physical communication'* required *'Confidence to "trust the process"'*, but this in turn gave rise to the experience that *'EMDR Therapy Clears traumas TF-CBT cannot shift'*.

The implications of these findings are discussed with particular relevance for how counselling psychologists can contribute towards best practice in trauma treatment which both 'cares for the carers' and offers clients a potentially more rapid and complete recovery.

Chapter One. Introduction

Recent trauma treatment guidelines published by key players in the UK mental health arena – principally, the World Health Organization (WHO, 2013), National Institute of Clinical Excellence (NICE, 2015), and the UK Psychological Trauma Society (UKPTS) (McFetridge et al., 2017) – all recommend equally trauma-focused cognitive behavioural therapy (TF-CBT) and eye movement desensitization and reprocessing therapy (EMDR Therapy) as the psychological therapies of choice for children, adolescents and adults diagnosed with post-traumatic stress disorder (PTSD). These recommendations have been based on evidence from research studies - see, for example, the meta-analysis by van Etten & Taylor (1998) and the more recent review by Shapiro (2014) - which have concluded that EMDR Therapy is at least as effective as TF-CBT on most measures for patients; these studies also show EMDR Therapy appears to be more efficient, and both are more effective than other treatment modalities.

Research has centred overwhelmingly on the impact of trauma-focused therapies on patient outcomes. However, the past two decades have seen a growing awareness of the negative impact of delivering trauma treatment on the mental healthcare professionals who provide it (see, for example, Figley, 1995; 2012; 2015), whether during treatment sessions, or cumulatively over the longer term. Trauma treatments are now generally acknowledged to present particular risks to well-being for the therapists who deliver them (Herman, 1997), and by definition, "all trauma therapists are at risk" (Pearlman & Saakvitne, 2015, p.158).

Negative impacts have been variously conceptualised in the research as 'burnout' (Maslach & Jackson, 1982), 'vicarious traumatisation' (VT) (McCann & Pearlman, 1990), 'compassion fatigue' (CF) (Figley, 2015), the short-term response 'secondary traumatic stress' (STS), and the more chronic condition 'secondary traumatic stress disorder' (STSD) (Figley 2015). However, there is a lack of conceptual clarity in the literature about these constructs

(Baird & Kracen, 2006; Elwood, Mott, Lohr, & Galovski, 2011). Terms are often used interchangeably as they are considered to overlap and to "share a common negative bond" (Canfield, 2005; p.98); research has indeed found STS, VT and burnout to be highly convergent constructs, and STS and VT to have limited construct validity (Devilly, Wright & Varker, 2009; Sabin-Farrell & Turpin, 2003). More detailed definitions of each construct, and the subtle differences proposed to exist between them, can be found in the Glossary of Terms (page 13). However, as the focus of this study is on all potential and cumulative impacts (negative or positive) experienced by trauma therapists as a result of their work, I have chosen to include studies investigating any or all of these constructs in my review. As Figley avers, "compassion fatigue is a more user friendly term" (1995, p.20) for STSD, which is the most inclusive construct to describe chronic secondary traumatisation, so I have selected CF to refer to cumulative negative impacts affecting individuals in the helping professions, unless there is good reason to discuss a specific construct by name.

More recently there has also been an acknowledgement that trauma work has positive as well as negative effects on therapists and some limited research has taken place on positive outcomes (Bartoskova, 2015; Manning-Jones, De Terte & Stephens, 2015). Positive impacts are termed 'compassion satisfaction' (CS) by Stamm (2002) and 'post-traumatic growth' (PTG) by Tedeschi & Calhoun (1995; 2004), and more detailed definitions are also provided in the Glossary of Terms (page 13).

Research thus far into the impact of trauma work on clinicians suffers from several limitations; one notable lack is that there has been no investigation to date, to my knowledge, of the effects of delivering the two different recommended trauma treatment approaches, TF-CBT and EMDR Therapy. From my own experiences as a trainee counselling psychologist on placement at two NHS Traumatic Stress Clinics, and from the anecdotal reports of colleagues, both trainee and experienced alike, it appears there may be significant differences in impact on

the clinician - both negative and positive – as a result of delivering these two approaches. If this is so, there may be a range of implications (all other factors being equal) for preferred choice of modality, with consequences for the long-term welfare of both trauma clients themselves and the counselling psychologists (or other trauma practitioners) who work with them.

In this chapter I would, firstly, therefore argue for the relevance of filling this gap in the research, both for counselling psychology in particular, and for trauma therapists in general. I will then describe the two modalities – TF-CBT and EMDR Therapy – currently recommended to treat PTSD, in order to examine why the differences in approach may result in differential impacts for clinicians. Finally I will critically review the existing research on what is currently known regarding the impact of trauma work (whether generic, or specifically TF-CBT or EMDR Therapy) on therapists, with a view to suggesting how this study may begin to address limitations in our knowledge.

1.1 Relevance for counselling psychology

The fundamental origins and nature of counselling psychology are set out in the first paragraph of Woolfe, Strawbridge, Douglas, & Dryden's (2010) counselling psychology handbook as "… a particular approach to helping people, which proposed an alternative that challenged prevailing approaches" (p.1). Bridging the therapeutic practice of counselling and the science of psychology, with a distinctive identity founded both in the experience of being a 'scientist-practitioner' and a 'reflective practitioner', these active tensions lie at the heart of what it is to be a counselling psychologist. As a trainee counselling psychologist, I have particularly relished the opportunity to work and learn at the cutting edge of trauma, where recent advances in neuroscience research (for example, van der Kolk, 2014) and a growing evidence base for new treatment modalities such as EMDR Therapy (Shapiro, 2001) and sensorimotor psychotherapy (Ogden & Fisher, 2015) are offering a radical transformation in mental

healthcare. I believe we may, as a result, be facing a potential paradigm shift (Kuhn, 1970) in the 21st century as to how we work in a trauma-informed way with the significant and growing mental health challenges in our society (Cozolino, 2010; van der Kolk, 2014).

Historically, counselling psychology has been grounded in and inspired by North American humanistic thinkers, such as Maslow and Rogers, to value our understanding of the subjective worlds of both 'self' and 'other' as central to the discipline. I would argue that although as psychologists we have, rightly, devoted the focus of our clinical and research attentions to the well-being and outcomes of those 'others' that we treat, sometimes this has been at the expense of our own self and well-being. Woolfe et al. (2010) stress

> "… the self of the helper is acknowledged as an active ingredient in the therapeutic process. … [Like] our clients we are people, with issues and difficulties in our lives, and understanding how this impacts upon relationships with clients demands a willingness to explore our own histories, attitudes and emotional defences" (p.11).

In common with our clinical psychologist peers, the NHS is our biggest employer and we as clinicians are familiar with the ever-increasing pressure on resources and lengthening waiting lists. As departmental funding is cut, and teams are re-organised, it is vital that we attend to our own well-being both individually and systemically. As Herman (1997) memorably stated,

> "It cannot be reiterated too often: *no one can face trauma alone*. If a therapist finds herself [*sic*] isolated in her professional practice, she should discontinue working with traumatized patients until she has secured an adequate support system. … The role of a professional support system is not simply to focus on the tasks of treatment but also to … insist that [the therapist] take as good care of herself as she does of others" (p.153; italics Herman's own).

In view of this, the dearth of literature or research enquiry until relatively recently by our profession into the well-being of those clinicians skilled in trauma-focused therapies, who daily risk indirect or secondary traumatisation whilst treating others, is quite surprising. As Figley comments, with respect to his theory of secondary traumatisation: "the most effective therapists are most vulnerable" (2015, p.1). He goes on to assert:

> "At the heart of the theory are the concepts of *empathy* and *exposure*. If we are not empathic or exposed to the traumatised, there should be little concern for compassion fatigue" (Figley, 2015, p.15; italics added).

At the heart of our clinical training as counselling psychologists lie person-centred concepts of empathy, unconditional positive regard and congruence (Rogers, 1951). These are viewed as necessary conditions and paramount for establishing a therapeutic alliance, which is considered the most healing factor in all psychotherapeutic work (Lambert, 1992), and fundamental to working at relational depth with clients (Mearns & Cooper, 2005). The reparative nature of an empathic therapeutic relationship has been noted to be particularly important in working effectively with those who are traumatised and distrustful, having suffered abuse at the hands of others (Cloitre, Stovall-McClough, Miranda, & Chemtob, 2004; Meichenbaum, 2013; Parnell, 2013).   However, as Figley (2015) cautions, in empathising with the accounts of the traumatised, we risk becoming traumatised ourselves.

There has also historically been an emphasis in trauma-focused treatments on exposure as a key therapeutic component, whereby both the client – and, inevitably, the therapist – repeatedly engage in detailed (and often harrowingly gruesome) accounts of the precipitating traumatic events (see, for example, Cloitre, 2009). All symptoms of traumatic stress have repeatedly been shown to correlate in their severity with cumulative exposure to traumatic events (Kolassa & Elbert 2007; Kolassa, Illek, Wilker, Karabatsiakis, & Elbert, 2015).   Similarly,

parallels drawn between the concepts of STSD, CF, and VT tend to link cumulative exposure to accounts of traumatic events with the risk of "profound changes in the core aspect of the therapist's self" (Pearlman & Saakvitne, 2015, p.152). Counselling psychologist Amirah Iqbal makes the important point that

"This implies a shift or change in the therapist's perception of experiencing the self, others, and the world. If this affects the therapist's relationships with others and their inner world this may have implications on the therapist's ethical and professional practice" (2015, p.45).

Iqbal (2015) goes on to review the significant ethical considerations concerning the impact trauma work can have on counselling psychologists, which in turn can be harmful to clients. Both the BPS and HCPC codes of conduct, performance and ethics (BPS, 2009; HCPC, 2012) outline our full commitment to preventing client harm, which psychologist members pledge to uphold; the Division of Counselling Psychology professional practice guidelines also outline supplementary best practice recommendations (DCoP, 2009). However, Iqbal (2015) points out that lack of training in awareness of the specific risk factors and symptoms of STSD may mean trauma clinicians are inadvertently putting themselves and their clients at risk. Potential risk factors listed by Iqbal (2015) include the nature of the work, frequency of supervision, organisational structure, and the background, training (including education regarding awareness and normalisation of STSD symptoms) and access to personal therapy available to the therapist. The report concludes that there is a lack of research exploring these factors and there are currently no guidelines available to counselling psychologists, or other trauma practitioners, to inform best practice in trauma treatment.

If our fundamental approach, both professionally and ethically, as counselling psychologists is to help other people to the best of our abilities, and if our identity as scientist-

practitioners includes challenging prevailing approaches, perhaps it behoves us to examine how best we might 'care for the carers', by exploring our own experiences of delivering the recommended trauma treatment protocols and looking rigorously at the personal and professional costs that currently lie unexamined when supposedly evidence-based treatment decisions are made (Corrie, 2010). Given that, for counselling psychologists, the therapeutic relationship and use of self as a reflective practitioner form vital components of the fundamental ethos of our profession (Douglas, Woolfe, Strawbridge, Kasket, & Galbraith, 2016; Fouad, 2012), selecting a therapeutic modality which will protect and resource the clinician as well as the client may go a long way towards preventing the personal and professional costs of compassion fatigue and reduce the risk of further harm to the already traumatised who seek our help.

1.2 Trauma diagnosis and treatment

Valent (2015) emphasises that, in order to understand the reactions of therapists who treat traumatised individuals, it is necessary to understand their clients' responses first, because it is their responses that evoke the secondary responses in therapists. In this section I will therefore briefly outline the historical definition of PTSD and recent recognition of C-PTSD as valid diagnostic categories, before summarising the latest published guideline from the UKPTS (McFetridge et al., 2017) which provides recommendations for treatment. This guideline incorporates earlier NICE (2015) and WHO (2013) recommendations for TF-CBT and EMDR Therapy as the most effective treatment modalities for phase 2 of the 3-phase integrated treatment approach originally pioneered by Herman (1992). I will then describe the development of the clinical protocols for TF-CBT and EMDR Therapy, acknowledging the key theories which underpin these different modalities, before comparing the implications of the differences for their potential impact on the clinicians who deliver them.

1.2.1 PTSD diagnosis and recommended treatment guidelines

The word 'trauma' originates in the Greek word meaning 'wound', initially referring to physical injury. A traumatic experience can be defined as "the experience of extreme stress – physical or psychological – that overwhelms an individual's normal capacities to process and cope" (Brach, 2015, p.31).

Simple trauma refers to a one-off experience of a traumatic event, whereas complex trauma occurs in the context of early, prolonged and/or inescapable trauma experiences (Cozolino, 2010; Herman, 1997; van der Kolk, 2014). Experiencing or witnessing one or more traumatic events may result in harmful changes which, if chronic, result in traumatization, involving intrusive and avoidant experiences, physiological arousal, and alterations in mood and cognitions. These symptoms were eventually recognised as a psychiatric diagnosis termed 'post-traumatic stress disorder' (Friedman, 2016; van der Kolk, Weisaeth, & van der Hart, 1996) and included first in DSM-III (APA, 1980), representing a milestone in the field of traumatic stress studies. DSM-III crucially defined the essential feature of PTSD, Criterion A., as the direct experience of a psychologically distressing event that is outside the range of usual human experience, giving rise to intense fear, terror, and/or helplessness. Three symptom clusters were also identified – intrusions, hyperarousal and avoidance; a diagnosis required persistence of symptoms for more than one month and resultant functional impairment or significant symptom-related distress. The DSM-III diagnostic criteria for PTSD were minimally revised in DSM-III-R (APA, 1987), DSM-IV (APA, 1994), and DSM-IV-TR (APA, 2000), and a very similar syndrome was classified in ICD-10 (WHO, 1992). The most recent evidence-based revision to DSM-5 (APA, 2013) added a fourth symptom cluster – negative alterations in cognitions and mood – resulting in PTSD no longer being conceptualised as a fear-based 'Anxiety Disorder'

(Friedman, Resick, Bryant, & Brewin, 2011), but reclassified as a new category, 'Trauma- and Stressor-Related Disorders' (Friedman, 2013).

However, it is increasingly recognised that a large proportion of clients - in particular repeat referrals to trauma services - may have experienced complex, chronic trauma, often including adverse childhood experiences (Cloitre, Garvert, Brewin, Bryant & Maercker, 2013; Felitti et al., 1998; Karatzias, Jowett, Begley, & Deas, 2016). A new diagnosis, 'Complex PTSD' (CPTSD), will therefore be included in the forthcoming revised edition of ICD-11 (WHO, 2018); it will include the original ICD-10 PTSD symptom clusters:

1. Re-experiencing

2. Avoidance

3. Hyperarousal (WHO, 2016)

plus:

4. Affect dysregulation

5. Negative self-concept

6. Relationship disturbances (Maercker et al., 2013a; Maercker et al., 2013b).

Establishing the conceptual framework of the PTSD diagnosis has had the effect of enabling a sudden growth in research studies focusing on finding effective treatments. However, although there are currently no NICE guidelines on, or Cochrane reviews of, the effectiveness of psychological treatment for CPTSD, the *'Guideline for the treatment and planning of services for CPTSD in adults'*, recently published by the UKPTS (McFetridge et al., 2017), provides a review of published evidence and accepted good clinical practice for those planning trauma services, to treat both PTSD and CPTSD effectively. The recommendations are that, within the context of a healing relationship with a therapist, trauma treatment may incorporate compassion-focused therapy (CFT) (Gilbert, 2013), and should address cognitive,

affective and sensorimotor domains within Herman's (1992, 1997) original 3-phase structured approach:

1. *Phase 1: Stabilisation* - establishing safety, symptom management and emotion regulation.

2. *Phase 2: Processing trauma memories* – using the NICE (2015) recommended treatments for PTSD: either TF-CBT (Ehlers & Clark, 2000) or EMDR Therapy (Shapiro, 2001).

3. *Phase 3: Re-integration* - the (re-)establishing of coping and life skills, alongside social and cultural connections.

Both TF-CBT and EMDR Therapy appear, on the surface at least, to have much in common (Schnyder et al., 2015) and both are equally recommended for use during Phase 2. However, on closer inspection, the theories underlying PTSD have resulted in very different clinical protocols for each approach which, because they affect how trauma treatment is actually delivered by clinicians, will be examined in more detail in the following sections.

1.2.2 Treatment protocol for TF-CBT

One of the earliest influential theories to attempt to conceptualise PTSD, 'emotional processing theory' (Foa & Kozak, 1986; Foa & Rothbaum, 1998), suggested that a fear-inducing traumatic experience is encoded in memory as a semantic network containing sensory information about

1. the stimulus (the sights, sounds, smells, and other sensations of - for example - a car crash)

2. the individual's cognitive, behavioural and physiological responses (thoughts, such as "I am going to die", muscles tensing, increased heart rate, etc.), and,

3. information concerning the meaning of the event (for example, "driving is life-threatening").

Foa & Kozak (1986) hypothesised that the fear network for trauma differed from a phobia because it can generalize to similar but previously neutral stimuli - for example, other cars, then buses, and then all transport. Repeated exposure to some, but not all, the generalised stimuli prevents habituation (Rachman, 1980). Recommended treatment therefore involves prolonged exposure (PE) or 'reliving', where the therapist helps the individual activate as much of the fear network as possible through detailed (sensory, physiological, behavioural and cognitive) re-exposure, then cognitively restructures the semantic elements with incompatible new information, such as "I survived".

Ehlers and Clark's (2000) 'cognitive model' and Brewin, Dalgleish & Joseph's (1996) 'dual representation theory' developed more specific and detailed explanations of how trauma memories are processed differently in a parallel (dual) process. Brewin et al. (1996) suggested that, under conditions of extreme threat, hippocampal processing is inhibited so the encoding of explicit, autobiographical, and 'verbally accessible memories' (VAMs) is disrupted.   In contrast, the amygdala is activated and encodes 'situationally accessible memories' (SAMs) which contain sensorimotor information about the stimulus and the individual's physiological and emotional state at the time; these are re-triggered when an individual is in a similar state (internal and/or external) to the original event. Ehlers & Clark's (2000) theory also suggested individuals with PTSD tend to incorporate an idiosyncratic mix of negative internal appraisals of the self – often, for example, as powerless, defective or to blame - and external appraisals of others as not to be trusted, and of the world as unsafe.

All three models contribute to the current TF-CBT treatment protocol (Clark & Ehlers, 2004; Kar, 2011). Imaginal exposure remains a core component, involving the client in detailed,

repeated, prolonged revisiting of trauma memories for approximately 30-45 minutes during each treatment session in order to diminish the fear response through extinction (Foa and Rothbaum, 1998). Across sessions, usually 12-30 in number, the focus is increasingly on each memory's most distressing aspects, or 'hot spots'. The therapist uses cognitive restructuring in session following the exposure work, by employing Socratic questions to shift the dysfunctional beliefs thought to be central in maintaining PTSD symptoms (Grey, Young & Holmes, 2002; Zoellner et al., 2011). Between, or sometimes during, sessions, clients are also encouraged to approach a graded hierarchy of objectively safe but feared trauma reminders in the environment (*'in vivo'*), whilst practicing Phase 1 stabilisation techniques such as grounding, breathing or meditation exercises to reduce distress levels.   Lee (2006) succinctly summarises the key prolonged exposure and cognitive restructuring components of the treatment protocol:

> "In simple, fear-based PTSD, the theories indicate that treatment should involve activation of the fear network in its entirety, via a reliving paradigm, whereby *as much detail as possible about the original event is retrieved* and, *at peak moments of distress*, where salient meaning can be identified (Grey et al., 2002), the therapist encourages the client to reframe the meaning using Socratic dialogue. … A good working understanding of fear-based PTSD and its theoretical underpinning provides the 'first principles' to build upon when dealing with increasingly complex presentations of PTSD." (p.149, italics added).

The features of the TF-CBT protocol emphasised in italics –"*as much detail as possible about the original event is retrieved"* and the requirement to experience the client's "*peak moments of distress*" – may have particular relevance regarding the potential for this treatment to impact the therapists negatively, because severity of traumatic stress symptoms is known to correlate with cumulative exposure to traumatic experiences, whether experienced at first or

second hand (Kolassa & Elbert 2007; Kolassa et al., 2015). This correlation is what initially

piqued my interest to explore the impact of these key factors on clinicians during treatment

delivery.

1.2.3 Treatment protocol for EMDR Therapy

EMDR Therapy, the alternative recommended treatment for PTSD, was originally

developed by Shapiro (1989, 2001) from a chance observation that the side to side eye

movements she made whilst walking in a park appeared to diminish her disturbing thoughts.

She subsequently formulated the 'adaptive information processing' (AIP) theory, which

conceptualises presenting PTSD symptoms as deriving from memories of traumatic

experiences that have been dysfunctionally stored along with the original emotions, beliefs and

physical sensations (Shapiro, 2001). During a traumatic event, high arousal and amygdaloidal

activation inhibits normal hippocampal memory processing, and this may continue long

afterwards – for example, clients try to avoid thinking about the event, or a nightmare wakens

them before Rapid Eye Movement (REM) sleep can complete processing. Amygdala activation

instead stores traumatic events in implicit, emotional and sensorimotor codes. The memory

feels raw and unprocessed, physically re-presenting as if 'frozen in time', and unable to

assimilate with other networks which may be encoded with more adaptive life experiences. In

other words, an episodic memory is not processed and integrated normally into the semantic

memory system. Instead the past remains present, and easily triggered by any internal and

external stimuli similar to the original event (with the associated emotions, sensorimotor and

cognitive information) thus maintaining a vicious cycle of traumatisation and preventing updating

and integration with more adaptive memory networks (Shapiro, 2001; Shapiro & Laliotis, 2015).

Although ostensibly similar to the earlier information processing models conceptualised

by Brewin et al. (1996) and Ehlers & Clark (2000), following further clinical and experimental

observations and research Shapiro (2001; Shapiro & Laliotis, 2015) went on to develop a treatment protocol based on very different assumptions about the nature of trauma memory processing. This EMDR protocol involves eight distinct stages:

1. *History taking* – Obtaining background information, assessing suitability for EMDR, and targeting potential trauma memories for processing. (This would correspond approximately to the assessment and formulation phase for TF-CBT).

2. *Preparation* – Providing psycho-education regarding symptoms and treatment of PTSD as well as teaching metaphors and techniques to foster stabilisation, self-soothing and a sense of control in the client. Clients learn to use the Subjective Units of Distress (SUD) scale to help them rate and then learn to lower their trauma-induced symptoms. (This stage correlates to Phase 1 of Herman's (1997) 3-phase trauma treatment approach and similar learning is offered in TF-CBT also).

3. *Assessment* – The next stages 3-6 are unique to EMDR Therapy. Stage 3 involves accessing a target memory identified for processing by eliciting the image and negative belief associated with it as well as the desired positive belief, and establishing current emotion and physical sensations as baseline measures.

4. *Desensitization* - Using bilateral stimulation (BLS) to process experiences towards an adaptive resolution. BLS can be instigated in the client as side to side eye movements following the clinician's hand movements, as auditory signals through headphones, tactile handheld vibrating 'buzzers', or the therapist tapping alternately on the client's hands or legs. Techniques, such as 'floatbacks' to take the client's

imagination further back in time, and 'cognitive interweaves' to introduce more adaptive cognitions, are used to release blocked or circular processing and facilitate progress. The client is taught they can raise their hand (the 'Stop' sign) as a control option to pause processing at any time.

5. *Installation* – Enhancing the validity of a positive belief and integrating it fully within the memory network.

6. *Body scan* – Completing processing of any residual disturbance associated with the target memory.

7. *Closure* – Briefing and use of Phase 1 grounding techniques to ensure client stability at the end of the session and between sessions. (Stages 3-7 constitute a typical EMDR processing session and correlate to Phase 2 of Herman's (1997) 3-phase model).

8. *Re-assessment* – Evaluation of treatment effects and their integration within the client's social system. (This corresponds to Phase 3 of Herman's (1997) structured approach, and would be similarly covered in TF-CBT also).

The core of the EMDR treatment protocol thus involves focusing simultaneously on internally generated spontaneous (i.e. 'free') associations arising from the traumatic images, thoughts, beliefs, emotions and bodily sensations, whilst also attending to short sequential sets of BLS. In sharp contrast to the exposure-based therapy insistence on a client focussing prolonged attention on the original traumatic incident, an EMDR Therapy client is encouraged to

"let whatever happens, happen". In this way, according to AIP theory, the information

processing system is facilitated to make the most appropriate connections necessary, with the

aim of achieving optimal psychological adaptation and resolution, and the generalisation of

treatment effects to other life contexts.

The most experimentally rigorous published research on EMDR Therapy (for example,

Gomez, 2012; Lee & Cuijpers, 2013, Marcus, Marquis, & Sakai, 2004; Rothbaum, 1997; Wilson,

Becker, & Tinker, 1995; 1997) showed that three to five hours of EMDR processing were

sufficient to produce PTSD remission rates of 77-90% and/or to reduce PTSD symptoms to

within one standard deviation of normal means on multiple measures (Maxfield & Hyer, 2002).

1.2.4 Comparison of TF-CBT and EMDR Therapy protocols

Comparisons of EMDR Therapy and TF-CBT are beset by difficulties. For example,

Shapiro (2001) points out that, although the protocol for EMDR Therapy has remained

essentially the same since 1990, the protocols for TF-CBT treatments have changed

substantially over the years, to the extent that no two studies by independent research teams

have used the same protocol. In addition, Marks, Lovell, Noshirvani, Livanou, & Thrasher

(1998) found some TF-CBT research outcomes have been achieved by using therapist-assisted

in vivo exposure (which is often impractical in normal clinical practice) and high levels of

homework compliance, which tends to be lower in clinical compared to research settings (Scott

& Stradling, 1997).

Despite these methodological drawbacks, studies comparing EMDR Therapy with TF-

CBT have shown fairly consistently that overall EMDR Therapy is more effective on some

measures and equivalent on others, but generally requires fewer treatment sessions (for

example, Ironson, Freund, Strauss, & Williams, 2002; Lee, Gavriel, Drummond, Richards, &

Greenwald, 2002; van der Kolk, et al., 2007). A meta-analysis by van Etten & Taylor (1998) of

all PTSD treatment modalities found TF-CBT and EMDR Therapy to be the most effective, and

moreover concluded that EMDR Therapy was "the more efficient" treatment (p.140). Of the ten

most recent randomised controlled trials (RCT) reviewed by Shapiro (2014), all but one showed

EMDR Therapy as equivalent or superior to exposure-based CBT and five showed more rapid

treatment effects. The Power, McGoldrick, Brown, et al. (2002) study included was the largest

comparison so far, with the longest follow up, and it showed EMDR Therapy was approximately

50% faster, achieving good outcomes in a mean of 4.2 sessions, compared to 6.4 sessions of

exposure-based cognitive restructuring therapy.

It is argued by some (e.g. Herbert et al., 2000) that EMDR Therapy and TF-CBT are

both exposure treatments. However, this has been contested, for example by Spector (2007),

who argues that the short bursts of exposure to traumatic material and the free association so

central to the EMDR procedure is very different from TF-CBT approaches, which require

prolonged, undistracted and uninterrupted stimulus exposure – an expected minimum of 25-100

minutes is typically recommended (Foa et al., 1999).

EMDR Therapy has similar goals to TF-CBT regarding provision of psycho-education,

learning emotion regulation and coping skills, and the restructuring of memory or meaning

making to afford more positive appraisals or beliefs about the traumatic event (Schnyder et al.,

2015). However, in summary, EMDR Therapy differs significantly from TF-CBT in that it does

not require

    a. extended exposure,

    b. detailed descriptions of the events,

    c. direct challenging of negative cognitions, or

    d. homework (WHO, 2013).

The comparatively long exposures typically used during TF-CBT result in habituation

and extinction, leaving the residual trauma memory intact and creating a new memory that

competes with it (Craske, Herman, & Vansteenwegen, 2006). In contrast, the short exposures

and free association inherent in EMDR processing appear to cause memory reconsolidation

(Solomon & Shapiro, 2008; Shapiro, 2014), a distinction that has important clinical implications

(Suzuki et al., 2004) including a range of beneficial treatment effects not found with extinction-

based therapies (for example, de Roos et al., 2010).

For clarity, the following Table 1 below summarises the key aspects of TF-CBT and

EMDR Therapy in terms of how their theoretical models, and neurobiological and psychological

foundations, underpin and relate to their therapeutic aims and treatment procedures.

	TF-CBT	EMDR Therapy
Theoretical Model	Emotional processing theory (Foa & Kozak, 1986) posits that a traumatic experience is encoded in memory as a semantic network including the original fear-inducing stimulus along with cognitive, affective, physiological and behavioural responses and the meaning (appraisal) of the event. Repeated exposure to some, but not all, generalised stimuli prevents habituation. Detailed, prolonged and repeated imaginal exposure during treatment diminishes the fear response through habituation and extinction. Brewin et al.'s (1996) dual representation theory and Ehlers and Clark's (2000) cognitive model further expanded the theoretical model underpinning the rationale for TF-CBT, as below:	The Adaptive Information Processing (AIP) Model posits that the EMDR procedure stimulates an innate neurophysiological process facilitating AIP, thus enabling resolution of trauma memories dysfunctionally stored in non-declarative (implicit) memory. Shapiro (2000) posits both a psychological & neurological basis for accelerated IP as a result of bilateral stimulation
Neurobiological Basis	Neurotransmitter & hormonal changes during traumatic experiences mean trauma memories are processed differently in a parallel (dual) process as 'situationally-accessible' memories (SAMs) rather than 'verbally-accessible' memories (VAMs) (Brewin et al. 1996). These can be re-triggered by external or internal cues/stimuli resulting in PTSD symptoms. Imaginal exercises focusing on the 'hot spots' (worst aspects of the trauma memory) and *in vivo* graded exposure	Neurotransmitter & hormonal changes during traumatic experiences mean information is dysfunctionally stored in non-declarative memory and can be triggered by external or internal cues/stimuli resulting in PTSD symptoms. Eye movements, or other bilateral stimulation (auditory, tactile, etc), may induce an altered brain state – perhaps similar to REM sleep (Stickgold, 2002) - that facilitates resynchronisation of cerebral hemispheres (Bergman, 1995) and enables AIP to occur (Van der

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	exercises alongside grounding, breathing or meditation techniques work to reduce the fear response through habituation and extinction and store the trauma memory as a VAM.	Kolk et al., 1997) so that the memories are reconsolidated in episodic, declarative, memory.
Psychological Basis	Ehlers & Clark (2000) also suggest negative appraisals of self, the world and the future maintain and exacerbate traumatic responses. Cognitive restructuring uses Socratic questions to shift dysfunctional cognitions.	Dual attention enables simultaneous focus on both external (present) cues and internal trauma memories and both intensifies and reduces arousal (Welch & Beere, 2002) whilst facilitating AIP.
Aims	1 To change problematic meanings (appraisals) of the trauma about self and world 2 To access and change the memory of the traumatic event 3 To facilitate learning to discriminate between the past trauma and the present, often by bringing both simultaneously to mind (Ehlers 2015).	1 To shift storage of trauma memory to declarative (explicit) memory to achieve therapeutic resolution 2 To desensitise stimuli triggering present distress 3 To incorporate adaptive attitudes, skills and behaviours for enhanced individual and relationship functioning (Shapiro, 2001, 2002)
Treatment Phases	1 Individualised *case formulation* 2 *Psych-education* and anxiety management 3 *Updating* trauma memories through exposure and cognitive restructuring: 3.1 *Accessing memories* of worst moments of trauma & their currently threatening meanings 3.2. Identifying information to update trauma memories through *cognitive restructuring* 3.3 *Linking new meanings* to the worst moments in the trauma memory 4 *Discrimination training*, targeting the triggers of re-experiencing. Expected minimum 25-100 uninterrupted minutes of exposure to traumatic material (Foa et al., 1999). Improvements consistent with 'reliving' and habituation / desensitisation (Lee et al., 2006). 5 Therapist encourages client to *drop unhelpful behaviours* and cognitive processes. 6 '*Reclaiming your life'* assignments (Ehlers & Clarke, 2000; Harvey, Bryant & Tarrier, 2003).	1 *Client history & tx planning* 2 *Preparation* - Psych-education & coping skills to ensure safety, stabilisation, and engender sense of self-mastery. 3 *Assessment* – identification of target memories to process 4 *Desensitisaton* - Dosed short imaginal exposures to traumatic material paired with sequential sets of bilateral stimulation (e.g. eye movements). Free association is central to procedure and movement away from traumatic target during processing does not imply avoidance. The IP system is viewed as innately adaptive: changes in affective, cognitive and somatic responses occur and new insights emerge spontaneously, as memory is reconsolidated as a source of resilience, with minimal therapist intrusion. Improvements consistent with 'distancing' (dual focus attention) not 'reliving' effects (Lee et al. 2006). 5 *Installation* - of positive cognitions. 6 *Body scan* – focuses on clearing any remaining somatic trauma responses 7 *Closure* – safe ending to session 8 *Re-evaluation* (Shapiro, 1999).

Table 1. Theoretical models and neurobiological and psychological foundations

underpinning TF-CBT and EMDR Therapy aims and treatment protocols.

Another consideration, reported by both Marks et al. (1998) and Richards, Lovell, & Marks (1994), which has particular relevance for this current research study, is that research therapists frequently describe high levels of personal distress during administration of exposure-based therapies.   In contrast, during an EMDR Therapy session, a client may only attend to the target memory for a short period of time during processing, and the therapy does not require a client to relay detailed descriptions of the traumatic event to the therapist in order to proceed to a successful resolution. This may clearly have implications for therapist exposure to trauma and the correlated risk of compassion fatigue (Kolassa & Elbert 2007; Kolassa et al., 2015). Shapiro (2001) recommended, in view of concerns regarding both client and therapist distress during exposure-based therapy sessions, that special attention should be given to "clinician and client preference (e.g., tolerance and comfort) for the type of therapy being used" (p.359). However, to date, no studies have researched this factor.

Crucially, the latest DSM and ICD revisions have included clarification and extension of Criterion A, so that exposure to a traumatic stressor now consists of either *direct* personal experience of an event that involved actual or threatened death or serious injury, or, *witnessing* such an event that threatened another person, or, *learning about* an event as experienced by a family member or other close associate (APA, 2013; WHO, 2016). However, as Figley (2015) points out, nearly all the research on traumatised individuals, has excluded

"…those who were traumatized indirectly or secondarily and focus[es] on those who were directly traumatized (i.e., the direct victims). But, descriptions of what constitutes a traumatic event (i.e. Category A in DSM-III…) clearly suggest that simply the knowledge that a loved one has been exposed to a traumatic event can be traumatizing. … Perhaps even more important, the burnout and countertransference literature suggests that therapists are vulnerable to experiencing stress as a result of

their jobs, yet few studies can identify the active ingredients that are most connected to this job/profession-related stress. It appears that secondary traumatic stress – or, as we prefer, compassion fatigue – is the syndrome that puts most therapists at risk." (p.xiv).

Given that TF-CBT and EMDR Therapy are treated to all intents as equivalent by the UKPTS (2017), NICE (2015) and WHO (2013) practice guidelines in terms of patient outcomes, the implications of this dearth of information on burnout, VT, STSD or CF in therapists who are delivering one or both of these treatment approaches (and who therefore may be indirectly experiencing significant levels of exposure to horrific and traumatising descriptions of events), will be further examined in the following review which will critically evaluate existing research in this area.

1.3 Critical review of research on impact of trauma exposure on therapists

Over the past twenty years there has been a proliferation of research investigating the potential negative impact on therapists of working with trauma clients (Baird & Kracen, 2006; Canfield, 2005; Elwood, et al., 2011). More recently there have also been systematic attempts to study positive changes that clinicians may experience as a result of trauma work (Bartoskova, 2015; Manning-Jones, et al., 2015). However, past research into impact - positive or negative - of vicarious exposure to trauma has limitations, both methodological and with relevance to counselling psychology, and these studies will be critically reviewed now.

Contradictory findings, in particular, present a confusing picture; Baird & Kracen (2006) attempted to carry out a meta-analysis to clarify key factors influencing the impact of trauma work on therapists. They also reported that, perhaps due to the relative youth of this field of enquiry, most studies were methodologically weak (many included were unpublished doctoral theses not subject to peer review) and this, they concluded, restricted the validity of their

analysis to a 'research synthesis'. Whilst I suspect the methodological limitations reported may

have contributed to the lack of clarity in the field, I nevertheless followed their search strategy,

using the initial steps recommended by Cooper & Hedges (1994). I searched for research

studies using PsychLit, PsychINFO, Medline and University of London databases by inputting

various combinations of keywords including *therapist, clinician, mental health professional,*

impact, trauma*, post-trauma*, secondary trauma*, compassion fatigue, vicarious trauma*,

PTSD, STSD, STS, CF, VT, burnout, PTG, EMDR, EMDR Therapy, TF-CBT and exposure

therapy. However, because of the previously stated overall methodological limitations of

research in this area, I chose to include only studies which had been peer reviewed. There is

one exception: Lipke (1995) is included, even though it is now dated and was only published as

an appendix in Shapiro's first (1995) book on EMDR. This is because it is one of the few

studies to compare EMDR Therapy with TF-CBT approaches and thus provides early useful

exploratory data. Several studies grouped findings as relating to organisational, therapist or

client factors (although inevitably there is some overlap) when discussing their results, so I will

follow this convention here too, where appropriate.

Before reviewing quantitative then qualitative studies, there are, firstly, several overall

criticisms which can be applied to the majority of studies investigating the impact of trauma

work, whether negative or positive, on clinicians. Most studies fail to discriminate homogenous

samples, often including trainees, counsellors, psychotherapists, psychiatrists and even social

workers, law enforcement officials and nurses, along with clinical and counselling psychologists,

in the same sample (e.g. Cunningham, 2003; Follette, Polusny & Milbeck, 1994; Nelson-Gardell

& Harris, 2003; van Minnen, Hendriks & Olff, 2010). Several studies define sample participants

as 'trauma therapists' very loosely as, for example, individuals who work in trauma more than

50% of their time (Garcia et al., 2015), or for an average of 45% of their time, with a range of 10-

80% (Arnold, Calhoun, Tedeschi & Cann, 2005), or with an average caseload consisting of just

27% PTSD clients (Craig & Sprang, 2010), or do not specify length of trauma work experience at all (Devilly et al., 2009). This results in a wide range of exposure to trauma. Devilly et al. (2009) are unusual amongst quantitative studies in employing a control group (of non-trauma therapists), whilst Birck (2002) ingeniously compared trauma clinicians to interpreter controls; both studies reported higher CF in trauma therapists than controls. With the exception of a few studies including EMDR Therapy in their investigation (Dunne & Farrell, 2011; Lipke, 1995; van Minnen, et al., 2010), most did not specify or compare type of trauma treatment under study. Although some form of exposure-based cognitive therapy was usually designated, protocols may vary considerably as a result (Shapiro, 2001; Elwood et al., 2011). Other criticisms include that often papers did not distinguish conceptually between burnout, VT, STS and CF (Baird & Kracen, 2006) and measurement of these constructs in clinicians were frequently at low or sub-clinical levels, unlikely to raise cause for concern (Elwood et al., 2011). Canfield (2005) noted that "[m]ost prior research is based on quantitative methods, using self-assessment scale designs…" (p.90). These are typically postal or web-based surveys, which lead to criticisms regarding sampling errors, the known limitations of self-report measures, use of correlational rather than causal designs, and limits as to what can be discovered by closed-item questioning (Canfield, 2005). Craig & Sprang (2010) noted that no research study has directly compared the impact on trauma therapists of using an evidence-based practice versus a different, non- or less- evidence-based practice, and I have similarly found no such research to the present date.

1.3.1 Quantitative research

As Canfield (2005) observed, the majority of studies investigating impact of trauma work on therapists has been quantitative in design. The early study design by Lipke (1995) is fairly representative, although unusual in including EMDR for comparison with cognitive exposure-based trauma treatments. Lipke sent a postal survey comprising 26 structured (multiple-

response) and unstructured (open) questions to the first 1,295 EMDR Therapy clinicians trained

by Shapiro. He received 443 responses, a response rate of 34%, consistent with research

survey norms, and reported the following:

"… of the 90 or so respondents who compared EMDR to exposure procedures,

57% rated EMDR more effective, 59% rated it as less stressful to clients, and 47% as

less stressful to the therapist. The comparable results for exposure were 19%, 11% and

21%. In comparing the "general negative side effects" of EMDR with other methods… of

326 respondents, 46% reported these less often with EMDR and 8% reported negative

effects more often with EMDR. In a magnitude of results seldom seen in behavioural

sciences, 86% of 357 respondents reported "emergence of repressed material" was

more common with EMDR than other treatments, and 3% reported it was less common

with EMDR" (Lipke, 2012, p.82).

Although these results are, as Lipke himself comments, of a magnitude seldom seen, no

replication or further investigation occurred until Dunne & Farrell's (2011) response, which

attempted to address key limitations they identified in Lipke's study: the possibility of sampling

bias (as only enthusiastic EMDR Therapy trainees may have responded) and the fact that no

statistical tests were carried out. Additionally, as mentioned earlier, Lipke's results were not

subjected to peer review but published as an appendix in Shapiro's (1995) first EMDR book.

Dunne & Farrell's (2011) paper published results from Dunne's (2010) doctoral thesis,

and was a mixed methodology study designed to further explore clinicians' experiences of

integrating EMDR Therapy into their existing clinical practice. Firstly, 74 qualified international

EMDR Therapy practitioners were recruited at two EMDR conferences to complete an un-

validated 14-item questionnaire on demographic and practice-related issues, focused on

comparing original theoretic orientation with difficulties experienced integrating EMDR Therapy.

Significantly more CBT therapists found integrating EMDR Therapy into their practice easy compared to any other therapeutic orientation; Integrative practitioners found integration easier than Humanistic/Experiential, and Analytic therapists reported the most difficulties of all. The final open-ended question elicited details of difficulties experienced; responses included 'time constraints', 'anxiety/confidence', 'workplace issues', 'changes in practice/ theory' and 'client characteristics'. Nine further respondents from the first EMDR conference then participated in semi-structured telephone interviews, comprising similar questionnaire items plus further open-ended questions exploring integration difficulties in more depth. Integration was a major hurdle for at least 40% of participants in both studies, although much less so for practitioners with a CBT orientation. Content analysis revealed therapists' difficulties included

"the EMDR protocol itself, original theoretical orientation … personal style and workplace issues of non-acceptance of EMDR and bullying, patient characteristics and the therapist's anxiety and confidence." (Dunne & Farrell, 2011, p.185).

Setting aside reservations concerning use of un-validated questionnaires, self-selected respondents - which may introduce sampling bias - and the theoretical and philosophical issues and methodological problems which can be raised when mixing quantitative and qualitative research designs (Cresswell & Plano Clark, 2011), this pragmatic study elicits an interesting and rich dataset from a relatively small sample of international trauma practitioners' reports of difficulties experienced integrating EMDR as a treatment modality, and this merits further exploration.

A study by van Minnen et al. (2010) showed that 255 trauma professionals surveyed at a Dutch psycho-trauma conference reported significantly greater preference for and use of EMDR Therapy over imaginal exposure (IE), pharmacotherapy or supportive counselling, for both simple and complex PTSD clients, even controlling for superior training in IE. Participants

reported they found exposure-based approaches less credible and more stressful for the clinician, fearing clients' symptom exacerbation and increased risk of dropout.

In recent years, however, the focus of exploration has shifted to examining potential positive impacts from trauma treatment, leading to post-traumatic growth (PTG) for both clinicians and clients alike. There have been three recent quantitative (and two qualitative) studies exploring VPTG in clinicians (Bartoskova, 2015). Linley, Joseph, & Loumidis (2005) found preliminary evidence of VPTG in their small survey of 85 trauma therapists, but no predicted correlation with Antonovsky's (1979) construct, 'sense of coherence' (SOC), which includes three components, comprehensibility, manageability and meaningfulness, of which the last is considered most salient for positive health outcomes in therapists. This finding may be a limitation of the study's sample, but it also casts doubt on the usefulness of the construct as a predictor for VPTG.

Linley & Joseph (2007) explored organisational and therapist factors implicated in VPTG and found supervision provision, having a history of personal trauma, and female gender were positively correlated to positive psychological change, although sampling bias may limit this last finding because an unrepresentative 78% or 122 of the 156 therapist participants were female. Of particular relevance to this present study, however, they also found that CBT therapists were more likely to experience burnout and less likely to experience VPTG than humanist or transpersonal therapists.

Both Linley & Joseph (2007) and Brockhouse, Msetfi, Cohen & Joseph (2011) further examined the SOC construct but found contradictory results: Linley & Joseph (2007) found high SOC scores predicted greater VPTG and low scores predicted negative impacts of trauma work, whereas Brockhouse et al. (2011) found high scores negatively correlated with VPTG; this divergence is hard to explain and casts further doubt on the validity or usefulness of this construct. Both studies, however, also reported that more empathic therapists experiencing

vicarious exposure during trauma work were likely to experience greater VPTG, which is interesting considering the concerns voiced by those researching CF that empathy may render therapists particularly vulnerable to negative impacts of trauma work (e.g. Figley, 2015). This should encourage a re-examination of the complexity of these phenomena, which quantitative studies may not be best equipped to explore (Rasmussen, 2005).

Most quantitative papers have continued to focus instead on using large scale web-based surveys to investigate the more tangential impacts of therapist, client and organisational factors which may mediate between secondary exposure and therapist distress when delivering generic exposure-based trauma treatments. These studies, which have often delivered similarly equivocal results (for example, see review by Baird & Kracen, 2006), will therefore be outlined and critiqued in brief here.

There is confusion in terms of therapist factors: the finding that having a personal history of trauma is predictive of developing STS or VT is supported by studies including Buchanan, Anderson, Uhlemann, & Horwitz (2006), Nelson-Gardell & Harris (2003), Schauben & Frazier (1995) and Pearlman & McIan (1995), but equally is *not* supported by other studies, such as Follette et al. (1994). Further survey-based research into therapist factors has found younger therapists more likely to burn out, whilst more experienced therapists report higher levels of CS (Craig & Sprang, 2010; Cunningham, 2003), although Cunningham's sample consisted of 182 social workers and Craig & Sprang's sample, n=542, comprised a mix of 44% clinical psychologists and 46% social workers. More consistent findings seem to be that secure attachment patterns, availability of social support, and good coping strategies are protective factors for therapists (for example, Chrestman, 1999).

Research into the impact of client factors on trauma therapists shows equivocal findings too. For example, the survey by Adams, Boscarino & Figley (2006) of 236 social workers in New York found exposure to more highly traumatised clients was positively correlated with CF,

and Cunningham (1999) reported more therapist distress from working with sexual abuse compared to cancer patients. Garcia et al. (2016) found treating veterans with personality disorders or suspected malingering predicted burnout in trauma therapists, whereas exposure to their trauma content did not, although the survey focused on a restricted veteran client group, relied upon single-item un-validated questions and may have suffered from sampling bias, all of which limit generalisability. Way et al. (2004), in contrast, reported clinicians (n=95) treating sexual abuse survivors for a shorter period of time experienced more intrusive symptoms of distress.

Surveys have reported consistently that organisational factors such as clinical supervision and co-worker support (Rich, 1997), control over workload (Killian, 2008) and training for both new and experienced clinicians (Chrestman, 1999; Sprang, Clark, & Whitt-Woosley, 2007) seem to buffer the development of CF. However, whilst there is some support for a positive correlation between amount of trauma work (including caseload, hours with trauma clients and cumulative exposure) and likelihood of developing STS and VT (e.g. Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995), other studies (e.g. Brady, Guy, Poelestra, & Brokaw, 1999; Nelson-Gardell & Harris, 2003; van Minnen & Keijsers, 2000) do not support this link at all. This includes the survey by Devilly et al. (2009), which provided a reasonable sized sample (n=152) with a control group of non-trauma therapists, targeted measures and more sophisticated regression analyses.

It may be speculated that these contradictory findings regarding the key therapist, client and organisational factors mediating between delivery of trauma treatment and therapist well-being may be due to one or more of the methodological and conceptual limitations already outlined. The sampling errors are particularly striking, and also mean there is very little research that is directly relevant to counselling psychology. In addition, it may be that quantitative paradigms, particularly those involving Likert-scale questionnaire surveys, are

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simply not the most effective choice to investigate the complex and nuanced interactions between therapist experiences of the positive and negative impacts of trauma treatment. In support of this, a systematic review by Sabin-Farrell & Turpin (2003, p. 467) concluded that the quantitative evidence is "meagre and inconsistent", and methodological design issues compromise the validity of quantitative claims, whereas in contrast they found qualitative studies provided considerable support for the existence of negative impacts resulting from trauma work.

1.3.2 Qualitative research

There has been, however, very little qualitative research so far investigating either positive or negative impacts of trauma work (Bartoskova, 2015; Manning-Jones et al., 2015; Sabin-Farrell & Turpin, 2003), but the following five studies examined below have provided valuable insights into these phenomena.

Steed & Downing (1998) were one of the first studies to respond to this gap in the research. They carried out an exploratory thematic analysis on data from semi-structured interviews investigating 12 female therapists' experiences of working with traumatic material. Themes emerged concerning both negative and positive coping strategies, and impacts of the work relating to STSD symptoms, with a perceived need for further education and training. The study is limited in that all participants were female, four were counsellors and eight psychologists, and not all worked with sexual abuse on a full-time basis, leading to a wide range of different experiences and exposure to trauma. More serious limitations were that not all therapists were able to recall their beliefs and level of functioning before they began working in trauma, showing a need for longitudinal research to study cumulative effects. Furthermore, not all could distinguish negative impacts of trauma work from effects of unresolved personal issues. The authors conclude that this interaction, between personal history of abuse, response to client's traumatic material, and negative impacts experienced, requires further investigation.

However, not only did this study initiate a nuanced understanding of the complex interactions between positive and negative impacts of trauma work and organisational and therapist variables, but it also identified a potential need for ongoing training and education in trauma.

Arnold et al. (2005) interviewed 21 therapists (10 male, 11 female) and found both positive and negative consequences of trauma work were reported, with increasingly negative schemas about self and world alongside perceived VPTG. However in their sample, participants only worked with trauma clients 45% of the time on average (range 10-80%), so may be at lower risk of negative impacts than therapists working full-time. As with Steed & Downing's (1998) study, it was also difficult to differentiate between the effects of trauma work and therapists' own personal trauma history.

An Australian study, McCormack & Adams (2016), used Interpretative Phenomenological Analysis (IPA) to analyse interviews from 4 females (2 consultant psychiatrists, 1 clinical psychologist and 1 psychologist/clinic manager) providing psychological treatment to inpatients with a wide range of psychiatric diagnoses. Provision of trauma work was estimated to constitute 50-60% of their clinical practice, and participants reported experiencing significant distress from vicarious exposure to traumatic patient narratives. Although limited by the small sample size, this study extended our knowledge of positive and negative impacts of trauma work to an inpatient setting, highlighted an alternative pathway to VPTG through redefining therapeutic identity in the face of such challenges, and demonstrated how qualitative approaches such as IPA can contribute a rich and valuable dataset to the research through close examination of subjective interpretations of previously unexplored phenomena.

Merriman & Joseph (2016) similarly carried out an IPA to explore the therapeutic implications of counselling psychologists' responses to client trauma. Although, again, type of trauma treatment was not defined or specified, this study is of particular interest and relevance

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to this current study, given that 9 counselling psychologists (2 men, 7 women) were interviewed. Analysis yielded two key findings, firstly that participants experienced significant difficulties with use of self in response to traumatic material and second they were able to recognise that this therapeutic use of self continued to develop over time both through training and cumulative experience of trauma work. In critiquing their own study, Merriman & Joseph (2016) outline the key limitations of taking a qualitative IPA approach: criticisms included not just the small sample size, but also identified interpretative issues by recognising that different researchers might have focused on other aspects of participants' experiences, and selected different excerpts, or made different interpretations, of the interview material. The authors also note that, whilst all participants in their study were counselling psychologists, their theoretical orientations were heterogeneous (encompassing CBT, psychodynamic, humanistic and integrative backgrounds) and therefore they recommend future research to focus on participants with similar orientations and experience.

Most recently, counselling psychologist Lucie Bartoskova (2017) conducted an IPA to investigate how trauma therapists experience the effects of trauma work and whether there are common factors which lead toVPTG. Ten Scottish trauma therapists (7 female, 3 male) with a caseload of at least 40% trauma clients were interviewed. All participants reported both VT and VPTG, but they also recognised that different traumas can have differing impacts, depending on the personal history and individual responses of each therapist. They all also identified a range of self-care and coping strategies, including team, supervisory and private life support, self-care such as exercise and mindfulness, the value of the therapeutic relationship and of maintaining healthy boundaries and life balance. Bartoskova (2017) concludes by stating the importance of understanding how to minimise adverse outcomes, particularly with trainee therapists who may be more vulnerable to VT and burnout, and by highlighting the relevance of this qualitative research on VPTG to counselling psychology, with its pluralistic philosophy which recognises

the complexity of trauma work. The study is limited, however, by the heterogeneous nature of the 'trauma therapist' sample, as the researcher-selected criterion of a minimum of 40% trauma caseload resulted in a wide range of trauma exposure amongst participants.

1.3.3 Summary of critical review

In summary, there has so far been limited research investigation of the effects of trauma work, whether negative or positive, on clinicians, and little differentiating the two recommended trauma treatments, EMDR Therapy and TF-CBT. There is, in particular, a paucity of literature on therapist experiences of delivering EMDR Therapy to treat PTSD: it is either dated and/or methodologically limited, failing to provide large enough homogenous samples of mental health professionals with equal training, qualification and experience in trauma work.

Previous studies exploring therapist experiences of delivering generic trauma treatment, where the modality is either unspecified or consists of elements of PE or TF-CBT, have tended to use relatively large scale questionnaire surveys, usually conducted through email or postal surveys (Canfield, 2005).   Many have used unvalidated questionnaires, others employed validated measures of constructs such as burnout, CF, VT or STSD, even though these constructs have questionable validity and there appears to be much overlap between them. Either type of questionnaire inevitably limits the scope and depth of therapist responses, exploring factors which have been decided *a priori* by the researchers as relevant to clinicians (Rasmussen, 2005). In asking survey respondents to respond to pre-selected questionnaires the researchers are to some degree 'forcing' participants' choice as to what information they can provide. Whilst such studies are useful to highlight the overall impact of delivering non-specified trauma treatments on therapist well-being, and to throw up some ideas for further enquiry, how clinicians experience and make sense of the treatment sessions they offer, and the particular

nuances of impact between working in different modalities and interacting with different clients, cannot be adequately explored using quantitative approaches alone (Rasmussen, 2005).

Canfield (2005) highlighted the lack of qualitative studies in this area and recommended that the semi-structured interview is able to offer "a forum for open dialogue and [provide] rich, descriptive data of the lived experience of trauma counsellors" (p.96). Whilst qualitative studies usually tend to use much smaller samples than quantitative studies, they are able to explore issues in greater depth which allows for unexpected, and often more detailed and nuanced, material to arise.

Through critically reviewing the few qualitative studies in the area, phenomenology has emerged as a methodological approach particularly suited to exploring the subjective experiences of the trauma therapists during treatment delivery, as it is able to acknowledge how these particular individuals make sense of their experiences in this particular context. However, there has been no research at all, whether quantitative or qualitative, directly comparing therapist experiences of delivering both recommended treatments for PTSD in the UK (McFetridge et al., 2017). All things being equal in terms of patient outcomes, it would be important to know if one of the treatments was experienced by clinicians as more or less stressful to deliver, given the implications for therapists' risk of developing CF, with all the associated personal, professional and service provider costs.

1.4 Research design and questions

This critical review of the research suggests a qualitative design may address the gap identified in the literature. It is proposed, therefore, that the following study uses Interpretative Phenomenological Analysis (IPA) to gain an in-depth understanding of how clinicians experience delivering TF-CBT and EMDR trauma treatments and how they make sense of their

lived experience (Finlay, 2011). It is suggested that the primary research question explores:

"What is your experience of delivering TF-CBT and EMDR Therapy to treat PTSD?"

Related to this primary question, the following subsidiary areas of interest may also be examined:

a. What is your experience of delivering TF-CBT and EMDR Therapy during an actual session?

b. What, if any, effects continue between sessions?

c. What experiences of delivering these treatments may have led to long-term changes, and what might those changes (positive or negative) be?

Through conducting in-depth semi-structured interviews with nine counselling and clinical psychologist participants about their experiences, this study aims to produce a deeper understanding of this challenging area of clinical practice with relevance to counselling psychologists in particular and trauma therapists in general.

1.5 Organisation of the remainder of the study

In chapter two I will justify my epistemological position and choice of methodology before describing in detail the research method and procedure I used. Chapter three will set out my research findings in terms of the themes arising from the participants' transcribed interviews. Chapter four will summarise and discuss these findings, and reflect on their potential contribution towards a) developing evidence-based clinical practice regarding trauma treatment, and b) extending counselling psychology as a trauma-informed profession concerned with the well-being of both clients and therapists alike.

Chapter Two. Methodology

The previous chapter critically examined the existing literature and identified a gap in the research, providing a rationale for this study's research question: 'What do clinicians experience when delivering TF-CBT and EMDR Therapy, both during actual treatment sessions and cumulatively over the longer term?' In this chapter I will justify my choice to use a qualitative approach to answer the research question. I will provide a rationale for taking a critical realist position as my epistemological stance and then outline my criteria and reasons for selecting Interpretative Phenomenological Analysis (IPA) as an appropriate methodological approach. After describing how the research process was carried out, and the findings produced and evaluated, I will also explore considerations of personal and epistemological reflexivity.

2.1 Rationale for a qualitative approach

Both quantitative and qualitative approaches are empirical methods as they concern the collection, analysis and interpretation of data (Ponterotto, 2005). Which is selected as most appropriate depends on the research questions being asked, and what answers are being sought.

Generally speaking, quantitative methods are characterised by the use of measurable (quantifiable) data, strict control of variables, large scale samples and statistical procedures to test hypotheses by analysing group means and variances (Ponterotto & Grieger, 1999). The RCT is considered the 'gold standard' of quantitative methodology today (Salkovskis, 2002). Such positivist paradigms take a nomothetic and etic perspective, focusing on findings which are considered objective and impersonal, and attempt to discover generalizable truths which can apply to all humans.

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Humanistic psychological approaches, upon which counselling psychology is founded, have increasingly questioned the legitimacy of using positivist methods designed to investigate the natural sciences in order to study humans (Woolfe et al., 2010). Ponterotto (2005) argues we are in the middle of a much larger paradigm shift (Kuhn, 1970) to a broader and more balanced use of both quantitative and qualitative methods, which will serve to promote more rapid scientific advances in the field of counselling psychology. Rafalin (2010) too, champions a methodological pluralism for counselling psychologists, arguing we "need to be willing to engage with qualitative and quantitative paradigms as our object dictates" (p.48).

Qualitative methods are a broad class of procedures designed to explore, describe and interpret the experiences of individuals in context-specific settings (Denzin & Lincoln, 2000); they often use participants' own words to describe psychological experiences, events, or other phenomena. The particular procedure, or method, used depends on the underlying research paradigm which guides the chosen methodological approach (McLeod, 2001; 2015).

Rafalin (2010) suggests, however, that currently the pendulum may have swung too far, pointing to the "flurry of small-scale, interpretative qualitative research studies carried out by counselling psychologists in training" (Rafalin, 2010, p.46). Kasket (2016) similarly argues that, whilst the aim of generating practice-applicable research is vital to the professional doctorate in counselling psychology, a significant proportion of trainee research has focused attention on the experiences of other counselling psychologists in their roles either as trainees or as therapists. Whilst she allows that pragmatic considerations, such as the time needed for NHS ethical clearance, often restrict choice of research focus, she cites Blocher's (2000) comments regarding the limitations of American qualitative research, as equally applicable to the UK: "The myopia induced by navel-gazing on the part of organized counselling psychology has had a pronounced negative effect on the growth and acceptance of the field" (Blocher, 2000, cited in Kasket, 2016; p.230). The overarching aim of my research question therefore is to generate

valid information within an appropriately selected qualitative methodology which will have the potential to improve the evidence base for counselling psychology research and practice, and hopefully to be relevant also to the wider field of carers working in trauma.

Aside from prevailing fashions in empirical research, the key factor in selecting a quantitative, qualitative or indeed mixed methodology must, however, surely be consideration of what the objective dictates – that is, in an ideal world, the most appropriate approach to answer the research question effectively in order to produce valid, useful results (Cresswell & Plano Clark, 2011). Roth & Fonagy (2005) argue there can be no optimum research design, as each methodology is designed to answer only a limited range of questions. In the real world a good fit can still be achieved between research question, methodology and researcher and, as West (2013) suggests, an elegance results when a relevant research question produces rich and useful data that, in turn, leads to significant and impactful findings.

When the research question is focused on exploring clinicians' experiences of the impact of delivering different trauma treatments, qualitative approaches may be considered more appropriate or relevant, as they have been specifically developed to enable the in-depth description and interpretation of subjective experiences and the textured meanings individuals make of them (McLeod, 2001, 2015). In contrast to positivist quantitative paradigms, qualitative methodologies take an ideographic and emic approach which values the unique constructs and behaviours arising in specific individuals and socio-cultural contexts. These values resonate well with counselling psychology's emphasis on subjective experience and the importance of relational ways of being (Woolfe et al., 2010); this also celebrates the inter-subjectivity (literally meaning 'between subjects') inherent in a view of the researcher as an 'impassioned listener' rather than a dispassionate and 'objective' scientist (Orford, 2008).

Rasmussen (2005) posits that a limitation of previous research in this area has been the quantitative attempts to measure the impact of delivering trauma treatment on the clinician.   In

contrast, inter-subjectivity theory would recommend defining research questions that explore the "reciprocal and dynamic interplay of subjectivities of therapist and client and the ways in which they interact to help or hinder the therapeutic process" (Rasmussen, 2005, p.27). And, in a context where clinicians' experiences have traditionally been accorded a lower profile than that of patient outcomes, most importantly qualitative methods give a voice to *all* human beings. This enables a balance to be redressed in terms of the potential, as yet unexplored, long-term costs (personal, professional, and organizational) which may be associated with delivering particular trauma treatments. My goal therefore is to explore clinicians' subjective lived experiences of delivering both treatments and to attempt to describe and interpret the meaning they make of these experiences from my perspective as a practitioner/scientist who, in turn, can relate personally to the experience of delivering trauma treatment (Finlay, 2011). My overarching aim is to generate new insights into how practitioners can work more safely and effectively in trauma settings. In order to do this I need to be able to justify my epistemological position within this qualitative research paradigm.

2.2 Epistemology and ontology

Epistemology, a division of philosophy focused on the theory of knowledge, is concerned with how the relationship is conceptualised between the research participant, who is viewed as the 'knower', and the researcher, who is positioned as the 'would-be knower' (Ponterotto, 2005). Every research question makes one or more epistemological assumptions about what can be known and how (Willig, 2013).

For this research study I propose to adopt the epistemological position of critical realism. Realism makes the assumption that we are able to gather data about the world to provide information on how things really are. It represents one end of a continuum with relativism which, in contrast, takes the position that there is no such thing as an absolute reality; instead

all things are relative, and contextual. Critical realism is part way along the continuum in that it acknowledges, whilst there is a reality somewhere 'out there', the researcher may not be able to directly access it. Taking a critical realist perspective toward clinicians' descriptions of their experiences whilst using a particular trauma treatment acknowledges there may not be a direct relationship between their account and 'what really happens'. However, it should be possible for the researcher to make inferences about the underlying psychological and social processes which inform and produce the account, in order to make sense of, and derive meaning and insights from, the data.

Taking a critical realist stance also acknowledges that the production, or exchange, of knowledge assumes an inherent subjectivity, which is similar to a more constructionist perspective (Madill, Jordan, & Shirley, 2000). It implies that "… data needs to be interpreted in order to further our understanding of the underlying structures which generate the phenomena…" (Willig, 2013; p.16). Critical realism is an epistemological stance which therefore accords well with IPA, because my chosen methodology also acknowledges that the inter-subjectivity between a participant's subjective account and the researcher's interpretation of it necessarily affects the knowledge produced.

IPA also assumes that participant experiences are influenced by biopsychosocial factors and historical and cultural contexts and these are not always amenable to verbal expression. This is especially pertinent in the context of NHS trauma work where sensorimotor and 'felt sense' information experienced inter-subjectively between clinician and client during sessions has a particular valence (Ogden, Pain, Minton, & Fisher, 2006). This openness in the methodology to contextual factors and the possibility of non- or pre-verbal experiences is another advantage of IPA, which makes it particularly suited to this research subject (Madill et al., 2000).

Ontology is concerned with the nature of the world and asks the question 'What is there to know?' (Willig, 2013). Every research question also makes assumptions about the nature of the world and about people. From an ontologically realist perspective I view my research question as situated in a world of NHS trauma treatment. This is a reality that, to an extent, as a trauma therapist myself I believe I understand and know alongside my participants. However, a critical realist perspective takes a relative stance and acknowledges that the information I gather may not provide direct access to that 'reality' and also that participants may each experience that reality differently, both from each other, and from me (Willig, 2013).

2.3 Interpretative phenomenological analysis

I will now justify my selection of IPA as an appropriate method to enable an in-depth exploration of clinicians' subjective experiences of delivering the two recommended trauma treatments, EMDR Therapy and TF-CBT, and how they understand its impact on them, both during treatment sessions and cumulatively, over the long-term.

IPA is a qualitative approach developed to explore the unique lived experiences of individuals and to interpret how people make sense of these experiences, or phenomena (Eatough & Smith, 2008; Finlay, 2011; Smith, 2004). It has been influenced by the philosophical concepts of phenomenology, hermeneutics and idiography (Smith, Flowers, & Larkin, 2009) which together explore the idea that reality is contextual. This viewpoint complements the critical realist position adopted for this research study, and is concordant too with the underlying philosophical assumptions inherent in the humanistic foundations of counselling psychology.

Phenomenology is the philosophical approach to the study of experience, specifically the careful examination of human experience, in the main focusing on aspects which have particular significance or meaning to us (Smith et al., 2009). Husserl argued that "focusing our experiencing gaze on our own psychic life necessarily takes place as reflection" (Husserl, 1927,

quoted in Smith et al., 2009; p.12), and this reflecting allows us to more accurately know our own particular experience of the essential qualities of any given phenomenon. This endeavour parallels not only the fundamental aim of counselling psychology training to be a reflective practitioner, but also resonates with what trauma clinicians (and their clients) are attempting to do during treatment, and what I, as a researcher-practitioner, am attempting to achieve in relation to each participant and the data emerging from their interviews with me.

In essence, I believe this stance also appears to fit well with the mindful, conscious, 'noticing without judgement' therapists teach clients in Phase 1 of trauma treatment, which allows clients to stay grounded and observe themselves and their processes, without triggering trauma responses such as shame and dissociation (Ogden & Fisher, 2015). This 'without judgement' stance mirrors the 'bracketing' that Husserl (1982) proposed we need to do in order to consciously set aside our 'taken-for-granted' automatic ways of perceiving the familiar context of our everyday world, or 'lifeworld'. As Buddhists well know, setting aside our preconceptions, associations, evaluations and judgements, in order to experience afresh the purest quintessence of the world 'as it is', represents a lifelong learning task at which it is unlikely we will ever fully succeed. As with perfume production, Husserl (1982) recommended a series of 'eidetic' reductions in order to distil out this essence ('*eidos*') of an experience or phenomenon, so that we may know it as truly as we are able. Husserl (1982) suggests these reductions therefore will take us, through a process of divergence and convergence, from participants' unique and personal experiences of a particular phenomenon to elicit an irreducible common set of properties which characterise the essence of that phenomenon; in this way he proposed a way forward for qualitative science to authentically move from the particular to the general. Whilst Husserl's ultimate aim was to go beyond, or transcend, the content of conscious experience, to explore consciousness itself (another Buddhist enterprise), "IPA has the more modest ambition of attempting to capture particular experiences as experienced for particular

people" (Smith et al, 2009; p.16) and it is this aim I wish to harness to explore my research question.

Heidegger (1962/1927) developed Husserl's work in the direction of hermeneutics, the theory of interpretation; he initially grounded his position in Husserl's 'lifeworld', a world concerned primarily with consciousness, awareness and perception, and containing people, relationships and language. However, Heidegger focused more on the ontological nature of existence and our uniquely human capacity for self-awareness and self-reflection, which he saw as irrevocably and always situated in the context in which we find ourselves, a concept he described as 'Dasein' (meaning, 'there-being'). In this concept he recognised that an individual is always a 'person-in-context', inevitably subjective and interpretative. Heidegger uses the term 'inter-subjectivity' to refer to

"the shared, overlapping and relational nature of our engagement in the world. … Inter-subjectivity is the concept which aims to describe this relatedness and to account for our ability to communicate with, and make sense of, each other." (Smith et al., 2009, p.17).

Inter-subjectivity thus also relates profoundly to the history and fundamentals of psychology and how we as humans exist, relate and develop. From being a baby, born into Stern's (1985) world of interpersonal relating so fundamental to human emotional development, we learn to swim in a current of linguistically-mediated inter-related connections with others. Counselling psychology, founded in Rogerian humanistic principles, holds the therapeutic alliance at the core of our professional practice, recognising that inter-subjective awareness and reflexivity is crucial to effective work at relational depth (Douglas et al., 2016; Mearns & Cooper, 2005). And in complex trauma work, inter-subjectivity underscores the understanding that using our authentic self to connect with the client is essential to repair attachment bonds which have

been broken or damaged (De Zulueta, 2006; Parnell, 2013). Finally, inter-subjectivity recognises that, in the process of answering the research question, interpretation of clinicians' meaning-making activities is necessary in order to engage in a full phenomenological understanding of the nature and experience of trauma work for them.

Heidegger, dissecting the meaning of the word phenomenology, recognised that a *phenomenon* is something that is perceived to appear, whereas *logos* is a complementary activity concerned with analysing and seeking the deeper meaning of the phenomenon, which may be hidden beneath its surface. Heidegger also suggests, perceptively and crucially, that

"Whenever something is interpreted as something, the interpretation will be founded essentially upon the … fore-conception." (Heidegger, 1962/1927; p.191-192).

This gives us clear insight into the process of IPA research activity, where we must try to prioritise our perception of a new phenomenon as it appears, whilst holding in mind the possibility of latent meanings hidden below the surface. At the same time we must both bracket off our pre-conceptions about the new phenomenon, whilst also recognising that our new understanding can also work in the other direction to affect our prior conceptions. Gadamer (1975) explains this well, as

"A person who is trying to understand a text is always projecting … The important thing is to be aware of one's own bias, so that the text can present itself in all its otherness and thus assert its own truth against one's own fore-meanings" (p. 267-269).

This dynamic process of iteratively moving back and forth between phenomenon and interpretation, known as the hermeneutic circle, is central to the IPA approach. As Smith et al.

comment succinctly, "[w]ithout the phenomenology, there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen" (2009; p.37).

However, because the phenomenon under investigation in this research study is not a thing or an object but an individual, a person just like the researcher, the interpretative elements of IPA become a two stage hermeneutic process where "the researcher is trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2003, p.51). IPA is particularly interested in experiences which are of special meaning or significance to the participant and Smith et al. (2009) observe that the person often "engages in considerable 'hot cognition' in trying to make sense of it" (p.33). This is of relevance too, because trauma treatment also works by finding the 'hot cognition' and up-dating the meaning of it whilst the client is in a state of emotional flux. This leads me also to consider the importance of accessing both thoughts and emotions during a successful research interview.

Two other phenomenologists, Merleau-Ponty and Sartre, also posit useful concepts whose contributions are of particular relevance for my choice of IPA for this research study. Merleau-Ponty (1962) argues that, because of our capacity for reflection and self-awareness, we understand ourselves as individuals, separate from the world, which we experience through our bodies. This notion of embodiment is a key concept in trauma treatment where memories of trauma are held somatically and revealed in the body's responses to reminders of the original event. The consequence is a continual, raw sense of re-experiencing in the present-moment of traumatic experiences that, logically, are known to have occurred in the past (van der Kolk, 2014). Mirror neurons may connect therapists unconsciously to clients' physiological and physical responses, and lead them to feel empathic somatising (Porges, 2011), a type of experience I sense it may be important to recognise and acknowledge in the research data, even if it can never be entirely captured via verbal means.

Sartre also made an interesting point which is relevant to work in trauma research: he realised, on an occasion where he became self-consciously aware that he was being watched, that the direction of perception can aim both ways (Sartre, 1956/1943). This is a critical concept in trauma work for the client, who often experiences shame at being observed as somehow damaged or defective – either by their own internal self, or externally, by others – and this can impact negatively on the therapy (Ogden & Fisher, 2015; van der Kolk, 2014). This is also important for the clinician, who may also feel observed, critiqued, exposed or shamed by the process of disclosure during an interview. Both experiences interfere with the relationship (therapeutic or research) and, as Smith et al. comment, the shame only makes sense when seen in an interpersonal context which also contains the possibility of reparation (2009; p.20).

Unlike nomothetic quantitative paradigms which are concerned with what can be successfully generalised, a third major influence on IPA is idiography. This focus on the particular is expressed in two ways. Firstly there is a commitment to a thorough and rigorous examination of every particular detail in analysing the data. Secondly, there is a commitment to "understanding how particular experiential phenomena (an event, process or relationship) have been understood from the perspective of particular people, in a particular context" (Smith et al., 2009; p.29). In fact, there is an argument that the particular and the general are inextricably linked, mirroring the hermeneutic circle. Thus, the idiographic approach allows the responses of individual participants to be preserved and heard, whilst at the same time, through a process of interpretation and the convergence and divergence of themes arising from their data, it also offers the possibility of elucidating, or distilling, common experiences. The knowledge acquired from the idiographic approach advocated by IPA will therefore provide a deeper understanding of the lived experiences of the clinicians who deliver both recommended approaches to trauma treatment, and these experiences held in common may then serve to inform clinical practice for other therapists, as well as furthering the evidence base for counselling psychology knowledge.

2.4 Evaluation of alternative methods

Aside from phenomenology, there are three other main approaches to carrying out qualitative research (grounded theory, discourse analysis and narrative analysis), and several distinct versions within these approaches, from which it would be possible to consider choosing a method.

Grounded theory (Glaser & Strauss, 1967) was developed in order to facilitate the emergence of new theories, which would be grounded in the data from which they were derived. There are several versions, of which constructivist grounded theory (Charmaz, 2006) is the most widely used in counselling psychology, in part because it attempts to address criticisms regarding the limited attention paid to researcher reflexivity in constructing or identifying themes. Grounded theory is focused on discovering social processes and commonalities across participant accounts, whereas my research question is interested more in individual phenomenological experiences. IPA also looks for common themes, but focuses on convergence and divergence between individual accounts and therefore is more suitable for uncovering individual nuances and doing justice to the complexities of clinicians' experiences.

Discourse analysis is interested in issues of power and interaction (for example Potter & Wetherell, 1987). Foucauldian discourse analysis, for example, is interested in how discourses, or bodies of knowledge, can use language to shape, regulate, or constrain our understanding or experiences. IPA, like discourse analysis, is interested in the way language shapes people's experiences. However, IPA also includes other modes of experience, such as non-verbal language, physiological and sensorimotor responses, and acknowledgement of the 'felt sense' (Gendlin, 2003), awareness of which forms a significant part of trauma treatment. Discourse analysis is ruled out therefore as I wish to capture the full range of clinicians' experiences in the room with clients, as well as that which occurs in the room with myself, the researcher.

Narrative analysis comprises a wide range of approaches concerning the content or structure of people's stories. Although these approaches are derived from social constructionism (Bruner, 1990), other developments are more interested in the relationship between stories or the stories we tell about our own experiences, so incorporating aspects of discursive psychology and phenomenology. I am principally interested in the individual descriptions of phenomenological aspects of clinicians' experiences, what it *feels* like to give different types of trauma treatments and what sense clinicians make of these responses in terms of personal meanings and the shared cultural context of working in a trauma clinic. Focusing rather on the type or structure of the accounts themselves would, I feel, take away from rather than contribute to the richness of the data and there is no underlying epistemological rationale to do so.

2.5 Procedure

From the start of this research study, I wrote down reflective notes in a dedicated journal about anything of significance that arose during the process. Kvale (1996) argues that ethical issues in particular need to be considered at each of the stages he identified in the research process, and so I have loosely based the structure of this section on these stages. As I now outline the procedure I followed for this study, I hope it will become evident that ethical issues were considered, and reflective notes documented in my research journal, throughout the entire process.

2.5.1 Research theme

Firstly, Kvale (1996) states that the purpose of an interview study should not be limited to the potential scientific value of the knowledge sought, but ethically should also seek to improve the human situation. From the outset, therefore, I sought to investigate previously

unexplored factors which may affect trauma therapist well-being and ultimately their ability to effectively deliver treatment, which then also potentially impacts on client well-being. I also documented in my research journal my initial personal and theoretical questions which shaped the development and ultimate aims of this research theme.

2.5.2 Design

Ideas leading to my choice of methodological design and reasons for my participant selection criteria were initially explored using my research journal. Once I had decided to use an IPA approach, with semi-structured interviews for data collection, I began to note phrases and questions in my journal from my reading of prior research that I felt might contribute towards items in my interview schedule. A research colleague conducted a trial interview with me, so I could reflexively evaluate the ability of these draft questions to evoke detailed and meaningful responses relevant to my research question. These questions then formed the basis of my first interview schedule and, lightly edited, the remaining interviews which followed.

Ethical issues which concerned the research design included correct sampling, obtaining the participants' informed consent, ensuring anonymity, and considering possible adverse effects for participants of taking part in the study (Kvale, 1996); these will be addressed in the following sections.

2.5.3 Participant recruitment

Smith et al. (2009) argue that IPA research requires participants who have experienced similar phenomena and this therefore necessitates purposive sampling; they also recommend a range of four to ten interviews as appropriate for doctoral level research. As each participant was to be interviewed only once, I felt, in order to explore each individual's experience fully and

have sufficient data to be able to recognise patterns of divergent and convergent perspectives across interviewees, a sample size of nine participants would be appropriate.

Whilst it is estimated that approximately half the 3,500 or so counselling psychologists registered with the Division of Counselling Psychology work in the NHS, and numbers are increasing, this represents a relatively small proportion compared to clinical psychologists (Jones Nielsen & Nicholas, 2016), and there is no reason to believe that the ratio of those who are additionally qualified to practice TF-CBT and EMDR Therapy is not roughly similar. I was therefore concerned that I would be unable to recruit sufficient counselling psychologists for my sample.

Consequently, I decided to open my selection criteria to include clinical psychologists. Qualified counselling and clinical psychologists have both undergone three-year doctoral-level education which encompasses identical foundations in undergraduate degrees in psychology, similar training in research and clinical practice, they adhere to both BPS and HCPC codes of ethics and conduct, and share sufficiently similar competencies to allow employment parity at the same Band Level of jobs within the NHS. This shared 'kinship' with clinical psychologists, in particular with respect to our grounding in psychological theory and research, is in marked contrast to the training of psychotherapists or counsellors, who were therefore excluded from this study (Strawbridge & Woolfe, 2010). Recruitment for participation in the study was therefore targeted at both qualified counselling and clinical psychologists, together referred to as 'clinicians'.

In order for potential participants to be able to compare the impact of delivering both trauma treatments, clinicians also needed to have been trained and qualified in both EMDR Therapy and TF-CBT, and to have had experience of completing treatment with at least one client diagnosed with PTSD in each modality. The clients diagnosed with PTSD had, by definition therefore, experienced at least one traumatic event, involving one or more of the

following: natural disaster, accident, sexual and/or physical abuse, domestic violence, terrorism, torture, and/or military combat (Zimering, Munroe, & Gulliver, 2003).

Originally I intended to place recruitment advertisements inviting participation in the research study on the noticeboards of each NHS Traumatic Stress Clinic (TSC) in London. However, research has shown that the organisational and supervisory support available in a service can have significant effects on whether clinicians train in and continue to deliver a particular treatment modality (Berger & Quiros, 2016; Cook, Schnurr, Biyanova & Coyne, 2009). Across London, it is understood that certain services favour one approach over the other. Therefore, in order to further maintain as far as possible the homogeneity of the participant group, I chose to recruit from one TSC which provides supervision and support equally and without bias for both TF-CBT and EMDR Therapy.

I followed the British Psychological Society ethical guidelines (BPS, 2009) and this study was granted full ethical approval by City, University of London, Psychology Department, Research Ethics Committee on 28th November 2016 (Appendix A.). A copy of the ethics application, containing a summary of the study and ethical considerations, and the ethics approval letter, was then provided to the manager of the TSC. Following a discussion with her as to the parameters of the research and the ethical considerations involved, permission was granted to carry out my study in the service (Appendix B.). A recruitment poster was put up in the department and sent to all the clinical supervisors by email (Appendix C.) thus avoiding direct pressure being put on any potential participant.

Once a clinician volunteered interest in participating in the study via email, I contacted them by telephone to ascertain their eligibility, describe more fully the research study and answer any initial queries. I then emailed each potential recruit a Participant Information Sheet (see Appendix D.), which provided a written summary of the research study, including how data would be collected, used and stored, and what steps would be taken to maintain confidentiality

and anonymity. I wrote a brief accompanying email which thanked them for their interest and let them know I would contact them shortly by telephone to arrange a date and time for the semi-structured interview.   I also let them know they were free to change their mind about participating at any time without penalty.

Prior to the start of each recorded interview I checked again whether participants had any questions regarding information provided on the Participant Information Sheet (Appendix D.). I then asked them to complete and sign a Participant Consent Form (Appendix E.) to show they understood the purpose of the research and agreed to an audio-taped interview followed by publication of material from the interview, subject to anonymization and confidentiality requirements.

Prior to the start of the recorded interview I asked participants to complete a brief Participant Description Form (Appendix F.); the details obtained are recorded in the summary table of biographical and professional data in Appendix G.   This form asked for basic demographic details, as well as information on the year they had achieved their counselling/clinical doctorate and TF-CBT and EMDR Therapy qualifications, approximate number of years of general clinical practice and specific trauma work, and approximate number of clients treated in each modality. This data was gathered in order to describe the sample and ensure participants met the selection criteria.

In summary, a total of four counselling psychologists and five clinical psychologists contacted me and all recruits participated subsequently in the research. There were two men and seven women, with ages ranging from 34-58. All had completed TF-CBT and EMDR Therapy training and recorded a range of years' experience in both general psychological treatment services (3-17), and specialist trauma treatment (1-15); they also reported a range of estimated number of clients seen using TF-CBT (8-150) and EMDR Therapy (4-125).   From participants' responses during the interview, three clinicians expressed a clear preference for

TF-CBT, three for EMDR Therapy and three professed to use both modalities equally; these preferences are also included in the summary table in Appendix G.

2.5.4 Interviews

Mattie, who met my selection criteria, agreed to participate in my first interview, which will serve as an example of the procedure I followed in all subsequent participant interviews. In common with all the participants, I did not approach her directly: she had decided to respond as a result of an informal conversation with a mutual colleague who had seen the research advert. Once *Mattie* had completed her Consent and Participant Description Forms, I began the audio-recorded semi-structured interview schedule. This started with a 'warm-up' introductory question, inviting the participant to outline briefly their professional journey to this point and their reason(s) for specialising in trauma, in order to set the scene and to establish rapport. Four open-ended questions followed, based on earlier work by Figley (2015) and aimed at eliciting responses to my research question by asking participants to compare their own experiences of delivering TF-CBT and EMDR Therapy, both during treatment sessions, in the interval between sessions, and over the longer term. I also included a final open-ended question asking if there was anything else the participant would like to add.

Following this interview, my four interview questions were edited slightly to emphasise the how and what of *participants'* own experiences (rather than those of their clients). The questions were otherwise unchanged (See Appendix H. for the final interview schedule) as I felt reassured from this first interview that the schedule could generate a rich and meaningful data set relevant to the research question.

However, because, in this first interview, I had not specifically underscored and emphasised my particular interest in participant (as opposed to client) experiences of TF-CBT and EMDR Therapy, *Mattie's* interview was somewhat over-inclusive; I therefore decided to

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exclude from analysis her comments where they focused on her clients' experiences rather than her own as not being relevant to the research question. Kvale (1996) supports this decision, arguing that it is legitimate to discriminate which topics are selected and analysed in order to maintain a clear and consistent focus on answering the research question, as long as the researcher is transparent as to what material has been excluded.

I completed one audio-recorded semi-structured interview of approximately 60 minutes' duration with each participant in order to explore their experiences of delivering both TF-CBT and EMDR Therapy and their understandings of the impact – whether negative or positive - these modalities have on them both during and after treatment sessions. Each interview was run exactly following the recruitment and interview procedures described above.

All interviews took place at each participant's place of work during working hours only, so I assessed the risks to our personal safety as minimal. In addition, all NHS workplace locations are covered by regular statutory NHS health and safety risk assessments regarding all staff and visitors on site.

Brinkman & Kvale (2015) discuss the significance of paying attention to the interview environment: as interviews took place at the participant's place of work, usually in their own treatment room, I felt they were generally relaxed and could draw on context-dependent memories of previous treatments they had carried out in the same room. Participants were also able to make references to props used in treatment (for example, their grounding oils or EMDR equipment) or refer to the positioning of their chairs or pictures in the room in order to illustrate points. Once rapport was established, I asked participants to focus on their own experiences of delivering EMDR Therapy and TF-CBT. This generally resulted in a detailed conversation where differences and similarities were naturally considered and explored; points were expanded upon by the use of prompts such as 'can you tell me more about…?' and 'how did you feel about…?'

Semi-structured interviews are generally agreed to be the most effective method of collecting the rich and detailed descriptive accounts required by the IPA method (Kvale, 1996; Smith & Osborn, 2003). As the researcher, I tried spontaneously to adapt my questions in response to interesting comments made by participants. This allowed greater flexibility of exploration and depth of engagement compared to the more fixed and limiting structure of questionnaires and surveys. If any questions in the schedule were not covered spontaneously I tried to weave them into the discussion as naturally as possible.

Most interviews lasted approximately one hour owing to time constraints of the clinicians during their working day. The last five minutes or so were devoted to ensuring participant well-being by debriefing using the Participant Debrief Sheet (Appendix I.) and answering any questions, before finally thanking them for taking part in the study.

During the debriefing I checked whether the interview had raised any emotional or ethical issues for participants. In all interviews, bar one, I had no notable concerns. All participants, by the nature of their work, already had access to supervision support and their own personal therapy, but, in the event they might require further emotional support, I had prepared contact details of an independent counselling service. Limits to confidentiality were clearly outlined at the beginning of each interview and I knew I had recourse to my own research supervisor for advice should any ethical issues arise. I did notice during my interview with *Mattie* that her comments regarding her repeated exposure to trauma raised some concerns for me about her workload and professional resilience to burnout (Iqbal, 2015). I discussed my concerns with her as sensitively as I could during the debriefing, and *Mattie* assured me she felt fully supported in a professional and personal context: she limited her work to part-time, engaged in healthy coping strategies, and accepted the cumulative changes in her worldview in the context of her long but otherwise extremely rewarding professional career. I also brought this issue to supervision immediately afterwards and it was agreed that, as *Mattie*

was working within a supportive and fully supervised capacity, and as the rest of her interview indicated she was passionate, caring and good-humoured, these concerns were within acceptable limits. I had no further cause for concern in any other interviews.

I recognised also there was a small risk of vicarious (tertiary) traumatisation for myself as a researcher if participants mentioned confidential case material concerning their clients' traumatic experiences,. However, as this research was not focused on trauma directly experienced by my participants, and as I had access to therapy and supervision myself, I felt the risk was acceptable.

Immediately after each interview I wrote research journal entries reflecting on my own thoughts, conceptions, ideas, imagery, feelings and body sensations, observations of the participant's verbal and non-verbal behaviours, the surrounding environment, and anything else regarding the process which impacted on the experience. A particular focus of my research concerned the importance of how sensory information relayed through the body can convey significant information that we may remain unaware of (Brinkman & Kvale, 2015). Ellingson (2012) encourages researchers to pay attention to sensorimotor information during the interview, both within themselves and through noticing responses in their participants. Having been trained in sensorimotor psychotherapy for trauma work (Ogden & Fisher, 2015) I found this a particularly apt and rich source of additional data which I tried to capture in my notes after each interview.

2.5.5 Transcription

All nine audio-recorded participant interviews were transferred immediately from my Sony digital recording device to a password protected laptop stored in a locked metal filing cabinet. A key ethical issue here is of ensuring anonymity: participants were assured that any identifying information, including that of confidential client material, would be altered to protect

anonymity and all participants, and any clients mentioned, would be given pseudonyms. The Participant Consent Forms (Appendix E.), which included names and signatures, were stored in a locked filing cabinet separately from the data. All data and records will be destroyed when the research study ends.

A second ethical consideration concerning transcription involves how authentically it reflects participants' verbal (and non-verbal) communications. I carried out the transcriptions myself, verbatim, as this allowed me to appreciate and embed each individual participant's voice and views. As the researcher, I am motivated to produce a faithful transcription but this is a slow, repetitive and painstaking process. I used 'Inqscribe' (www.inqscribe.com), a free downloadable transcribing app which slowed down recorded speech so I could capture fast-spoken phrases more accurately.

Smith et al. (2009) state that IPA requires a semantic record of the interview, in order to allow interpretation of the content and meaning of a participant's account. To clarify the verbal content and meaning, I therefore attempted to record as much additional non-verbal communication as I could; this was described in square brackets, for example [laughs], [shrugs]. I also denoted brief hesitations as three dots '…' and significant pauses by [Pause]. *Italics* were used to signal an emphasis on a word or phrase and CAPITALS used to show an emphatic tone with raised volume.

Immediately after each interview, I also included notes in my research journal regarding, for example, participants' facial expressions or body language which may affect interpretation of what was spoken. I also offered all participants the opportunity to review the transcript of their interview in order to check that it represented an accurate reflection of the meanings they wished to convey.

2.5.6 Analysis

I carried out the analysis of each interview by following the six steps for IPA recommended by Smith et al. (2009), as follows:

2.5.7.1 Reading and re-reading

The first step involved reading through the transcript several times, initially listening to the audio-recording at the same time, in order to immerse myself as far as possible in the participant's voice and viewpoint. Following Smith et al.'s (2009) recommendation, I also documented in my research journal any observations, feelings, interpretations or associations arising in myself, or any notable recollections of the interview. This bracketing process, for later appraisal and possible incorporation, is particularly important as I am also trained to practice in TF-CBT and EMDR Therapy; the section on reflexivity below examines this issue further.

2.5.7.2 Initial noting

Steps one and two tended to merge as I immersed myself in as detailed, open-minded and comprehensive examination of the text as I could, reading and re-reading and typing brief notes in a column on the left side of the transcript of any aspects of interest. These observations fell into three main categories:

i. Linguistic observations

Linguistic observations were recorded in [*italic*] text. They focused on the minute observation of any interesting use of language, including any striking key words, phrases, pronoun use, metaphors and acronyms, pauses, hesitations or repetitions, and any other exclamations or idiosyncrasies of speech. I also included here notes on volume, tone and degree of fluency of speech, as well as a record of any emotional or physiological responses, body language, or other striking physical or behavioural patterns I noticed in the participant, or myself.

ii. Descriptive observations

Descriptive observations were recorded in [normal] text. These described the content of what the participant said at face value. I tried to focus on their descriptions of "key objects of concern such as relationships, processes, places, events, values and principles" (Smith et al., 2009; p.83), and the meaning of those significant things for the participant.

iii. Conceptual observations

Conceptual observations were recorded in [**bold**] text. They focused on interrogating the text in more depth and detail, questioning and considering more abstract concepts which might be underlying the language that participants used and the patterns of meaning inferred from their descriptions of their lived experiences.

I found that my tentative interpretations at this stage were inevitably viewed through the lens of my own personal and professional experiences and understandings. I therefore tried to note down any pre-conceptions I recognised and whether I noticed these changing as I continued my dialogue with the participant's lifeworld (Gadamer, 1975). As Smith et al. (2009)

point out: "As long as the interpretation is stimulated by, and tied to, the text, it is legitimate" (p.89-90). Therefore, throughout the process of interacting with the data, I tried to keep the focus primarily on the participant and anchor any considerations or contemplations of my own firmly on the evidence of their statements. Appendix J. shows an example of this exploratory coding process and themes emerging from an excerpt of one participant's account (*Mattie*).

2.5.7.3 Developing emergent themes

The third step involved retaining the complexity of this now much larger data set - the original transcript, plus all my additional notes and comments - whilst at the same time reducing the amount of detail. This data reduction process involved mapping the connections and patterns between my notes, grounded in the participant's descriptions, in order to identify any emerging themes. There was a difficult balance to be struck between retaining sufficient detail and yet distilling the essence with enough understanding and abstraction to form a recognizable theme (Finlay, 2008). When choosing emerging theme titles I attempted to balance being concise and precise, whilst also capturing the voice of participants and the range of understandings between them and myself, the researcher.

2.5.7.4 Searching for connections across themes

Once the emergent themes had been identified, the fourth step involved searching for patterns and connections between them using a range of techniques, including abstraction, subsumption and polarization (Smith et al., 2009). I printed out a list of emergent themes and then cut it up so each was on a separate piece of paper. I then positioned and re-positioned the themes, clustering them together into initial superordinate and subordinate categories, whilst making notes in my journal of the process. Themes which emerged from the transcript of the first participant were organised in a summary table to show the development of super-ordinate

themes each with a number of sub-themes underneath, along with a short identifying phrase from the participant and a time code locating the comment within the transcript (see Appendix K. for an example).

2.5.7.5 Moving to the next case

Having analysed the first participant's transcript I began again on the next participant's account, repeating steps one to four. As IPA is an idiographic process, I tried to bracket off the knowledge I had acquired from the previous participant's account, to let each participant speak with their own unique voice, and to identify their own particular emerging themes without contamination.

Only once these steps were complete, I then used the initial table of themes from the first participant as a basis for confirmation, addition or revision of the table of themes and sub-themes for the second participant. I continued this process for each subsequent participant.

2.5.7.6 Looking for patterns across cases

This stage involved playing with all the superordinate and subordinate themes from all the participants in a creative process of convergence and divergence, identifying which grouped together and which did not. The themes and sub-themes were therefore typed out and cut up as before and then laid out over the floor so different combinations could be tried until the best fit resulted. This required looking for shared meanings or similarities (homogeneity), contrasted with differences (heterogeneity) with others. The process was iterative, where I continually moved from a close focus on the data and away from it towards my own interpretations, and back again, all the while checking I was grounding my theories in the evidence of the data.

Smith et al. (2009) recommend that, for a theme to be considered important, it should be supported by text from at least half the participants. My conservative threshold criterion for

inclusion therefore was that themes were represented by five or more participants. In reality, all themes and sub-themes were represented by comments from eight or nine participants. Initially four themes emerged which were surprisingly dense, richly detailed and homogenous.

However, I decided to exclude data from this analysis if it was not strictly relevant to answering the research question. I therefore excluded one of the four themes which emerged because it centred on clinicians' opinions regarding which modality was appropriate for which type of client. I felt that this was not directly relevant to an exploration of the clinicians' own experiences of delivering the modalities, and therefore lay outside the remit of my research question.

I also chose to exclude a sub-theme of Theme 1 which emerged from clinicians' experiences of the similarities between both modalities because, with comments from only four participants, it did not quite meet the threshold for inclusion. This sub-theme deserves a brief mention here, though, as it concerns similarities between the use of cognitive interweaves in EMDR Therapy, and cognitive restructuring techniques (such as the Responsibility Pie) which are used in TF-CBT, and this will form an area of exploration for my case study within this portfolio. A typical participant comment on this sub-theme was:

"…*there's massive overlap… a lot of the time you're doing ... potentially, quite similar things. … So a lot of the [EMDR] cognitive interweaves … it's just very similar questions that you would ask when you are trying to restructure a cognition in CBT."* *(Annie: 06:43).*

In general I excluded comments where participants focused on their clients' experiences of the modalities, rather than their own. However, this was not always clearcut: there was some overlap between clinicians describing their clients' reactions to one or both modalities,

and how these then impacted on clinicians themselves; these comments have been included, provided they also met the threshold criterion. How the included themes and sub-themes were represented across participants is shown in Appendix L.

From this hermeneutic process I found that three clear super-ordinate themes eventually emerged:

1. *"It's not about the modalities, really"* – it's trauma work in general

2. *"My comfort zone"* – containing or constraining?

3. *"Trust the process"*

A summary of the themes and sub-themes is shown in Table 2 below, with a fuller account given in Appendix M.

Themes & Sub-themes	Sample comment	Time code
Theme 1: "It's not about the modalities, really" - it's trauma work in general		
Compensations:	*Jo:* You feel alive, it's on the edge, it feels meaningful. I'm very committed to refugee work, my mother was a refugee. I *can* make a difference.	14:05
Close connections:	*Mattie:* People say 'Actually it was you being with me that made the difference' …that's what we'd say about most modalities, isn't it?	50:15
Cumulative costs:	*Alex:* If people continue to do full-time trauma work it changes your view of all of society.	43:42
Clinicians' coping strategies:		
• Supervision	*Annie:* I *always* need supervision, particularly when you're not feeling massively confident with a new protocol.	13:33
• Preparation	*Mattie:* Before I start processing I know what it's going to be; often the client is frightened of something I'm not, cos I've been there before…	25:32
• Boundaries	*Steve:* I've learned to be better at cutting off: just going home, shower, that's ended, I don't have any stories on me.	48:29
• Other interest	*Alex:* I'm doing some research into trauma-focused work, which pulls you a little bit away from the heaviness of the emotional content.	53:10
• Other support	*Kitty:* Sometimes it's easier to talk to your peers; sometimes we have to go off and have a bit of a cry together.	30:27
• Exercise	*Mattie:* I have to go to the gym otherwise I know I won't cope. It's a sort of protected space... but also... you do things there which are bilateral…	43:19
• Resourcing	*Mattie:* I use the [EMDR] buzzers on myself after a session.	42:16
Theme 2: "My comfort zone" – containing or constraining?		
Containing:	*Annie:* TF-CBT is definitely my comfort zone: I feel a lot more confident and competent in doing it. That feels containing for the client and for you…	06:43
Constraining:	*Rose:* CBT felt a bit more of a battle, it was trying to make sense of things and actually it was making things more confused.	36:49
Theme 3: "Trust the process"		
Intense physical communication:	*Rose:* She said 'My heart broke.' …Watching her physical response so intently … you could feel like your heart [TEARS WELLING UP] breaks for them.	44:18
Confidence to "trust the process":	*Annie:* [My supervisor] talks about "You've got to trust the process" And I kinda go, yup, no, I am, I'm trusting it. But, BUT! I'm really anxious about it!	25:10
Clears the trauma TF-CBT cannot shift:	*Sara:* An EMDR client would say 'I feel completely different and this is amazing, thank you for giving me my life back.' Whereas with CBT it's just not the same.	12:16

Table 2. Summary of themes and sub-themes.

Kvale (1996) states that ethical issues involving the analysis include how critically and deeply interviews can be analysed and whether participants should have a say in how their

comments are interpreted. I therefore tried to analyse – and report - the data with sensitivity,

and an awareness that participants may read my comments in future, in particular having

extended an invitation for them to do so. If I had any doubts about the data I contacted the

participant concerned to discuss what they would like me to do, and documented the outcome

of this discussion in my research journal.

2.5.7.8 Reporting

Participants were informed that excerpts of the anonymised transcription of their

interview may be quoted in my thesis, and included in any paper submitted for publication in a

relevant mental health journal. Participants were invited to provide their email address if they

wished to be kept informed of research progress and any eventual publication; in particular they

were invited to read the transcript of their interview to ensure they were comfortable with the

anonymised data being reported in the research study and any potential publication.

2.6 Evaluating the research

Smith et al. (2009) argue that the quality and validity of qualitative research needs to be

evaluated using appropriate criteria. However, they do not recommend using the validity and

reliability criteria commonly applied to quantitative research. Instead, they recommend

Yardley's (2000) approach, which presents four broad, and somewhat overlapping, principles for

assessing qualitative studies, as follows:

2.6.1 Sensitivity to context

Yardley (2000) suggests sensitivity to context needs to be demonstrated at all stages of

the research process, from an appropriate response to the existing research literature,

formulating a rationale for a research question which links to an appropriate methodology,

negotiating an empathic and sensitive research interview, to – most importantly according to Smith et al. (2009) - the explicitly documented analysis and interpretation of the data.

It is important here to be aware there are several limitations of IPA methodology, as identified by Willig (2013). If the main objective of IPA is to gain "an insight into another person's thoughts and beliefs in relation to the phenomenon under investigation" (Willig, 2013; p.96), it makes the assumption that the researcher can show sufficient sensitivity to context to discover this information from an individual's account. As counselling psychologists, one could argue that we are uniquely skilled to carry out empathic and sensitive interviews, but I also recognise that my training in TF-CBT and EMDR Therapy may at once be both an advantage and a disadvantage in terms of understanding my participants' experiences without conflating them with my own. It is therefore vital to reflect upon and document in my research journal the 'bracketing' process which accompanied my analyses (Finlay & Gough, 2003).

However, according to Eco (1990), IPA data is also limited in the sense that not all interpretations on the part of the researcher are good or valid - and this perhaps will be particularly so when non-verbal forms of communication are also opened up to interpretation. I have attempted therefore to be tentative in considering the accuracy of my data analysis and have tried to document and evidence my interpretations as clearly as possible, because, as Smith et al. (2009) observe, interpretative "subjectivity is dialogical, systematic and rigorous in its application and the results of it [must be] available for the reader to check subsequently" (p.80).

Ricoeur (1970) distinguishes a double hermeneutic between two different interpretative positions: a hermeneutics of empathy, which allows the original experience to exist in its own terms, and a hermeneutics of suspicion, which uses theoretical perspectives, such as psycho-analysis, to question the phenomenon. Smith et al. (2009) argue that "[s]uccessful IPA research combines both stances – it is empathic *and* questioning, and the simple word 'understanding'

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captures this neatly" (p.36). As I wrestled with understanding sensitively what I felt may be contradictions, alternative contexts and underlying meanings contained within participants' accounts, I wrestled too with balancing respect for the reality my participants' words were trying to convey, as well as acknowledging the unique perspective I was also bringing to the interaction. Smith et al. (2009) emphasise that, in moving through ever deeper levels of analysis, interpretation of meaning, and understanding, it is essential for IPA to stay grounded in the meeting of the researcher with the original text; I therefore tried always to return to the evidence, and, when in doubt, to err on the side of allowing the participants' voices freedom to speak from their own contexts, rather than imposing my interpretations on them.   The hermeneutics of suspicion accept a legitimate plurality of interpretation, and therefore I must accept that a final accurate interpretation can never be achieved (Kvale, 1996).

2.6.2 Commitment and rigour

Yardley (2000) suggests commitment and rigour are demonstrated by the degree of attentiveness that is paid to documenting the particular details of the study, ranging from the careful selection for appropriateness and homogeneity of the chosen sample, to the attention paid to eliciting depth and detail of participants' views during the interviews.

Most importantly, Smith et al. (2009) argue the analysis must be conducted rigorously and systematically with sufficient idiographic engagement, as well as sufficient interpretation to move beyond a simple description. I documented the challenges I faced during my transcription and analysis phase as comprehensively as I could in my research journal: I struggled with what is sufficient and what may be too much interpretation and chose on balance to err on the side of respecting and encouraging individual participants' voices to shape the emerging themes and narrative structure of the analysis. Whilst hermeneutics provides a framework for my

interpretations, I also recognise that the end result is always a subjective and flawed account of how I, as the researcher, *think* other individuals are thinking (Smith et al., 2009).

Gadamer (1975) also suggests that, with each re-reading the meaning of a text can change the reader iteratively, thus producing further interpretations and re-interpretations. I noticed too, as I continued the analysis, that engaging with each participant's text changed me and my perceptions, for example as to the depth and range of experience that delivering these two different trauma treatments might encompass. I realised that inevitably this hermeneutic 'spiral' as I call it (because one cannot 'un-know' what has been discovered) in turn affected how I engaged again with that participant's account, and with those that followed.

Nevertheless, as Husserl (1982) suggests, methods such as IPA also involve the process of reducing data, through a process of divergence and convergence, from participants' unique and personal experiences of a particular phenomenon to elicit an irreducible common set of underlying themes which reveal the essence of that phenomenon. When this process is carried out with commitment and rigour, to show the analysis and interpretation in a detailed and transparent way, as I have tried to do, this is considered a valid method for qualitative science to authentically move from the particular to the general.

Moreover, because it is recognised that interview data can be interpreted in an infinite number of ways, I also appreciate that other researchers may have focused on different aspects of the participants' experiences and drawn different interpretations from the transcripts. Finlay & Gough (2003) argue that reflective practice and a cyclical approach to bracketing are required in IPA research, to become aware of as many of our fore-conceptions as possible when engaging in an interpretative dialogue. However, I also must recognise that my inevitable inability to completely bracket off my own perspective also forms a key and unique element of the analysis. Smith et al. (2009) therefore suggest it is essential to leave a 'paper trail' to enable independent evaluation of whether there a logical and coherent argument where the nuances and

contradictions in interpreting the data are dealt with.   I have attempted therefore to be as clear, open and transparent as possible in documenting my own process of selection and interpretation of my data, to enable the reader to draw their own conclusions as to the validity of my research findings.

2.6.3 Transparency and coherence

Yardley's (2000) third principle also overlaps with the two previous ones. I have tried to be both coherent and transparent in describing each stage of the research process is as clearly and cogently as possible so a reader might understand and be able to evaluate exactly what I did and my reasons why . For example, I hope it is possible to see there a degree of fit between the research literature and my rationale for choosing this particular methodological approach, or why I chose to include certain themes and exclude others from the analysis.

It is important to be transparent too about the theoretical assumptions of this research, which are based on Figley's (2015) theory of CF. This theory suggests that exposure to and empathy for clients' traumatic experiences may impact on a clinician's own sense of well-being, and the assumption is made that the clinician, as a reflective practitioner, would become aware of this and would be willing and able to verbalise their experiences during an interview. The topic-specific assumption of this study is that most therapists will have experienced both adverse and positive effects from delivering these trauma treatments and that they are sufficiently self-aware and reflective that they will be able to verbally identify and describe their experiences of these effects.

It is important to be transparent also about the methodological assumptions underpinning this project. For example, it is assumed that a semi-structured interview format is one that is particularly conducive to exploring clinicians' inner feelings and thoughts concerning

the impact of delivering trauma treatments. Kvale (1996) argues that the qualitative research interview is

> "a uniquely sensitive and powerful method for capturing the experiences and lived meanings of the subjects' [*sic*] everyday world. Interviews allow the subjects [*sic*] to convey to others their situation from their own perspective and in their own words" (p.70).

A further assumption is that, owing to the interviews being conducted in the privacy and familiarity of a participant's own counselling room, and the stated confidential and anonymised nature of the study, clinicians would be willing to express and describe their experiences freely and coherently, without fear of stigmatisation or any other professional or personal repercussions (Kvale, 1996). However, a limitation of the study might be the participants' inability, or reluctance, to put into words and communicate during the interview the essence of their experiences of trauma work.

Willig (2013) also argues that, because participant accounts rely on written transcripts of their verbal descriptions, which attempt to communicate their private inner experiences, "an interview transcript … tells us more about the ways in which an individual talks about a particular experience within a particular context, than about the experience itself" (p.94). Language, far from describing an experience coherently and transparently, precedes and therefore shapes, constructs, limits and defines the type of reality we can experience. And because our experience of language is unique to ourselves, I recognise I can never really access another person's experience through their use of words, and this therefore also limits the validity of the transcript.

It is assumed that the text arising from a transcription of the interview is a coherent verbal expression of the participant's mental processes, yet greater or lesser self-awareness or

reflexivity may respectively enhance or restrict a participant's ability to express their mental experiences and bodily felt sensations in words. Willig (2013) suggests that IPA may therefore be restricted to those participant groups who are able to articulate - in depth and detail - their thoughts, feelings, and perceptions through words. I would argue however that, as the ability to communicate subtle nuances and textures of experience forms an important part of a clinicians' skill set, it is likely that participants in this current study would be more able than most to express themselves perceptively and accurately.

Participants' words may also get 'lost in translation' when transcribed from audio interview to typed page – valuable non-verbal information such as tone of voice, emphasis, body language, pauses and silence may alter the meaning significantly.   This is partly why it also felt important to document and value the use of non-verbal language, body language and the 'felt-sense' being communicated during interviews, and one advantage of IPA is that it allows this.

2.6.4 Impact and importance

Yardley's (2000) final point echoes Rafalin (2010): however good the quality of the finished research, it must also be relevant, interesting and should make a significant contribution to the field. Willig (2013) critiques a further limitation of the IPA approach that, whilst it is able to provide rich and detailed descriptions of participants' experiences, it cannot explain why these experiences happen, nor why there are individual differences between participants, which necessarily limits its relevance and importance. In this study, however, my research question is focused primarily on how participants experience delivering two different types of trauma treatment and what meanings they attach to these experiences; the focus is not on asking them to justify why they feel as they do, nor why they differ amongst themselves in their perceptions.

In terms of impact and relevance, my research study might be accused of 'navel-gazing' (Blocher, 2000), as yet another example of a trainee counselling psychologist interviewing other counselling psychologists about their experiences. I would, however, argue strongly that this study is very relevant and necessary. We, as counselling psychologists, have a clear professional and ethical responsibility to inform ourselves, as well as clinicians from other disciplines, of how choice of trauma treatment modality may impact on clinician well-being (Iqbal, 2015) with its inevitable broader consequences for service provision and client well-being.

2.7 Reflexivity

Willig (2013) argues that good, ethically-grounded research makes reflexivity explicit on both a personal and epistemological level and I shall now consider these aspects in turn.

Personally, and as a trainee counselling psychologist researcher and practitioner, I recognise that I bring my own individual experience and my existing professional skills, knowledge and training to this research study. My military family upbringing, together with my professional identity as a psychologist, with a particular focus on working with veterans with PTSD, underpin my fundamental motivation to explore how best to help people challenged by trauma. In the past my therapeutic work also brought a painful personal experience of the risks of professional burnout. In order to continue my professional development and wishing to specialise in trauma, I enrolled on the professional doctorate in counselling psychology and I now deliver both TF-CBT and EMDR Therapy in my clinical practice. It is from my own experience of perceiving distinct differences between these approaches, that my curiosity arose as to how these two modalities, equally recommended in terms of client outcomes, might differentially impact clinician well-being.

I recognise that these questions arise from my own personal and professional perspective as a counselling psychologist, which therefore inevitably defines and limits the whole research process, including my search of the existing literature, choice of research question and preference for methodological approach. These necessarily and ethically should accord with my world view: reflective practice and a cyclical approach to bracketing are required not only in IPA research, but also in counselling psychology as a humanist discipline. As scientist-practitioners, it is vital to be aware of as many of our pre-conceptions as possible, when engaging in an interpretative relationship – be it research or clinical (Finlay & Gough, 2003).

Following Willig's (2013) recommendation, I recognise too that it is important to make explicit my epistemological position as a critical realist (Madill et al., 2000). This is because, through taking this perspective, I am making the assumption that any findings will reflect nuanced personal accounts of experiences situated in the context, or world views, of both participant and researcher - rather than being able to uncover objective generalizable 'truths' (Finlay, 2011).   Nevertheless, it is my deepest wish that I am able to communicate the validity of these personal accounts of a previously unexplored aspect of trauma treatment, and which therefore may open up further dialogue and exploration to improve the ethical and effective choices in training and practice, and ensure the long term well-being of clinicians as well as clients.

Chapter three will next present the results of my data analysis obtained by following the method and procedures described above.

Chapter Three. Analysis

3.1 Overview

This chapter aims to explore in some detail the experiences of delivering TF-CBT and EMDR Therapy, the recommended trauma treatments for PTSD, as described by the individuals I interviewed.   These semi-structured interviews provided richly textured, at times poignant, at times surprising, accounts of the participants' lived world of delivering trauma treatment (Finlay, 2011). The resulting themes and sub-themes emerged surprisingly clearly and consistently from these accounts, but they are also inevitably deeply interwoven. Whilst participants' experiences have been separated into themes as a result of the systematic procedures outlined in the previous chapter, this necessarily linear account is more for clarity of explication; in reality, these themes appear to form interconnected and coherent descriptions of phenomena clinicians experienced, both during treatment sessions, and cumulatively over the longer-term. The themes identified spring from a hermeneutic circle, as interrogation of participants' interview transcripts led to a developmental process whereby meaning spiralled forth from the interplay between the details of these individual accounts and my responses to them.

The very nature of the research question, which drives this exploration of the impact on clinicians of delivering the two recommended trauma modalities, implicitly invited participants to make comparisons between TF-CBT and EMDR Therapy. It was somewhat surprising therefore, to note that many participants began their interview by asserting that they experienced little or no meaningful difference between the modalities - for better, or for worse. As *Mattie* attests robustly,

> "*It's not about the modalities, really, it's about the fact that the patients are coming with the worst things that have happened.*" (Mattie: 45:27).

So my first theme *"It's not about the modalities, really"* explored the similarities noted by most participants across all trauma work, which emerged as four distinct sub-themes:

i.   *Compensatory rewards*

ii.   *Close connections with clients*

iii.   *Cumulative costs*

iv.   *Coping strategies*

However, as the interviews progressed it became clear that participants' experiences of each treatment modality were not as straightforward as these initial comments appeared. Two further themes emerged as clinicians reflected more deeply upon their experiences of the two treatment approaches under consideration.

One theme revolved around the idea that, as *Annie* firmly stated, "*TF-CBT is* definitely *my comfort zone" (Annie: 06:43).* A sub-theme emerged around confidence, competence, control, and above all, containment, as features affecting some clinicians' preferences towards TF-CBT. These converging accounts of the benefits experienced with TF-CBT differed markedly from a second sub-theme involving other participants' contrasting views of TF-CBT as frustratingly constraining, that "*it's just much more clunky" (Sara: 46:36)* and that *"EMDR is less confrontational" (Mattie: 05:08)* with the client. These factors appeared to result in a contrasting experience of TF-CBT as anything but comfortable or comforting – *Sara*, for example, described TF-CBT as "*really draining, really, really, draining, um, really tiring." (Sara: 40:08).*

A third theme emerged where clinicians' experiences of EMDR Therapy diverged in terms of their confidence and ability to 'go with the flow' and *"trust the process" (Annie: 25:10).* Some admitted feeling very anxious or ambivalent about their abilities to contain whatever unexpected memories or intense emotions a client may communicate intensely, and often physically through the 'felt sense' of their bodies, during the processing, as *Annie* described:

"…Yup no, I am, I'm trusting it… But, BUT! I'm really anxious about it!" (Annie: 06:43).

Others, in a contrasting sub-theme, described how feeling confidence in trusting the process was exciting, exhilarating and almost magical in its effects, as *Sara* expresses vividly here:

'It is exciting and the reward is amazing. … And it is miraculous, so you do get a huge reward from EMDR which you don't get from exposure work." (Sara: 22:49).

It was interesting to note, however, that a third sub-theme emerged, where even 'hardcore' TF-CBT adherents such as *Kate* acknowledged that EMDR Therapy was often more effective at clearing the traumas which TF-CBT seemed unable to shift: "*I do use EMDR as well, usually if things haven't shifted with the CBT …" (Kate: 08:04).* Choosing EMDR Therapy as a first or supplementary treatment may therefore have significant implications for the effectiveness and efficacy of trauma treatment outcomes for the client, and this may also impact the clinician: I am left wondering whether these accounts turn full circle - where the speed and efficacy of EMDR processing acts as a significant reward for clinicians and thus eases the cumulative costs of trauma work and acts as an important protective factor? As *Steve* commented:

"But, you know, the rewarding side of [EMDR] are the outcomes. … In terms of EMDR, why I'm biased is because it works faster, and it accesses other things that CBT doesn't." (Steve: 51:10-51:58).

A summary of the three main themes and their sub-themes could perhaps therefore be illustrated by the following diagram:

1. "It's not about the modalities, really"
i. Compensations of Trauma Work
ii. Close Connections
iii. Cumulative Costs
iv. Coping Strategies

Or is it...? **?**

3. "Trust the Process"
i. Intense Physical Communication
ii. Confidence to "Trust the Process"
iii. EMDR Clears traumas tf-CBT cannot shift

2. "My Comfort Zone"
i. Containing: Control, confidence & competence
ii. Constraining: "Clunky" & Challenging

?
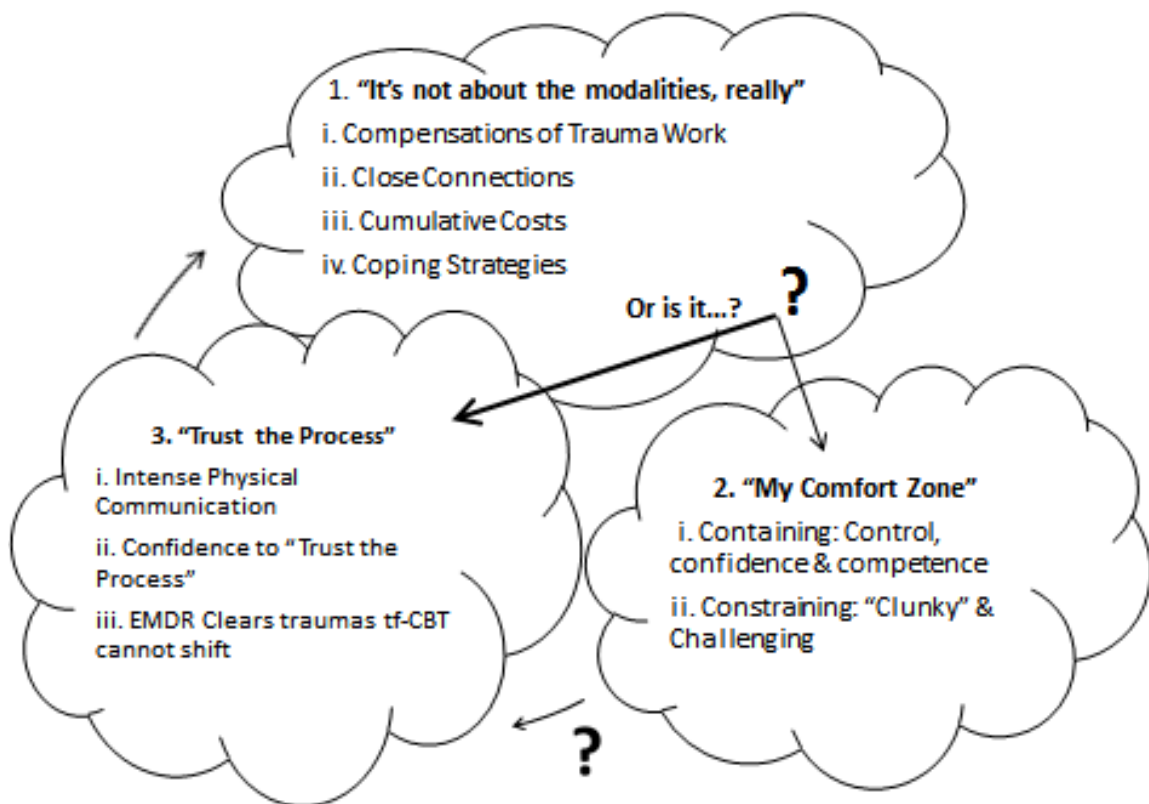
Figure 1: Themes and sub-themes emerging from analysis of participants' comments.

I used clouds to illustrate these themes in partial acknowledgement of a common idea in trauma treatment that post-traumatic growth is the silver lining to be discovered within the storm clouds of traumatic stress; I suspect this may apply as much for clinicians as for clients. Each of the following subsections will now consider these super-ordinate themes and their sub-themes in more detail.

3.2 Theme 1: "It's not about the modalities, really" – it's trauma work in general

Perhaps because my 'warm-up' question asked participants about how they came to specialise in trauma treatment, most clinicians began by enthusiastically recounting the rewards

of trauma work *in general* for them, and focusing more on perceived similarities rather than any differences between modalities. As *Mattie* initially claimed, *"It's not about the modalities, really"* *(Mattie: 45:27)*. It may also be that some participants needed to feel more relaxed with me before they were prepared to admit that the work also had significant negative and cumulative effects, and that they needed to find coping strategies to help them manage. Clinicians also highlighted the importance of the therapeutic alliance, their connection with the client, over and above choice of modality. These subthemes will be examined in more detail in the following sections.

3.2.1 Compensatory rewards

In the first five minutes of *Annie's* interview she succinctly summarises the main satisfactions of trauma work in general. *Annie's* comments are worth quoting at length because she encapsulates key themes reiterated by most of the other clinicians:

"T*here's something really rewarding as a therapist about people going from, maybe being potentially very disabled, to being actually hopefully quite functional again. I think sometimes you don't see that shift when you're working in other areas. That's the other lovely thing about working with trauma, is that you hear some of the very worst things that people can do to one another and on the flip side you also see some of the very best of humanity, and some of the real strengths and resiliencies of people. If you see someone ... overcome some of these difficulties and have a real resilience, I think it's a real honour to play a part in that kind of recovery. I feel quite proud of them and sometimes you can feel proud of the work that you do as a therapist as well, which is really nice." (Annie: 03:54-05:55).*

There is something of 'it was the best of times, the worst of times' in *Annie's* quote, in experiencing the extremes of human nature, that is perhaps very stimulating, as *Jo* also picks up on:

"The truth, as I learnt to know myself better, is that the front line nature of trauma is very appealing to me… It's a bit of an adrenaline rush and you feel like you're fighting the fight and you are on the edge and it's never boring… and you hear these extra-ordinary… not wonderful stories, but extra-ordinarily captivating stories…" (Jo: 06:34).

Jo also highlights how the personal significance of the work, in particular the political and social justice aspects of it, increases her sense of meaningful reward:

"I was coming from quite a political background so it also seemed very meaningful and quite a strong sense of identity that came out of that… I also, I'm very, very committed to the refugee work … and again I think it's historical … my mother was a refugee." (Jo: 14:05).

Steve also resonates with *Annie's* comments about the satisfying effectiveness of treatment when he says *"With trauma I like the fact that people can come with diagnoses and leave without."* (Steve: 03:11), and *Kitty* emphasises too, with the repetitions in her statement, just how unusual such unequivocal outcomes are in other psychological services:

"Very, very rarely, very, very rarely in any of the other settings I've worked in have you seen, such, such, tangible and important change." (Kitty: 45:24).

Several therapists – *Rose, Kitty*, and *Sara* - echoed *Annie's* sentiments that they found the work an honour and a privilege; in particular *Sara* highlights the intimate connection this work allows with her clients during processing, and, perhaps also, the trust that this implies:

> *"It's such a privileged position, because … it's almost like you join them in some ways." (Sara: 33:13).*

Sara's comment here also introduces another sub-theme noted by most participants, the importance of the therapeutic relationship in all types of trauma work.

3.2.2 Close connections

All the clinicians bar one (*Annie*) explicitly referred to the absolute primacy of the therapeutic relationship underpinning all trauma work - as *Steve* emphasised through his repetition of the word *"vital"* here: *"Concerning complex trauma, in my opinion, it is VITAL, the relationship. It is* vital*." (Steve: 43:52).* The importance of this supersedes any consideration of modality, as *Mattie* underlines:

> *"People say, 'Actually it was you being with me that made the difference'. That's broadly speaking what we would say about most modalities, isn't it?" (Mattie: 50:15).*

Steve cites the effect of economic and time constraints he experiences in the NHS having become so extreme that he feels these pressures are now affecting his ability to establish a 'good enough' (Winnicott, 1989) working relationship within the required time frames of trauma treatment:

"If [it] was just applying a technique, why wouldn't we all get the same results? … Because whatever you do, the relationship is a big component. Whatever modality you're doing these days it's hard, because of the climate that we're living in. … There is a huge pressure on services and that affects the outcome, of course it does." (Steve: 40:12).

He also underscores the known correlation between insecure or disorganised early attachment patterns and complex trauma as highly significant in affecting successful treatment outcomes:

"Before talking about EMDR or CBT, we're talking about traumatic material. So you are looking at patients who are more likely to have attachment difficulties, patients who may have... even difficulties to engage in treatment. Saying to them 'Ok, that's the fourth session and now we have to start doing the trauma work' - which many of us HAVE to do because of the pressure, because you don't have that privilege of continuing establishing the relationship forever - then the outcome will definitely be affected one way or another." (Steve: 42:11).

Mattie, however, provides a slightly different angle on attachment and the therapeutic connection, before implying a difference between TF-CBT and EMDR Therapy for trauma work:

"The ones who have had really appalling childhoods quite often form quite a strong attachment, despite my expectations [PAUSE, THINKING] … I think EMDR is more in your face… in the client's face, and in my face. But I think sometimes… people

do like that. Even in the people that have been tortured and … abused… they seem to

find the human nearness… intimacy… more acceptable." (Mattie: 16:48).

I am aware her word "*intimacy*" is almost shocking to me in its juxtaposition with "*tortured*

and … abused", contrasting as it does acceptable and unacceptable intrusions into body space,

and yet the acceptability of this human connection seems to provide a thread of hope and

healing leading out of the Minotaur's den of trauma for both clinician and client.

The strength and resilience of the clinician-client connection appears to run parallel with

the clinician's ability to endure, alongside the client, "*the worst things that have happened"*

(Mattie: 45:27), as *Sara* also notes

> *"I know my sessions are very intense, and I know clients don't really want to*
>
> *come and see me! [LAUGHS] But then they will also have a very good therapeutic*
>
> *alliance: they know they're doing intense stuff… and I can tolerate it." (Sara: 19:50).*

The ability of the therapist to survive and tolerate the worst appears to be a significant

therapeutic factor in the relationship, as *Kitty* compares the healing power of 'being with'

compared to 'doing to':

> *"The relationship is key… and it just seems important to… bear witness to what*
>
> *happened to that person with them, rather than … '*doing *something' to them." (Kitty:*
>
> *21:41).*

However, it may be that a clinician's ability to endure carries with it hidden costs which

accumulate over time; this risk, inherent in all trauma work, will be examined in the next section.

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3.2.3 Cumulative costs

Most clinicians interviewed began by stating the rewards of trauma work in general, and emphasising the vital importance of the therapeutic connections they enjoyed with their clients, which they also associated with good outcomes. It was often not until later in the interview, perhaps when they felt more comfortable with me, that there would be an acknowledgement of the changes they had noticed cumulatively in themselves over time as a result of the work. *Kitty*, the most recently qualified clinician with just one year's experience of trauma work, had already noticed effects, as she says: *"It does change you… it makes you realise the worst that human beings can do to each other." (Kitty 25:33).* *Mattie*, with nine years' of trauma experience, states:

"It's not about the modalities, really, it's about the fact that the patients are coming with the worst things that have happened… and so if you work with those patients all the time you tend to think that the world is full of child abusers and torturers. I notice that I seriously do believe that." (Mattie: 45:27).

Mattie's comments here and elsewhere raised ethical concerns for me regarding her well-being, as discussed in my previous chapter. Another clinician, *Jo,* observed she felt *"on the one hand quite overwhelmed, but also quite effective cos you could make a difference" (Jo: 06:34),* which perhaps supports the idea that the rewards can have a protective function in balancing the challenging nature of the work, and these rewards are primarily about making a significant difference in terms of transforming clients' lives.

It was not necessarily – as I had hypothesised – the repeated exposure to specific details of traumatic events that seemed to affect clinicians the most; it appears that the unexpected, or the very emotional, occurring in a session has most impact, as *Kate* describes:

"Hearing the detail doesn't usually bother me anymore, maybe because I've heard so many traumatic things. In the beginning I think that yes, I probably did get more upset by things that I was hearing... I hope that's not a bad sign of burnout [LAUGHING] or something! I almost can predict in certain countries or situations ... what is going to happen, but when I hear something... new, a new horrific thing I hadn't heard before, it still can affect me…' [Kate: 33.24).

Mattie, like *Rose (52:03),* similarly makes the point that it is the client's emotional reactions rather than the details of what happened that upset her most: *"It wouldn't get to ME unless THEY were really upset."* (Mattie: 27:10).

In terms of the cumulative effect of this intensely emotional and at times unpredictable work, *Kate*, who has worked in trauma for 15 years, the longest of all the participants, summed up the changes she has noticed. Her comments are worth reporting in full as they are representative of the range of responses most clinicians reported:

"I probably do have a more cynical view ... about the world; I do think a lot bad things happen to people... in other countries as well as here. I'm probably much more suspicious now of just anyone you meet. I probably see more danger and people I wouldn't trust in the world around me. I do think it's made me more... kind of anxious, looking for danger everywhere. ... And yeah, the other sad thing that's happened, I used to love watching documentaries and I can't do it any more, I'd be crying all the way

through. Torture scenes just feel too real now. You just think about certain people. It's just too much. I feel tired of talking to people - and that used to be helpful - but now I'm just so… tired of talking to people, which is sad, but that feels too exhausting - even if it's my family - who are nice to talk to [LAUGHS]. I feel that's probably a negative consequence of the work - I don't ring people as much in the evenings either, I just want to switch off." (Kate: 52:38 - 58:08).

This poignant litany, cataloguing the cumulative effects of trauma work - which appear noticeably similar to the PTSD symptoms that her clients bring - was reflected as a familiar refrain to a greater or lesser degree by all the other clinicians I interviewed. I suspect *Kate's* repeated use of the word *"just"* also downplays 'just' how corrosive and damaging the effects of long-term trauma work may be for clinicians. In common with many other accounts, this understated admission of vulnerability came late in the interview (most meetings lasted around one hour), again perhaps as trust between us had had time to establish. A particularly insidious effect of trauma work is the social isolation, which can be heard here in *Kate's* reiteration of *"tired of talking to people",* belying perhaps the ploddingly exhausting, draining and repetitious nature of full-time trauma work. As Judith Herman memorably cautioned

'It cannot be reiterated too often: *no one can face trauma alone.* If a therapist finds herself [*sic*] isolated in her professional practice, she should discontinue working with traumatised patients until she has secured an adequate support system.' (Herman, 1997; p.153, *italics Herman's own*).

The exhausted isolation *Kate* and others describe may effectively cut a clinician off from the very sources of help and support that are most needed, and unwittingly replicate trauma's power to isolate and abuse. All clinicians I interviewed, without prompting, also detailed one or

more strategies they used to cope and care for themselves (which will be outlined in the next section), as *Steve* observes:

"*I think both [TF-CBT and EMDR Therapy] are the same: you are exposed to trauma material in both of them. Um, it's all about self-care, I focus more on self-care...*" (Steve: 50:12).

3.2.4 Clinicians' coping strategies

Thankfully, given the pernicious effects which appear to accumulate from trauma work no matter which modality is used, all the participants mentioned at least one, and usually several different, forms of coping and self-care strategies; a brief summary of the most commonly featured follows.

3.2.4.1 Preparation and Experience

Picking up on the points raised at the end of the previous section, a particular aspect that stood out seems to be the complex and ambivalent nature of the protection for the clinician offered by their prior experience and preparation. Participants used words like "*habituated" (Alex: 40:02)* and *"desensitised" (Rose: 52:03)* to describe how being exposed to *"the worst things that have happened" (Mattie: 45:27)* might have led to a 'numbing out' that at once conferred both benefits and drawbacks for their work. As *Annie* reflects, her prior experience seems to serve a protective function:

"*You've generally got a good sense of what's coming and that … feels containing… I know what I'm getting myself in for [PHEW] ... so there's that sense of, 'Right I can kind of* steel *myself for that'. I've heard a lot of really awful*

things now, and I might hear variants on a theme of something awful, but I'm -
touch wood - there's probably not going to be anything that completely floors me"
(Annie: 17:51-19:29).

Annie's choice of metaphor – *"steel myself"* - seems to suggest going in to battle, psychologically braced for *"what's coming"*, repetitions of the word "*awful"* perhaps mirroring the telling and re-telling which keep bombarding the clinician. The word "*steel"*, for me, conjures up the sense of a sword whose steel has been hardened in the fire, or perhaps the putting on of steel armour, in order to prevent being 'floored', another metaphor likening the therapeutic encounter to the experience of a knight riding into battle. This sense of something unexpected getting under one's armour of psychological preparedness, and knocking one out or down, is echoed by *Kate's* comments, which again include repetitions of the words "*awful", "horror"* and "*horrible":*

"…maybe it's because I'm not expecting it. I'm in 'horror mode'. I'm
probably preparing to hear lots of awful things about awful attacks... and…
maybe I'm just dissociating a bit from hearing awful things people do to each
other and when, when somebody does something really kind or sacrifices
themselves [sic] for somebody else, that... goes under the armour of 'this is all
going to be so horrible' and … that's actually what gets me emotional… cos I'm
not expecting it: there's some kind of happiness in all the horror." (Kate: 44:13-
47:38).

Through the litany of repeated *"awful"* accounts that *Kate* must endure whilst in full *"horror mode"* (almost as though she feels she is functioning as a dissociated robotic

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programme), I find the final alliteration of *"happiness in all the horror"* all the more striking in its poetic incongruence. This recalls *Jo's* earlier description where she appears to gird herself for a battle and adrenaline fuels a potent mix of anxiety and excitement:

> *"The front line nature of trauma is very appealing … it's a bit of an adrenaline rush and you feel like you're fighting the fight…" (Jo: 06:34).*

Kitty, too, uses the phrase to *"man up"* in a similar *"macho"* way *(Kitty: 48.05)*, and I become aware of the irony that, for many of the participants, their experience of trauma work as a crusade, or battle, perhaps uncomfortably mirrors the actual experiences of many clients, whether veterans or refugees from a war zone.

However, several clinicians also observed that the emotional component of trauma treatment has a necessary therapeutic value and they need to encourage the client to *"go there" (Mattie: 25:32)* in order for the therapy to be effective. It is worth quoting *Mattie* fully here because she usefully sums up what it is like to hold all these complex and often conflicting experiences participants described - both encouraging the client to express distressing emotions, whilst remaining psychologically braced for most trauma content, unless or until the client brings something unexpected:

> *"Usually, before I start the processing I know what it's going to be. And I think it's better for them to go there than not go there. So that then they can come out the other side. [PAUSE] Often I think the client is frightened of something that I'm not so frightened about cos I've been there before with somebody else. I think I'm not so worried about what I'll hear any more, I'm more*

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worried about their reaction. … You know, a lot of things do worry me, or get to

me, or make me sad, or upset... but generally, it's not a sudden discovery during

processing, it'll be before that, in the assessment." (Mattie: 25:32).

Research shows that amount of clinical experience is positively correlated with

clinicians' ability to feel confident in containing strong emotion – both theirs and the

client's (Craig & Sprang, 2009; Haccoun & Lavigueur, 1979). In this study it is

noticeable that the participants who have seen the most trauma clients (see Appendix

(*Mattie, Steve, Kate, Jo* and *Alex*) also reported being comfortable with extreme

emotional expression during sessions. Indeed they see it as a fundamental part of the

treatment, as *Kate* acknowledges:

"I need *people to be emotional ... so I think when people are tearful and*

emotional while they're doing reliving then I feel I'm doing it properly and there's

a chance things might shift." (Kate: 19:39).

I would argue that the ability to retain one's humanity and emotional resilience in

the face of such expressions of pain may be vital to the well-being of both clinicians and

their clients, particularly given the importance of the therapeutic relationship, and the

significance of the clinician's use of self to help restore previously damaged emotional

connections in their clients. I would also argue this complex and challenging work is

only possible in the context of a fully supportive and resourcing working environment.

3.2.4.2 Supervision and Organisational Support

Previous research (Cook, Biyanova & Coyne, 2009) has shown the vital importance of supervisory and organisational support for clinicians, both during the normal course of their work, and particularly when embedding new skills following training in a different modality.   Given the often extremely distressing and highly emotional nature of the work as described above, this is perhaps all the more necessary for trauma work. Participants' comments corroborated these findings, as *Annie* observes

> *"… I think that the culture of the clinic really encourages you... So I feel like really, genuinely, we do offer both types of treatment. I always need supervision about everything, but particularly when you're not feeling massively confident with a new protocol. I certainly wouldn't want to be doing [a new treatment] if all I was getting was supervision every month or six weeks." (Annie: 12:32).*

Supervision seems to fulfil two key functions for participants; firstly, and particularly with newly qualified clinicians such as *Kitty,* it provides technical advice, as she identifies

> *"If you've got an hour of supervision then you need to crack on through: what am I doing with client A, B, C, and D? Sometimes you've got to be quite targeted… and I can go and process the emotions with my peers half an hour later. I need to know more urgently what I'm doing technically... or if I've got a*

query about risk that needs to be addressed NOW, so... that's what I'd prioritise."

(Kitty: 32:46).

As a recently qualified clinician, *Kitty* also distinguishes clearly between her use of supervision as a trainee, which carried a component of evaluation, and her use of peer support, where the parity she seemed to experience with her colleagues may have allowed safe expression of emotions without fear of judgement:

"I mean obviously there's supervision. But when there were other trainees here I talked a lot to them. Because we were all at the same process of learning and development and I know that they're not gonna... [PAUSE] you know, they're not gonna judge you … And sometimes we had to go off and have a bit of a cry together because, yeah... it's just what was needed at the time."

(Kitty: 30:27).

However other clinicians seemed to see a second function of supervision as providing the support and space to release emotions. For example, *Steve* uses supervision *"for talking about a crappy session that happened with me; I'm not someone that keeps it in" (Steve: 48:29).* *Kate* highlights the vital difference a good peer supervision group makes for her in terms of emotional support, noting that *"this team has allowed me to keep doing [trauma work] without being badly affected." (Kate: 55:46).*

However, *Jo* sounds an important caveat, describing how, when two or more supervisors working in different modalities are used as equal sources of support and direction, stress-inducing conflicts of advice can occur:

"If I feel shaky - which I think sometimes these complex cases make me feel - I go to this one [supervisor] and I say 'Well what do you think?' 'Blah, blah, blah, blah, blah.' I'll go and put that in place. And then I'll go to the next one: 'Oh my God, but why have you done that? They're clearly dissociative…' You know? And I don't know what to do. Whereas actually maybe one has to… just hold to one. Because … they can conflict, or encourage meandering. I think I should make a commitment - either way." (Jo: 06:37).

Jo makes a contrast between her supervisors' advice; one is depicted as providing generic "*blah, blah, blah*" guidance perhaps lacking in meaning or direction for her, but to which she responds with an unquestioning obedience. The specific and questioning evaluation from her other supervisor: "*Oh my God, but why have you done that?*" seems to paralyse and deskill her: "*I don't know what to do*". This, it could be argued, serves the opposite function of supervision. Dual supervision risks being experienced as conflictual and unsafe and ultimately may shut down communication, discouraging vital questions regarding best clinical practice. Perhaps, as *Jo* reflects, it is more important to "*make a commitment – either way*". *Annie* also recognises "*why stick your head above the parapet?*" *(Annie: 13:33)*, rather than risk losing one's way ("*meandering*"), or getting caught up in a "*conflict*" about different approaches. Because research shows supervision can be such a key factor affecting the uptake of a new modality (Cook, Biyanova & Coyne, 2009) and Dunne and Farrell (2011) highlighted the role of organisational 'bullying' in hampering the integration of a new therapeutic approach, perhaps these issues need to be further investigated.

Being able to communicate safely and connect with other trauma therapists seems vital in supporting and enabling clinicians to continue the work they do, particularly when other avenues such as friends and family may be closed due to the confidential and often extremely distressing nature of the work. This boundary is one of several that clinicians commented on as affecting - for better or for worse - the impact of their work.

3.2.4.3 Boundaries

Alex, as he was discussing a particularly disturbing case, succinctly summarised his three main coping strategies as

> *"it would normally be through supervision and, ah, generally talking it through with colleagues… and not doing too much at any one point in time."* *(Alex: 42:09),*

His comments introduce a further set of coping strategies to do with setting limits and boundaries on the work.   *Rose* agrees that *"…it's just finding that balance, and it might be reducing days of clinical work in a week and doing different things." (Rose: 52:41).* These limits can be external; for example, *Kate* realises that

> *"having boundaries imposed for me by the NHS about limits to how… long you work every day and, um… what your role is, has been helpful to me."* *(Kate: 55:46).*

However, many clinicians have learnt, through experience, to set their own internal limits, as *Steve* states:

"I've learned to be better at cutting off, so cutting off not in an unhealthy way, but just going home, shower, that's ended, I don't have any stories on me." *(Steve: 48:29).*

Rose's mention of *"doing different things"* above introduces a variety of other interests that clinicians described as helping in *"cutting off"*, as *Steve* says, or distracting from the work.

3.2.4.4 Other interests

Some interests clinicians mentioned were still work-related but not clinical practice. So for example, *Alex* aimed for variety within his profession, by offering supervision himself, and explaining that

"I mainly do medico-legal work. That can also have an effect because you are listening to trauma stories but you're not doing the treatment so... you don't have to hold the client's story from one week to the next. I'm also now doing some research into trauma-focused work… doing something like that pulls you a little bit away from the heaviness of the emotional content." *(Alex: 44:35).*

Mattie also said she enjoyed doing research *(51:10)*, and, alongside several other participants (*Kitty: 1:04:37; Jo: 06:34*; *and Kate: 04:08),* mentioned engaging in outside but related interests such as history, geo-politics and human rights *(Mattie:*

48:35). However, other clinicians pursued more mundane escapes: for example *Kate* enjoyed "*drinking a glass of wine … and watching silly TV shows like X Factor" (Kate: 58:08).* She also identified a common distracting factor for clinicians who are parents with families, comparing them to a clinician who

"*… doesn't have the kids as an automatic switch off, so it's easier for [them] to carry around work-related worries. Whereas we are kind of forced into a complete other world... the next school trip and things like that... so that's naturally helped me." (Kate: 50:20).*

Another outside interest mentioned by most, but not all participants, is physical exercise. Activities such as running and cycling were particularly favoured. As *Mattie* noted perceptively, these involve bilateral stimulation which she seems to imply helps her process traumatic material as effectively as it helps her clients:

"*I think all the techniques that we use for patients we should apply to ourselves ... and the big one is exercise. I just blanket try and go to the gym most days… otherwise I know I won't cope. It's a sort of protected space... but also... you do things there which are bilateral like the cross-trainer and the running, so twenty five minutes of that... is quite handy... And cycling's the same, it's also bilateral..." (Mattie: 43:55).*

It may be relevant to note one class of self-care strategies which are particularly available to, and perhaps appropriate for, trauma therapists; these are the resourcing strategies usually taught to clients as part of Phase 1 of trauma treatment. Some

clinicians, such as *Kitty (27:07)*, described attending meditation classes after work and using breathing and imagery techniques on themselves for relaxation and grounding purposes. However *Mattie* explains in more detail the use she makes of the handheld EMDR 'buzzers':

> *"You've got to try and be sane and... give the techniques a go, otherwise you're being a hypocritical fraud, aren't you? When I used the buzzers, I sometimes used to use them myself afterwards. It's quite difficult at work because if people come in ... they think you're a bit weird. It's quite difficult doing eye movements here anyway because people can see in [INDICATING GLASS DOOR PANELS] and it feels very exposing, although I've just had to get used to it."* (Mattie: 42:16).

I sense *Mattie's* account is in part intended to be amusing and provocative, but there is a serious component, and I found it poignantly underscored her need to process traumatic material after a session, which overrode any feelings of vulnerability at being exposed to what others might think of her, even in the supposed sanctuary of her consulting room. On the positive side, EMDR Therapy does seem to offer a particularly wide range of effective resourcing techniques, which therapists do appear to access for themselves, as well as offer to clients. Notable by their absence were similarly spontaneous comments from the three participants who preferred TF-CBT (*Kitty, Kate* and *Alex*) describing instances of using CBT techniques on themselves, although, as this was not specifically prompted by my questions, that does not mean it categorically does not happen.

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3.3 Theme 2: "My comfort zone" – containing or constraining?

Although many participants began their interviews by claiming *"it's not about the modalities, really" (Mattie: 45:27)*, there have been, thus far, a few intriguing glimpses of the very real, if sometimes quite subtle, differences clinicians described between TF-CBT and EMDR Therapy. The following two themes explore differences in clinicians' perceptions of both approaches in more detail and depth. Theme 2 documents clinicians' experiences of the *"comfort zone" (Annie: 06:43)* of their original training modality – overwhelmingly for eight out of the nine participants this was TF-CBT – which, for some, confers a sense of containment, control, competence and confidence; these converging accounts contrast with other clinicians' views of TF-CBT as constraining – being experienced as more *"clunky" (Sara: 16:19; 46:36),* challenging and confrontational than the fast-paced but more unpredictable flow of EMDR Therapy.

In exploring Theme 2 it is important to remember that *all* clinicians interviewed will have been steeped in a basic CBT foundation throughout their three-year doctoral training. Compared to EMDR Therapy, embarking on a subsequent specialised TF-CBT training is cheaper (and often freely offered as work placement training), quicker (two- compared to seven-day workshops), and more widely available to trainees as well as recently qualified clinicians (EMDR Therapy training in the UK is only open to third year trainees and above). Therefore, within this context, it is perhaps unsurprising that TF-CBT was the first trauma-focused training reported by all but one of the participants (*Steve*) in this study. Many participants also reported having attended numerous other trauma-focused cognitive- and/or exposure-based trainings subsequently (such as NET), which increases the amount of teaching and support input experienced over time for exposure-based CBT-type approaches, compared to the stand-alone seven-day course which is at present considered sufficient as an EMDR Therapy qualification in order to practice. Given the complexity and challenging nature of most trauma referrals now

being made to NHS Traumatic Stress Clinics, clinicians reported there seemed to be relatively few 'simple PTSD' cases for trainees to gain experience and confidence with; owing to this shortage many new clinicians may therefore be 'thrown in at the deep end' with complex, challenging and potentially dissociative clients. As *Mattie,* one of the clinicians with the longest experience of working with trauma, observes,

> *"I've never had anybody with simple PTSD … I would be quite interested actually in working with somebody who just had something like a road accident, just to see…"* (Mattie: 36:45).

It is therefore perhaps unsurprising that a significant theme during interviews is the sense of security and control that their TF-CBT training confers, in terms of containing both their clients' as well as their own anxieties. Clinicians describe several aspects of this which will be examined now in more detail.

3.3.1 Containing: Confidence, competence and control

Annie succinctly summed up many of the potential benefits she experienced delivering TF-CBT, which were commonly described by several other interviewees as well:

> "*TF-CBT is* definitely *my comfort zone; I've done a lot more work in it and I feel a lot more confident and competent in doing it. … You feel slightly more contained and more in control… you can keep it very focused and that, I think, feels containing for the client, but it also feels very containing for you as a therapist."* (Annie: 06:43).

Steve, with his repeated emphasis on the words *"you know"*, underlines his sense of how much informational control TF-CBT provides

> *"You know exactly what's happening, you know where you are, you know what you're doing, you know what you're updating." (Steve: 33:44).*

It is striking how this use of repetition, like a reassuring 'rhythm and routine', appears to recur almost unconsciously through several participants' accounts of the experience of working in TF-CBT. *Steve,* in particular, uses repetition very vividly to describe his experience of delivering TF-CBT – for example, when he provides an illustration: *"Go back to the hotspot dedededah, dedededah" (Steve: 15:33)* and describes a sense of blocking and frustration with: *"like that specific patient that was like stuck, stuck, stuck, stuck, stuck." (Steve: 18:55)*. Whenever he refers to TF-CBT updating in his account, it is always in a 'sing-song', slightly bored, way, almost as if he can't quite be bothered to finish the sentence or, perhaps by implication, the updating itself:

> *"…using TF-CBT, focusing on the worst moment, the hotspot, and trying to update, you know: 'You are safe now, blah, blah, blah', all that kind of thing… I noticed in CBT, I reached a maximum really of 'You're safe now, blah, blah, blah', all of that, and everything was ok-ish, but..." (Steve: 08:05).*

Steve also strikingly contrasts the speed and directness of EMDR processing, using the phrase *"OK, go with that!"* with what feels like a boring, frustrating and stuck quality of working with TF-CBT:

> *"I have a patient, she says 'You know that time where I felt I wasn't listened to by my friend?' 'Ok, go with that!' The first set she is right to her mother, so... we are accessing that channel. Whereas, if it was CBT, you would probably be focusing on the incident with her friend. Err and ... updating and blah, blah, blah..."* (Steve: 33:44).

Although *Steve* used this manner of speech several times in the context of describing his experience of TF-CBT, other clinicians also showed similar changes in speech pattern. For example, *Jo* contrasts her feelings of being out of control during EMDR Therapy, with the predictability of TF-CBT:

> *"I remember getting into a state about [the EMDR technique] and thinking, 'Oh my God, like I'm not doing it right' and feeling out of control, which is something I do feel with EMDR sometimes... [Whereas with TF-CBT] I feel more in control. Because we're doing a very 'And now, what do you feel and what do you see, and what do you taste and da, da, da.'"* (Jo: 19:27- 21:54).

Jo's rhythmic cadence describing the process of delivering TF-CBT recalls *Steve's* repetitions. These contrast markedly with *Sara's* enthusiastic and forward driving exclamations as she describes EMDR processing, evoking a sense of release like a greyhound out of a gate, which is similar to *Steve's "OK go with that!"* as follows:

"In session, when I'm processing … I let people process and - 'Go, go, go… go, go, go… go, go, go, GO!' [WAVING HER HANDS EXCITEDLY IN THE AIR]." (Sara: 59:34).

Given the often extreme therapeutic challenges trauma clinicians feel responsible for and have to be prepared to contain (as described in previous sub-themes), newly qualified clinicians may feel the need to stick closely to a protocol or manual, place a premium on feeling in control, and lack the confidence to be flexible (which may come later with experience), as *Kitty* describes for TF-CBT:

"Because it was my first time using that model, I was thinking 'Right, stick to the model, stick to the model'.   I know some of the more experienced practitioners would kind of play around with the model and they would introduce an update, but I thought 'No, stick to the model, you've got to stay on model'." (Kitty: 11:13).

Kitty's repetition of *"stick to the model"* seems to echo the way she feels she has to keep pulling herself back to the protocol, the structure of which may allay her anxiety and allow her to feel safely held by the model. This anxiety is not confined to inexperienced clinicians, nor to TF-CBT, however, as *Jo* described herself earlier in this section *"getting into a state"* with the EMDR protocol. *Kate*, a self-avowed champion of TF-CBT, accepted that her generic CBT foundations give her more confidence:

"Yeah, they go back a long way and you trust them and you know them, and I feel more confident in CBT than EMDR and … that is probably why I always start with

CBT, even if I know EMDR can work really well rationally, I feel more comfortable with

CBT and safer." (Kate: 1:04:44).

Rose, too, reflected upon the immediate feedback obtained from the client during TF-CBT that further increases her sense of control:

"It's probably more my own comfort zone, and it's that wanting to have a bit of control [LAUGHS]. Um... and containing the session. I want the session to be as safe and containing as possible, so if I'm not feeling safe and contained then I'd find it harder to make sure they're ok. … With TF-CBT, because there's more continuous dialogue, when you check in you'll get feedback immediately." (Rose: 12:08).

Annie, *Rose and Kate* all reported experiencing this immediate verbal feedback as helping reduce their anxiety, and *Annie* also notices that it may perform a similar emotion regulation function for the client, even if possibly at the expense of treatment efficacy:

"I suppose on the flip side one of the advantages - or disadvantages, potentially, in terms of efficacy - when people have to verbalise something in CBT you are automatically distancing them slightly from the intensity of the emotion. You've got to put words to it. So that puts the brakes on slightly for them." (Annie: 34:09).

However, this sense of *"putting the brakes on"* is one that other clinicians appear to find frustrating when delivering TF-CBT, as we shall see below. *Kate* takes a different view of the more distancing effect of verbalising in TF-CBT, as she explains:

"I think some people can be very detached when they are talking through a traumatic experience [using TF-CBT] but if they use EMDR they can't use the words to get that intellectual detachment. So sometimes, to try to help them get in touch with their feelings, I'll try EMDR to see if it can help them tap into their actual memory more, and feel some of the emotions." (Kate: 13:02).

Although clinicians enjoyed the sense of control and directionality that TF-CBT offers, it seems the containing aspects can also become constraining, as several clinicians seem to have discovered, particularly compared to the more effortless 'free-flowing' nature of EMDR processing they describe.

3.3.2 Constraining: "Clunky" and challenging

Sara vents her frustrations with what she perceives to be the long-winded and clumsy nature of TF-CBT trauma processing:

"With CBT …it's a bit more clunky: you're having to identify what the hot cognition is. And sometimes you think you've got it, and you update it and you've got the main one, but you haven't always got the subsidiary ones, or the bit that might make the complete difference." (Sara: 16:19).

She also warns that it may be easy to believe the client is making progress in TF-CBT, only to discover later through EMDR that an update hasn't had any impact:

"In EMDR, it's much more things are just slipping into place, being put together, whereas CBT is … it's just much more clunky. And also in CBT you think 'Oh I've done

that, I've looked at that cognition, and we've worked on that' and yet it hasn't actually

made any difference." (Sara: 46:36).

Sara later returns to this idea again, as it seems to preoccupy her:

"I always find it funny, with CBT, I think I've cognitively restructured something,

and I really believe it, and then, a few sessions later we do EMDR, and they have this

'light bulb moment' and you think, 'But I thought we'd covered that? I thought we'd done

that?'." [LAUGHING] (Sara: 1:16:49).

Steve agrees, arguing *"if [EMDR] is more effective with a client, why am I wasting my*

twelve sessions trying to focus on that [TF-CBT] hotspot, and we are failing?"(Steve: 23:24).

There is a related sense for clinicians that whilst TF-CBT might serve to progress the

direction of *their* agenda, this is not necessarily what makes sense or holds meaning for the

client. As a result, this agenda, at cross-purposes to the needs of the client, can perhaps feel

more like a battle imposed on the client than the collaboration CBT practitioners aspire to, as

Rose recounts

"I felt with TF-CBT it was like ... the timelines were almost more for me... and it

felt a bit more like I was putting it into ... my order, rather than how he's experiencing it

and... EMDR just freed it up and it felt like much more shifted. Whereas the CBT felt it

was a bit more of a battle, that it was trying to make sense of things and actually it was

making things more confused." (Rose: 36:49).

Other clinicians articulated this in the reverse sense, commenting *"EMDR is less confrontational" (Mattie: 05:08)* and *"it seems less persecutory" (Sara: 39:39).* However, not only was TF-CBT often experienced as confrontational or challenging to the client, but also as challenging in a different sense for the clinician, because of the hard intellectual work involved, as *Kate*, a keen proponent of TF-CBT, identified:

"I'd always prefer CBT... because I find it much more rewarding. I think it also feels more challenging... because it feels like... you're always trying to piece together... what it is that's maintaining the PTSD, what beliefs or thoughts, and how you can try to shift them... and get people to think of things in a different way. It just feels like it's more intellectually demanding... and it feels like in EMDR you are supposed to sort of hand over control to the person." (Kate: 37:10).

Alex's comments resonate with *Kate's*, and employ a striking metaphor:

"It's almost like with EMDR, the EMDR is in the driving seat. Maybe with the [TF-CBT] hotspot updates you feel that you're actually in the driving seat and you can kind of control it a little bit more, you know." (Alex: 15:36).

However, being in the driving seat may come at a price, both for the client and the clinician. *Sara* compares her experience of TF-CBT and EMDR work directly:

"I think it's really draining, the CBT, exposure work, really, really, draining, um, really tiring. If you were doing three EMDR sessions in a day, then that's alright. Three CBT, it just seems like so much more ... preparation somehow, as well." (Sara: 40:08).

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Kate too admits that, even though TF-CBT is her first choice, it

> "…feels harder. Like I definitely feel more tired after CBT sessions, because it does feel more intense, and I'm thinking and working the whole time. EMDR feels a bit… like I'm getting a break." (Kate: 28:09).

Finally, *Mattie* questions the effectiveness of the repeated exposure required by TF-CBT for the client:

> "Is this really the most useful approach? I remember about a year ago I went to have a meeting with Felicity de Zulueta and she actually said to me 'Look, it doesn't do patients any good to just go over their trauma like that', and I thought, 'Shit!'" (Mattie: 04:25).

Mattie goes on to consider, with some considerable emotion, the implications of this relatively recent development in trauma treatment thinking (de Zulueta, 2006; 2009), both for her clients, and for herself:

> "When does it stop being useful to go on and on about the same bloody awful thing? Some people are just not going to get that much better from seeing their husband and children killed in front of them. They're not. And then… to expect them to is, I think, just disrespectful… and immoral." (Mattie: 07:29).

I sense *Mattie's* anger and frustration at being part of a "*disrespectful … and immoral*" treatment paradigm, by uselessly repeating traumatic imagery - going "*on and on*" - as she explodes off the page with "*the same bloody awful thing*" and the emphatic definitiveness of "*They're not*".   She goes on to argue that the "*dominant discourse*" requires challenging and updating:

> *"People do write about that, you know? But somehow the dominant discourse is so dominant that people just don't ever let those thoughts come in." (Mattie: 07:29).*

The implicit and explicit questions raised throughout Theme 2 regarded the benefits of TF-CBT, both in terms of providing a sense of working within one's *"comfort zone" (Annie: 06.43; Rose: 12.08)*, and feeling more in control; this may help clinicians contain their clients' emotions, as well as their own anxieties regarding the considerable responsibility and complexity that trauma treatment involves - particularly with the clients who are more "*acute, more symptomatic and... more dissociated" (Mattie: 32:49).* As clinicians so evocatively described, TF-CBT offers a relatively predictable rhythm to sessions which remain largely under the clinicians' control in terms of timing, selection of hotspots for cognitive updates, the immediacy of feedback from the client, and the slightly distancing consequence of clients' repeated verbalising of emotionally upsetting material.

Added to these advantages is the wealth of publications available offering CBT tools and techniques, and the sense of confidence instilled by CBT's historical foundations in a well-evidenced theoretical base, as *Alex* recounts:

> *"The other thing that is... nice about TF-CBT is you feel like there's an awful lot of papers you can go to which weigh up this or weigh up that, and think about what do you*

with shame, what do you do with guilt, what do you with helplessness, and... if I'm

working using EMDR I'm borrowing a lot of those CBT ideas for that rather than ... I don't

necessarily find that the EMDR literature is as accessible… maybe... because CBT is

above and beyond trauma work… there just so happens to be more resources" (Alex:

18:42).

Given too, that EMDR Therapy is a relative newcomer to the trauma treatment world, and its empirical and theoretical basis, although rapidly growing, is not yet perhaps quite as extensive, it makes sense that clinicians may feel reluctant to move from their "*comfort zone*", as both *Annie* and *Rose* described it *(Annie: 06.43; Rose: 12.08).*   Even *Steve*, a proponent of EMDR Therapy, praised this aspect of CBT:

"I LOVE the theoretical framework of CBT… it's beautiful, it's very solid, it's very

understandable… It helps me in the sense that I'm not one of these blind EMDR

therapists who sees EMDR and sees nothing else. I still value the theoretical,

neurological model of CBT, the trauma model of CBT, that I think in EMDR is lacking.

There is increasing evidence to be fair towards EMDR but [the] theoretical … basis of

EMDR is not as solid as CBT… So I use a mix, of course, but I like to explain to my

patients the neurological model, or the trauma model, from the CBT point of view."

(Steve: 14:03).

And yet, as clinicians - even avowed fans of TF-CBT - described their experiences of the downsides of the approach, it became apparent to me, and to some of the participants too, that perhaps there was a need for some reflection and questioning of, as *Mattie* terms it, "*the dominant discourse*" of repeated exposure in trauma treatment.

3.4 Theme 3: "Trust the process"

Theme 3 – "Trust the process" emerged from participants' deeper examination of how they experience both the pros and cons of using EMDR and how these might impact their own and their clients' well-being. Three clearly differentiated but intertwining sub-themes emerged from participants' comments regarding EMDR Therapy. The first sub-theme focused around the differences clinicians perceived between the *"more conscious… more rational" (Sara: 46:36),* more analytic and verbally-based stance inherent in cognitively based exposure work and the noticeably more intense physical connections and reactions experienced – by both clinicians and clients alike - during EMDR processing.

A second sub-theme emerged from the reports of several clinicians who admitted feeling ambivalence at best, and extremely anxious at worst, about the perceived loss of control they experienced during EMDR processing. This was particularly apparent with the acutely symptomatic and frequently dissociative complex cases so prevalent amongst referrals to NHS traumatic stress services at present, as several participants had described. Comments emerging in this sub-theme reflected upon how confident (or not) clinicians felt in terms of being able to *"trust the process" (Annie: 25:10)* and relinquish some of their need for control.

The third sub-theme in Theme 3 opens up considerations of clinicians' experiences, alluded to in Theme 2 ("My comfort zone"), regarding concerns around the efficacy of TF-CBT. Clinicians seem to sense that, if they can *"trust the process" (Annie: 25:10),* EMDR Therapy often seems able to clear traumas that TF-CBT cannot shift, and it does so faster, and more comprehensively. This sub-theme includes clinicians' reflections on what the implications of these observations may be for their clinical practice.

3.4.1 Intense physical communication

Many interviewees broached the subject of the intensity of the physical connection between themselves and their clients during EMDR processing spontaneously, but also tentatively, as if they were unsure the subject was safe to approach. For example, after a pause in our interview, *Annie* without prompting, and almost guiltily as if it was something she wanted to confess, appeared to be exploring her feelings in the moment with a sense of curiosity and wonder:

"The other big thing that I've noticed… it sounds really obvious… but, it's like physically ... the difference... There's something a lot more physical about doing EMDR." (Annie: 22:30).

Annie linked this to the lack of verbal communication or feedback she got during EMDR processing, compared to TF-CBT, and how this led to an increased reliance on close scrutiny, on her part, of any physical signals or cues emanating from the client:

"You're watching someone so ... 'cos you're not getting the huge amounts of verbal feedback that you get in TF-CBT, you feel like you really are... watching them intently and you're looking at like, 'Oh, their throat just did a thing - is that, is that something?' You're watching them so intently and you're kind of doing the hand… [WAVES HER HAND TO AND FRO] ... and so I feel like I am literally … on the edge of my seat, maybe not in an anxious way, but I'm definitely very intensely ... yeah, there's something I'm very … focused in your body I think when you're doing an EMDR session, that I probably don't have as much when I'm doing TF-CBT." (Annie: 23:20).

I sense *Annie*, who is usually strikingly eloquent, here is almost feeling her way, struggling to articulate these new ideas that she clearly senses in her body. I notice, too, that she is perhaps unaware that her body language is unconsciously reflecting her words, through her hand gestures and leaning forward towards me, as I am sitting in her client's chair. At one point she abruptly switches back and forth between referring to herself in the first and second person, between feeling in her body (her 'felt sense' perhaps) and a more distanced observing of herself, when she remarks: "*I'm very ... focused in your body, I think, when you're doing an EMDR session, that I probably don't have as much…*" I wonder also if she is unconsciously describing the blurring or blending that can occur when focusing with such intensity on *"your body"* – is she referring to herself, or to her imagined client, sitting in my place?

Several clinicians comment on this intuitive blending with a client that seems to occur during EMDR processing and they tend to use the metaphor *"tuning in",* as if they are a tuning fork reverberating with each client's particular harmonic frequency. For example, *Steve* grapples to express the difference:

> *"You are more kind of tuned to the patient, rather than 'Go back to the hotspot dededededah dedededah'. It's quite different. You know you are tuned, you are just like able to ... you're just like able to... in my opinion, be more tuned to your client…"* (Steve: 15:33).

Sara, too, tries to describe what EMDR processing is like, but with the same sense of almost sheepish tentativeness as *Annie,* which is betrayed by her reference to the word *"wacky"* here:

"I'm tuning in with my client all the time. It's almost like - this is really wacky! - but it is almost like a channel of energy between me and them and I feel it. And I'm using this sensation in my solar plexus, when I'm doing the processing work, you know, using my feelings, that solar plexus feeling. … I think it's actually… such a privileged position, because it's almost like you join them in some ways, and that's when you know when [the processing] is going." (Sara: 33:13).

Rose too notices the intensity of physical communication during EMDR work, which she feels is somewhat less with TF-CBT, and, as if to make her point, I notice her eyes well up with tears as she remembers a recent EMDR session that has affected her deeply:

"…the kind of words she said was 'My heart broke' or 'My heart's breaking' and you could almost see that, because it was about bereavement. I found that a really upsetting session, and perhaps I wouldn't if I'd been using TF-CBT, but I think it was something about watching her physical response as she was saying those words, and you could... you kind of feel like your heart breaks for them. And you're… yeah ... [TEARS WELLING UP] … maybe I might have had that experience using TF-CBT but I think there was something about really watching her eyes and ... her face, while she was having that experience..." (Rose: 44:18).

Rose also makes a distinction between the effects of working in the two modalities in this respect:

"I feel it more physically at the end of an EMDR session, perhaps whereas cognitively with TF-CBT it might be more mental. Whereas I think I can feel a bit more tired in my body [after EMDR]." (Rose: 24:57).

Annie senses, too, that she is left with a different residue after a session of EMDR processing compared to TF-CBT:

"Potentially with the EMDR you get less... detail... so it's not like your mind can chew over... whereas with this [TF-CBT] guy there would be an image that potentially I could loop back to, and chew over..." (Annie: 39:27).

Annie's use of the metaphor to *"chew over"* reminds me of a tough piece of steak that it's necessary to work hard on to break down in order to assimilate into your system. Alternatively it conjures up an image of 'chewing the cud' as ruminants do, which perhaps resonates for me with the 'rumination' that people tend to do when they are trying to process something difficult. On the other hand, *Annie* remarks further on the physicality of EMDR processing which leads to an intensity of imprint that might need to be 'de-toxed' like a hangover:

"I would wonder if what you maybe do get left with a little bit more is a physical... a physical kind of hangover of the session that maybe you need to get rid of in some kind of way. Yeah, something that you hold a little bit more bodily, maybe..." (Annie: 39:54).

Annie also notices she finds EMDR Therapy more physically tiring, particularly if using her hand to induce eye movements in the client. Her repetition of *"my",* rather like a stuck

record, almost seems to be mirroring the tiredness of the physical repetitions of her hand movements and how that can translate into a 'stuckness' which is expressed in the faltering of her verbal pacing:

"But just physically, by the end of a long session, and then I notice that my hands are getting tired and my, my, my, um like pacing goes. That's quite tough." (Annie: 23:20).

The issue of repetitive strain injury (RSI) from the hand movements is not often brought up in regard to EMDR Therapy and I have not come across any research on this subject. However, if clinicians are seeing a number of clients, it does seem to become an issue, as several participants, like *Annie, Kate, Alex* and *Sara*, commented. Clinicians often went into descriptions and considerations of the various methods of bringing about bilateral stimulation (BLS) they had tried with their clients, and how differently these seem to be experienced by themselves and their clients. Although clinicians often acknowledged that the research to date (Lee & Cuijpers, 2013; Van den Hout, 2012) seems to support eye movements as the most effective method for processing, some also found bilateral tapping well tolerated by clients, particularly by those who it was felt needed a human connection, as *Jo* recounts:

"She actually needed the touch to stay grounded. She just needed the human touch … and we'd have these quite profound sessions where … you just feel connected. There's something about EMDR that can be very connecting ... in a way that TF-CBT... I don't know ... (Jo: 22:05).

Jo describes her 'felt sense' of the close connection of processing in a way that recalls *Sara's* evocation of being joined to her client, although *Jo's* contrast between her experiences of tapping to that of using handheld buzzers is worth citing in full:

"You know when you actually see someone who's really reliving something, you can just feel it anyway, cos there's a connectedness. Especially I've found with the [DEMONSTRATES TAPPING]. It's different with … buzzers… [they] are very distant, that's different. So for example, tapping … I'm sitting here, and I'm tapping on their hands, it's very close. You feel very close and if someone's weeping or shaking or… you're really joined and that can be very... very, very powerful and very healing for the person, but it almost feels as if you're absorbing it. Whereas when I'm sitting with the buzzers, I mean, I could be making my shopping list." (Jo: 46:46).

Jo's reference to her shopping list presents a strikingly dismissive image of detachment, very different to the intimacy and connection described with the tapping. In contrast, *Sara* argues *"What I like about the buzzers is, I don't get RSI from the arm [movements]… so it means it's easier too." (Sara: 28:53).* Given her previous comments about the intense emotional connection she experiences with clients, buzzers do not seem to distance *Sara* in the same way *Jo* experiences. *Alex* also sees advantages to using buzzers:

"A lot of people don't like you being that close to them, and so a lot of people hate the eye thing, you know ... [and] um it's really sore on your arm. Some EMDR trainers and supervisors place an awful lot of store in eye movements... I've not found it amazingly different." (Alex: 14:51).

Alex's account contrasts with several other clinicians' descriptions, such as *Mattie's* comments (quoted in full in section 3.2.3), where she experiences EMDR processing as

"more in your face… in the client's face, and in my face. But … people do like that … they seem to find the human nearness… intimacy… more acceptable."(Mattie: 16:48).

The closeness and physicality of processing in EMDR seems overall to imbue the communication which clinicians experience between themselves and their clients with a deep and intuitive emotional intensity. However, the physicality of EMDR Therapy also appears to tap into the clients' experiences of trauma memories in a session in a profound and powerful, if slightly mysterious, way. *Steve* for example identifies how he has found EMDR Therapy particularly good for working with physical trauma symptoms in clients:

"What I've found, and I can say now after my long practice, is EMDR is brilliant for anything 'body' - body flashbacks, physical flashbacks - it's really, really more helpful than CBT … Because part of the theoretical basis of trauma in general, as we know, [is] that your body stores the trauma in your senses." (Steve: 08:05).

Sara too recognises the power of working with the body to process trauma memories, even if she is mystified by the mechanism of how it works

"[What] the individual really clearly understands is, we're clearing this from the body. It's just the body sensation, we're just ... 'Let's just clear it, let's just do it'. And there's something … something… different about that process. There's something

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different, and I don't know why that is. Maybe it's because they're not having to say

everything about their experience?" (Sara: 23:16).

Sarah's repetition of the word *"just"* epitomises the gentle but powerful approach she

espouses with her clients, and the *"something different"* seems to evoke her tentative grappling

with the possibilities of what that powerful but mysterious process might involve. When she

hypothesises that verbal communication almost seems unnecessary, perhaps she is implying

that all the deep communication that is necessary has already been transmitted via the

physicality inherent in EMDR Therapy. *Sara* also echoes *Steve's* earlier comments in

distinguishing between the more 'intellectual' nature of CBT, compared to the very physical and

emotional alchemy of the EMDR process:

"The thing is, CBT is all very abstract and it's in the head, but if you look at

trauma, it's actually in the body, it's… they feel it." (Sara: 1:06:43).

I find myself wondering how unnerving it might feel for a cognitively trained clinician to

allow themselves to accompany a client through this very intense and viscerally physical

connection, which seems so powerfully reparative and transformative. The next sub-theme

explores clinicians' expressions of the anxieties and ambivalence they feel around learning to

have confidence and *"trust the process" (Annie: 25:10)* of EMDR work.

3.4.2 Confidence to "trust the process"

As we have seen from previous sections, referrals to TSCs are often characterised by

the extreme complexity and challenging nature of their traumatic symptoms. Clinicians, too,

frequently express great pride in their work and yet bear a heavy responsibility for their clients'

emotional and physical well-being, both during sessions and, as *Alex* commented, through

having to "*hold the client's story from one week to the next." (Alex: 44:35).* This burden may

manifest in the often considerable anxiety clinicians seem to experience, particularly around

elements of treatment that may be unpredictable or uncontrollable, such as dissociation. For

example, *Mattie* describes how the greater emotional lability of acute clients she selects for

EMDR Therapy can lead to an increased and (as *"always expecting"* implies) continuous sense

of anxiety for her:

> "*Often it's quite worrying… I'm always expecting the worst, which would be that
>
> they dissociate. And um… sometimes that does happen, and um… it's quite
>
> frightening." (Mattie: 21:23).*

Mattie has seen upwards of seventy trauma clients, using both EMDR Therapy and TF-

CBT, so her use of the word *"frightening"* feels unexpectedly frightening to me too, and I find

myself empathising with just how continuously stressful her work seems to be. However she

appears able to tolerate these strong emotions as she goes on to express an almost

humorously phlegmatic response to recognising a client's signs of dissociation during EMDR

processing:

> "*Err, if their eyes stop going from side to side then there's no point in waving
>
> around your arm any more. Um, yeah. If they can still move their eyes, even if they're
>
> crying, I wouldn't stop. Unless they looked really upset and I felt really sorry for them."
>
> (Mattie 24:32).*

In contrast, other clinicians, like *Jo* and *Kate,* notice feeling helpless, powerless, and out

of control when faced with the possibility of an EMDR client's dissociation, as *Kate* so vividly

describes her desperation to understand what is going on, regain a sense of control and do no harm to her client:

> *"I feel anxious using EMDR …and a little more helpless … I think my GREATEST fear is they'll get distressed and I will struggle to calm them down and make them feel ok again." (Kate: 08:04).*

For *Kate*, the unexpected and the unknown seem to be particularly stressful (as she elaborated in the prior sub-theme on coping strategies which involve psychological preparation and experience). An example is when she comments

> *"I think that's what's so scary - they SUDDENLY get emotional and you have no idea what they think or even guess, but you don't really know what's going on in their heads, and you don't even know if they'll dissociate, and it will be hard to get them back in the room, yeah. So maybe I'm just a ...control freak [LAUGHS] but I like to know what's going on as much as I can all the time..." (Kate: 1:11.56).*

These anxieties contrast vividly with comments from the two clinicians who appear most confident with EMDR Therapy, *Steve* and *Sara*. *Sara* almost seems to relish the emotional intensity of sessions, with a sense of 'bring it on!' as she says

> *"I don't worry about people experiencing emotion, I don't mind if they cry their eyes out, I don't mind if they're highly distressed. I think, 'Well, that's how you felt at the time, but you can tolerate it. We can tolerate it together.' And, maybe that's also helpful to them: they can see that I can sit with their emotion as well." (Sara: 49:40).*

Steve, too, demonstrates an ease with 'not knowing' that differs markedly from some of the other clinicians' experiences, and he shows a willingness to allow the client's processing to flow, trusting that *"whatever that is"* is exactly what needs to happen:

> *"… I don't know where is the patient, only when they give me the feedback will I know what actually made them [GASPS]... hyperventilate ... I know that's happening and I know there's something processing going on, so I'm not really concerned, yeah. And as long as the picture is changing, then I know that something's happening, whatever that is." (Steve: 33:20).*

Perhaps in lieu of the clinical experience regarding EMDR processing that takes some time to accrue, an antidote to the fear-inducing sense of not knowing is, as *Mattie, Alex, and Jo* all observe, is the close relationship that builds over time through knowing their clients really well. *Jo* provides an example as she describes a challenging EMDR treatment:

> *"Because I knew her very well I could tell when she would start to dissociate and so we did a lot of that... orienting her to where she was in the present, and... We'd go in and we'd go out, and we'd go in and we'd go out of the rape things ... and I felt I was enough in control of that to make that work." (Jo: 31:27).*

The gentle rhythm that *Jo* evokes with her repeated *"we'd go in and we'd go out"* is like a calming lullaby and it evokes so vividly in me the way she experiences hitting her stride. She seems able almost effortlessly - because, as she says, she remains just *"enough in control"* - to go with the flow and really *"trust the process" (Annie: 25:01)* of EMDR, allowing it to *"make that*

work" for her and the client. This contrasts with her much more staccato and almost panicky phrasing, very similar to *Kate's* earlier comments above, when *Jo* describes her anxious feeling of 'not knowing' at other times during EMDR processing-

> *"I'm only getting a few words, I don't know what's going on, and: 'Where are you?' you know? And I'm not getting a full detailed description of where you are, I don't know where you are, I feel out of control, I feel helpless, I don't want this person to be feeling ... you know getting re-traumatised" (Jo: 37:32).*

Jo's singing *"we'd go in and we'd go out"* forms a lilting and creative counterpoint to this sense of panicky deskilling that occurs when learning any technically challenging new skill simultaneously under pressure and in the absence of sufficient feedback. It also contrasts vividly with her previous description of TF-CBT cognitive restructuring, an almost bored and seemingly formulaic incantation – *"And now, what do you feel and what do you see, and what do you taste and da, da, da." (Jo: 21:54)* - which seems to evoke quite vividly how she experiences delivering TF-CBT in a session.

Another specific area that clinicians admitted to feeling unsure of, was how long to continue each set of BLS. *Jo* describes the desperate searching for clues when she says

> *"It's an inexact science, or … art really. When have you done enough taps, you know? When have you done looking, looking frantically for when is the facial expression changing? And I just wouldn't know, and I'd carry on tapping and I'd carry on tapping and I'd be looking and - are there tears seeping out, or aren't there? And I couldn't see... just what the hell is going on? So, it's much easier at some level to be able to ... talk." (Jo: 20:53).*

Annie and I share a laugh about the possibility of a future research study to explore this sense of 'not knowing' when to stop a set of BLS in EMDR Therapy, as she comments playfully

> *"I don't know what the hit rate of success is [LAUGHING], of 'I stopped because it*
> *felt right', you know? I mean that would be a fascinating research study in and of itself!*
> *Cos what I'm looking for [is] some kind of reaction in them, and then some kind of sense*
> *of that starting to subside slightly before you stop. But... you're not sure? [LAUGHS]"*
> *(Annie: 36:54).*

The common consensus amongst participants who commented on this seemed to be an intuitive sense of allowing a wave of emotion surge and pass, as the following descriptions attempt to capture: *"I'm watching for the emotion to go up and then come down again… yeah, so the peak and then the dip…" (Sara: 29:52),* and, *"I guess it's just trying to follow the wave? That's the only way I can think of describing it... or a strong emotional shift." (Rose: 32:06).*

Compared with comments from some of the other clinicians *Steve* appears relaxed and confident enough to cede control to, and share responsibility with, the client in terms of the progress of processing; this is perhaps an important therapeutic aspect of trauma work because, so often in their prior experiences, power and control may have been wrested away from a client (De Zulueta, 2006). As *Steve* says, regarding dissociation:

> *"I'm very laid back about it, like I say 'Fine, you know, you don't want to do it*
> *today, it's fine.' Or, we reached this place today, [they] dissociated, and they say 'Ok,*
> *today can we stop?' and I say 'Yeah, sure.' Um, so giving that control … I think they*

have it in CBT too I'm sure, but in my case, in EMDR, that 'Stop' sign - that's it, it's over.

Yeah." (Steve: 54:20).

This relinquishing of control cannot be forced; *Kate* admits reluctantly *"it feels like in EMDR you are supposed to sort of hand over control to the person." (Kate: 37:10).* She adds too that *"it's kind of like they're doing all the work… maybe if I felt allowed to … add things more, maybe I'd feel more of a therapist." (Kate:25:35)*, a wistful phrase which seems to capture the deskilling feeling of learning a complex new protocol, as well as perhaps the amount of active work which is involved in *Kate's* more usual role as a TF-CBT clinician.

Annie describes the dual responsibility she feels for having to contain both her and her client's feelings in the face of such uncertainty. Her *"ugh"* feels like a visceral expression of her distaste and aversion for this challenging learning process:

"'I think what's very different is, the [EMDR] processing will go where it needs to go, but you're not necessarily gonna know what that is. So I think there is that, much more that sense of 'ugh' [SHARP INTAKE OF BREATH], I don't quite know where it's gonna go. And that, I think, just feels quite challenging, as a therapist anyway, because you wanna feel like you're in control of it, partly for you, and partly for them." (Annie: 18:28).

The extent of just how difficult this relinquishing of control may feel for a clinician is evoked vividly in *Annie's* ambivalence towards being asked to trust in a process that she doesn't yet feel fully confident in:

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"'EMDR definitely involves a lot more trust. [My EMDR supervisor] talks a lot about 'You've got to trust the process, you've got to trust the process'. And I kinda go, yup, no, I am, I'm trusting it, but... BUT! It feels like I'm really anxious about it [SQUIRMING AND LAUGHING] and then... it will either go somewhere… OR you take it to supervision!" (Annie: 25:10).

Having the confidence to *"trust the process"* seems to only come as a matter of time, experience and practice, as *Alex* observes:

"I don't know if I would entirely subscribe to the more control thing [in TF-CBT] because I think you normally see by the changes in somebody's face [in EMDR]. I don't seem to worry about any of these things, I don't know whether it's cos I've been doing it for ages." (Alex: 56:26).

Sara displays also a confidence that seems to come from her belief in her ability to manage whatever comes up, and her faith in the client, when she says

"You're relying on the client to do the work, knowing in full faith that they will get there. … You have to trust the client and the client could go anywhere. See, I know, no matter what happens to my client, they'll be alright. [LAUGHS] And they'll be alright in the room and I know I can manage anything that comes up. I know that it doesn't matter what happens, I know it will be alright." (Sara: 26:18).

And if a clinician dares to take this leap of faith, they may experience the reward of an exciting and – another quasi- religious reference – potentially miraculous outcome. As *Annie*

imagines in her mind a successful processing she waves her arms in the air and exclaims animatedly *"Wheee.... let's go!! And it IS fascinating, where they go... sometimes..." (Annie: 44:07),* although I suspect the slight pause followed by *"sometimes"* still betrays her lingering ambivalence. With *Sara* there is no such ambivalence, but a repeated emphasis on how exciting and rewarding the work can be:

"It is exciting and the reward is amazing. And it is miraculous, so you do get a huge reward from EMDR which you don't get from exposure work" (Sara: 22:49).

If clinicians can allow themselves to *"trust the process" (Annie: 25:10)* it became apparent from these interviews that participants were describing their experiences of EMDR Therapy being able clear traumatic memories that TF-CBT cannot shift, and this potential for a *"miraculous"* outcome seems to add to the excitement and rewards of their work, as the third sub-theme will explore further.

3.4.3 EMDR Therapy clears traumas TF-CBT cannot shift

Most, if not all, participants – even those committed to TF-CBT as a first treatment choice - noticed that EMDR Therapy often seemed able to clear the traumas that TF-CBT cannot quite shift. A representative comment comes from *Annie,* as follows:

"[TF-CBT] helped, but it hadn't really quite done the job, so we just did a couple of sessions of EMDR and it cleared it out much better. [TF-CBT] might get a physical and emotional shift, but not necessarily all of it, not always. Not with the more complex trauma. I think that a very simple trauma - 'Oh look my leg's actually here, it's not

actually got chopped off' - Boom, fine, done. Not with the complexity of the trauma that

we deal with here. That's where EMDR really comes into its own." (Annie: 44:49).

Given, as *Annie* identifies, the complex and challenging nature of referrals to NHS
trauma services, and the ever increasing pressure on those services and the clinicians who
work in them, a treatment that seems to work faster and more comprehensively must merit
consideration. Variations on *Annie's* observations were provided by all participants except
Mattie, who uses EMDR Therapy and TF-CBT flexibly as she feels most appropriate. *Sara*
reflects in more detail on her experience of the incomplete 'clear' she gets with TF-CBT:

"I was doing the basic TF-CBT and exposure and, I know my outcomes are quite

good, but I never really felt secure that I would get the perfect result, that people would

be completely free from the re-experiencing. There was still, there was still... there in the

body, they still had that sense of... vulnerability. It wasn't completely gone. You see the

SUDS going down and yes, they say the SUDS have gone down, and also the intrusive

memories do go down, the nightmares go down, but... not completely." (Sara: 12:31).

Both *Sara* and *Steve* muse on what the mechanisms might be that seem to distinguish
how EMDR Therapy works from TF-CBT. *Sara*, a clinical psychologist well-grounded in CBT
theory and practice, almost seems to be referring to a notion of the unconscious as she reflects
on the difference:

"EMDR uncovers the unknown - unknown to me and unknown to the client - and I

think that it provides the, it's the magic key, that you can access through EMDR. With

CBT you think, 'THIS is what's going on'.   [Whereas] different bits of information fit

together with EMDR, and you think 'Ohh, I didn't realise THAT'." (Sara: 24:20).

Steve similarly hypothesises on the nature of EMDR Therapy that makes it so effective

in his view:

"EMDR has [a] certain psychodynamic component to it, which is this free

association: 'Just go with that'… and you allow the brain to heal. The assumption is that

your body heals after a wound, [so] why wouldn't your brain heal? So it's just wherever

the brain goes, I'm going with it. That free association, which is very psychodynamic

really, gave me that freedom to – no, it gives THE PATIENT the freedom to go to places

that CBT, if I'm focusing on the hotspot and updating that specific memory with their

feelings and thoughts and blah, blah, blah, doesn't really access." (Steve: 05:35).

It may be worthwhile here quoting an anonymised case study that *Steve* recounted to

me during his interview because it describes vividly the process during a treatment where,

unusually for *Steve* and at his client's request, he had begun by using TF-CBT and

subsequently changed to EMDR Therapy.

Steve's Case Study

"…She was raped by her boyfriend … and she had some intrusions to it and flashbacks. So we were targeting that, using TF-CBT, focusing on the worst moment, the hotspot, and trying to update, you know: 'You are safe now, blah, blah, blah', all that kind of thing.   In terms of ... [PAUSE] intrusions, there was decrease, but I never felt that there was full resolution of the trauma. She still presents hyper-aroused, and she still presents with some reliving in terms of sensations - YOU SEE: BODY SENSATION! BODY!   Now, where I noticed in CBT I reached a maximum really … and everything was ok-ish… BUT... there is still: 'Yeah, but I feel this and feel that'. And then I persuaded her actually to change modality and ... we started doing EMDR and ... before we realised it, her mind started to go down, when I did the floating back technique, back straight away to a sexual assault by her own father, which triggered exactly the same body sensation. She freaked out from accessing this information. Which it [would have been] really impossible to reach if I'm focusing on the hotspot. Um, she reached there, freaked out, I said 'Go with that', we continued the processing and here you got body sensations, everything, just shifted and… She's fine. She doesn't have it any more." (Steve: 08:05).

According to *Steve*, because the client's brain can go where it needs to heal itself, *"I don't have to target every single incident; you have the generalisation effect." (Steve: 08:05).* This is vividly illustrated by another example, where *Steve* recalls a client he treated briefly with EMDR Therapy:

"…Her father was very abusive for eight years sexually and we identified two specific traumas… that's the ONLY two we targeted. But the sexual abuse lasted for eight years. What happened to all of that? We didn't have to do that." (Steve: 08:05).

Sara too confirms *Steve's* experience that she believes EMDR Therapy clears the traumas that TF-CBT doesn't seem able to shift. In fact, she felt so strongly about the importance of her point, to make sure she got it across she asked me to switch the voice recorder back on at the end of our interview so she could reiterate her views, as follows:

"EMDR therapists would have the experience of 'THAT is just amazing, that's been completely cleared'. It is like a mini miracle. Whereas I don't think CBT therapists would say that in the same way. You just don't get the same result; you don't get the same clearing. Because in terms of EMDR, you will get a complete clear, whereas in terms of TF-CBT, you just don't. And I don't think that that is picked up in the research. In terms of those measures that you're using, yes, the measures might come down – ok, so you're not getting the intrusive memories - but are you getting that change in the body? It's a very cognitive measure, the PCL5. It's not picking up on 'What's it actually feel like now, after you've had treatment?' And an EMDR client would say 'I feel completely different and this is amazing, thank you for giving me my life back', whereas with CBT, it's just not the same." (Sara: 12.16).

3.5 Drawing Together the Themes

In summing up, I will let *Steve* return us full circle to the beginning of this analysis chapter as he talks about the compensations of trauma work. However, here he elaborates on the specific experiences of delivering EMDR Therapy that are so rewarding – the good

outcomes, the speed, the client's satisfaction and the way he feels EMDR seems able to clear

trauma more completely than TF-CBT:

"But you know the rewarding side of [EMDR] are the outcomes. The rewarding

side of it is really, really rewarding… because patients are like 'WOW, that's one

session!' I saw a guy the other day, he had lots of, a mix of things, GAD… Two

sessions. And he was going through things and going through things, and he said to

me, 'My God, that was magic'. Yeah, it's rewarding because you get the money, but you

get as well the satisfaction. In terms of EMDR, why I'm biased, is because it works

faster, and it accesses other things that CBT doesn't." (Steve: 51:10).

It is striking how many clinicians, as well as clients like *Steve's* above, refer to the idea

that EMDR Therapy is somehow *"magic"*. According to *Sara (24:20) "it's the magic key",* which

can unlock the mind's healing potential. Woven throughout this analysis there have also been

several references to an almost religious sense of a belief system with EMDR Therapy that a

clinician needs to be able to *"trust the process" (Annie: 25:10).* As *Sara* identifies, in ceding

control to the client, "y*ou have to trust the client … knowing in full faith that they will get there"*

(Sara: 26:18) and this can result in *"a mini miracle" (Sara: 12.16).* Perhaps this almost

superstitious belief in the magic of EMDR Therapy arises because we don't yet fully understand

the mechanisms by which these good outcomes are achieved. Perhaps too we should note

Alex's caveat, again couched in religious terminology, about "*the sort of slightly evangelical*

conversations about [EMDR]… that kind of put me off it." (Alex: 03:42). As he also observes,

"One of my difficulties with EMDR is that it seems to be very hard to say to EMDR people 'Oh, that didn't work that time'. They're not very amenable to that. Yeah. And I mean that's a superficial impression, but…" (Alex: 03:42).

Clearly, any therapeutic belief system needs to be able to withstand rigorous scientific investigation and EMDR Therapy is no exception. Part of the difficulty lies perhaps in the subtle shadings of meaning in therapeutic change which are so hard to capture quantitatively, particularly by cognitive measures not designed to ask the right questions, as *Sara* noted above (*12.16*). *Jo* captures the difficulty in defining the ephemeral quality of the EMDR process, when she says uncertainly *"It's an inexact ... um, science - or whatever you call it - art, really." (Jo: 20:53)* and yet, this is not to diminish the apparent effectiveness of its power, whereby "*people can come with diagnoses and leave without." (Steve: 03:11).*

When faced with such complex and challenging cases clinicians can feel trauma work is *"frightening" (Mattie: 21:23)* and may be tempted to fall back on their first training in the solidly evidence-based TF-CBT approach as their *"comfort zone" (Annie: 06:43; Rose: 12:08)*. They may feel more competent, in control, and confident that they will be able to contain the often unexpected and extreme emotions arising both in themselves and their clients. However, as *Mattie (02:29)* says, we need sometimes to be able to challenge *"the dominant discourse"* and this is doubly important when both clients' and clinicians' well-being may be at stake.

Kate challenged her own usual TF-CBT practice of gathering a lot of information from the client, when she reflected during our interview and came to the painful recognition *"If I'm slowing down treatment success because I need to know [all the details], it's a bit heart-breaking for the client." (Kate: 1:02:14)*. At the end of the interview, when I asked her if there was anything else she'd like to comment upon, she said

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"I just keep thinking that I should try to use EMDR more. I know it's so useful and good and I set myself up for not using it, except for people who are blocked and not progressing in treatment. So, yeah, that's all that was going through my mind… [SMILES]" (Kate: 01:15:43).

Reflecting on the interview process itself, it seemed particularly valuable to allow space for contemplation and reflection as to why we, as clinicians, do the things we do. Several clinicians approached me later and spontaneously said they'd enjoyed having the rare luxury of time to think about these issues, echoing *Jo's* comments, which were captured on tape:

"That's why this is so interesting to ask the question. You raise very big questions! The thing is, we don't, one doesn't, well, we don't talk like this. We're not encouraged to talk about these things in supervision. We just don't have time." (Jo: 1:07:53).

I am left feeling poignantly aware of both the privilege and responsibility to record and express as honestly and completely as I can the voices of these clinicians, who have generously gifted me with their time, and shared their thoughts and feelings with me about this aspect of their trauma work.

Chapter Four. Discussion

Having discovered a significant gap in the research literature, the aim of my study has been to explore clinicians' experiences of delivering the two NICE (2015) recommended treatment modalities for PTSD. I therefore employed a qualitative methodology using IPA to analyse interviews with five clinical and four counselling psychologist participants on their experiences of delivering TF-CBT and EMDR Therapy. In this study three themes emerged from this analysis, each with several sub-themes, as follows:

1. **"It's not about the modalities, really" – it's about trauma work in general**

    1.1. Compensatory rewards

    1.2. Connection with clients

    1.3. Cumulative costs

    1.4. Coping strategies

2. **"My comfort zone" – containing or constraining?**

    2.1. Containing: Confidence, competence and control

    2.2. Constraining: "Clunky" and confrontational

3. **"Trust the process"**

    3.1. Intensity of physical connection

    3.2. Confidence to "trust the process"

    3.3. EMDR Therapy Clears traumas TF-CBT cannot shift

These themes and sub-themes were introduced and described in some detail in the previous chapter. In this chapter I will draw together key conclusions from each of these three themes in turn whilst reflecting on how they relate to prior studies in this area as outlined in my literature review. I will then update considerations of reflexivity with a perspective from the end of the study, summarise possible limitations of the study and suggest opportunities for future research. Finally, I will consider the implications of my findings for counselling psychology.

4.1 "It's not about the modalities, really" – it's trauma work in general

One of the most striking findings first to emerge from this study was the unanimous assertion echoed by all participants that, as *Mattie* stated so robustly, *"It's not about the modalities, really" (Mattie: 45:27)*. This theme may therefore make sense as describing the overarching common denominators any clinician delivering trauma treatments is likely to experience. All participants recognised that any trauma work carries with it the potential for exposure to "*the very worst things that people can do to one another and on the flip side you also see some of the very best of humanity" (Annie: 03:54)*. From these common experiences emerged sub-themes considering the significant and meaningful rewards of the work, including the close therapeutic connections clinicians forged with their clients, as well as the negative changes to their perceptions of self, other people and the world they recognised accumulated over time as a result of trauma work, and the coping strategies they put in place to enable them to continue.

Because previous research in this area has not explored clinicians' experiences of delivering TF-CBT and EMDR Therapy, and often has not distinguished between different trauma treatment models, many of the observations to emerge from this first theme regarding generic trauma work therefore accord with existing research. However, because I used IPA to also explore how clinicians experienced delivering these two recommended modalities,

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participants were able to provide accounts of their lived experience of both approaches, which may therefore provide insights which go beyond the existing literature.

4.1.1 Rewards of trauma work in general

Previous research has shown that achieving good client outcomes is highly rewarding for therapists, both in general psychotherapeutic work (Norcross, 2002) and specifically for trauma treatment (Arnold et al., 2005). The sub-theme which emerged regarding the 'Compensatory Rewards' of all trauma work, no matter which modality, thus supports the literature in this area. As *Steve* commented, *"With trauma, I like the fact that people can come with diagnoses and leave without." (Steve: 03:11)*. All participants described how proud and privileged they felt to participate in this work, and how unusual trauma treatment was in being able to achieve such dramatic results compared to other mental health specialities, which they seemed to find very exciting, meaningful and intrinsically rewarding. This accords with research that finding significance and meaning in the work, and realising one has the ability to make a difference to the lives of trauma survivors, enhances trauma therapists' belief in their professionalism and leads to increased likelihood of VPTG (Manning-Jones et al. 2015). However, further in depth consideration by most participants, even the TF-CBT adherents and EMDR sceptics amongst them, seemed to indicate that the rapid results and complete 'clears' of trauma symptoms they experienced with EMDR Therapy were perceived as over and above that obtainable from TF-CBT; these apparent improved client outcomes were also described as ultimately even more rewarding for participants. This point will be returned to in Theme 3.

4.1.2 The importance of the therapeutic alliance for trauma work

Another sub-theme to emerge initially across both modalities, in keeping with the previous research literature, was the absolute primacy accorded by all participants to the

therapeutic relationship (Lambert, 1992). From what is known from the existing literature this experience of a reparative relationship is absolutely vital for complex trauma survivors who have experienced the worst breakdowns and abuse from their connections and attachments to other human beings (Cloitre et al., 2004; de Zulueta, 2006; Meichenbaum, 2013; Parnell, 2013).

However, it may be worth asking the question regarding how much this connection is both needed and experienced as a positive resource by the clinicians themselves, as much as by their clients, and whether choice of treatment modality affects the experience of this two-way connection. From several participants' comments, it appears that the close physical connection offered by EMDR Therapy may provide something to both client and clinician that is unavailable in TF-CBT. The therapeutic power of 'being with' someone lies at the heart of counselling psychology with its humanistic and phenomenological foundations (Mearns & Cooper, 2005; Milton, 2016). It also appears, from participants' descriptions, to be more characteristic of EMDR Therapy, with its subtle yet powerful emphasis on physical connection; participants also seemed to acknowledge that in their experience, clients, particularly those with complex trauma, welcomed this intimacy and human connection, despite – or perhaps because of – their previous traumatic experiences with other humans. This power of 'being with' may tap in to Gendlin's (2003) 'felt sense', and seems to contrast with the busier, more intellectual and task-oriented 'doing to' which appeared to characterise clinicians' experiences of TF-CBT. Several participants tried to express this distinction, and to articulate the nature of the two-way phenomenon. For example, as *Jo* reflected on the distinct differences she experienced during EMDR processing depending on her use of different BLS techniques, she noticed that these seemed to have significant implications for the level of connection she feels with her clients. There is increasing recognition of the vital social need we all have to feel connected with others, in particular during challenging and stressful situations (such as are exemplified by trauma work), in order to feel safe and maintain good mental and physical health (for example,

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Cacioppo & Patrick, 2008; Porges, 2003). This may be no different for clinicians than for the clients they treat; therefore a treatment approach which deepens therapists' 'felt sense' of their connection with their clients may also serve to increase the protective, resourcing and rewarding elements of trauma work for both.

4.1.3 Negative impacts of trauma work in general

In common with accounts which emerged from previous qualitative research (e.g. Arnold et al., 2005; McCormack & Adams, 2016), most participants in this study also admitted to experiencing negative impacts as a result of engaging in trauma work, whichever modality. Their comments seemed to document cumulative negative changes to their sense of self, others and the world, leading to social withdrawal and loss of connectedness to others, indicative of the defining characteristics outlined in prior research literature of VT and CF (Figley, 2015; Linley & Joseph, 2007; Pearlman & Mac Ian, 1995).

In terms of the overall negative impacts of trauma work in general, it was striking to note the very high and continuous levels of fear and anxiety expressed by many participants which was not limited to the more recently qualified. Therapist anxiety has been linked to reduced ability to empathise, especially for less experienced clinicians, which in turn affects the client-therapist relationship and lowers client satisfaction with therapy (Negd, Mallan & Lipp, 2011; Rasmussen, 2005). It is debateable, according to existing trauma work research (Dunne & Farrell, 2011; Haccoun & Lavigueur, 1979), how much these commonly expressed fears amongst the participants about losing control and being unable to contain a client's extreme emotions or ensure their safety during a session, might be due to individual differences in personal style, temperament and character, or how much other factors - such as therapist experience, training, social support (in particular supervisory and peer input), or type of therapy – are implicated. It may be that there is a particular kind of temperament or personality trait

which is drawn to the excitement, strong emotions, and potential unpredictability of trauma work, and equally, there may be personal characteristics which are less adaptive for this particular work, potentially leading to more stress and burnout for a clinician, and requiring greater organisational and training support. Indeed, the content analysis carried out in Dunne & Farrell's (2011) mixed methods study identified levels of anxiety and confidence and "personal style" (p.185) as factors affecting their participants' reported difficulties in integrating EMDR techniques. However, these factors were perceived as less relevant if their previous orientation was TF-CBT, compared to Integrative, Humanistic/ Experiential, or Analytic backgrounds. Some participants in this present study did report difficulties integrating EMDR, even with their prior training and practice in TF-CBT. Experience, or lack of it, did not seem to be the critical factor, although it may have interacted with anxiety, confidence and "personal style", or other individual characteristics and temperament differences. For example, other participants clearly relished emotional expression during sessions as part of the healing process; they reported little or no sense of anxiety regarding dissociation, and appeared sufficiently confident in their capabilities to hand a large measure of control for the session over to the client. Although therapist anxiety appeared across both modalities, it seemed to apply particularly to more newly qualified clinicians' fears regarding the 'free association' nature of EMDR processing, and the way TF-CBT, in contrast, provides a constant stream of reassuring information which some participants felt helped them contain strong client emotions and risk of dissociation. This finding differs somewhat, therefore, from responses to Lipke's (1995, 2012) survey, which rated EMDR Therapy as less stressful for both client and clinician, and with fewer negative side effects (such as dissociation and dropouts). It also differs from comments by trauma conference attendees, reported in van Minnen et al.'s (2010) study, who expressed a preference for EMDR Therapy because they found the exposure-based approaches more stressful, similarly fearing intolerable symptom exacerbation in their clients and consequent increased dropout rates. Whether these

differences are predicated on individual factors such as therapist experience and confidence with using the EMDR modality, or organisational factors, such as supervisory and peer support, or an interaction between the two, needs further clarification, as this has implications not only for therapist well-being but also potentially for negative side effects for clients.

As previous research shows (Haccoun & Lavigueur, 1979), younger or less experienced clinicians find anxiety and other strong emotions difficult to tolerate, both in themselves and in their clients, and this might explain why some of the younger and more recently qualified participants stated they preferred to remain in their *"comfort zone" (Annie: 06.43; Rose: 12.08)*. As noted repeatedly by participants in this study, TF-CBT - which was all but one clinicians' original training – continuously elicits verbal updates from the client and the sessions are more 'clinician-directed' than EMDR Therapy, where trainees are advised to 'let whatever happens, happen'. Despite EMDR's rigid and structured protocol and the insistence usually given in training and supervision to adhere to it, there may be something about allowing the client's 'free association' with EMDR Therapy which some clinicians experienced as very uncontaining compared to TF-CBT (whilst others found it exciting and exhilarating). There may be a Yerkes-Dodson effect in operation (Teigen, 2016) where ability to manage strong emotions interacts with more cautious or confident personality variables: as reported in this study, some clinicians may relish the excitement and emotional intensity of "front line" trauma work, others might feel ambivalent, and yet others seek ways to control and contain overwhelming emotions arising in themselves and their clients, including choice of treatment modality.

Similarly, Bartoskova's IPA study (2017) recognised that vicarious exposure to trauma can have a differing impact depending on the personal history and individual responses of each therapist, so clearly individual differences do play a part in clinicians' reactions to trauma work, although in precisely what way is still not clear. Previous quantitative research has also looked at individual factors, but has tended employ survey-based examinations of the effects of age,

experience and whether there is a past history of trauma (Craig & Sprang, 2010; Pearlman & Saakvitne, 2015). As therapist history of trauma was not the main focus of my study, no specific questions were asked in this area, and no participant spontaneously mentioned this issue during the interviews. There are many potential reasons why this subject was not brought up, if indeed it was a factor, including perhaps a desire for privacy in personal matters. However, studies have reported a higher than average incidence amongst therapists of past history of trauma and abuse (Pearlman & Mac Ian, 1995). Such experiences are linked to hyperactive nervous system arousal, and increases in anxiety and responsivity to perceived threat (van der Kolk, 2002; 2007). It might therefore be possible to speculate on possible links amongst therapist factors in this area. There is, too, acknowledgement of the closeness and considerable overlap between fear and excitement in healthy neuronal circuits (Cannon, 1953; Panksepp, 1998) and this knowledge could perhaps be harnessed as psych-education for potential trauma therapists to facilitate more positive interpretation and management of the strong sensations arising in trauma work. At present these ideas remain speculative and further research investigation would be needed to clarify these hypothesised relationships.

4.1.4 The importance of effective coping strategies

Given the high degree of ongoing anxiety expressed amongst many of the participants, notwithstanding choice of modality, it therefore makes choice of effective coping strategies all the more important, as previous research by Chrestman (1999) and Dunne & Farrell (2011) highlighted. Participants in Bartoskova's recent (2017) study identified a range of self-care and coping strategies, including team, supervisory and private life support, self-care such as exercise and mindfulness, the value of the therapeutic relationship and of maintaining healthy boundaries and life balance. All these factors were also identified as important by participants in this present study, thus supporting Bartoskova's (2017) findings. Three strategies in

particular deserve further attention – the protective (or defensive) role of psychological

preparedness, the importance of organisational factors such as supervision and peer support,

and the potential effectiveness of different forms of exercise.

Several participants, including *Kitty,* the youngest and most newly qualified clinician,

commented on how psychological preparedness enabled them to cope better with traumatic

accounts in session; they employed phrases such as to *"man up" (Kitty: 48.05),* described

functioning *"in 'horror mode'" (Kate: 44:13),* and used words like "*habituated" (Alex: 40:02)* and

"desensitised" (Rose: 52:03). These descriptions accord with Arnold et al. (2005) and Adams et

al. (2006), as both studies noted trauma workers may struggle to maintain empathic

engagement in order to protect themselves psychologically. Many of the participants' accounts

in this current study indeed did seem to describe a sense of girding themselves, almost like

knights armouring up to go into battle.

This psychological preparedness also fits with the literature on VPTG which recognises

that some distress may occur initially when inexperienced therapists hear traumatic accounts for

the first time (Arnold et al., 2005; Tedeschi & Calhoun, 1995, 2004). From participants'

comments it appears to be the novel or unexpected that has most potential to "*floor*" a therapist.

These findings also sit well with Merriman & Joseph's (2016) IPA study which reported that the

counselling psychologists they interviewed seemed to experience significant difficulties with use

of self in response to traumatic material, including numbing and distancing in order not to feel

flooded by the exposure; they were also able to recognise that this therapeutic use of self

continued to develop over time, both through ongoing training and experience of trauma work.

These participant reports may thus help to clarify anomalies in previous quantitative trauma

research regarding therapist age and experience, with younger age and less experience

associated with more therapist distress whereas increased experience - and presumably

exposure to trauma – is associated rather with increases in CS and VPTG (Craig & Sprang,

2010; Devilly et al., 2009). Manning-Jones et al. (2015) indicate research findings are very mixed concerning the relationship between VPTG and secondary traumatic stress. Further research might be important therefore, to distinguish between what is useful 'habituation' to novel traumatic accounts, and what comprises the cumulative negative changes in perceptions of self, others and the world that characterise VT and CF. This research also needs to include the role of organisational factors, particularly supervision and peer support, which have been implicated as important in facilitating clinician well-being and VPTG.

Indeed, Dunne & Farrell's (2011) content analysis identified not only personal but also organisational factors such as "workplace issues of non-acceptance of EMDR and bullying" (p.185) as relevant to the perceived difficulties integrating EMDR Therapy into clinical practice. Their finding - as well as that of Steed & Downing (1998), which recognised the crucial role of further education and training - was upheld by the current study. Participants noted that the support of the clinic, supervision, and even peers in the department was crucial as to whether they felt EMDR Therapy could be offered as a viable alternative, thus facilitating genuine client choice. Some participants also mentioned their experience of previous departments which had been less supportive of EMDR Therapy; this had dissuaded them from training and practicing in EMDR in the past, which they were now enjoying thanks to good organisational support and supervision. This finding also aligns with Cook, Biyanova et al. (2009) and Cook, Schnurr et al. (2009) regarding the importance of organisational factors, in particular training and supervisory support, workload, and time and financial resourcing, in facilitating clinicians' uptake of a new therapeutic modality. These resources were also found to reduce likelihood of burnout and promote VPTG (Linley & Joseph, 2007). These factors appear to be influential on novel therapy uptake over and above the knowledge that the treatment is an evidence-based practice (Addis, Wade & Hatgis, 1999; Cook & Wiltsey Stirman, 2015), and, indeed, in this study no participant

made mention of the influence of recommended treatment guidelines, whether WHO (2013), NICE (2015) or UKPTS (2017), on their choice of treatment modality.

One of the most helpful individual self-care strategies that the majority of participants identified was physical exercise. *Mattie's* suggestion, highlighting her experience of the particular effectiveness of bilateral activities, such as running and cycling, may be especially relevant for therapists needing to process their vicarious exposure to traumatic experiences after treatment sessions, no matter which modality; it implies that clinicians process traumatic material in the much the same way clients do, and that some form of BLS may serve to facilitate this processing. This hypothesis deserves to be further investigated and, if bilateral forms of exercise are found to be significantly more effective than other activities, the information needs to be more widely disseminated. It is particularly apposite given that Shapiro (2001) claims she discovered the foundations of EMDR whilst walking in a park and noticed her side to side eye movements alleviated her distress whilst she pondered a difficult personal problem. Given my interest in ecotherapy (Bazzano, 2013; Berger & McCloud, 2006; Buzzell & Chalquist, 2009), this also ties in with the known mental health benefits of walking in nature (Jordan, 2014; Milton, 2010). Green gym research shows that being in nature amplifies the beneficial effects of exercise, and BLS activities such as walking, running or cycling have typically, if inadvertently, formed the focus of these studies (Barton & Pretty, 2010; Pretty et al., 2007; Pretty, Peacock, Sellens & Griffin, 2005; Thompson Coon et al., 2011). The social isolation effects of trauma (whether primary or vicariously experienced) are well-known (Cozolino, 2010), and were noted by clinician comments in this current study too. Community and group nature-based activities offer a low cost and effective means of encouraging physical exercise, that also reduces trauma symptoms and enhances healthy connections with others (Bratman, Hamilton & Daily, 2012; Bratman et al., 2015; Corbett & Milton, 2011; Diamant & Waterhouse, 2010; Fieldhouse, 2003;

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Harris, 2013; Wise, 2015). This therefore may also be an area of potential benefit to both trauma clients and clinicians alike which is worth investigating in future.

Until now, this discussion has focussed on material arising from the first theme which appeared to show broad similarities between the modalities in terms of clinicians' experiences. This qualitative method allowed not only confirmation of much of the existing research findings but also extended them into new areas for investigation; participants' accounts offered glimpses of potential avenues to explore, in particular where differences experienced between the two treatment approaches seemed to arise.

Smith et al. (2009: 113) suggest it is "in the nature of IPA that the interviews and analysis will have taken you into new and unanticipated territory." (p.113). The remaining two themes to emerge from the interview data departed from existing research territory and it became clear, as participants continued to reflect more deeply on the nature of their work, that there appear to be distinct differences between their experiences of delivering the two modalities which may have implications for both client and clinician well-being. In fact, during interviews it was noticeable, as participants entered into their worldviews in their imaginations whilst describing their experiences of delivering TF-CBT and EMDR Therapy, how distinct changes in their physical, verbal and non-verbal, cognitive and emotional stances accompanied consideration of each modality (Ellingson, 2012; Finlay, 2011). When imagining themselves in a TF-CBT session, both proponents and critics alike of this modality appeared to change in similar ways: their body language seemed to close down visibly and their verbal descriptions tended towards the repetitive and stereotypical. In contrast, participants' descriptions of their EMDR practice seemed generally far more animated and vivacious, often accompanied by wide-flung arms, open facial expressions and an excited thrumming or dancing rhythm and flow to their speech. These verbal and non-verbal distinctions were so marked and seemed to cut across

whichever modality clinicians professed to prefer. I therefore chose to honour this clear-cut difference between participants' embodied understandings, as they grappled with responding to my research question, in the way that I structured the two remaining themes which emerged.

4.2 The containing vs. constraining aspects of TF-CBT as a "comfort zone"

Theme 2 focuses on "My comfort zone", which by and large taps into clinicians' experiences of delivering TF-CBT (their original training in all but one case). Several participants echoed *Annie* and *Rose,* who both described TF-CBT as their *"comfort zone" (Annie: 06.43; Rose: 12.08).* The feelings of confidence, competence and control some participants reported experiencing when using this choice of modality appeared to offer a sense of containment, both of their own and their clients' strong emotions; these factors are known to enhance trauma therapists' development of CS and VPTG (Stamm, 2002; Manning-Jones et al. 2015) and, although the link with resilience is thus far unclear, may serve as a protective resource for clinicians. However, a second sub-theme emerged as others described the structure of TF-CBT sessions as frustratingly slow and constraining. It was experienced by these participants as *"clunky" (Sara*: *16:19; 46:36),* intellectually demanding and mentally "*really, really, draining" (Sara: 40:08). S*everal clinicians also appeared to resent the confrontational and controlling stance they felt it necessitated.

Linley & Joseph (2007) identified that TF-CBT was negatively associated with VPTG and speculate that one reason for this is that TF-CBT therapists are more likely to work with severe client populations. However, this is not borne out by the current study's findings. Participants, even TF-CBT adherents, in the main tended to reserve EMDR Therapy for clients viewed as more symptomatic, dissociative, and treatment-resistant, with TF-CBT clinicians admitting to bringing it in as a last resort when TF-CBT has failed. As *Annie* commented, "…*with the*

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complexity of the trauma that we deal with here… That's where EMDR really comes into its own." (Annie: 44:49).

Despite participants' stated wishes to focus on client well-being and to offer their clients treatment choice, the reasons to select TF-CBT seemed, however, to speak more of certain participants' wish – or need - to feel in control, in particular regarding the structure, direction and timing of sessions, and clients' level of emotional expression. Often this seemed to link to a strong desire to contain both their, as well as their clients', anxieties, particularly with reference to their fears that clients could dissociate and potentially drop out of therapy as a consequence. There was overt reference to the use of TF-CBT's reliance on verbal content and cognitive focus as a means of putting the brakes on emotional expression, whereas EMDR processing, in direct contrast, seemed to be used to get clients more in touch with their emotions and prevent them intellectualising their fears. There was a recognition by some participants that perhaps a clinician's 'need to know', and to feel in control by using TF-CBT, might inadvertently be slowing or stalling the therapeutic process and not, ultimately, acting in the best interests of the client. Participants such as *Steve, Mattie, Rose* and *Sara* suggested that the client's brain and body seem to know best what is needed for healing to occur, whereas the clinician can only guess, and therefore a TF-CBT informed agenda might actually be blocking and getting in the way of a full and effective trauma recovery for the client. This tendency for some clinicians to want to 'put the brakes on' emotional expression and control their client's progress through TF-CBT may perhaps suggest a partial explanation for the research that shows that TF-CBT requires significantly more sessions than EMDR Therapy (Power et al., 2002; Shapiro, 2014; van Etten & Taylor, 1998).

Furthermore, whilst some clinicians expressed their fears regarding client dissociation, which they seemed to feel justified the use of TF-CBT in some cases, research shows that there are many levels from micro to macro dissociation which result in degrees of temporary cognitive

and language impairment as the pre-frontal cortex and language centres are inhibited (van der Hart, Nijenhuis & Steel, 2006). With EMDR, in contrast, it is sufficient for clients to maintain dual-attention awareness, and material can be processed, using titration if necessary, through cognitions, imagery, emotions, body sensations and ego state work (Paulsen, 2017). This may also partly explain why a therapy heavily reliant on cognitive and verbal processes, such as TF-CBT, may take longer and only achieve partial recovery.

As even cognitive therapy proponents like *Kate* note, TF-CBT feels like intellectually hard and challenging work (which she enjoys) but this also means it is often, as *Sara* admitted, "*really, really, draining… really tiring." (Sara: 40:08)* and it restricts the number of clients she feels able to see each day. The intellectually demanding and slow nature of the work may therefore be taking its toll on clinicians and their experiences may suggest one reason why earlier research showed that TF-CBT therapists are more likely to burnout (Linley & Joseph, 2007).

There is, too, a distinct contrast between TF-CBT therapeutic mechanisms aiming to achieve habituation and extinction, whilst leaving the original trauma memory intact and creating an overlay of adaptive cognitions, and the more extensive memory reconsolidation achieved with EMDR processing, which seems to result in a more complete resolution of trauma experiences, as predicted by the AIP model it is founded upon (Craske, Herman, & Vansteenwegen, 2006; Solomon & Shapiro, 2008). These distinctly different therapeutic mechanisms raise an important question for TF-CBT, as *Mattie*, reflecting on her experiences of this modality, asked: *"When does it stop being useful to go on and on?" (Mattie: 07:29).* Indeed, as *Mattie* continued her argument, at what point does it become necessary to challenge the prevailing dogma, the *"dominant discourse" (Mattie: 07:29)*, regarding the relative effectiveness and efficacy of TF-CBT and EMDR Therapy?

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4.3 "Trust the process" of EMDR Therapy to facilitate a rapid complete 'clear'

The third and final theme to emerge focused on what it was like for clinicians to go with the flow, to learn to have confidence and *"trust the process" (Annie: 25:10)* inherent in EMDR Therapy.

4.3.1   Intensity of the physical connection

Noticeably uncomfortable admissions emerged from several participants' accounts in the form of a first sub-theme acknowledging the intensely powerful physicality of the connection between clinician and client during EMDR sessions. This physicality, whilst serving to deepen the healing connection between clinician and client, seemed to be experienced as unnerving at first for some participants from traditional psychology backgrounds.

In addition, although EMDR Therapy might be experienced as less tiring mentally for the clinician than TF-CBT, from participant reports in this study it seems they tend to experience EMDR as harder work physically. Several clinicians commented they felt more physically tired at the end of EMDR sessions, and, underlying their discussion of choice of methods for bringing about BLS (arm movements versus tapping or handheld buzzers), lay the issue of repetitive strain injury (RSI). Research indicates that using side to side hand movements to bring about eye movements in the client appears the most effective method in terms of client outcomes (Lee & Cuijpers, 2013; Van den Hout, 2012). However, participants in this study, who described working exclusively with trauma clients for three or more days per week, mostly reported switching to use tapping or handheld buzzers to avoid RSI, even if, as *Jo* mentioned, the implications for the therapeutic connection may vary. Given the primacy accorded by all participants to the therapeutic alliance, it would seem that EMDR's ability to intensify this connection through the body might act as a powerful and positive resource for the client, as well as being deeply moving and rewarding for the clinician. It might be worthwhile to research this

area further, particularly as body-based approaches are increasingly recognised by the work of pioneers in trauma, such as Levine (2010), Ogden & Fisher (2015), Scaer (2014) and van der Kolk (2014), although they have yet to achieve the status of mainstream evidence-based practice. As Ogden et al. (2006) suggest,

> "… a thoughtful engagement with the client's embodied experience is largely peripheral to traditional therapeutic formulation, treatment plan, and interventions. The body, for a host of reasons, has been left out of the "talking cure". … By adding… body-oriented approaches to their repertoire, traditionally trained therapists can increase the depth and efficacy of their clinical work." (p.5).

The importance of the intense embodied connection participants seemed to experience with their clients during EMDR processing will be returned to later in this chapter.

4.3.2   Confidence to "trust the process"

The second sub-theme to emerge focused on participants' difficulties and ambivalences with letting go of their need for control and learning to have confidence and *"trust the process" (Annie: 25:10)* of EMDR. It is an experience which involves – linking to the first sub-theme – trusting in an intensely physical connection with the client, and thus appears unlike delivering any other verbally-mediated psychological intervention. A further experience relevant to EMDR processing is the anxiety which was reported in newly qualified EMDR practitioners concerning how long to continue BLS sets before pausing. Other clinicians described continuing BLS through sometimes very subtle indications that the client is experiencing a wave of emotion, and pausing once this has subsided. However, this can be difficult to observe, particularly perhaps for an inexperienced clinician, and any evidence-based information on the optimal moment to pause BLS may be very welcome as significantly reducing one source of clinician anxiety.

Research has shown that TF-CBT therapists find it easier to integrate EMDR into their practice than other orientations (Dunne & Farrell, 2011), perhaps owing to familiarity with following a treatment protocol and the similarities between some of the techniques (for example, cognitive restructuring and cognitive interweaves). Of the participants in this sample, all but one (*Steve*) had trained and practiced in TF-CBT first, and yet many still appeared to struggle with feeling confident in EMDR Therapy, even in a service which fully supported it and provided regular expert supervision, two factors which are shown to be critical to the uptake of any new therapy (Berger & Quiros, 2016; Cook, Biyanova et al., 2009; Cook, Schnurr et al., 2009). It seemed as though several clinicians, *Kate, Annie* and *Alex*, tended to start first with TF-CBT, their *"comfort zone"*, and then switch at the end of therapy to EMDR if symptoms haven't shifted. But, as *Steve* seems to suggest, if a clinician can be sufficiently confident to *"trust the process"*, that is, the 'free association' inherent in EMDR processing, then the client's mind is free to go straight to where it needs to in order to heal. This accords with Lipke's (1995, 2012) survey findings that 86% of clinicians reported the "emergence of repressed material" was more common with EMDR Therapy than other treatments, and only 3% reported it was less common. This 'free association' effect is linked to current theories explaining possible mechanisms underpinning the more complete and rapid recovery participants reported their clients may experience with EMDR Therapy (Solomon & Shapiro, 2008). This could be worth investigating further, as it may also help provide an explanation as to why the existing quantitative studies show that EMDR Therapy gives at least as good outcomes, yet faster, than TF-CBT (Power et al., 2002; Shapiro, 2014; van Etten & Taylor, 1998).

4.3.3   EMDR Therapy Clears traumas TF-CBT cannot shift

The third subtheme to emerge concerned clinicians' descriptions of achieving a more profound, rapid and transformative 'clear' with clients using EMDR Therapy, compared to the

response extinction obtainable with TF-CBT. Drawing together the threads from the three themes in this study, it appears that the notably intense and reciprocal physical connections participants described with their clients may be linked to these more complete 'magical' recoveries clinicians said they witnessed with EMDR Therapy, which seemed to be lacking in their descriptions of the exposure-based fear extinction they achieved through TF-CBT. As many current titles in the trauma literature reflect, 'the body bears the burden' (Scaer, 2014) and current models attest to the healing power of 'body-based' approaches (Ogden & Fisher, 2015; van der Kolk, 2014). Almost all participants commented on the effect – both on them and their clients - of the intense scrutiny of client facial and non-verbal signals required during EMDR processing. It may be interesting to investigate whether these intense human connections may also constitute a resourcing function, protecting clinicians from compassion fatigue and burnout, and enhancing their sense of satisfaction and reward from the work.   Thus participants' experiences seem to reflect current thinking in complex trauma research, which increasingly seems to be working towards a paradigm shift regarding the significance of more body-based approaches for healing trauma (van der Kolk, 2014).

In summary, using IPA as a qualitative research method to explore clinicians' experiences of delivering TF-CBT and EMDR Therapy has revealed overall similarities in the trauma work, in terms of costs and rewards, and the importance of the therapeutic alliance and of particular coping strategies, which by and large support and extend our understanding of existing research findings.   In addition this method has been able to provide distinctive and detailed accounts of participants' experiences that there are marked differences between the two modalities, which have opened up new lines of enquiry into the impact of choice of modality on clinician, as well as client, well-being.

4.4 Reflexivity

Looking back at all stages of this research project I have attempted to reflect continually on the assumptions and choices I made and to learn from the experience. For example, as a novice researcher, I learnt from practice interviews with colleagues to try to avoid leading questions which derived from my own expectations and biases. Nevertheless, I was encouraged to find that participants seemed confident enough to assert their views, as I felt this indicated they sensed a reasonably equitable balance of power during the interview sessions. For example, I did not expect participants - whether adherents of EMDR Therapy or not - to suggest, almost without exception, that they felt this modality is able to clear traumas that TF-CBT is unable to shift.

Reflecting further on possible biases and assumptions, I came to understand that my training in TF-CBT and EMDR Therapy cut both ways: although my prior knowledge provided me with the *appearance* of a common language and understanding of the modalities involved, common ground which may have facilitated the interview process with my participants, on the other hand I was concerned that I might assume certain meanings inherent in terms and descriptions that were in fact different for the interviewees (Langdridge, 2007). I tried to remain aware of what Finlay (2008) terms the 'seduction of sameness'. I therefore attempted to bracket off my own preconceptions of TF-CBT and EMDR Therapy in particular, and trauma work in general, during the interview, transcription and analysis process, and to notice how new information from participants affected my original views, by recording these personal reflections in my research journal. During analysis, in particular, I tried to pay close attention and remain open and curious to participants' own unique and particular (ideographic) perspectives, prioritising this new data, while also being open to the possibility of hidden meanings. This tension between description and interpretation became particularly apparent as I wrestled with making sense of and structuring participants' emerging themes (Finlay, 2008; Giorgi, 1992). I

felt a strong pull to impose my own interpretive, creative and more psychodynamic lens on themes, for example by contrasting notions of the 'container' and 'contained' regarding clinician and client anxieties (Bion, 1962). However, in writing down these concepts in my research journal and then setting them to one side, I was able to return to participants' lived experiences as expressed in the moment of their interviews (Giorgi, 1992).

This research has changed me in many ways, almost inevitably: I found I was witnessing participants' accounts diverging and converging with my own experiences, giving me fresh perspectives, as well as reassuring me at times that I was not alone in thinking or feeling a certain way. At certain points I realised how different our experiences may be. For example, as a clinician, I trained first in sensorimotor psychotherapy (Ogden & Fisher, 2015) for trauma work prior to TF-CBT and EMDR Therapy, so I realise only now that the intense physicality of EMDR work did not particularly surprise or discomfort me in the way several participants coming from TF-CBT backgrounds reported. Only through experiencing the interactive and dialectical nature of this research process directly myself, did I come to recognise and understand better the cyclical nature of this approach; the hermeneutic circle (or spiral as I prefer), involved continuous movement between the particular details emerging from an individual's account and my responses to them. These discoveries in turn changed me, my attitudes and preconceptions, as I attempted to distil out the essence of themes over each and every subsequent account. I recognise that how well I have been able to do this has inevitably been affected by my own experiences and motivations, which render me closer to Orford's (2008) 'impassioned listener' than an 'objective' scientist '. A particular example of this is where I came to realise that I myself as a trauma clinician had experienced considerable negative impacts from trauma work, as well as significant rewards, and I am left wondering whether the availability of information at the start of my training would have affected my choice of specialisation. As a result, at the end of this study I am left both painfully and passionately

aware of my belief in the necessity of informed choice for trainee trauma workers, and to achieve this fully we need to overcome the stigma and silence surrounding our own care and well-being.

4.5 Limitations of this study and opportunities for future research

Reflecting back on the process of carrying out this research study, I also became aware of the many choice points that occurred and decisions I took, which could have been made differently by another researcher. As a single researcher carrying out this study, certain limitations arise in the use of IPA, particularly the interpretative elements. I have attempted therefore to bracket likely assumptions and biases as far as I am aware of them and to document the process as fully as I can, following Moustakas' (1994) recommendations, although I have now come to understand how impossible it is to succeed in this process completely (Kvale, 1996). Accordingly, I also decided to extend the framework of Yardley's (2000) four evaluative principles to include her three subsequent recommendations (Yardley, 2008) in order to improve the validity of my analysis. Triangulation was carried out firstly by my research supervisor, who audited the analysis of one interview by reading the transcript and evaluating the documented evidence for the themes and sub-themes which emerged from it. One participant also evaluated my themes in detail and gave feedback confirming the faithfulness of my description and interpretation of her data. Secondly, member checking was carried out when I was recently invited back to the TSC to present my findings to a meeting comprised of seven of the nine participants; feedback from this session also helped to confirm whether they felt my data was an authentic reflection of their experiences. Thirdly, in common with Smith et al. (2009), Yardley (2008) also recommends leaving a comprehensive 'paper trail' of the research process. Therefore rigorous and systematic documentation of the particular

details of each stage of the research process was carried out so that the reader might also be able to fully understand and evaluate how the research process was followed.

There are, nonetheless, several limitations of this study which it is important to discuss. A first limitation is the cross-sectional nature of this study which meant that I was unable to quantify trauma exposure with any great measure of accuracy. There are few longitudinal studies in the literature, a significant weakness, given that both negative and positive impacts of trauma work appear to develop cumulatively over time; more longitudinal studies might therefore be able to address these limitations in future. A further related limitation is that of sample selection. Through careful selection of participants I aimed to achieve a homogenous sample whose accounts may be more relevant to counselling psychologists than most previous research. However, I recognise that despite this, participants' experiences of and exposure to trauma work varied significantly, and that, as clinicians, their accounts might afford a different perspective to that of, for example, social workers, psychotherapists and other trauma workers. However, Hefferon & Gil-Rodriguez (2011) recommend that with IPA the appropriate focus should rather be on transferability of findings from one group to another, therefore, it may be worthwhile for future investigations to extend the applicability of my findings to other groups of trauma care workers, as well as those treating specific types of trauma clients.

I recognise that a further limitation of this study is that I am reliant on the reports of clinicians, which necessarily provide only one viewpoint of the therapeutic relationship. Appreciating the inter-subjectivity inherent in my research question requires recognition that it is necessary to fully explore the "reciprocal and dynamic interplay of subjectivities of [both] therapist and client …" (Rasmussen, 2005, p.27). Unfortunately, ethical and logistical issues precluded gathering clients' accounts for this study. However, I recognise that clients may have different views and future research would be much strengthened by including both perspectives in the discourses surrounding effective trauma treatment (Rasmussen, 2005).

The tendency of clinicians to focus on their clients' experiences rather than their own meant I had to decide to exclude some interview data from analysis. Principally, I chose not to include my participants' considerations rationalising which modality worked best for which client. These responses did not directly answer my research question, which was aimed specifically at clinicians' own subjective experiences of delivering the two recommended modalities, and therefore did not meet my criteria for inclusion. However, future research might also investigate whether there are certain trauma client characteristics which would indicate that one treatment modality might be more effective and helpful to them than another.

In terms of opportunities for further investigation, several research areas seem promising. Firstly, more clarification is needed of the constructs, such as CF, VT and STSD, used to define and describe negative impacts of trauma work on the professionals who deliver it, and of the prevalence of clinically significant levels amongst clinicians; a greater use of control groups, and a better understanding of the relationship between exposure to trauma and development of negative impacts is also recommended (Elwood et al., 2011). There is scope too for clarifying constructs around PTG and VPTG: Manning-Jones et al. (2015) identify subtle but important differences between them and note there is a lack of accurate measurement for VPTG; neither is there sufficient understanding of the relationship of VPTG with either resilience or STSD.

Secondly, there is a similar necessity to improve the sensitivity of patient outcome measures. As *Sara* observed, most current clinical measures of PTSD (such as the IES-R and PCL-5) are verbally-based cognitive measures which do not seem able to pick up this extra dimension that participants in this study felt results in such a profound and miraculous recovery following EMDR treatment. It may be worthwhile therefore to investigate, clarify and confirm these client experiences first: Kvale & Brinkman (2009) recommend a mixed methods approach for this kind of enquiry, with a cross-over design where clients experience TF-CBT first then

EMDR Therapy, or vice versa, and complete IES-R and PCL-5 measures pre- and post- both treatments. In addition, semi-structured interviews could employ thematic analysis to explore those experiences of recovery which may not currently be being picked up by standard clinical measures. Subsequent research might then be able to explore more accurately the relationship between the effectiveness and efficacy of different trauma treatments and, in addition, the effects of these outcomes on clinicians' likelihood of experiencing burnout, CF or STSD, as well as increased CS and VPTG. Perhaps, in this way, it may be possible to challenge the *"dominant discourse" (Mattie: 07:29)*, that is, the hegemony currently surrounding TF-CBT, and open up research to explore in more depth and detail the mechanisms of transformation in EMDR Therapy that currently appear so *"miraculous" (Sara: 22:49)* and which seem to have such potential for enhancing both client and clinician well-being,

A third area of research which could be pursued involves an exploration of to what extent a good therapeutic connection provides meaning and a protective factor to therapists engaged in trauma work, and whether this would vary according to whether TF-CBT or EMDR Therapy is used. As an adjunct study, it might be interesting to compare the use of various EMDR methods for BLS in terms of their effects on the therapeutic alliance as these seem to be experienced differently from clinician to clinician; this may shed further light too on what is already known from previous research regarding client preferences and abilities for different BLS techniques (Herbert et al., 2000; Lee & Cuijpers, 2013; Rothbaum, 1997). I have been unable to find any reference to RSI in the current EMDR research literature, so from the point of view of clinician well-being, this issue might also be important to explore further. A final suggestion for a research study would be an investigation into the idea that bilateral types of exercise might be more effective at helping both clients and clinicians alike to engage in self-regulation as part of self-care. Beginning to build an evidence base of the most effective self-care strategies for clinicians engaged in trauma work would go some way towards meeting our

individual and professional, if not organisational, responsibility to mitigate negative effects of trauma work, as Iqbal (2015) recommended.

In sum, despite the limitations of this study, I believe the use of IPA methodology has allowed a more fine-grained exploration of some important and previously neglected aspects of trauma work (Moustakas, 1994). In so doing it has opened up a range of fresh avenues for future research, and my hope is this will also offer practical relevance for both client and clinician well-being when engaged in trauma work.

4.6 Implications for counselling psychology

Counselling psychologists well understand the tensions of working within the NHS (Strawbridge & Woolfe, 2010), which can often be at odds with fundamental tenets we value deeply, such as the validity of practice-based evidence (Rafalin, 2010), the importance of inter-subjectivity (Rasmussen, 2005), the primacy of the therapeutic relationship in repairing self-to-self and self-to-other connections (Milton, 2016), the fostering of resiliency and resources within a wider healthier community (Orford, 2008), and the positive psychology aim of achieving significant (in both senses of the word) PTG for clinicians and clients alike (Joseph, 2010, 2011; Joseph & Butler, 2010).

Returning to the assertion by Woolfe et al. (2010) I quoted at the beginning of this study, counselling psychology is distinguished as "… a particular approach to helping people, which propose[s] an alternative that challenge[s] prevailing approaches" (p.1). This study attempts therefore to question the positivist research paradigms which seem to have produced a reliance on using large scale surveys as a way of gathering data regarding impact of trauma work on clinicians, as well as restricted measures of trauma patient outcomes, both of which may support the CBT hegemony currently prevalent in guiding views on the most effective trauma treatment.

Recognising that clinicians' experiences of delivering trauma treatment and clients' experiences of recovery are complex and multi-faceted, using a qualitative approach such as IPA values the particular over the general in such a way that valid information and vital new insights arise (Moustakas, 1994). Information garnered from this study may therefore point the way to further research exploration by counselling psychologists, using a mix of methodologies as appropriate (Rafalin, 2010); future investigations may consider, for example, developing more sensitive and comprehensive measures of client recovery from trauma, a deeper questioning of what constitutes the most effective trauma treatments which are safe for both clients and clinicians, and more targeted and effective ways to 'care for the carers' than we achieve at present.

The Division of Counselling Psychology is about to develop a three-year strategic plan; it is anticipated that it will build on or adapt the existing BPS 2015-2020 Strategic Plan which contains six major objectives.   The first three key goals are of particular relevance to this study:

- *Promote the advancement in psychological knowledge and practice*

- *Develop the psychological knowledge and professional skills of our members*

- *Maximise the impact of psychology on public policy*

It is my aim, through publication of these findings in appropriate international mental health journals, such as the 'Journal of EMDR Practice and Research' and 'Counselling Psychology Quarterly' (please see Part B. Publishable Journal Article, which follows), and through presentation at one or more conferences on relevant topics, that this study may contribute towards opening up a more widespread exploration of the impact of trauma treatment on clinician well-being. To this end, my initial plan is to present a summary of selected key findings from my research at the EMDR UK & Ireland Annual Conference, London in March 2018, and at the Division of Counselling Psychology Annual Conference in July 2018. I have also been invited to send a version of the Part B. Publishable Journal Article to Dr Derek Farrell

with a view to reviewing for submission to be published in the 'Journal of EMDR Practice and Research'.

Following Iqbal's (2015) recommendations, dissemination of these findings may help to reduce the stigma of clinician compassion fatigue, and contribute to the production of trauma-informed guidelines which outline both the risks and rewards involved, as well as providing information on evidence-based effective coping strategies and self-care.   For example, Bartoskova (2017) and Dunne & Farrell (2011) identified similar coping strategies to those reported as effective by the participants in this study – in particular, the importance of professional, organisational and social support, as well as the clinicians' use of exercise, meditation and other individual self-care strategies. Making this information freely available means trauma practitioners can make informed choices to support their well-being and organisations may begin to fulfil their responsibilities towards therapists engaged in trauma work. Disseminating research which normalises the risks of trauma work may go some way towards reducing those risks, and this in turn also fully supports the principles regarding ethics and best practice set out for counselling psychologists in our professional guidelines (BPS, 2009; DCoP, 2009; HCPC, 2012).

4.7 Conclusions

In this study, it was striking how clinicians experienced similarities in the two recommended trauma treatment modalities, TF-CBT and EMDR Therapy, both in their negative impacts, but also in the considerable rewards they experienced, the strong therapeutic alliances they enjoyed with their clients and the range of coping strategies they employed to mitigate the stressors they experienced. There was a sense, however, that if clinicians felt confident enough to "trust the process" with EMDR, the more rapid and complete nature of the client transformations they witnessed has potential to add to the deep satisfactions – and excitement -

of their work. This finding is particularly important as it highlights previously unreported

differences in how the two recommended trauma treatments are experienced by clinicians, and

these may have significant implications for the well-being of both clients and their carers alike.

There is also a broader professional responsibility for us as counselling psychologists,

through triangulation of individual and professional experience with both qualitative and

quantitative research methods, to address real-world challenges (Kasket, 2016); in this case, to

identify and publicise factors affecting trauma practitioners' personal and professional well-

being, and in consequence, decisions regarding choice of treatment and its effectiveness for

individual and overall client outcomes, as well as its cost-effectiveness over the long term for

trauma service provision (Corrie, 2010).

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Appendices

Appendix A. Ethics application form & approval letter

CITY UNIVERSITY LONDON

Psychology Department Standard Ethics Application Form:
Undergraduate, Taught Masters and Professional Doctorate Students

This form should be completed in full. Please ensure you include the accompanying documentation listed in question 19.

Does your research involve any of the following? *For each item, please place a 'x' in the appropriate column*	Yes	No
Persons under the age of 18 *(If yes, please refer to the Working with Children guidelines and include a copy of your DBS)*		x
Vulnerable adults (e.g. with psychological difficulties) *(If yes, please include a copy of your DBS where applicable)*		x
Use of deception *(If yes, please refer to the Use of Deception guidelines)*		x
Questions about topics that are potentially very sensitive *(Such as participants' sexual behaviour, their legal or political behaviour; their experience of violence)*		x
Potential for 'labelling' by the researcher or participant (e.g. 'I am stupid')		x
Potential for psychological stress, anxiety, humiliation or pain		x
Questions about illegal activities		x
Invasive interventions that would not normally be encountered in everyday life (e.g. vigorous exercise, administration of drugs)		x
Potential for adverse impact on employment or social standing		x
The collection of human tissue, blood or other biological samples		x
Access to potentially sensitive data via a third party (e.g. employee data)		x
Access to personal records or confidential information		x
Anything else that means it has more than a minimal risk of physical or psychological harm, discomfort or stress to participants.		x

If you answered 'no' to all the above questions your application may be eligible for light touch review. You should send your application to your supervisor who will approve it and send it to a second reviewer. Once the second reviewer has approved your application they will submit it to psychology.ethics@city.ac.uk and you will be issued with an ethics approval code. You cannot start your research until you have received this code.

If you answered 'yes' to any of the questions, your application is NOT eligible for light touch review and will need to be reviewed at the next Psychology Department Research Ethics Committee meeting**.** You should send your application to your supervisor who will approve it and send it to psychology.ethics@city.ac.uk. The committee meetings take place on the first Wednesday of every month (with the exception of January and August). Your application should be submitted at least 2 weeks in advance of the meeting you would like it considered at. We aim to send you a response within 7 days. Note that you may be asked to revise and resubmit your application so should ensure you allow for sufficient time when scheduling your research. Once your application has been approved you will be issued with an ethics approval code. You cannot start your research until you have received this code.

Which of the following describes the main applicant? *Please place a 'x' in the appropriate space*	
Undergraduate student	
Taught postgraduate student	
Professional doctorate student	x
Research student	
Staff (applying for own research)	
Staff (applying for research conducted as part of a lab class)	

1. Name of applicant(s). (All supervisors should also be named as applicants.)

Joanna Wise (research student) and Dr Alexandra Mizara (supervisor)

2. Email(s).

███████████████████ **and** ████████████████

3. Project title.

Exploring therapists' experiences of using trauma-focused CBT and EMDR to treat patients with PTSD.

4. Provide a lay summary of the background and aims of the research. (No more than 400 words.)

Research centres on the impact of trauma-focused therapies on patient outcomes, but little to none compares the effects of these therapies on the therapists who administer them. NICE guidelines (NICE, 2015) equally recommend both trauma-focused Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitization and Reprocessing (EMDR) Therapy as the psychological therapies of choice for post-traumatic stress disorder (PTSD). Meta-analytic studies (for example, Van Etten and Taylor, 1998) conclude that EMDR Therapy is as effective as TF-CBT on most measures for patients, although EMDR Therapy does also appear to be more efficient.

There has also been considerable research to date on secondary traumatisation and burnout in healthcare professionals (see, for example, Figley, 1995, 2012; Maslach, 2003; Borritz et al., 2006), and trauma treatments are generally acknowledged to present particular risks to well-being for the therapists who carry them out (for example, Herman, 1997). However, no research compares TF-CBT and EMDR Therapy specifically in terms of their impact on the therapist's experience, whilst administering the treatment in session, during the interval between sessions, nor longer-term effects after treatment is complete. From my own experiences as a trainee counselling psychologist on placement at two NHS Traumatic Stress Clinics, and from the anecdotal experiences of colleagues, it appears there may be significant differences in impact for the therapist between these two approaches, which may therefore have important implications (all other factors being equal) on choice of modality. Given that, for counselling psychologists, the therapeutic relationship and use of self as a reflective practitioner form vital components of the fundamental ethos of our profession (Woolfe et al., 2010), selecting a therapeutic modality which will protect and resource the practitioner as well as the patient may

go a long way towards preventing the personal and professional costs of vicarious traumatisation and burnout.

The phenomenological and hermeneutic qualitative approach of Interpretative Phenomenological Analysis (IPA) will be used in this study to explore therapists' own experiences of administering EMDR Therapy and TF-CBT, focusing on the impact on them, both during and between sessions and at the end of treatment, when treating patients referred with PTSD. Counselling and clinical psychologists working in an NHS Traumatic Stress Clinic (TSC) setting who have qualified in both treatment approaches, and have experience of working with at least one patient in each modality, will be invited to participate in a semi-structured audio-recorded interview with the researcher. Transcripts will be analysed using IPA to explore themes pertaining to their experiences of working in both therapeutic modalities in terms of their relative impact on the therapist both during and between sessions, and after treatment has ended. It is hoped that themes arising may shed light on how we as counselling psychologists can contribute towards best practice in trauma treatment which cherishes and protects both therapist and client.

5. Provide a summary of the design and methodology.

This study will employ a phenomenologically-oriented qualitative design. Participants will be recruited from clinical and counselling psychologists working in an NHS Traumatic Stress Clinic setting who are qualified to use both TF-CBT and EMDR approaches for patients referred with a diagnosis of PTSD, and who have had experience of administering one full treatment programme of each type on at least one patient; a brief Participant Description Form (attached) will collect information on each participant's profession, qualifications and experience.

A minimum of eight participants will each be invited to take part in an individual audio-recorded semi-structured interview with the researcher, lasting approximately 60 minutes, in order to compare and contrast their experiences of using both therapeutic modalities to treat patients. A Topic Guide for the interviews is attached.

The audio-recorded interviews will be transcribed by the researcher and all identifying information removed from the transcripts. The transcripts will then be analysed using IPA to extract Initial Codes, and develop Categories, Themes and Theoretical concepts which describe and explore in some depth therapists' reported experiences comparing working in both therapeutic modalities in terms of their impact on their own well-being, with any implications for service providers and service provision that may result.

6. Provide details of all the methods of data collection you will employ (e.g., questionnaires, reaction times, skin conductance, audio-recorded interviews).

A short questionnaire (Participant Description Form, attached) to gather information on professional training and experience. An individual semi-structured audio-recorded individual interview (lasting approximately 60 minutes each) carried out by the researcher (please see Interview Topic Guide, attached).

7. Is there any possibility of a participant disclosing any issues of concern during the course of the research? (e.g. emotional, psychological, health or educational.) Is there any possibility of the researcher identifying such issues? If so, please describe the procedures that are in place for the appropriate referral of the participant.

Participants will be fully briefed before taking part in the research that, whilst disclosure of any mental health or risk issues cannot be ruled out, it will not be actively sought, as the focus of the study is on recounting their experience of using two differing therapeutic approaches when working in a professional setting with supervisory and managerial support.

The post-interview debriefing will last approximately 15 minutes and will provide an opportunity to assess whether the interview has raised any emotional issues. In the unlikely event participants require additional emotional support they will be provided with contact details of a counselling service.

Participants will be informed before the start of the interview that confidentiality will be maintained except where legal issues or concerns of harm to self and/or others are raised, in which case the participant will, where possible, be involved first in any decision to flag up these concerns with their supervisor and/or line manager of the service in which they are working.

8. Details of participants (e.g. age, gender, exclusion/inclusion criteria). Please justify any exclusion criteria.

Participants must fulfil the following inclusion criteria:
- Participants must be either fully qualified, HCPC registered, clinical or counselling psychologists contracted (on a paid or honorary basis) to work in an NHS Traumatic Stress Clinic setting, or Year 2 or 3 trainee clinical/counselling psychologists with sufficient prior clinical experience to be accepted on a supervised placement at the Clinic.
- Participants must have achieved at least a basic qualification in both TF-CBT and EMDR approaches
- Participants must have had experience of completing at least one full treatment on at least one patient in each modality.

Information regarding these criteria will be obtained by asking each participant informally and by inviting them to complete a Participant Description Form (attached).

There are no exclusion criteria in terms of age, gender, length of service or trauma treatment experience.

9. How will participants be selected and recruited? Who will select and recruit participants?

Initially, potential participants will be purposively invited by the researcher and then a snowballing strategy used to recruit further participants if necessary. Potential participants will be sent an email with a Participant Information Sheet giving details of the study (attached) and invited to respond to the email by contacting the researcher. There will also be Study Advertisements (attached) put on noticeboards within the Traumatic Stress Clinic with an email address for potential participants to use to contact the researcher.

Potential participants will be fully informed by the researcher, using the Participant Information Sheet (attached) as a guide, of the scope and content of the semi-structured interviews. It will be emphasised that there is no obligation to participate in the research, and it is possible to withdraw consent to participate in the research at any stage and for any reason.

10. Will participants receive any incentives for taking part? (Please provide details of these and justify their type and amount.)

Participants will not receive any incentives for taking part except necessary travel costs on production of receipts.

11. Will informed consent be obtained from all participants? If not, please provide a justification. (Note that a copy of your consent form should be included with your application, see question 19.)

Yes, please see Participant Consent Form (attached).

12. How will you brief and debrief participants? (Note that copies of your information sheet and debrief should be included with your application, see question 19.)

When a potential participant responds to the email invitation or to a Study Advertisement, the researcher will use the Participant Information Sheet (attached) as a guide to brief each participant regarding participation in the semi-structured interview for the research study. If they agree to take part in the study, the researcher will ask them to sign a Consent Form (attached).

Once a participant has signed the Consent Form agreeing to take part in the study, they will be asked to complete a brief anonymous Participant Description Form (attached) detailing their core profession, training and experience in the two therapeutic modalities. They will then be invited to take part in a semi-structured interview lasting approximately 60 minutes at their workplace, at a date and time convenient to them.

The researcher will brief participants again immediately before the interview using the Participant Information Sheet as a guide; in particular, participants will be reminded of their right to withdraw consent from the study at any time and for any reason.

The researcher will debrief participants following the interview and will provide them with a Participant Debrief Sheet to keep. It is anticipated the debriefing will take approximately 15 minutes to allow them to ask any questions they may have; it will also provide the opportunity to assess whether the interview has raised any emotional issues. In the unlikely event participants require emotional support they will be provided with contact details of a counselling service.

If participants wish to know more about the results of the study or any publications arising from it, they will be provided with the researcher's email address through which they can independently get in touch.

13. Location of data collection. (Please describe exactly where data collection will take place.)

Data collection will be in the form of digital audio files recorded on a Sony handheld voice recorder. Audio files will be transferred immediately after the interview to a password-protected laptop (which is stored in a locked metal filing cabinet) and then permanently deleted from the voice recorder. All electronic data stored on this laptop, including digital audio recordings, demographic data, interview transcripts, and research notes, will be encrypted and password-protected and each file will be identified only by a unique ID code. Participant Consent Forms which contain identifying data (names and contact emails) will be kept in a locked drawer in a separate location.

13a. Is any part of your research taking place outside England/Wales?		
No	**x**	
Yes		If 'yes', please describe how you have identified and complied with all local requirements concerning ethical approval and research governance.

13b. Is any part of your research taking place <u>outside</u> the University buildings?		
No		
Yes	x	If 'yes', please submit a risk assessment with your application or explain how you have addressed risks.

I will be visiting participants at a date and time of their choice at their NHS workplace; I believe it is reasonable to expect therefore that locations will be covered by regular statutory NHS health and safety risk assessments covering all staff and visitors alike on site.

13c. Is any part of your research taking place <u>within</u> the University buildings?		
No	x	
Yes		If 'yes', please ensure you have familiarised yourself with relevant risk assessments available on Moodle.

14. What potential risks to the participants do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.

Discussing the work of processing patients' traumatic events during the interview may raise emotional issues for participants. Most participants, by the nature of their work, will already have access to supervision support and their own personal therapy, but, in the unlikely event participants require further emotional support, they will be provided with contact details of an independent counselling service.

It is not anticipated that these interviews would raise any ethical issues with participants. In the extremely unlikely event an ethical dilemma might arise, the researcher, during the course of the interview, may, for example, sense that significant risk to of harm to participant, researcher, or other third parties such as patients, may be disclosed. However, the limits to confidentiality will be clearly outlined at the beginning of each interview and the researcher has recourse to her own research supervisor for advice should a complex issue of this nature arise.

As these meetings are taking place at the participants' own place of work, it is expected that statutory health and safety risk assessments, covering both staff and visitors, must be regularly carried out on NHS premises.

15. What potential risks to the researchers do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.

As participants may be discussing confidential case material concerning traumatic events which patients have brought to therapy, there is a small risk of vicarious (tertiary) traumatisation for myself as a researcher. However, whilst an exploration of participant experiences may encompass secondary traumatisation they have experienced in the past, it is a reasonable expectation that they would have received the necessary supervision and therapeutic input to help them process this material. Furthermore, as the Information Sheet will make clear, this research is not focused on any traumatic events participants may have directly experienced themselves. In addition, I have access to therapy and supervision sessions should I feel

affected by any elements of the research.

I will be visiting participants at a date and time of their choice at their NHS workplace; locations will therefore be covered by regular statutory NHS health and safety risks assessments covering all staff and visitors on site. Most participants will already be known to me, or known to other participants, so I feel the risks to my personal safety of interviewing on a one-to-one basis in a professional capacity in a workplace with other staff nearby, will be minimal.

16. What methods will you use to ensure participants' confidentiality and anonymity? (Please note that consent forms should always be kept in a separate folder to data and should NOT include participant numbers.)

Please place an 'X' in all appropriate spaces

Complete anonymity of participants (i.e. researchers will not meet, or know the identity of participants, as participants are a part of a random sample and are required to return responses with no form of personal identification.)	
Anonymised sample or data (i.e. an *irreversible* process whereby identifiers are removed from data and replaced by a code, with no record retained of how the code relates to the identifiers. It is then impossible to identify the individual to whom the sample of information relates.)	
De-identified samples or data (i.e. a *reversible* process whereby identifiers are replaced by a code, to which the researcher retains the key, in a secure location.)	
Participants being referred to by pseudonym in any publication arising from the research	x
Any other method of protecting the privacy of participants (e.g. use of direct quotes with specific permission only; use of real name with specific, written permission only.) ***Please provide further details below.***	

17. Which of the following methods of data storage will you employ?

Please place an 'X' in all appropriate spaces

Data will be kept in a locked filing cabinet	x
Data and identifiers will be kept in separate, locked filing cabinets	x
Access to computer files will be available by password only	x
Hard data storage at City University London	
Hard data storage at another site. *Please provide further details below*.	x

Hard data will be stored, along with the laptop containing electronic data, in a locked metal filing cabinet at the researcher's home. The exception to this is the participants' Consent Forms which will be kept in a locked metal filing cabinet at the researcher's place of work (which itself is only accessible through a staff pass and appointment system).

18. Who will have access to the data?

Please place an 'X' in the appropriate space

Only researchers named in this application form	x
People other than those named in this application form. *Please provide further details below of who will have access and for what purpose.*	

19. Attachments checklist. *Please ensure you have referred to the Psychology Department templates when producing these items. These can be found in the Research Ethics page on Moodle.

	Attached	Not applicable
*Text for Study Advertisement	x	
*Participant Information Sheet	x	
*Participant Consent Form	x	
Questionnaires to be employed		x
Participant Debrief Sheet	x	
Copy of DBS	Electronic copy available online	
Risk assessment		x
Others (please specify, e.g. topic guide for interview, confirmation letter from external organisation)		
Participant Description Form	x	
Topic Guide for Interview	x	

20. Information for insurance purposes.

(a) Please provide a brief abstract describing the project

This study will employ a qualitative design to explore therapists' own experiences comparing the impact of using TF-CBT and EMDR approaches to work with patients referred with PTSD. Participant clinical and counselling psychologists who meet the inclusion criteria will be asked to take part in a semi-structured audio-recorded interview lasting approximately 60 minutes, which will be conducted by the researcher in the therapist's own consulting room at the NHS Clinic where they work. Transcripts of tapes will be analysed using IPA to elicit themes regarding therapist experiences of the two NICE recommended therapeutic approaches for treating PTSD.

(b) Does the research involve any of the following:	Yes	No
Children under the age of 5 years?		x
Clinical trials / intervention testing?		x
Over 500 participants?		x
(c) Are you specifically recruiting pregnant women?		x
(d) Excluding information collected via questionnaires (either paper based or online), is any part of the research taking place outside the UK?		x

If you have answered 'no' to all the above questions, please go to section 21.

If you have answered 'yes' to any of the above questions you will need to check that the university's insurance will cover your research. You should do this by submitting this application to insurance@city.ac.uk, before applying for ethics approval. Please initial below to confirm that you have done this.

I have received confirmation that this research will be covered by the university's insurance.

Name …n/a…………………………………………… Date……………………………

21. Information for reporting purposes.		
	Please place an 'X' in all appropriate spaces	
(a) Does the research involve any of the following:	Yes	No
Persons under the age of 18 years?		x
Vulnerable adults?		x
Participant recruitment outside England and Wales?		x
(b) Has the research received external funding?		x

22. Final checks. Before submitting your application, please confirm the following, noting that **your application may be returned to you without review** if the committee feels these requirements have not been met.

Please confirm each of the statements below by placing an 'X' in the appropriate space	
There are no discrepancies in the information contained in the different sections of the application form and in the materials for participants.	x
There is sufficient information regarding study procedures and materials to enable proper ethical review.	x
The application form and materials for participants have been checked for grammatical errors and clarity of expression.	x
The materials for participants have been checked for typos.	x

23. Declarations by applicant(s)

Please confirm each of the statements below by placing an 'X' in the appropriate space	
I certify that to the best of my knowledge the information given above, together with accompanying information, is complete and correct.	x
I accept the responsibility for the conduct of the procedures set out in the attached application.	x
I have attempted to identify all risks related to the research that may arise in conducting the project.	x
I understand that **no** research work involving human participants or data can commence until ethical approval has been given.	x

	Signature (Please type name)	**Date**
Student(s)	Joanna Wise	10.10.16
Supervisor	*Alexandra Mizara*	17/10/2016

Reviewer Feedback Form

Name of reviewer(s).
Alexandra Mizara and Jessica Jones Nielsen

Email(s).
████████████████████

Does this application require any revisions or further information?		
Please place an 'X' the appropriate space		
No Reviewer(s) should sign the application and return to psychology.ethics@city.ac.uk, ccing to the supervisor.	**Yes** Reviewer(s) should provide further details below and email directly to the student and supervisor.	**X**

Revisions / further information required To be completed by the reviewer(s). PLEASE DO NOT DELETE ANY PREVIOUS COMMENTS.
Date: 11/11/2016 Comments: I do not believe the questions about related to this study are potentially <u>very</u> sensitive or believe there is potential for significant psychological stress, anxiety, humiliation or pain to be experienced by the participants during or after the interviews, which is supported by section 15. Therefore this would be considered a light touch review. I have no other issues with this except to consider my recommendation and make the necessary changes to reflect it. Please elaborate how your data will be de-identified or anonymous. You mention an anonymous participant sheet yet check that you are de-identifying data. This needs to be clarified. How long will you store data for? Jessica Jones Nielsen 11/11/2016

Applicant response to reviewer comments To be completed by the applicant. Please address the points raised above and explain how you have done this in the space below. You should then email the entire application (including attachments), with tracked changes directly back to the reviewer(s), ccing to your supervisor.
Date: 21/11/2016 Response: Thank you for your comments above, in view of which I have amended the check boxes on the first page to reflect your consideration that the questions related to this study are not especially sensitive, nor do they present the potential for significant psychological stress, anxiety, humiliation or pain for participants whether during or after the interviews, particularly in view of my response given in Section 14. I would very much appreciate that this study is therefore considered for a light touch review. I have tracked the amended check boxes accordingly as I recognise that perhaps I was over cautious as to the potential effects of the

consent form (which does have their name and signature on it) will, as previously stated, be stored separately from the participant sheets, audio files and transcripts.

Again, I was over-cautious in checking the option that I was de-identifying data; the reason I did so was in the event any identifying data (for example, the participant's name organisation, professional role) might arise during their interview. I wish to clarify that, in this event, any potentially identifying information would be de-identified and anonymised in the transcripts and therefore in any subsequent written quotes in the public domain. I have unchecked this box therefore and tracked the change.

The data will be stored for a maximum of three years. Once the doctoral thesis has been successfully completed and any papers arising from it have been published, the data – both hard and electronic copies – will be destroyed by shredding and permanent electronic file deletion respectively.

Reviewer signature(s). To be completed upon FINAL approval of all materials.	Signature (Please type name)	Date
Supervisor		2/11/2016
Second reviewer		11/11/2016

Psychology Research Ethics Committee
School of Arts and Social Sciences
City University London
London EC1R 0JD

28th November 2016

Dear Alexandra Mizara and Joanna Wise

Reference: PSYETH (P/L) 16/17 53
Project title: Exploring therapists' experiences of using trauma-focused CBT and EMDR Therapy to treat patients with PTSD

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval
Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments
You will also need to submit an Amendments Form if you want to make any of the following changes to your research:
      (a) Recruit a new category of participants
      (b) Change, or add to, the research method employed
      (c) Collect additional types of data
      (d) Change the researchers involved in the project

Adverse events
You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee (   ), in the event of any of the following:
      (a) Adverse events
      (b) Breaches of confidentiality
      (c) Safeguarding issues relating to children and vulnerable adults
      (d) Incidents that affect the personal safety of a participant or researcher
Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

Hayley Glasford   Richard Cook
Course Officer   Chair
Email: Email:

Appendix B. Traumatic Stress Clinic authorisation for research

PRIVATE AND CONFIDENTIAL

Mrs Joanna Wise
97 Crewys Road
London NW2 2AU

7ᵗʰ December 2016

Dear Joanna,

Re: Research on therapists use of EMDR and tf-CBT for PTSD

This is to confirm that you have permission to carry out your research into this subject by recruiting staff from the Traumatic Stress Clinic following your recent Ethics Approval from your university.

We wish you all the best with your project. Please come and present your findings at the Monday team meeting once it is complete.

With warmest good wishes,

Service Manager

Please note my hours of work are: Mondays-Thursdays 0900-1700.

Appendix C. Recruitment poster

CITY UNIVERSITY LONDON

Department of Psychology
City University of London

**PARTICIPANTS NEEDED FOR RESEARCH INTO CLINICIANS' EXPERIENCES
OF USING Trauma-Focused CBT and EMDR Therapy
TO TREAT PATIENTS WITH PTSD**

We are looking for volunteers to take part in a study exploring clinician experiences of using trauma-focused CBT and EMDR Therapy to treat clients diagnosed with PTSD.
If you are a clinical/counselling psychologist (qualified or trainee) trained in both TF-CBT and EMDR Therapy, (and have completed treatment with at least one client in *each* approach) I would be very interested to hear about your experiences.
If you agree to take part in the study, you will be invited to participate in a (60 minute) audio-taped semi-structured interview to compare your experiences as a therapist of working in the two modalities; both recently qualified and more experienced clinicians' views are welcome.

For more information about this study, or to take part, please email:
Joanna Wise (Researcher) - ▇▇▇▇▇▇▇▇▇▇▇▇▇▇
or Dr Alexandra Mizara (Supervisor) - ▇▇▇▇▇▇▇▇▇▇▇▇▇

This study has been reviewed by, and received ethics clearance through the City, University of London Psychology Department Research Ethics Committee [PSYETH (P/L) 16/17 53].
If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on 020 7040 3040
or via email: ▇▇▇▇▇▇▇▇▇▇▇▇

Appendix D. Participant information sheet

CITY UNIVERSITY LONDON

PARTICIPANT INFORMATION SHEET

Title of study:
Exploring clinicians' experiences of using trauma-focused CBT and EMDR Therapy to treat clients with PTSD.

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. Please ask us if there is anything that is not clear, or if you would like more information.

What is the purpose of the study?
Recent NICE guidelines recommend trauma-focused Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitization and Reprocessing (EMDR) Therapy as equally effective treatment approaches for post-traumatic stress disorder (PTSD) in terms of patient outcomes (NICE, 2015).

However, there is no research comparing the effects of using these approaches on the therapists who administer them. The aim of this study therefore is to find out whether these equally recommended trauma treatments differ in terms of their impact on the clinicians who carry them out, and if so, in what way(s).

I aim to complete this research by September 2017 as one component of my doctorate in counselling psychology at City, University of London.

Why have I been invited?
If you are a clinical or counselling psychologist (qualified, or in Year 2 or 3 of your training) currently working in an NHS Trauma Service, who is qualified in both TF-CBT and EMDR Therapy, and you have completed at least one full treatment in each modality with a client referred with a diagnosis of PTSD, I would very much like to interview you about your recollection of your experiences, both during and after sessions, and on completion of treatment, when working in these two different therapeutic approaches. I aim to complete a minimum of 8 individual interviews for this research.

Do I have to take part?
Participation in the research is entirely voluntary. You can choose not to participate in part or all of the study and can choose not to answer questions which are felt to be too personal or intrusive. You can withdraw at any stage without being penalized or disadvantaged in any way.

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, without giving a reason.

What will happen if I take part?
If you decide to take part, you will be invited to complete a short Participant Description Form to provide a summary of your core profession, training and experience in both TF-CBT and EMDR Therapy. You will then be invited to participate in one semi-structured interview lasting approximately 60 minutes with

myself, the researcher, Joanna Wise. This interview will take place at a date and time of your choosing, and at your place of work.

During the interview I will invite you to tell me in some depth about your experiences of administering both TF-CBT and EMDR types of trauma treatment, focusing on what it is like for you during a session, during the interval between sessions, and once treatment has concluded. I will ask you to describe your experiences of these two recommended treatment types to consider the advantages and drawbacks of both approaches.

I will transcribe, anonymise and analyse all the interviews myself to see if any identifiable themes arise from clnicians' reports of their experiences. I am very interested in clinicians' own words to describe their experiences, and so I would like also to use your comments (completely anonymised), if I may, to bring life and depth to the study. I'd like to emphasise that your contribution will be anonymous to protect your identity, but it will be much valued and appreciated nonetheless. The information you provide will form a valuable contribution to a doctoral research study, and an excerpt of this research may also be submitted for publication to a relevant mental health journal.

Expenses
I am very happy to arrange to meet with you at a date, time and location that suits you. If this involves any special travelling on your part, I would be happy to reimburse your travel expenses as necessary. Please keep any receipts and approach me for further details.

What are the possible disadvantages and risks of taking part?
It is unlikely, but possible, that taking part in the interview might raise some uncomfortable thoughts, memories or feelings for you. These are likely to be transient and you should not experience any long-term harm or side effects. However, please raise any difficulties or concerns at any time with either myself or my research supervisor (see contact details below).

There will be an opportunity to debrief at the end of the interview, so it is important to let me know as soon as possible if you feel any adverse effects. We can then discuss how best to support you, which may include providing information on where you may be able to access further help and support.

What are the possible benefits of taking part?
There are no direct benefits for participants taking part in the research, beyond an opportunity to reflect on and evaluate the experiences you have had of administering both types of trauma treatment.

There is, however, an indirect benefit in that your views, comments and feedback may also contribute to a greater understanding of the benefits, uses, and limitations of the currently recommended treatments for PTSD, in terms of impact on the clnicians who administer them.

What will happen when the research study stops?
During the life of the research study both raw and analysed data, and any identification codes, will be stored separately and in password protected and encrypted data files.

At the end of the research study your original data will be destroyed. Only anonymized data that was included in the thesis and any publication or presentation will remain. The anonymity of your contributions will be assured.

Will my taking part in the study be kept confidential?
- Yes. Only the researcher is able to link participant names to the interview data.
- Personal (identifying) information will be disguised or removed from the interview data; names, contact emails, consent forms and any other identifying information will be stored separately in a locked safe, away from the anonymised interview data.

- Audio recordings, transcription files and any research notes will be password protected and stored on a password-protected laptop in a locked safe. All data will be destroyed when the research study ends.
- Participant confidentiality will be respected, unless there are concerns regarding reporting of violence, abuse, self-inflicted harm, harm to others, or criminal activity.

What will happen to the results of the research study?
The results of this research will be published as a doctoral thesis, and may also be submitted for publication in a relevant journal, such as the *Counselling Psychology Review*, the *Journal of EMDR Practice and Research*, or *Behavioural & Cognitive Psychology*. The results may also be presented at a conference, such as the 'British Psychological Society Annual Conference'.

If you are interested to receive a copy of any published paper or a summary of results please write to me at █████████████████

What will happen if I don't want to carry on with the study?
You are free to withdraw from the study without an explanation or penalty at any time.

What if there is a problem?
If you have any problems, concerns or questions about this study, you should first ask to speak to a member of the research team.

If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 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: *Exploring therapists' experiences of using trauma-focused CBT and EMDR Therapy to treat patients with PTSD.*

You could also write to the Secretary at:
Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London EC1V 0HB
Email: █████████████████████████

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?
This study has been approved by City University London Psychology Department Research Ethics Committee – Ethics Approval Code: PSYETH (P/L) 16/17 53.

Further information and contact details

If you have any further inquiries about the research please contact:

Joanna Wise (Research Student) ██████████████████████

or Dr Alexandra Mizara (Research Supervisor) ████████████████████

Thank you for taking the time to read this Information Sheet.

Appendix E. Participant consent form

CITY UNIVERSITY LONDON

PARTICIPANT CONSENT FORM

Title of Study: *Exploring clinicians' experiences of using trauma-focused CBT and EMDR Therapy to treat PTSD.*

Ethics approval code: PSYETH (P/L) 16/17 53   Please initial boxes:

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: • Completing a short form asking me about my professional training • Being interviewed by the researcher • Allowing the interview to be audiotaped	
2.	This information will be held and processed for the following purpose(s): • To answer the research questions • To include in a doctoral thesis • To include in one or more papers for publication in appropriate professional journals • To include in one or more presentations at professional conferences. I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

_____   _____   _____
Name of Participant   Signature   Date

_____   _____   _____
Name of Researcher   Signature   Date

When completed, provide 1 copy for participant; 1 copy for researcher; Note to researcher: to ensure anonymity, consent forms should NOT include participant numbers and should be stored separately from data.

Appendix F. Participant description form

CITY UNIVERSITY LONDON

Exploring clinicians' experiences of using trauma-focused CBT and EMDR Therapy to treat PTSD.

PARTICIPANT DESCRIPTION FORM

Before taking part in a semi-structured interview with the researcher, please complete the following brief details to describe your professional qualifications, training and experience. *Thank you.*

Participant ID	Please leave blank
Gender:	
Age:	
Core Profession:	Please circle one: . Clinical psychologist : Trainee / Qualified Counselling psychologist : Trainee / Qualified Other profession (please specify): _____. Start Date of Training (if trainee): Date of Qualification (if qualified): Years of clinical experience (general): Years of clinical experience (trauma):
Trauma-focused CBT:	Name of training organisation: Level of highest qualification: Date highest qualification achieved: Approx. no. of trauma cases treated with TF-CBT:
EMDR Therapy:	Name of training organisation: Level of highest qualification: Date highest qualification achieved: Approx. no. of trauma cases treated with EMDR Therapy:

Thank you for completing this form.

If you have any questions please do not hesitate to contact me at the following:

Joanna Wise (Research Student) ▮▮▮▮▮▮▮▮▮▮
(or Dr Alexandra Mizara (Supervisor) ▮▮▮▮▮▮▮▮▮▮ .)
Ethics approval code: PSYETH (P/L) 16/17 53

Appendix G. Participants' biographical & professional descriptions

Pseudonym	Gender	Age*	Core Profession*	# Years Clinical	# Years Trauma	# TF-CBT Clients	# EMDR Clients	Preferred modality
Mattie	Female			12	9	20	50	Both
Kitty	Female			3	1	8	4	TF-CBT
Annie	Female			8	5	30+	12	Both
Rose	Female			5	5	30+	5	Both
Steve	Male			14	14	10+	125+	EMDR
Kate	Female			15	15	150	25	TF-CBT
Jo	Female			7	6	120+	35	EMDR
Sara	Female			17	3	10	25	EMDR
Alex	Male			12	10	60	40	TF-CBT

*The information in these columns has been redacted for the purposes of participant anonymity

for the City, University of London library copy.

Appendix H. Interview topic guide

TURN ON RECORDER!

Thank you for agreeing to take part in this study.

(Check the Study Information Sheet, Consent Form and Participant Description Form).

As you may know, NICE guidelines (2015) equally recommend TF-CBT and EMDR Therapy for PTSD in terms of patient outcomes. To my knowledge, however, no one has yet compared the impact of administering these treatments on the clinicians themselves. I am really interested in how you experience working with these two treatment approaches (all things being equal for the clients).

1. Please can you give me a brief summary of your training and experience in TF-CBT and EMDR Therapy until now (i.e. resumé of completed Participant Description Sheet)?
   How did you come to specialise in trauma work?

2. Can you describe to me the main experiences for you of delivering tfCBT and EMDR Therapy?

3. Prompts - for example:
   a. How do you feel the experience of TF-CBT and EMDR Therapy during an actual session?
   b. What, if any, effects continue between sessions?
   c. What experiences of delivering these treatments may have led to long-term changes in you, and what might those changes (positive or negative) be?

4. Everyone has difficult sessions. What are the main differences, if any, you experience between a difficult EMDR Therapy and difficult TF-CBT session, and how do you manage it? How do you manage after a hard day or week at work?

5. How would your life be if you worked in your less preferred approach all the time?

6. Is there anything else you'd like to add?

Prompts – Can you tell me a bit more about …?   How did you feel?
Probe – What do you mean by …? How? Why?

Thank you. I will now read the Debrief Sheet and answer any questions you may have…

Appendix I. Participant debrief sheet

CITY UNIVERSITY LONDON

Exploring clinicians' experiences of using trauma-focused CBT and EMDR Therapy to treat PTSD

PARTICIPANT DEBRIEF SHEET

Thank you for taking part in this study. Now that it's finished we'd like to tell you a bit more about it.

Recent NICE guidelines recommend trauma-focused Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitization and Reprocessing (EMDR) Therapy as equally effective treatment approaches for post-traumatic stress disorder (PTSD) in terms of patient outcomes (NICE, 2015).

However, there is no research comparing the effects of using these approaches on the clinicians who administer them. It would be interesting to interview clinical and counselling psychologists who are qualified in both TF-CBT and EMDR Therapy, and who have completed at least one full treatment in each modality with a client referred with a diagnosis of PTSD.

Our aim was to invite clinicians to reflect upon their own experiences of using these two treatments in some detail, comparing the impact on them, both during sessions, during the interval between sessions, and following on from completion of treatment.

We would like to explore whether there is a difference in impact and if so, whether this might influence choice of treatment, given the research so far indicates patient outcomes are similar for both. This might have particular relevance in terms of helping to prevent secondary traumatisation and burnout, which carry significant personal, professional and service provision costs.

If you have any further comments or questions regarding this research please do not hesitate to get in contact. Likewise, if this research has raised any concerns for you, please let us know straight away. If you feel in need of further support or information after this study is over, we recommend you get in touch with either myself, Joanna, or my research supervisor, using the email addresses provided below.

We hope you found the study interesting.

If you have any other questions please do not hesitate to contact me at the following:

Joanna Wise (Research Student) .

(or Dr Alexandra Mizara (Research Supervisor))

Ethics approval code: PSYETH (P/L) 16/17 53

Appendix J. Sample: *Mattie's* exploratory coding & emerging themes

Coding Key: *Italics* = Linguistic; Normal = Descriptive; **Bold** = Conceptual

Emerging Themes	Exploratory Coding	Transcript Excerpt and Location [Time Code]
Cumulative impact – from continuous exposure to trauma (i.e. *not* EMDR or CBT/NET) Vicarious Traumatisation? Trauma affecting Clinician's use of Authentic Self? NET treatment accords with Political Self (but TF-CBT doesn't?) Compensations/ rewards / meaning of trauma work NET Story-telling works to actively change the real world EMDR works at individual level to change internal world Not waving but drowning - in a swamp?	It's not EMDR or TF-CBT, it's continual exposure to trauma that changes you. **Reminds me of vicarious traumatisation – profound shifts in thoughts/beliefs about self, world and others.** Like innocence, once lost, how do you ever regain it*?? I sense her despair sadness & resignation from tone of voice.* **And her dilemma: of using her authentic self in the therapy, when it may not be helpful anymore, when she cannot offer hope anymore?** *Seriously – **for emphasis, but what would the opposite be?*** **Critical interpretation & ethical concerns here - how much is concern for her well-being/burnout (professional & personal) justifiable, acceptable, ethical??** NET or *the* NET? *Why THE net, like the internet?* NET has advantages that predispose me to like it because of my politically active past. **Meaning making > significance > rewards of trauma work? Protective factor??** *'Sort of' is a qualifier, i.e. not 100% approval rating?* You can use the NET story as a witness statement to actually do something in the real world. **Is therapy room not real world?** *Actually –* **does trauma therapy not count as *really* doing something? Sense of impotence in therapy session v. political activism which has significance for her and may therefore be resourcing? redemptive? protective?** How does NET differ from TF-CBT?? EMDR is 'just' working on individual clients' internal world. *'Just' is working at individual level which, if politically active, is 'not doing anything' (repeated twice).* **Sense of powerlessness, futility and inability to change the bigger picture. (for me: community psychology, and positive psychology issues come to mind here) … inability to prevent the flood, the swamp, of patients which follows** Using EMDR is not doing anything about child abuse or torture. **Political aspect addresses causes, inequalities, abusive power imbalances?** In the end *you get so swamped* with patients - *swamping metaphor, bogged down, unable to move, a morass of human misery. Dank, stinking, trapping. Swamped with* not *by* **– it's not the patients doing the swamping, it's the system?** *'You* think well that's what *I ought to be* doing really', *shift from you (general and impersonal), to I, more empowered in self, 'ought' perhaps gives idea of citizen's duties and responsibilities to society – les devoirs.* 'not sitting waving my arm around' – **feels quite dismissive comment re. EMDR - passive, feeble?**? getting swamped with patients – not waving but drowning in swamp of despair about the world? *Slightly mocking tone here* **as if EMDR is just waving arm around?** *What happened and why* – using past history to learn in order to change future. Trying to make people less likely to torture and abuse each other in future. *What, why, and how important touchstones here. 'Trying and torture', alliteration binds sentence together poetically for strength of effect.*	[45:27] 'It's not about the modalities, really, it's about the fact that the patients are coming with the worst things that have happened and so if you work with those patients all the time you tend to think that um... the world is full of child abusers and torturers. And um I notice that I seriously do believe that. … I find it quite difficult to tell people "Actually it will be fine", because I don't really believe that any more. … [48:35] '[However], the NET has sort of... advantages that will predispose me to like it because of my past. Because in my past I was more politically active, and because it's um... you know... saying that you are doing your witness statement for the patient, you can then use it for the... case... that's ... you know actually doing something about the real world... [49:11] … 'Whereas EMDR is more just working with the internal world, which is also obviously powerful, if it enables them to cope better, but it isn't really doing anything about what happened to them in the first place, so it's not doing anything about child abuse or torture... and in the end you get so swamped with patients that you think well that's what I ought to be doing really, not sitting here waving my arm around... but trying to find out what happened and why and... how we can make people less likely to ... torture and abuse each other in future.'

Appendix K. Sample: Themes and quotes from *Annie's* account

Participant Name: *Annie*	Emerging Sub-Themes	Time Code	Key Comment
Theme 1: It's not about the modalities, really" (trauma work in general)			
Costs of Trauma Work	Both modalities similar impact overall	34:09	Both have a similar degree of impact, but in potentially different ways.
Rewards of Trauma Work	Come with diagnosis, leave without	03:54	There's something really rewarding about people going from very disabled to quite functional again.
	Clearcut outcomes - unlike other services	03:54	You don't see that shift when you're working in other areas
	Best and worst of humans	05:25	You hear some of the very worst things and on the flip side also see some of the very best of humanity.
	An honour and a privilege	05:55	It's a real honour; I feel quite proud of them and sometimes proud of the work that you do as well.
	Range of interventions	3:14	I like that there's a different range of stuff, therapeutically, that it covers, I really like the breadth of it.
Coping Strategies	Organisational support makes difference	06:43	Places I've worked in the past haven't been as keen on using EMDR; I've much more positive view now.
	Org. support makes true choice possible	12:32	The culture of the clinic really encourages you so I feel like really genuinely we do offer both types of treatment,
	Supervision essential for new modalities	13:33	I definitely need supervision on [EMDR], particularly when you're not feeling massively confident.
	Prior preparation & experience helps	19:29	I've heard a lot of really awful things now – touch wood there's probably not anything that floors me.
	Other colleague's support	33:10	After a few sessions I'd have to come out and … I'd just go like 'Ohhh, that was horrible'
	Boundaries to work	39:54	I'm quite good generally about… leaving it here.
Conflict/Battle metaphor?	Sticking head above parapet versus team	13:33	If your sense doesn't tally with the team, why stick your head above the parapet?
	Steeling for battle	17:51	'Right I can steel myself for that'
	Nothing completely floors me now	19:29	Touch wood – there's probably not going to be anything [I hear now] that completely floors me.
Technical Similarities	Techniques very similar	06:43	There's massive overlap… a lot of the time you're doing… potentially quite similar things…
	Cognitive restructuring vs interweaves	07:59	a lot of the cognitive interweaves it's just very similar questions you ask when you're restructuring
Theme 2: "My comfort zone"			
Control, competence, containment & confidence	Confidence & competence	06:43	Definitely my comfort zone; Ive done a lot more work in it and I feel a lot more confident and competent…
	Containment & control	16:10	One of the things that feels helpful is that you feel slightly more contained and more in control…
	Containment for both	16:10	You can keep it very focused and that feels containing for the client but also very containing for you.
	Steeling myself is containing	17:51	You've got a good sense of what's coming, that feels containing: 'Right I can steel myself for that'
	Dual processing protects from intensity	34:09	I think you're parallel processing a lot which as a therapist disengages you from the emotional intensity.
	Confidence & containment re timing	21:24	I feel more confident in being able to work out [session] timings; timewise it feels more contained.
	Verbal feedback indicator of dissociation	30:09	You're getting a lot more verbal feedback… it's quite an early indicator that you're losing someone.
Concerns	Verbalising distances from feelings	34:09	When people have to verbalise something you are automatically distancing them from the intensity
	Verbalising puts brakes on	34:09	You've got to put words to it… that puts the brakes on slightly
	Requires more work/prep	41:51	If you're getting stuck with an update or something you have to spend a bit more time thinking about it

Participant Name: *Annie*	Emerging Sub- Themes ctd.	Time Code	Key Comment ctd.
Theme 3: Go with the flow and "Trust the process"			
Intensity of EMDR	Fewer details but more intensity	34:09	You're not getting as much of a rich description but I experience emotions they experience more intensely
	Fewer details so less to chew over	39:27	Potentially with EMDR you get less detail, so it's not like your mind can chew it over, whereas with CBT…
	EMDR much more physical	22:30	The other big thing sounds really obvious but there's something a lot more physical about doing EMDR.
	Physical intensity leaves hangover	39:54	I wonder if you get left with a physical kind of hangover of the session…something you hold bodily…
	Physically more tiring	23:20	By the end of a long session my hands are getting tired and my pacing goes, that's quite tough.
	Intently focusing in on the body	24:37	You really are watching intently: I'm very focused in your body which I don't have as much with TF-CBT.
	You can't help but be moved	34:09	You're watching them so much, as a human being you can't help but be moved
Considerations re BLS	Enjoy tapping as physical contact	23:20	I've done hand taps on their legs they quite like the physical contact and [its] reassuring for you and reassuring for them.
	Physical closeness vs detachment	28:19	You sit a lot closer, whereas if I sat back with the buzzers I'd probably start to feel quite detached
Faster	Flying by seat of pants	41:51	It does mean you could fly in at five mins to the session, cos your trains been late and it's just 'Let's go!'
	Cognitive interweaves very quick	07:59	So a lot of the cognitive interweaves, when clients get stuck, they're just very quick.
	Simple quick interventions	07:59	When you're doing an interweave you're just dropping in some of those questions, those ideas, hoping…
Challenge re loss of control	The processing will go where it needs to	18:28	The processing will go where it needs to go but you're not necessarily gonna know what that is.
	Relinquishing control is challenging	18:28	That feels challenging because you wanna feel like you're in control partly for you, partly for them…
	Trusting the process	25:10	Definitely involves a lot more trust. Sandi says 'You've got to trust the process, you've got to trust the process'.
	Experience managing session timing	21:24	I find it quite difficult the idea of timing, that feels a lot harder to manage, it might be partly lack of experience
Anxiety & Ambivalence	Excitement vs anxiety	44:07	Wheee… let's go! And it is fascinating where they go… sometimes…
	Ambivalence and anxiety	25:10	I kinda go yup no I am, I'm trusting it, but… but! It feels like I'm really anxious about it [SQUIRMING]
	Anxiety re being a good enough therapist	20:42	If I have a session like that then maybe I wasn't a good enough therapist and didn't manage things well
	Anxiety re containing dissociation	19:29	If you've got someone likely to dissociate I feel anxious about not being able to contain the process
	So close it's hard to judge dissociation	30:09	You're a bit too close and it's hard to judge:' Am I losing you?' Sometimes you wanna step back…
EMDR clears the trauma that TF-CBT cannot shift	EMDR clears bodily stuff better	44:22	TF-CBT doesn't seem to shift bodily stuff quite as well; couple of sessions of EMDR processes the rest
	Body memory of being strangled cleared	44:49	CBT helped but hadn't really quite done the job, couple sessions EMDR cleared it out much better.
	EMDR shifts complex trauma CBT can't	45:45	CBT might get a physical and emotional shift but not all of it; not with the complexity of trauma we see here

Appendix L. Themes & sub-themes represented across participants

Key: ✓ = Participant comments on theme. x = Participant does not comment on theme.

Themes & Sub-Themes	1 Kitty	2 Mattie	3 Annie	4 Rose	5 Steve	6 Kate	7 Jo	8 Sara	9 Alex	Total
Theme 1: "It's not about the modalities, really" - it's trauma work in general										
Compensations:	✓	x	✓	✓	✓	✓	✓	✓	✓	**8**
Close connections:	✓	✓	x	✓	✓	✓	✓	✓	✓	**8**
Cumulative costs:	✓	✓	✓	✓	✓	✓	✓	✓	✓	**9**
Clinicians' coping strategies:										
• Supervision	✓	x	✓	✓	✓	✓	✓	✓	✓	**8**
• Preparation	x	✓	✓	✓	✓	✓	✓	x	✓	**7**
• Boundaries	✓	x	✓	✓	✓	✓	✓	x	✓	**7**
• Other interests	✓	✓	x	x	✓	✓	x	✓	✓	**6**
Theme 2: "My comfort zone" – containing or constraining?										
Containing:	✓	x	✓	✓	✓	✓	✓	✓	✓	**8**
Constraining:	✓	✓	✓	✓	✓	✓	✓	✓	x	**8**
Theme 3: "Trust the process"										
Physical communication:	✓	✓	✓	✓	✓	✓	✓	✓	✓	**9**
Confidence:	✓	✓	✓	✓	✓	✓	✓	✓	✓	**9**
Clears the trauma:	✓	x	✓	✓	✓	✓	✓	✓	✓	**8**

Appendix M. Table of participants' themes & sub-themes

Participants' Themes and Sub-Themes		Time Code
Theme 1: "It's not about the modalities" (it's trauma work in general)		
Mattie	"It's not about the modalities, really, it's about the fact that the patients are coming with the worst things that have happened…"	18:53
a. Compensatory rewards of trauma work		
Kitty	What's great about doing trauma work is you get such tangible amazing results which you can't always see in other therapies.	42:51
Mattie		
Annie	It's a real honour to play a part in that kind of recovery, I feel proud of them and sometimes you can feel proud of the work that you do as a therapist as well.	05:55
Rose	It's seeing the pain as it leaves them, wanting to try and shift some of that pain, it's the reward of that. Also I love the patient group and feel privileged to meet them.	52:41
Steve	With trauma, I like the fact that people can come with diagnoses and leave without.	03:11
Kate	Seeing people feeling better at the end is really what keeps me going.	48:30
Jo	You feel alive, it's on the edge, it feels meaningful and also I'm very, very committed to the refugee work; my mother was a refugee; I *can* make a difference	14.05
Sara	It's exciting and the reward is amazing. And it is miraculous…	22:49
Alex	I definitely find it meaningful…	44:19
b. Close connection is key for trauma work		
Kitty	That relationship is key; it just seems important to bear witness to what happened to that person with them, rather than 'doing something' to them.	21:41
Mattie	People say "Actually it was you being with me that made the difference." That's broadly speaking what we would say about most modalities, isn't it?	50:15
Annie		
Rose	They found it more helpful to have me tapping them, they found that more reassuring to remember I was there.	21:59
Steve	As concerning complex trauma, in my opinion, it is *vital*, the relationship. It is *vital*.	43:52
Kate	I don't know, it feels important to me to hear them really explaining themselves in detail; I get to know them so much better…	40:51
Jo	It's all about the relationship.	22:31
Sara	My sessions are very intense and I know clients don't really want to come and see me. But they will also have a very good therapeutic alliance. They know they're doing intense stuff and I can tolerate it.	19:50
Alex	When I was trained in EMDR there was the technique but it's not like it's the answer to your whole therapeutic inter- … relationship.	27.09

	c. Cumulative costs of trauma work	
Kitty	It does change you… it makes you realise the worst that human beings can do to each other.	37:40
Mattie	If you work with those patients all the time you tend to think the world is full of child abusers and torturers; I notice I seriously do believe that.	45:27
Annie	Both (modalities) have a similar degree of impact, but in potentially different ways.	34.09
Rose	By the time you've worked in this service you've probably become a bit desensitized to the content of trauma because ... you've heard it.	52.03
Steve	My hyperarousal symptoms have definitely increased, yeah definitely, with that amount of trauma…	49.12
Kate	I do have a more cynical view about the world, I do think a lot of bad things happen to people; I'm more suspicious, more anxious, looking for danger everywhere…	52:38
Jo	It felt too close to home, you'd be hearing all the details and think 'This woman got attacked on a corner I drive past every day', and I started to feel quite unsafe.	11:38
Sara	In terms of how brutal people can be, I can't watch these [torture] films anymore because I know that isn't just fiction. It's reality for some people.	1:02:18
Alex	If people continue to do full-time trauma work it changes your view of all of society.	43.42
	d. Clinicians' coping strategies following trauma work	
Kitty	I'm a boxer; you can't go and train and still be thinking about work because you'll get punched in the face [LAUGHS]…	27:01
Mattie	Really you've got to try and be sane and give the techniques a go otherwise you're being a hypocritical fraud aren't you? I use the [EMDR] buzzers on myself after a session…	42:16
Annie	After a few sessions I'd have to come out and [another therapist's] room was over the way and I'd just go 'Ohhh, that was *horrible*'.	33:10
Rose	By the time you've worked in this service you've probably become a bit desensitized to the content of trauma… it's something about the emotional shifts, that's what resonates more for me.	52:03
Steve	I've learned to be better at cutting off; just going home, shower, that's ended, I don't have any stories on me.	48:29
Kate	Having boundaries imposed for me by the NHS about limits to how long you work every day, and what your role is, has been helpful to me	55:46
Jo	I couldn't do it 100% of the time; I'd see a few patients a couple of times a week, manage it that way.	11.38
Sara	You hear some really graphic things and you do want to share that sometimes, in supervision you just want to say 'Oh, imagine *that*'.	1:01:22
Alex	I'm now doing some research into trauma-focused work, which pulls you a little bit away from the heaviness of the emotional content	53:10
Theme 2: "My comfort zone" – containing or constraining?		
Annie	TF-CBT is definitely my comfort zone…	06:43

	a. Containing: Confidence, competence & control	
Kitty	Because it was my first time… I was so thinking 'Right, stick to the model, stick to the model, you've *got* to stay on model.'	11:13
Mattie		
Annie	TF-CBT is definitely my comfort zone: I've done a lot more work in it and I feel a lot more confident and competent in doing it. … That feels containing for the client, but also very containing for you as a therapist.	06:43
Rose	It's probably more my own comfort zone and it's wanting to have a bit of control, um, and containing the session.	12:08
Steve	In CBT I think you know exactly what's happening, where you are, you know what you're doing, you know what you're updating. But…	33:44
Kate	That's what I'm much more comfortable with, and more competent in, so it's always my treatment kind of choice. … I feel more confident in CBT than EMDR and that's partly why I choose it first.	07:33
Jo	I like being in control, I suppose it feels more… more containing.	
Sara	CBT is more conscious, it's more rational.	46:36
Alex	With EMDR, the EMDR is in the driving seat. Maybe with the [TF-CBT] hotspot updates you feel that you're actually in the driving seat and you can control it a little bit more.	15:36
	b. Constraining: "Clunky" & challenging	
Kitty	[I] always want to do the hardest things. Well, "you chose it, get on with it, you know, *man up*." And [I'm] being terribly macho about it.	48:05
Mattie	When does it stop being useful to go on and on about the same bloody awful thing? EMDR is less confrontational…	04:25
Annie	By the time you're getting into reliving, and doing the restructuring, there's that sense of 'Right, I can *steel* myself for that'.	17:51
Rose	CBT felt a bit more of a battle: that it was trying to make sense of things and actually it was making things more confused.	36:49
Steve	The reason EMDR does it faster is [if] there is a bit of blocking it's easier to target using EMDR. Why am I wasting my 12 [TF-CBT] sessions trying to focus on that hotspot and we are failing?	21:13
Kate	[TF-CBT] feels harder. I feel definitely more tired after CBT sessions, because it does feel more intense, and I'm thinking and working the whole time.	28.09
Jo	It felt very front line… it's a bit of an adrenaline rush and you feel like you're fighting the fight and you are on edge; it's never boring.	06:34
Sara	It's a bit more clunky; sometimes you think you've got the main [hot cognition] and you update it, but you haven't always got the subsidiary ones, or the bit that might make the complete difference. … I found that really, *really* draining.	16:19
Alex		
Theme 3: "Trust the process"		
Annie	[My supervisor] talks a lot about "You've got to trust the process, you've got to trust the process." And I kinda go yup no I am, I'm trusting it, but… but! It feels like I'm really anxious about it [SQUIRMING AND LAUGHING].	25:10

	a. Intense physicality of communication	
Kitty	The different approaches can have a very different impact on you.	1:08:48
Mattie	In EMDR you are looking at people and you're often within 3 feet of them; they like that because they feel you're with them. Even in the people that have been tortured and abused, they seem to find the human nearness, intimacy, um… more acceptable.	16:15
Annie	The other big thing I've noticed, it sounds really obvious, but it's physically, the difference. There's something a lot more physical about doing EMDR as a therapist. Cos you're physically closer, you can see it in their throat when they are trying not to cry and I think, as a human being, you can't help but be moved by that, quite a bit.	34:09
Rose	She said "my heart broke." I found that a really upsetting session - perhaps I wouldn't if I'd been using TF-CBT – but it was something about watching her physical response as she was saying those words, and you could feel like your heart [WELLING UP] breaks for them.	44:18
Steve	There isn't any competition with EMDR when it comes to physical updates; EMDR in a physical way is very, very good in updating physical flashbacks because, as we know, your body stores the trauma in your senses.	18:55
Kate	It feels like talking [TF-CBT] doesn't reach the body: people will start feeling the feelings, or feeling like vomiting, and it feels like it's not as soothing for the body as maybe EMDR is in some way.	39:57
Jo	She just needed the human touch; we'd have these quite profound sessions where you just feel connected, there's something about EMDR that can be very connecting in a way that TF-CBT …can be very business-like, and… I'm not that sort of therapist.	22.31
Sara	I'm tuning in with my client all the time. It is almost like a channel of energy between me and them and I feel it. I'm using this sensation in my solar plexus when I'm doing processing, that solar plexus feeling, it's such a privileged position because it's almost like you join them in some ways, and that's when you know when [the processing] is going.	33:13
Alex	Seeing the reactions in the person I'm doing EMDR with, I can see her body responding to the trauma memories in a way that *could* - depending on how I'm feeling at the time - could be very disturbing.	39:22
	b. Confidence to "trust the process"	
Kitty	It's the same when you start with any... new type of therapy or... whatever, especially something that is kind of quite technique-driven like this... you're thinking "am I doing it right, am I doing it right?"	17:04
Mattie	Before I start the processing I know what it's going to be, and I think it's better for them to go there than not go there, so that then they can come out the other side. Often I think the client is frightened of something I'm not so frightened about cos I've been there before with somebody else.	25:32
Annie	Wheee… let's go! And it is fascinating where they go… sometimes…	44.07
Rose	I think if I probably felt a bit more experienced, then I'd feel more comfortable or confident and think ok, its ok.	17:20
Steve	In EMDR you have 'Go with that', which is the free association component, which is very psychodynamic really. It gave me… it gives	05:35

	the patient the freedom to go to places that CBT… doesn't really access.	
Kate	[With EMDR] it's kind of like they're doing all the work. But maybe if I felt allowed to add things more, maybe I'd feel more of a therapist?	25:35
Jo	Because I could tell when she would start to dissociate and so we'd go in and we'd go out, and we'd go in and we'd go out, and we'd go in and we'd go out of the rape, and I was enough in control to make that work	31:27
Sara	EMDR just allows the mind to run and put pieces together and the therapist doesn't have to do it, the person does it. You're relying on the client to do the work, knowing in full faith they will get there	16:19
Alex	Usually I've known them fairly well by the time I've started EMDR with them, so I know what their body does if they dissociate. I don't seem to worry about any of these things, I don't know whether it's cos I've been doing it for ages.	57:23
c.	**Clears the traumas that TF-CBT cannot shift**	
Kitty	My [CBT] supervisor's said "Oh well, you can't shift that sticky bit, what you need is, what they need is, just to do a bit of EMDR."	52:29
Mattie		
Annie	[TF-CBT] might get a physical and emotional shift, but not necessarily all of it. Not with the complexity of the trauma that we deal with here. That's where EMDR really comes into its own.	45:45
Rose	The patients I used EMDR with, I definitely saw really good shifts there. Actually a bit quicker. With two of them I felt quite unhopeful that TF-CBT was gonna be very helpful; then I used the EMDR and it all shifted. Yeah.	47:33
Steve	Using TF-CBT there was a decrease, but I never felt there was a full resolution. Everything was ok-ish, but then we started doing EMDR and everything just shifted. And she's fine; she doesn't have it any more.	08.05
Kate	I don't have – and I should make! - the space and time to think about why I don't use [EMDR] more; I know it's so useful and good and I set myself up for not using it except for people who are blocked and not progressing in treatment.	59:53
Jo	We'd already done a lot of the context and formulated and fleshed things out then we went into the EMDR – I'm unclear why, and that's why I think this is so interesting to ask the question – you raise very big questions! The thing is, we don't talk like this, we're not encouraged to talk about these things in supervision. We just don't have time.	1:06:37
Sara	In terms of EMDR you will get a complete clear, whereas in terms of TF-CBT you just don't. An EMDR client would say "I feel completely different and this is amazing, thank you for giving me my life back." Whereas with CBT it's just not the same.	12:16
Alex	I've used EMDR as a top-up if you like, when I've done other forms of therapy such as NET or TF-CBT and there's still bits left over at the end.	07:11

Part B: Journal Article

Exploring counselling and clinical psychologists' experiences of delivering EMDR: An interpretative phenomenological analysis.

Words: 9870

Exploring counselling and clinical psychologists' experiences of delivering EMDR Therapy: An interpretative phenomenological analysis.

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Dr Jacqui Farrants …

Exploring counselling and clinical psychologists' experiences of delivering EMDR Therapy: An interpretative phenomenological analysis.

Abstract

NICE (2015) guidelines equally recommend trauma-focused cognitive behavioural therapy (TF-CBT) and eye movement desensitisation and reprocessing (EMDR) therapy as the psychological treatments of choice for post-traumatic stress disorder in terms of client outcomes. However, little research to date has explored the impact of these modalities on the clinicians who deliver them. This paper is based on a larger study that used Interpretative Phenomenological Analysis to explore the experiences of four counselling and five clinical psychologists of delivering EMDR and TF-CBT trauma treatments. This paper focuses on delivering EMDR Therapy, which was experienced by participants as an intense physical connection with their clients, and, if clinicians found confidence to "trust the process", the good outcomes obtained were experienced as profoundly rewarding. Limitations of the study and implications for trauma work in general and counselling psychology in particular are discussed.

Keywords: trauma; eye movement desensitisation and reprocessing (EMDR); trauma-focused cognitive behavioural therapy (TF-CBT); interpretative phenomenological analysis (IPA); counselling psychology

Introduction

Recent trauma treatment guidelines published by key players in the UK mental health arena – principally, the National Institute of Clinical Excellence (NICE, 2015), and the UK Psychological Trauma Society (McFetridge et al., 2017) – recommend equally trauma-focused cognitive behavioural therapy (TF-CBT) and eye movement desensitization and reprocessing (EMDR) therapy as the psychological therapies of choice for children, adolescents and adults diagnosed with post-traumatic stress disorder (PTSD). These recommendations have been based on evidence from randomised controlled trials, reviews and meta-analyses which concluded that EMDR Therapy is at least as effective as TF-CBT on most measures for clients and it also appears more efficient (van Etten & Taylor, 1998; Shapiro, 2014).

In this paper, I will outline briefly the research which has explored the impact of trauma work in general, and the two recommended modalities in particular, on the therapists who deliver it. I will then consider how this study might address existing methodological weaknesses with the aim of furthering our understanding of how counselling psychologists, and other practitioners, might provide safer, more effective trauma treatment.

Impact of trauma work on therapists

Research has centred overwhelmingly on the impact of trauma-focused treatment on client outcomes.   However, as Dunne & Farrell (2011) comment

> "…clinicians' interests and concerns are often overlooked in the research literature on psychotherapy. The research on eye movement desensitisation and reprocessing … is no exception." (p.177-178).

The past two decades have seen a growing concern over the potential negative impacts of delivering trauma treatment on the mental healthcare professionals who provide it (e.g. Figley, 2015), variously conceptualised as vicarious traumatisation, burnout, compassion fatigue

or secondary traumatic stress. Whilst there are subtle differences in the use of each construct, there are also many overlaps, which contribute to criticisms regarding the lack of clarity, contradictory findings and methodological weaknesses cited in recent literature reviews of research in this area by Canfield (2005), Baird & Kracen (2006) and Elwood et al. (2011). These reviews indicate that research into therapist, client and organisational factors has delivered mostly equivocal findings, with the exception that social support and good coping strategies seem to offer consistently protective effects.

More recently, Manning-Jones, de Terte & Stephens (2015) and Bartoskova (2015) comprehensively reviewed research on vicarious post-traumatic growth (VPTG), a construct acknowledging that positive psychological changes can also be experienced by therapists engaged in trauma work with PTSD clients. Both reviews found a range of psychological, behavioural and organisational factors are implicated in facilitating VPTG, including empathy and organisational support. Manning-Jones et al. (2015) hypothesise there may be no relationship between VPTG and secondary traumatic stress, or a positive linear, or curvilinear, association. Both reviews conclude further research clarification is needed.

Overall methodological limitations of existing research

Research thus far into the impact of trauma work in general on therapists frequently appears contradictory perhaps because it suffers from several methodological limitations, aside from the difficulties in conceptualisation and measurement of the constructs involved (Elwood et al., 2011). For example, most studies fail to discriminate homogenous samples, often including trainees, counsellors, psychotherapists, psychologists, psychiatrists, and even social workers, interpreters, and nurses, in the same sample (e.g. Bartoskova, 2017; Lipke, 1995; van Minnen, Hendriks & Olff, 2010); these sampling limitations also mean there is very little research that is directly relevant to counselling psychology. Moreover, several studies define 'trauma therapists'

very loosely as, for example, individuals who work in trauma for an average of 45% of their time, with a range of 10-80% (Arnold et al., 2005), or an average caseload of just 27% PTSD clients (Craig & Sprang, 2010), resulting in a wide range of exposure to trauma.

As Canfield (2005) noted too, "[m]ost prior research is based on quantitative methods, using self-assessment scale designs…" (p.90). These are typically postal or web-based surveys, which lead to criticisms regarding sampling errors, and the known limitations of self-report measures and use of correlational rather than causal designs. In particular, questionnaires limit the scope and depth of therapist responses, exploring factors which have been decided *a priori* by the researchers as relevant to the clinicians (Rasmussen, 2005). A systematic review by Sabin-Farrell & Turpin (2003, p. 467) concluded that the quantitative evidence is "meagre and inconsistent", and methodological design issues compromise the validity of quantitative claims, whereas in contrast they found qualitative studies provided considerable support for the existence of negative impacts resulting from trauma work.

Comparing EMDR Therapy with TF-CBT

With the exception of the few published studies which include EMDR Therapy in their investigation of the impact of trauma work on clinicians (Dunne & Farrell, 2011; Lipke, 1995; van Minnen et al., 2010), most do not specify or compare the types of trauma treatment employed. Although some form of exposure-based cognitive therapy is usually designated, protocols may vary considerably as a result (Shapiro, 2001; Elwood et al., 2011). Despite this, Lipke's survey (1995), the first to compare EMDR Therapy with exposure therapies, found that the majority of respondents found EMDR Therapy more effective and less stressful both to clients and to the therapists themselves than exposure-based therapies. They also reported fewer negative side effects with EMDR Therapy and emergence of more repressed material.

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Dunne & Farrell (2011) attempted to address the methodological limitations of Lipke's (1995) survey with their mixed methods study design. They reported that significantly more CBT therapists found integrating EMDR Therapy into their existing practice easy, compared to Integrative, Humanistic/Experiential and Analytic therapists. Content analysis of semi-structured telephone interviews revealed therapists' difficulties included the therapist's personal style (in particular, levels of anxiety and confidence), and organisational factors such as bullying and lack of support for EMDR Therapy (Dunne & Farrell, 2011).

A study by van Minnen et al. (2010) showed that trauma professionals surveyed at a Dutch psycho-trauma conference reported significantly greater preference for and use of EMDR Therapy over IE, pharmacotherapy or supportive counselling, for both simple and complex PTSD clients, even controlling for superior training in IE. Participants reported they found exposure-based approaches less credible and more stressful for the clinician, fearing clients' symptom exacerbation and increased risk of dropout.

Linley & Joseph (2007) used qualitative methods to explore organisational and therapist factors and found that TF-CBT therapists were more likely to experience burnout and less likely to experience VPTG than humanist or transpersonal therapists.

These studies suggest therefore that there may be significant differences in impact between the two NICE (2015) recommended psychological treatments for PTSD - TF-CBT (Ehlers & Clark, 2000) and EMDR Therapy (Shapiro, 2001) - for the therapists who deliver them. Both approaches appear, on the surface at least, to have much in common (Schnyder et al., 2015), but, on closer inspection, the clinical protocols are very different.

EMDR was developed by Shapiro (2001) from a chance observation that the side to side (bilateral) eye movements she made whilst walking in a park appeared to diminish her disturbing thoughts. During EMDR treatment, clients are encouraged to "let whatever happens, happen" whilst attending to short sequential sets of bilateral stimulation (BLS) – either eye

movements, auditory signals through headphones, handheld vibrating 'buzzers', or the therapist tapping alternately on the client's hands or legs. Internally-generated spontaneous (i.e. 'free') associations arising from initial traumatic images, thoughts, beliefs, emotions and bodily sensations, are thought to facilitate optimal psychological adaptation and resolution, and the generalisation of treatment effects to other life contexts. Techniques, such as 'floatbacks' to take the client's imagination further back in time, and 'cognitive interweaves' to introduce more adaptive cognitions, are used to release blocked or circular processing and facilitate progress. The client is also taught they can raise their hand (the 'Stop' sign) as a control option to pause processing at any time.

In contrast, Lee (2006) succinctly summarises the key prolonged exposure and cognitive restructuring components of the TF-CBT treatment protocol as follows:

"In simple, fear-based PTSD, the theories indicate that treatment should involve activation of the fear network in its entirety, via a reliving paradigm, whereby *as much detail as possible about the original event is retrieved* and, *at peak moments of distress*, where salient meaning can be identified …the therapist encourages the client to reframe the meaning using Socratic dialogue. … A good working understanding of fear-based PTSD and its theoretical underpinning provides the 'first principles' to build upon when dealing with increasingly complex presentations of PTSD." (p.149, italics added).

The features of the TF-CBT protocol emphasised in italics –"*as much detail as possible about the original event is retrieved*" and the requirement to experience the client's "*peak moments of distress*" – may have particular relevance regarding the potential for this treatment to impact therapists negatively, because severity of traumatic stress symptoms is known to correlate with cumulative exposure to traumatic experiences, whether experienced at first or second hand (Kolassa et al., 2015).

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In summary therefore, EMDR Therapy differs significantly from TF-CBT in that it does

not require:

- extended exposure,

- detailed descriptions of the traumatic events, or

- direct challenging of negative cognitions (Spector, 2007).

Relevance for counselling psychology

As Figley commented, with respect to his theory of secondary (vicarious) traumatisation:

"At the heart of the theory are the concepts of *empathy* and *exposure.* If we are not

empathic or exposed to the traumatised, there should be little concern for compassion

fatigue." (Figley, 2015, p.15; italics added).

At the heart of our clinical training as counselling psychologists lie person-centred concepts of

empathy, unconditional positive regard and congruence (Rogers, 1951). These are viewed as

necessary conditions and paramount for establishing a therapeutic alliance, which is considered

the most healing factor in all psychotherapeutic work (Lambert, 1992), and fundamental to

working at relational depth with clients (Mearns & Cooper, 2005). The reparative nature of an

empathic therapeutic relationship has been noted to be particularly important in working

effectively with those who are traumatised and distrustful, having suffered abuse at the hands of

others (Meichenbaum, 2013). And yet, cumulative exposure to accounts of traumatic events

may be linked to the risk of "profound changes in the core aspect of the therapist's self"

(Pearlman & Saakvitne, 2015).

Bartoskova (2017) carried out an Interpretative Phenomenological Analysis (IPA) study

with 10 trauma therapists looking at common factors leading to VPTG and found that vicarious

exposure to trauma had differential impacts, depending on the personal history and individual

responses of each therapist. Bartoskova (2017) concluded by highlighting the relevance of

qualitative research on VPTG for counselling psychology, as both are founded in a pluralistic philosophy which is able to recognise the complexity of trauma work.

Merriman & Joseph (2016) also used IPA to explore the therapeutic implications of counselling psychologists' response to client trauma; participants reported experiencing significant difficulties with use of self in response to traumatic material, but also that they were able to recognise that this therapeutic use of self continued to develop over time, both through training and cumulative experience of trauma work. Although type of trauma treatment was not defined or specified, the study is of particular interest and relevance to this current study, given that they interviewed nine counselling psychologists (two men, seven women); Merriman & Joseph (2016) recommended future research should focus on participants with similar orientations and experience.

Counselling psychologist Amirah Iqbal makes the important point with respect to vicarious traumatisation, that:

"This implies a shift or change in the therapist's perception of experiencing the self, others, and the world. If this affects the therapist's relationships with others and their inner world this may have implications on the therapist's ethical and professional practice." (2015, p.45).

Counselling psychologists are bound by codes of conduct, performance and ethics which outline our full commitment to preventing client harm (BPS, 2009; DCoP, 2009; HCPC, 2012). However, Iqbal (2015) points out that lack of training in awareness of risk factors, including as yet unspecified components of trauma work, may mean counselling psychologists are inadvertently putting themselves and their clients at risk. Iqbal's (2015) report also concludes that there is a lack of research exploring these factors and there are currently no guidelines available to counselling psychologists, or other trauma practitioners, to inform best practice in trauma treatment.

Rationale for this current study

  In summary, there has so far been limited research investigating the experiences of clinicians delivering trauma treatment, particularly that which explicitly distinguishes between the two recommended treatments, EMDR Therapy and TF-CBT. Rasmussen (2005) posits that a further limitation of previous research in this area has been the quantitative attempts to measure the impact of delivering trauma treatment, and suggests that qualitative designs may address this gap in the literature.   In a context where clinicians' experiences have traditionally been accorded a lower profile than that of client outcomes, most importantly qualitative methods give a voice to *all* human beings. Canfield (2005), too, highlighted the lack of qualitative studies in this area and recommended that the semi-structured interview is able to offer "a forum for open dialogue and [provide] rich, descriptive data of the lived experience of trauma counsellors" (p.96). Whilst qualitative studies usually tend to use much smaller samples than quantitative studies, they are able to explore issues in greater depth which allows for unexpected, and often more detailed and nuanced, material to arise.

  Through examining the few qualitative studies in the area, such as Bartoskova (2017) and Merriman & Joseph (2016), phenomenology has emerged as a methodological approach particularly suited to exploring the subjective experiences of the trauma therapists regarding treatment delivery, as it is able to acknowledge how these particular individuals make sense of their experiences in this particular context.

  The study that this paper is based on therefore aimed to explore clinicians' subjective lived experiences of delivering both recommended trauma treatments and to attempt to describe and interpret the meaning they make of these experiences. The goal of the study is therefore summarised in the primary research question which asked participants:

  "What is your experience of delivering TF-CBT and EMDR Therapy to treat PTSD?"

This paper focuses on one of the themes emerging from this research question which concerns clinicians' experiences of finding confidence to trust the very different process of EMDR Therapy and discovering it seems able to clear traumas that TF-CBT cannot shift. The overarching aim is to generate new insights into how practitioners can work more effectively as well as safely in trauma settings.

Method

The study this paper is based on used IPA, a qualitative methodology developed to explore and interpret how people make sense of their unique lived experiences (phenomena) through the gathering of rich and detailed subjective accounts (Smith, 2004).

IPA is founded upon philosophical concepts of phenomenology, hermeneutics and idiography (Smith, Flowers & Larkin, 2009). The interpretative elements of IPA incorporate a two stage hermeneutic process where "the researcher is trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2003, p.51). This complements the critical realist epistemological position this study adopted which acknowledges that the inter-subjectivity between an individual's subjective account and the researcher's interpretation of it necessarily affects the knowledge produced (Willig, 2013). As Smith et al. comment succinctly, "Without the phenomenology, there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen" (2009; p.37).

Unlike nomothetic quantitative paradigms, which are concerned with what can be successfully generalised, a major influence on IPA is idiography; this focus on the particular is expressed as a commitment to "understanding how particular experiential phenomena … have been understood from the perspective of particular people, in a particular context" (Smith et al., 2009; p.29). Thus, the idiographic approach allows the responses of individual participants to be preserved and heard, whilst at the same time, through a process of interpretation and the

convergence and divergence of themes arising from their data, it also offers the possibility of elucidating common experiences. The aim of this study is therefore that the knowledge acquired by using IPA will provide a deeper understanding of the lived experiences of the clinicians who deliver both recommended approaches to trauma treatment, TF-CBT and EMDR Therapy.

Participants

A total of four counselling psychologists and five clinical psychologists were recruited by purposive sampling from a Traumatic Stress Clinic understood to provide parity of organisational and supervisory support for both EMDR Therapy and TF-CBT (Berger & Quiros, 2016). Two men and seven women participated, aged from 34-58. All had completed TF-CBT and EMDR Therapy training and recorded a range of years' experience in both general psychological treatment services (3-17), and specialist trauma treatment (1-15); they also reported a range of estimated number of clients seen using TF-CBT (8-150) and EMDR Therapy (4-125). Three clinicians expressed a clear preference for TF-CBT, three for EMDR Therapy and three professed to use both modalities equally. Identifying information has been eliminated or disguised to ensure anonymity and confidentiality.

Ethical procedures were followed in accordance with the British Psychological Society's code of ethics and conduct (BPS, 2009).

Data collection

One 60 minute semi-structured interview was carried out with each participant at their normal place of work in order to explore their experiences of delivering both TF-CBT and EMDR Therapy and their understandings of the impact these modalities may have on them both during and after treatment sessions. Any questions in the interview schedule (Appendix 1) not covered

spontaneously were woven into the discussion as naturally as possible in order to elicit a rich and detailed descriptive account from each participant (Kvale, 1996). Each interview was audio-recorded and transcribed verbatim by the first author.

Data analysis

Analysis of the interviews was carried out by following the six steps for IPA recommended by Smith et al. (2009). The first step involved reading through a transcript several times whilst listening to the audio-recording and documenting in the research journal any observations, feelings, interpretations or associations arising as part of the bracketing process (Gadamer, 1975). Step two involved adding brief observations in a column to the left of the transcript under three main categories – linguistic, descriptive and interpretative. As Smith et al. (2009) point out: "As long as the interpretation is stimulated by, and tied to, the text, it is legitimate" (p.89-90). Step three involved mapping the connections between observations in order to identify any emerging themes, which were then noted in a third column, to the left of my observations column. Step four entailed searching for patterns between emerging themes in order to distil a set of master themes encapsulating this first participant's particular experiences. Step five involved beginning again with the next participant's account, repeating steps one to four. As IPA is an idiographic process, it was important to bracket off the knowledge acquired from the previous participant's account as far as possible, in order to identify particular emerging themes without contamination. Only once steps one to four were complete, the initial table of themes from the first participant was then used as a basis for confirmation, addition or revision of the table of themes and sub-themes for the second participant. This process was continued for each subsequent participant. The sixth step involved playing with all the superordinate and subordinate themes in a creative process of convergence and divergence, identifying which grouped together and which did not. This process was iterative, continually moving from a close

focus on the data, away from it towards the researcher's interpretations, and back again, all the while checking the theories were grounded in the evidence of the data.

Following Smith et al.'s (2009) recommendations for a threshold criterion in order for a theme to be considered important, it was decided that a theme should be represented by comments from over half the participants (i.e. five). In reality, all three themes and sub-themes were represented by comments from eight or nine participants (Table 1). The third theme, which forms the focus of this paper's analysis, concerned clinicians' experiences of delivering EMDR Therapy and learning to "trust the process".

Themes & Sub-Themes	1 Kitty	2 Mattie	3 Annie	4 Rose	5 Steve	6 Kate	7 Jo	8 Sara	9 Alex	Total
Theme 1: "It's not about the modalities, really" - it's trauma work in general										
Compensations:	✓	x	✓	✓	✓	✓	✓	✓	✓	8
Close connections:	✓	✓	x	✓	✓	✓	✓	✓	✓	8
Cumulative costs:	✓	✓	✓	✓	✓	✓	✓	✓	✓	9
Clinicians' coping strategies:										
Supervision	✓	x	✓	✓	✓	✓	✓	✓	✓	8
Preparation	x	✓	✓	✓	✓	✓	✓	x	✓	7
Boundaries	✓	x	✓	✓	✓	✓	✓	x	✓	7
Other interests	✓	✓	x	x	✓	✓	x	✓	✓	6
Theme 2: "My comfort zone" – containing or constraining?										
Containing:	✓	x	✓	✓	✓	✓	✓	✓	✓	8
Constraining:	✓	✓	✓	✓	✓	✓	✓	✓	x	8
Theme 3: Confidence to "Trust the process"										
Physical communication:	✓	✓	✓	✓	✓	✓	✓	✓	✓	9
Confidence:	✓	✓	✓	✓	✓	✓	✓	✓	✓	9
Clears the trauma:	✓	x	✓	✓	✓	✓	✓	✓	✓	8

Key: ✓ = Participant comments on theme. x = Participant does not comment on theme.

Table 1. Themes & sub-themes represented across participants

Smith et al. (2009) argue that the quality and validity of the research needs to be evaluated using criteria appropriate to qualitative rather than quantitative research. Therefore

Yardley's (2008) recommendations - triangulation, member checking and creating a 'paper trail' - were employed. Triangulation was carried out by the second author and research supervisor, who audited the analysis of one interview by reading the transcript and evaluating the documented evidence for the themes and sub-themes which emerged from it. One participant also evaluated the themes in detail and gave feedback on the accuracy of the researcher's description and interpretation of her account. Member checking was carried out when the first researcher presented a summary of the findings to a group comprised of most participants, feedback from which helped to confirm the accuracy of the data. Thirdly, Yardley (2008) recommends leaving a comprehensive 'paper trail' of the research process. Therefore rigorous and systematic documentation of each stage of the research process was carried out so that a reader might be able to fully understand and evaluate how the research process was followed.

Results

Three super-ordinate themes emerged from analysis of participants' semi-structured interviews. Two super-ordinate themes focus on similarities between trauma treatment modalities overall, and clinicians' experiences of the containing and constraining aspects of TF-CBT, and these lie outside the present scope of this paper. The third super-ordinate theme, which will form the focus of this analysis, emerged from a profound examination by participants of how they experience delivering EMDR Therapy and how this might impact their own and their clients' well-being. Three clearly differentiated but intertwining sub-themes emerged from participants' accounts which will be considered in turn:

1. Intense physical communication

2. Confidence to "trust the process"

3. EMDR Therapy clears the traumas that TF-CBT cannot shift.

Intense physical communication

The first sub-theme to emerge focused on the differences clinicians perceived between the *"more conscious… more rational" (Sara: 46:36),* more analytic and verbally-based stance inherent in cognitively-based exposure work and the noticeably more intense physical connections and reactions experienced – by both clinicians and clients alike - during EMDR processing.

Many interviewees seemed to broach this subject tentatively, as if the topic was difficult to express and perhaps even unsafe to discuss. For example, *Sara* appears to feel embarrassed - betrayed by the word *"wacky"* – as she tries to describe what EMDR work is like for her:

> *"I'm tuning in with my client all the time. It's almost like - this is really wacky! - but it is almost like a channel of energy between me and them and I feel it. And I'm using this sensation in my solar plexus … that solar plexus feeling. … it's actually… such a privileged position, because it's almost like you join them in some ways, and that's when you know when [the processing] is going." (Sara: 33:13).*

Several clinicians commented on this intuitive blending by using the metaphor *"tuning in",* as if they are a tuning fork reverberating with each client's particular harmonic frequency. *Rose* too describes the intensity of physical communication in EMDR work, which she feels is somewhat less with TF-CBT, and I notice her eyes well up with tears as she remembers a recent EMDR session that has affected her deeply:

> *"…the kind of words she said was 'My heart broke' or 'My heart's breaking' and you could almost see that, because it was about bereavement. I found that a really*

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upsetting session - and perhaps I wouldn't if I'd been using TF-CBT - but I think it was

something about watching her physical response as she was saying those words, and

you kind of feel like your heart breaks for them... yeah ... [TEARS WELLING]." (Rose:

44:18).

Rose also makes a distinction between the effects of working in the two modalities in this
respect:

> *"I feel it more physically at the end of an EMDR session, perhaps whereas*
> *cognitively with TF-CBT it might be more mental." (Rose: 24:57).*

Annie also notices she finds EMDR sessions more physically tiring, particularly if using
her hand to induce eye movements in the client. Her repetition of *"my",* rather like a stuck
record, almost seems to be mirroring the tiredness of the physical repetitions of her hand
movements:

> *"But just physically, by the end of a long session, I notice my hands are getting*
> *tired and my, my, my, um like pacing goes. That's quite tough." (Annie: 23:20).*

Some participants also found bilateral tapping well tolerated by clients, particularly those
who needed a human connection, as *Jo* recounts:

> *"She just needed the human touch … and we'd have these quite profound*
> *sessions where … you just feel connected. There's something about EMDR that can be*
> *very connecting ... in a way that TF-CBT... I don't know ... (Jo: 22:05).*

Jo describes her 'felt sense' (Gendlin, 2003) of the close connection in a way that recalls *Sara's* evocation of being joined to her client, although *Jo's* contrast between her experiences of tapping to that of using handheld buzzers is worth citing in full:

"It's different with … buzzers… [they] are very distant. So for example, tapping … I'm sitting here, and I'm tapping on their hands, it's very close. You feel very close and if someone's weeping or shaking … you're really joined and that can be very... very, very powerful and very healing for the person, but it almost feels as if you're absorbing it. Whereas when I'm sitting with the buzzers, I mean, I could be making my shopping list." *(Jo: 46:46).*

Jo's reference to her shopping list presents a strikingly dismissive image of detachment, very different to the intimacy and connection described with the tapping. In contrast, *Sara* argues *"What I like about the buzzers is, I don't get RSI from the arm [movements]… so it means it's easier too." (Sara: 28:53).* Given her previous comments about the intense emotional connection - *"that solar plexus feeling"* - she feels with clients, buzzers do not seem to distance *Sara* in the same way *Jo* experiences.

The closeness and physicality of processing in EMDR Therapy, whichever BLS method is used, seems to imbue the communication between clinicians and clients with a deep and intuitive emotional intensity. However, the physicality of EMDR processing also appears to tap into the clients' experiences of trauma memories in a profoundly powerful, if slightly mysterious, way. *Steve* for example identifies how he has found EMDR Therapy particularly good for working with physical trauma symptoms in clients:

"What I've found, and I can say now after my long practice, is EMDR is brilliant

for anything 'body' - body flashbacks, physical flashbacks - it's really, really more helpful

than CBT … Because part of the theoretical basis of trauma in general, as we know, [is]

that your body stores the trauma in your senses." (Steve: 08:05).

It may feel very unnerving for a cognitively trained clinician to allow themselves to
accompany a client through this very intense and viscerally physical connection, which seems
so powerfully reparative and transformative. The next sub-theme explores clinicians'
expressions of the anxieties and ambivalence they feel around learning to have confidence and
"trust the process" (Annie: 25:10) of EMDR Therapy.

Confidence to "trust the process"

A second sub-theme emerged from the reports of several clinicians who admitted feeling
ambivalence at best, and extremely anxious at worst, about the perceived loss of control they
experienced during EMDR processing, and thus whether they felt able to *"trust the process"*
(Annie: 25:10). Clinicians commented that they felt a significant responsibility for their clients'
emotional and physical well-being, both during sessions and, as *Alex* described, through having
to *"hold the client's story from one week to the next." (Alex: 44:35).* This burden may manifest in
the often considerable anxiety several clinicians seemed to experience, particularly around
elements of treatment that may be unpredictable or uncontrollable, such as dissociation. For
example, *Kate* comments:

"I think that's what's so scary - they SUDDENLY get emotional and you have no

idea what to think or even guess, but you don't really know what's going on in their

heads, and you don't even know if they'll dissociate, and it will be hard to get them back

in the room." (Kate: 1:11.56).

These anxieties contrast vividly with comments from other clinicians, for example *Sara*, who almost seems to relish the emotional intensity of sessions, as she says

"I don't worry about people experiencing emotion, I don't mind if they cry their

eyes out, I don't mind if they're highly distressed. I think, 'Well, that's how you felt at the

time, but you can tolerate it. We can tolerate it together.' And, maybe that's also helpful

to them: they can see that I can sit with their emotion as well." (Sara: 49:40).

Another specific area that some clinicians admitted to feeling unsure of, was how long to continue each set of BLS. *Jo* describes the desperate searching for clues when she says

"When have you done enough taps, you know? When have you done looking,

looking frantically for when is the facial expression changing? And I just wouldn't know,

and I'd carry on tapping and I'd carry on tapping and I'd be looking … And I couldn't

see... just what the hell is going on?" (Jo: 20:53).

The common consensus amongst participants who commented on this seemed to be an intuitive sense of allowing a wave of emotion surge and pass, as the following descriptions attempt to capture: *"I'm watching for the emotion to go up and then come down again… yeah, so the peak and then the dip…" (Sara: 29:52),* and, *"I guess it's just trying to follow the wave? That's the only way I can think of describing it... or a strong emotional shift." (Rose: 32:06).*

In contrast to some participants, *Steve* claims to feel relaxed and confident enough to cede control to and share responsibility with the client for progress; this is perhaps an important therapeutic aspect of trauma work as, during their prior abusive experiences, power and control may have been wrested away from a client (De Zulueta, 2009). *Steve* comments, regarding dissociation:

"I'm very laid back about it, like I say 'Fine, you know, you don't want to do it today, it's fine.' Or, we reached this place today, [they] dissociated, and they say 'Ok, today can we stop?' and I say 'Yeah, sure.' Um, so giving that control … I think they have it in CBT too I'm sure, but in my case, in EMDR, that 'Stop' sign - that's it, it's over." *(Steve: 54:20).*

This relinquishing of control cannot be forced; *Kate* admits reluctantly *"it feels like in EMDR you are supposed to sort of hand over control to the person." (Kate: 37:10).* She adds too that *"it's kind of like they're doing all the work… maybe if I felt allowed to … add things more, maybe I'd feel more of a therapist." (Kate:25:35)*, a wistful phrase which perhaps describes the deskilling effect of learning a complex new protocol, as well as the amount of active work which may be involved in *Kate's* preferred role as a TF-CBT therapist.

Annie describes the dual responsibility she feels for having to contain both her and her client's feelings in the face of such uncertainty:

"'I think what's very different is, the [EMDR] processing will go where it needs to go, but you're not necessarily gonna know what that is. … And that, just feels quite challenging, as a therapist anyway, because you wanna feel like you're in control of it, partly for you, and partly for them." (Annie: 18:28).

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The extent of just how difficult this relinquishing of control may feel for a clinician is evoked vividly in *Annie's* ambivalence towards being asked to trust in a process that perhaps she doesn't yet feel fully confident in:

"'EMDR definitely involves a lot more trust. [My EMDR supervisor] talks a lot about 'You've got to trust the process, you've got to trust the process'. And I kinda go, yup, no, I am, I'm trusting it, but... BUT! It feels like I'm really anxious about it [SQUIRMING AND LAUGHING]." (Annie: 25:10).

In *Alex's* experience, having the confidence to *"trust the process"* seems to have come as a matter of time and experience:

"I don't know if I would entirely subscribe to the more control thing [in TF-CBT] because I think you normally see by the changes in somebody's face [in EMDR]. I don't seem to worry about any of these things, I don't know whether it's cos I've been doing it for ages." (Alex: 56:26).

Sara displays also a confidence that seems to come from her belief in her ability to manage whatever comes up, and her faith in the client, when she says

"You're relying on the client to do the work, knowing in full faith that they will get there. … You have to trust the client and the client could go anywhere. See, I know, no matter what happens to my client, they'll be alright. [LAUGHS] … I know I can manage anything that comes up." (Sara: 26:18).

And if a clinician dares to take this leap of faith, they may experience the reward of an exciting and – another quasi- religious reference – potentially miraculous outcome. With *Sara* there is no such ambivalence, but a repeated emphasis on how exciting and rewarding the work can be:

"It is exciting and the reward is amazing. And it is miraculous, so you do get a huge reward from EMDR which you don't get from exposure work" (Sara: 22:49).

If clinicians can allow themselves to *"trust the process" (Annie: 25:10)* it became apparent from these interviews that EMDR Therapy is viewed as having the ability to clear traumatic memories that TF-CBT cannot shift, and this potential for a *"miraculous"* outcome may add to the excitement and rewards of the work, as the third sub-theme will explore further.

EMDR Therapy clears traumas TF-CBT cannot shift

The third sub-theme opens up considerations of clinicians' experiences that, if they can *"trust the process" (Annie: 25:10),* EMDR Therapy often seems able to clear traumas that TF-CBT cannot shift, and faster. A representative comment comes from *Annie,* as follows:

"[TF-CBT] helped, but it hadn't really quite done the job, so we just did a couple of sessions of EMDR and it cleared it out much better. [TF-CBT] might get a physical and emotional shift, but not necessarily all of it, not always. Not with the complexity of the trauma that we deal with here. That's where EMDR really comes into its own."
(Annie: 44:49).

Both *Sara* and *Steve* muse on what the mechanisms might be that seem to distinguish how EMDR works from TF-CBT. *Sara* almost seems to be referring to a notion of the unconscious as she reflects on the difference:

"EMDR uncovers the unknown - unknown to me and unknown to the client - and I think that provides … the magic key that you can access through EMDR. With CBT you think, 'THIS is what's going on'.   [Whereas] different bits of information fit together with EMDR, and you think 'Ohh, I didn't realise THAT'." (Sara: 24:20).

Steve similarly hypothesises on the nature of EMDR processing that makes it so effective in his view:

"EMDR has [a] certain psychodynamic component to it, which is this free association: 'Just go with that'… and you allow the brain to heal. The assumption is that your body heals after a wound, [so] why wouldn't your brain heal? So it's just wherever the brain goes, I'm going with it. That free association, which is very psychodynamic really, gave me that freedom to – no, it gives THE PATIENT the freedom to go to places that CBT, if I'm focusing on the hotspot and updating that specific memory with their feelings and thoughts and blah, blah, blah, doesn't really access." (Steve: 05:35).

According to *Steve*, because the client's brain can go where it needs to heal itself, *"I don't have to target every single incident; you have the generalisation effect." (Steve: 08:05).* This is vividly illustrated by another example, where *Steve* recalls a client he treated briefly with EMDR Therapy:

"…Her father was very abusive for eight years sexually and we identified two specific traumas… that's the ONLY two we targeted. But the sexual abuse lasted for eight years. What happened to all of that? We didn't have to do that." (Steve: 08:05).

Sara too confirms *Steve's* experience that she believes EMDR Therapy clears the traumas that TF-CBT doesn't seem able to shift. In fact, she felt so strongly about the importance of her point, she asked me to switch the voice recorder back on at the end of our interview so she could reiterate her views, as follows:

"EMDR therapists would have the experience of 'THAT is just amazing, that's been completely cleared'. It is like a mini miracle. Whereas I don't think CBT therapists would say that in the same way. You just don't get the same result; you don't get the same clearing. Because in terms of EMDR, you will get a complete clear, whereas in terms of TF-CBT, you just don't. And I don't think that that is picked up in the research. In terms of those measures that you're using, yes, the measures might come down – ok, so you're not getting the intrusive memories - but are you getting that change in the body? It's a very cognitive measure, the PCL5. It's not picking up on 'What's it actually feel like now, after you've had treatment?' And an EMDR client would say 'I feel completely different and this is amazing, thank you for giving me my life back', whereas with CBT, it's just not the same." (Sara: 12.16).

In summing up, *Steve* elaborates on the specific experiences of delivering EMDR Therapy that are so rewarding – the good outcomes, the speed, the client's satisfaction and the way EMDR Therapy seems able to clear trauma more completely than TF-CBT:

"But you know the rewarding side of [EMDR] are the outcomes. The rewarding side of it is really, really rewarding. Because patients are like 'WOW! I saw a guy the other day: two sessions. … And he said to me, 'My God, that was magic'. In terms of EMDR, why I'm biased, is because it works faster, and it accesses other things that CBT doesn't." (Steve: 51:10).

It is striking how many clinicians, as well as clients, refer to the idea that EMDR Therapy is somehow *"magic"*. According to *Sara (24:20) "it's the magic key"*, which can unlock the mind's healing potential. Woven throughout this analysis there have also been several references to an almost religious sense of a belief system with EMDR Therapy, that a clinician needs to be able to *"trust the process" (Annie: 25:10).* As *Sara* identifies, in ceding control to the client, "y*ou have to trust the client … knowing in full faith that they will get there" (Sara: 26:18)* and this can result in *"a mini miracle" (Sara: 12.16).* Perhaps this almost superstitious belief in the magic of the EMDR process arises because we don't yet fully understand the mechanisms by which these good outcomes are achieved. Clearly, any therapeutic belief system needs to be able to withstand rigorous scientific investigation and EMDR Therapy is no exception. Part of the difficulty lies perhaps in the subtle shadings of meaning in therapeutic change which are so hard to capture quantitatively, particularly by cognitive measures not designed to ask the right questions, as *Sara* noted above (*12.16)* and yet, this is not to diminish the effectiveness of its power, whereby "*people can come with diagnoses and leave without."* *(Steve: 03:11).*

Several clinicians admitted they found trauma work was sometimes *"frightening" (Mattie: 21:23)* and that they feel tempted to fall back on their first training in the solidly evidence-based TF-CBT approach as their *"comfort zone" (Annie: 06:43; Rose: 12:08)*. They claimed to feel more competent, in control, and confident that they would be able to contain the often

unexpected and extreme emotions arising both in themselves and their clients. However, as *Mattie (02:29)* says, we need sometimes to be able to challenge *"the dominant discourse"* and this is doubly important when both clients' and clinicians' well-being may be at stake. *Kate* seemed to challenge her own usual TF-CBT practice of gathering a lot of information from the client, when she reflected during our interview and came to the painful recognition *"If I'm slowing down treatment success because I need to know [all the details], it's a bit heart-breaking for the client." (Kate: 1:02:14).* At the end of the interview, when I asked her if there was anything else she'd like to comment upon, she said

> *"I just keep thinking that I should try to use EMDR more. I know it's so useful and good and I set myself up for not using it, except for people who are blocked and not progressing in treatment. So, yeah, that's all that was going through my mind… [SMILES]" (Kate: 01:15:43.19).*

Reflecting on the interview process itself, it seemed particularly valuable to allow space for contemplation and reflection; this activity forms a necessary component, as counselling psychologists are well aware, of the ability to continuously challenge and improve our clinical practice (Douglas et al., 2016).

Discussion

Overview

IPA was used in this study to address short-comings in the previous, predominantly quantitative, research literature and to provide a richly detailed and nuanced dataset with the potential to generate fresh insights for improving clinical practice and informing novel research directions.   Having carried out semi-structured interviews with nine clinical and counselling

psychologist participants on their experiences of delivering TF-CBT and EMDR Therapy, three key themes emerged from the analysis. The first theme explored clinicians' experiences of the similarities in trauma work in general, notwithstanding choice of modality, and this may therefore make sense as describing the overarching common denominators any clinician delivering trauma treatments is likely to experience; as such it accords with, and extends, findings from prior research on positive and negative impacts of trauma work in general (Baird & Kracen, 2006; Bartoskova, 2015; Canfield, 2005; Elwood et al., 2011; Manning-Jones et al., 2015). The second theme focused on the contrast between containing and constraining aspects clinicians experienced when delivering TF-CBT, and details of these findings may be published in a further paper.

The third theme "Trust the process" that emerged from this larger study will be discussed here. It focuses on participants' very different experiences of delivering EMDR Therapy through the three sub-themes which emerged and these will now be discussed in the light of previous research, and recommendations for future investigations. Finally limitations of this study and implications for counselling psychology will be outlined.

Study findings and suggestions for further research

The effectiveness and efficacy of the EMDR Therapy outcomes experienced by participants in this study accords with Lipke's (1995) EMDR practitioner survey findings, as well as the patient outcome research (Shapiro, 2014), but whether EMDR work was experienced as less stressful to the clinicians seemed to depend more on individual factors. Dunne & Farrell (2011) indicated that a therapist's personal style and their levels of confidence and anxiety were significant factors concerning ease of integrating EMDR Therapy with their prior therapeutic orientation and this current study supports their findings. Some participants appeared to relish the strong and often unpredictable emotional expression in EMDR sessions and remain

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unconcerned by the risk of dissociation, recognising the therapeutic value of modelling the toleration of overwhelming feelings together with their clients. Other clinicians found containing their own and their clients' anxieties was made more challenging by the relative lack of information available during EMDR processing regarding client well-being, and this seemed to affect whether control over session content and pacing was retained by the therapist, or shared with the client. These findings partially contrast therefore with reports from both Lipke (1995) and van Minnen et al. (2010) that clinicians feared symptom exacerbation and dropout more with exposure-based approaches, but seem to indicate that perhaps personal factors, in particular individual confidence or anxiety, may play a significant mediating role. Further research is needed to clarify whether organisational factors, such as supervisory and peer group support – particularly for newly trained practitioners – as highlighted by Dunne & Farrell (2010), may mitigate these personal factors, and support therapists to develop confidence as suggested by Manning-Jones et al. (2015).

Participants repeatedly reported they found TF-CBT much harder work mentally, which may support Linley & Joseph's (2007) finding that TF-CBT therapists are more likely to burn out and less likely to experience VPTG. This may also be due to the repeated exposure to detailed traumatic accounts that TF-CBT entails (Lee, 2006), as Figley (2015) cautions, or perhaps the speed and effectiveness of EMDR Therapy outcomes are intrinsically more rewarding and this is a protective factor contributing to therapist VPTG (Arnold et al., 2005). The 'magical' references to EMDR Therapy outcomes made by participants also deserve further research quantification, as it appears that current clinical outcome measures may not be sufficiently sensitive to capture the complete effect of the EMDR process on clients' recovery from trauma.

Of concern however, are clinicians' reports that EMDR Therapy is more physically tiring, particularly as there is currently a dearth of investigation into RSI when using the more effective technique of inducing BLS via hand/eye movements. Although several clinicians acknowledged

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the research to date supporting eye movements as the most effective method (Lee & Cuijpers, 2013; Van den Hout et al., 2012), comments regarding their experience of RSI showed it clearly affected their choice of BLS technique, and this in turn appeared to affect their sense of connection with their clients in different ways. Given that the therapeutic alliance is a key factor in achieving good outcomes (Lambert, 1992) it may be important to investigate this area in more depth. Further research on the allied finding, that some participants reported anxiety concerning the best moment to pause BLS sets, may provide a useful evidence-based guideline for clinicians and optimise the client's experience of processing.

Drawing together the threads from the three sub-themes in this study, it appears that the notably intense and reciprocal physical connections participants described with their clients may be linked to the more complete 'magical' recoveries clinicians said they witnessed with EMDR Therapy, which seemed to be lacking in their descriptions of the exposure-based fear extinction they achieved through TF-CBT. As many current titles in the trauma literature reflect, 'the body bears the burden' (Scaer, 2014) and current models attest to the healing power of 'body-based' approaches (Ogden & Fisher, 2015; van der Kolk, 2014). Almost all participants commented on the effect – both on them and their clients - of the intense scrutiny of client facial and non-verbal signals required during EMDR processing. It may be interesting to investigate whether these intense human connections may constitute a resourcing function, protecting clinicians from compassion fatigue and burnout, and enhancing their sense of satisfaction and reward from the work. Furthermore, whilst some clinicians expressed their fears regarding client dissociation, research shows that there are many levels from micro to macro dissociation which result in degrees of temporary cognitive and language impairment as the pre-frontal cortex and language centres are inhibited (van der Hart, Nijenhuis & Steel, 2006); this may partly explain why a therapy heavily reliant on cognitive and verbal processes, such as TF-CBT, may take longer and only achieve partial recovery. Using the EMDR approach, in contrast, it is sufficient for

clients to maintain dual-attention awareness, and material can be processed, using titration if necessary, through cognitions, imagery, emotions, body sensations and ego state work (Paulsen, 2017). Thus participants' experiences seem to reflect current thinking in complex trauma research, which increasingly seems to be working towards a paradigm shift regarding the significance of more body-based approaches for healing trauma (van der Kolk, 2014).

Limitations of the study

Limitations arise in the use of IPA when a single researcher carries out the procedure, particularly the interpretative elements, as decisions could be made differently by another researcher, and it is recognised as impossible to succeed in the bracketing process completely (Kvale, 1996). The first author, however, attempted to bracket known assumptions and biases (particularly those arising from experiences and prior knowledge of EMDR Therapy and TF-CBT), to document the bracketing process, and research procedure as a whole, as fully as possible by maintaining a detailed 'paper trail', and to employ feedback from triangulation and member checking to check the faithfulness of the analysis, following Yardley's (2008) recommendations.

A second limitation of this study may be the small sample size, which means it is important to remain tentative when discussing implications; although this sample yielded a richly detailed and nuanced dataset, more interviews might provide a broader range of insights into clinicians' experiences of trauma work. Willig (2013) suggests, however, that with IPA the focus should rather be on transferability of findings from one group to another.

Implications for counselling psychology

Following Iqbal's (2015) recommendations, the implications for counselling psychology of disseminating the findings of this study through publication may be threefold. Firstly, novel

research areas may be opened up for enquiry to support evidence-based - and increasingly

trauma-informed - practice. Secondly, publication disseminates this practice-based knowledge

which may then contribute towards formulating trauma-informed guidelines available to

counselling psychologists, and other trauma practitioners, to improve the well-being of both

clinicians and, ultimately, their clients. Finally, sharing these findings may reduce the risk of

trauma practitioners inadvertently harming themselves or their clients, and thus upholds the

codes of conduct, performance and ethics at the heart of counselling psychology's ambitions to

continually strive for best practice.

Disclosure statement

No potential conflict of interest was reported by the authors.

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Appendices

Appendix 1. Interview schedule

Thank you for agreeing to take part in this study.

(Check the Study Information Sheet, Consent Form and Participant Description Form).

As you may know, NICE guidelines (2015) equally recommend TF-CBT and EMDR Therapy for PTSD in terms of client outcomes. To my knowledge, however, no one has yet compared the impact of administering these treatments on clinicians themselves. I am really interested in how you experience working with these two treatment approaches (all things being equal for your clients).

1. Please can you give me a brief summary of your training and experience in TF-CBT and EMDR Therapy until now (i.e. resumé of completed Participant Description Sheet)? How did you come to specialise in trauma work?

2. Can you describe to me how you experience delivering TF-CBT and EMDR Therapy?

3. Prompts - for example:
   - How do you experience TF-CBT and EMDR Therapy during an actual session?
   - What, if any, effects continue between sessions?
   - What experiences of delivering these treatments may have led to long-term changes in you, and what might those changes (positive or negative) be?

4. Everyone has difficult sessions. What are the main differences between a difficult EMDR Therapy and difficult TF-CBT session, and how do you manage it? How do you manage after a difficult day or week at work?

5. How would your life be if you worked in your less preferred approach all the time?

6. Is there anything else you'd like to add?

   Prompts – Can you tell me a bit more about …? How did you feel?
   Probe – What do you mean by …? How? Why?

   Thank you.
   I will now read the Debrief Sheet and answer any questions you may have…

Appendix 2. *Counselling Psychology Quarterly* Publishing Guidelines

About the journal

Counselling Psychology Quarterly is an international, peer reviewed journal, publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

Please note that this journal only publishes manuscripts in English.

This journal accepts the following article types: articles.

Peer review

Taylor & Francis is committed to peer-review integrity and upholding the highest standards of review. Once your paper has been assessed for suitability by the editor, it will then be double blind peer-reviewed by independent, anonymous expert referees. Find out more about what to expect during peer review and read our guidance on publishing ethics.

Preparing your paper

Structure

Manuscripts should be compiled in the following order: title page; abstract; keywords; main text; acknowledgements; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).

Word limits

Please include a word count for your paper.
A typical article or book review for this journal should be no more than 10000 words; this limit includes tables; references; figure captions; footnotes; endnotes.

Style guidelines

Please refer to these style guidelines when preparing your paper, rather than any published articles or a sample copy.

Please use any spelling consistently throughout your manuscript.

Please use double quotation marks, except where "a quotation is 'within' a quotation". Please note that long quotations should be indented without quotation marks.

Formatting and templates

Papers may be submitted in any standard format, including Word. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting templates.

Word templates are available for this journal. Please save the template to your hard drive, ready for use.

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References

Please use this reference guide when preparing your paper. An EndNote output style is also available to assist you.

Checklist: what to include

1. **Author details**. Please include all authors' full names, affiliations, postal addresses, telephone numbers and email addresses on the cover page. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. Read more on authorship.
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4. 5-7 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.
5. **Funding details**. Please supply all details required by your funding and grant-awarding bodies as follows:
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Part C: Case Study

Caring and responsibility in the crosshairs:

Using a 'Responsibility Pie' to compassionately restructure a

veteran's guilt-based complex trauma.

Words: 6044