An exploration of senior therapists' experience of working with complex trauma in Ireland: An Interpretative Phenomenological Analysis

by

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Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Psychotherapy is entirely my own work, and that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

Signed: Gerard Meehan ID No.: 54175984 Date: 25/06/2025

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Abstract

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Complex trauma can result from multiple, cumulative and prolonged experiences of psychological injury from events such as childhood abuse and/or neglect, which lead to difficulties along several developmental trajectories. The publication of the SAVI report (Sexual Abuse and Violence in Ireland) and inquiries into Ireland's history of institutional abuses have contributed to the emergence of several specialist trauma services and private practitioners working with complex trauma presentations. Despite the growth within Ireland of this specialised therapeutic area, little is known about the experience of therapists working with this clinical population. This study explores the lived experiences of therapists, who have long term experience of working with complex trauma in Ireland, using Interpretative Phenomenological Analysis (IPA).

Through interviews with nine experienced trauma therapists, three core experiential themes were identified. Firstly, *the vicarious impacts: "you feel like it's in your bones"* reflects the profound embodied impacts of trauma practice. The second theme, *being pushed: "it's continuously challenging"* illuminates the ongoing professional and personal demands of working with complex trauma. Lastly*, feeling driven: "this kind of work is so addictive"* explores both the light and shadowed motivations of trauma work, along with its inherent growth processes. The findings reveal the vicarious costs of trauma work manifest at a primarily embodied level, particularly for women, while emotional resilience appears to increase with experience. The study also elucidates the process of adapting to the specialized aspects of trauma work, the challenges related to professional boundaries, the issue of professional isolation (particularly in private practice), and the difficulty in obtaining trauma-informed supervision within Ireland. The findings are discussed in light of the relevant previous research on trauma work. Recommendations and implications for clinical practice, supervision and training are detailed.

Chapter 1: Introduction

This study emerged out of my own curiosity as a psychotherapist after working with complex trauma in challenging environments were suicide risk, self-harm and psychiatric diagnoses were common presentations. In my own opinion, complex trauma played a considerable role in the early lives of many of the clients, who sought help from myself and fellow colleagues. In recent years, there has been increased awareness amongst mental health providers of the impact of trauma generally, including complex trauma (Champine et al., 2019). Despite the growth in interest in complex trauma, this is a relatively recent trend with more research attention needed (Maercker, 2021). This study investigated psychotherapists' experience of working long term with complex trauma within Irish clinical settings. My hope as a researcher was by exploring the lived experience of senior psychotherapists working within this specialised field, there would be scope to build knowledge to inform supervisory practice, self-care routines, organisational policy and inform training programmes within Ireland.

This chapter will summarise the background and justification for embarking on this research project. A brief description of the methodology and methods used, along with the aims and objectives of the study will also be presented.

1.1 Background and Rationale

Contemporary theories of complex trauma view this concept through the prism of chronic abuse and neglect, which see traumatic insults leading to a constellation of psychological symptomology (Cloitre et al., 2009). For the purpose of this study, complex trauma will be defined using Judith Herman's (1992) original conceptual framework of complex (post-traumatic stress disorder) or CPTSD, which distinguishes a cluster of adaptions to trauma resulting in a range of interconnected symptoms

including affect dysregulation, alterations of consciousness, disrupted self-identity, interpersonal difficulties, compulsive behavioural responses, issues of somatic disconnection and changes in belief systems.

Recent years have witnessed an increasing focus on trauma informed approaches internationally within psychological service provision (Raja et al., 2021). Moreover, the recent acceptance of complex post-traumatic stress disorder (CPTSD) within the ICD-11 diagnostic classification of diseases in 2018 has led to a rapid energising of research interest in this clinical concept (Maercker, 2021). Out of this growing global research literature is an emerging picture of CPTSD as being a common psychological problem, which is likely to require increasing levels of psychological treatment (Hyland et al., 2021).

In Ireland, a number of events have catalysed an increasing focus on the psychotherapeutic support of complex trauma survivors. The publication of the SAVI report, (McGee et al., 2002) found the prevalence of child sexual abuse at rates of 20% for women and 16% for men. This report revealed the negative consequences of psychological trauma for those impacted by childhood sexual abuse with high rates of post-traumatic stress disorder (PTSD) evidenced. A later public report by *The Commission to Inquire into Child Abuse*, (CICA, 2009) identified pervasive levels of historic childhood physical/emotional abuse and neglect, as well as endemic levels of sexual abuse within Irish residential institutions (Gleeson & Ring, 2020). Furthermore, global instability has seen increasing numbers of refugees seeking asylum within Ireland (Refugee Council Ireland, 2023) with evidence suggesting this population experiences high levels of psychological trauma (Bogic et al., 2015). The first Irish epidemiological study (Hyland et al., 2021) on CPTSD revealed that 7.7% of the general population meet the criteria for this diagnosis. Against this backdrop, several

public and non-governmental services have been established to offer specialised psychotherapy for those exposed to childhood abuse and neglect (National Counselling Service, One in Four and Towards Healing) and for refugee/migrant survivors of torture (Spirasi). Moreover, growing awareness around domestic violence has resulted in increasing numbers of referrals of victims to counselling services (Women's Aid, 2023). Allied to this, are the growing number of private psychotherapists, who are seeking specialised training to respond to the needs of clients presenting with complex symptomology.

As a corollary to this emerging general interest on complex trauma is the increasing trend of understanding the adverse impacts of working within this clinically specialised field. Research constructs such as burnout (Miller et al., 1995), secondary traumatic stress (Figley, 1995) and vicarious trauma (McCann & Pearlman, 1990) have long been used to understand the detrimental effects of working with complex trauma. International research on these constructs over the last three decades has demonstrated that those providing psychological support to traumatised individuals are vulnerable to experiencing a broad range of adverse psychological, relational and physical symptoms (Fernández et al., 2024; Baird & Kracen, 2006; McCann & Pearlman, 1990). Quantitative studies on trauma therapists evidenced prevalence rates of secondary traumatic stress at between 19.2% (Cieslak et al., 2014) and 70% (Sodeke-Gregson et al., 2013). Contrastingly, newer qualitative studies are starting to reveal the post traumatic growth potentials of this specialised clinical work (Coleman et al., 2021; Bartoskova, 2017; McCormack & Adams, 2015). This growing international expansion of research inquiry into positive experiences of working with psychological trauma, has identified a range of improvements including psychological resilience, optimistic beliefs systems, and healthy perspectives on relationships (McNeillie & Rose, 2021).

Qualitative research on therapists working in Ireland with complex trauma remains scarce, Wheeler and McElvaney, (2018) investigated the positive impacts of working with child victims of sexual abuse within a specialist service. Building on this work, O'Connor, (2019) used a qualitative approach to explore the experience of the helping professions (including psychotherapists) working with child sexual abuse victims and families within a specialist organisation. Recently, Forde and Duvvury, (2021) explored working with a somatic/humanistic modality within the Rape Crisis Centre. However, this current study contrasts with this previous research, as it aims to explore the experience of senior therapists that is those working long term within this specialised area and to recruit participants from differing clinical environments within Ireland rather than from specific services.

Despite the growing clinical interest in trauma informed care and the increasing numbers of therapists working with complex trauma presentations, limited research exists on practitioner experiences within an international and Irish context. This study proposed to use an Interpretative Phenomenological Analysis (IPA) approach to underscore the lived experience of senior psychotherapists working with complex trauma within Irish clinical settings.

1.2 Aim and Objectives

The aim of this study was to explore senior therapists' experience of working with complex trauma in Irish psychotherapy settings.

The specific objectives were to explore:

- Participants' lived experience of working psychotherapeutically with clients presenting with complex trauma.

- How participants were impacted in their therapeutic work and personally, while working with complex trauma?
- Participants' experiences and views of what was helpful and unhelpful in working with clients presenting with complex trauma.

1.3 Methodology

The study selected Interpretative Phenomenological Analysis (IPA) as its methodology based on the work of Smith et al. (2022). Nine psychotherapists participated in semi-structured interviews for this study. Participants ranged in age between (42 to 68) and had regularly worked with complex trauma for over 5 years within organisations and/or private practice. IPA is a phenomenological approach, which was viewed by the researcher as being well-suited to gathering and analysing data around this phenomenon along with being sensitive to the contextual milieu of the participants' experiences (Smith et al., 2022). Within IPA the researcher has to take account of their own biases through a process of ongoing reflexivity throughout the course of the research (Smith & Nizza, 2021). Reflexive notes are included at the end of the chapters of this study.

1.4 Thesis Structure

This thesis is comprised of six chapters, this introductory chapter provides a brief overview of the background, rationale, aims and objectives of this study. Chapter two offers a summary and critique of the relevant literature within the field of complex trauma and psychotherapy, including a description of complex trauma's historical antecedents, central theoretical concepts, contemporary definitions, epidemiological frequency, neurological research base and clinical treatment. An outline of the research

on the vicarious impact of psychotherapists working with complex trauma is provided. The academic literature at the interface of self-care, supervision, training and complex trauma is highlighted. This chapter concludes with a discussion on the small body of qualitative research conducted on therapists working with complex trauma in Ireland.

Chapter three outlines the methodology and methods, as well as describing the aims and objectives of the study. There is a rationale for choosing IPA as a research approach, along with a description of its philosophical foundations, which encompass influences drawn from phenomenology, hermeneutics and an idiographic approach. Issues involving the researcher's reflexive processes and a detailed account of how the study was conducted from its beginnings through to the write up are outlined. This chapter is finalised with an account of the ethical considerations for this project, along with the use of Yardley's (2000) framework to ensure the validity and to assess the quality of the study.

Chapter four presents the findings of the study. A master table illustrates the overarching group experiential themes and sub themes evident across the participants' accounts. Quotations are used throughout this chapter to demonstrate the commonalities and divergences across the research data. Chapter five critically situates the findings of the study within the theoretical and research literature. This includes a selection of relevant literature that converges and diverges from the findings. This chapter also discusses how these findings progress the understanding of therapists working within this specialised field, with a particular focus on the Irish context. This final chapter looks at the strengths and limitations of this study, while examining the implications of the study for psychotherapy practice, clinical supervision, training and future research.

1.5 Researcher's Reflexive Comments

From the very beginning of my psychotherapy career, it has always struck me how powerful a role early life trauma plays in shaping an individual's personality. I remember as a novice therapist working with individuals, whose intense suffering left me feeling completely at sea and struggling to make sense of their complicated internal worlds. Even today, this sense of confusion and struggle still accompanies me along the path of my clinical practice. As a trauma therapist, the multi-layered nature of this type of clinical work confronts me daily with many personal and professional challenges. Sitting with the horrors and betrayals of the client's narratives within the clinical space has left me at turns having to re-evaluate my sense of trust in world, but it has also left me awed at times by the client's resilience. Working in this field also regularly leaves me reflecting on the endless complexity of the human mind with both its strength and fragility in the face of traumatic experiences. These working experiences have generated a constant inner dialogue around the nature of human psychological trauma, with reflections on whether it is the power of the external experience itself or the clients' meaning making around their particular experience itself which matters? Or questioning what role does human neurology, personality, and socio-cultural influence play in the client's experience of complex trauma. This interest in psychological trauma has never wavered throughout my career and I found myself drawn to the perpetual questions which surround this topic.

Trauma would also seem to have deep historical roots within our national, societal and personal psyches as Irish people. It is probably no surprise that many within the profession of psychotherapy including myself have turned our professional focus on this specialised field, given the great suffering it causes. I have on occasion reflected on my own internal conversations, which ask, why do people work in this

field with all of its tragedy and inhumanity to the most vulnerable in our society? How does it change them? What do they feel about their career? How do they process the darker side of the work? These internal dialogues have culminated in the current research question. It was a surprise to me that little research had focused on therapist experiences of working long term within this clinical area in Ireland, given the zeitgeist that now surrounds complex trauma practice.

The Doctorate in psychotherapy has allowed for the opportunity to explore this little understood professional environment. This research journey has helped me to recognise many similarities between myself and others within this clinical speciality and to feel a deeper solidarity with my profession. It is my hope that completing this study will progress an understanding of therapist experiences of working with complex trauma within Ireland and be a stepping stone in my future professional development.

Chapter 2: Literature Review

2.1 Introduction

In introducing the concept of complex trauma in 1992, Judith Herman broadened the understanding of psychological trauma away from 'single event trauma' to reflect the experience of those, who have been exposed to chronic, persistent, and relational trauma. This conceptual shift has heralded an increasing international interest in complex trauma, which can often be the clinical reality of those offering psychotherapy to traumatised clients. Weisaeth (2014) points out that every society generates its own historical and societal contexts, which in turn produce different signature symptoms of psychological trauma. Arguably, several changes have shifted Irish political and societal attitudes over the last two decades to a better understanding of the experience of trauma. In 1999, Taoiseach Bertie Ahern issued an apology on behalf of the state to survivors of institutional child abuse (Ahern, 1999). Added to this, were the publication of the SAVI report (2002), and the final report by the *Commission to Inquire into Child Abuse* (CICA, 2009), both of which highlighted the prevalence and consequences of psychological trauma within Ireland. These events offered a foundational starting point in confronting and therapeutically supporting psychological trauma within Irish society (Gleeson & Ring, 2020). There has also been the ongoing need to contextualise and adapt trauma treatments, against for example the backdrop of new immigrant groups coming to Ireland with specific traumatic presentations (Kelly, 2008) and other scenarios.

Out of these demands has come the emergence of specialised services working with complex trauma (National Counselling Service, One in Four, Towards Healing and Spirasi), along with an increasing number of private therapists choosing to train and work within the field of psycho-trauma. Allied to this, the HSE model of care

document, *Adults Accessing Talking Therapies* (2021) advocates for the inclusion of trauma informed models in helping individuals with complex trauma presentations, who present to Irish public mental services.

Inevitably, those therapists working with complex trauma clients for prolonged periods are affected by vicarious impacts. Numerous studies have identified the negative impacts on therapists of working with traumatised populations (Coleman et al., 2021; Merriman & Joseph, 2018; McCormack & Adams, 2015; Figley, 1995; McCann & Pearlman, 1990), but also the positive effects (Bartoskova, 2017; Arnold et al., 2005). However, little is known about the psychotherapists who have worked regularly at the coalface of Irish specialist service provision for traumatised populations. By exploring the experiences of these individuals, it is hoped that this study will reveal a deeper understanding of this work. This chapter offers an overview of the relevant literature within the rapidly expanding field of complex trauma with a particular consideration given to the phenomenon of therapists working with psychological trauma. This chapter will offer some historical context, along with covering evolving definitions, neurological research and psychotherapeutic treatment approaches. Current academic knowledge on vicarious impacts and research on therapist experiences of working with complex trauma will also be reviewed.

2.2 Literature Search Strategy

Areas related to the main topic were defined and listed in order to perform an online search. The researcher used the DCU EBSCOhost research platform, when inputting key terms into databases, which included Pubmed, PsycINFO and Sage journals.

The following key terms were inputted into the EBSCOhost database in different combinations: ‘complex trauma’, ‘complex ptsd’, ‘complex post-traumatic

stress disorder', 'c-ptsd', 'relational trauma', 'childhood trauma', 'developmental trauma', 'therapist*', counsellor*, 'therapist* experience', and 'counsellor* experience'.

The resulting research papers that referred specifically to complex trauma, complex PTSD and therapist or counsellor experiences were prioritised. However, other research literature identified on complex trauma during the searches relating to its conceptual development, definition, treatment approaches and impact on clinicians were also reviewed. Bibliographies of books and journal articles were also examined for relevant research sources.

2.3 Historical Origins of and Ontological Debates around Psychological Trauma

Frequent accounts of psychological overwhelm and its consequences are littered throughout historical literature, with features of human trauma recognisable within Homer's *Iliad* (Shay, 2014). Despite this, it is only over the last half century that a therapeutic understanding of psychological trauma has begun to form into a recognisable clinical discourse with diagnostic features and treatments (Dell & O'Neil, 2009).

During the 1970's an intense period of social activism drew attention towards traumatic reactions, which resulted from the military conflict of the Vietnam war (Sulieman, 2008), but also interpersonal violence (Wilkin & Hillock, 2014). Ultimately, both the psychiatric and psychological professions were challenged to respond with new forms of psychiatric diagnosis and clinical interventions. These sociological and cultural pressures provided the conditions for the introduction of post-traumatic stress disorder (PTSD) into the Diagnostic and Statistical Manual of Mental Disorders, Third

Edition (DSM-III) in 1980. Despite the influence of the PTSD diagnosis on the development of treatments of psychological trauma, a number of questions remained due to its formulation being based around single event experiences (Suleiman, 2008).

Beginning in the early 1990's, academic voices (Herman, 1992; Terr, 1990) started to challenge the PTSD conceptualisation as being too narrow to address the needs of the many and diverse types of human trauma, which were often the reality of busy clinical settings. In 1992, American psychiatrist/researcher Judith Herman published *Trauma and Recovery*, which is still regarded as one of the pioneering works within the field of trauma. In introducing a theoretical debate around the conceptualisation of trauma, Herman looked to ground a new definition of psychological trauma in the phenomenon of everyday life of individuals rather than a diagnosis primarily based on the military stress of war veterans (Suleiman, 2008).

Since the early 1990's, a growing body of research indicates that the frequency and type of interpersonal trauma an individual has encountered throughout their development significantly predicts the severity and complexity of their future psychological disorders (van der Kolk, 2019; Briere & Scott, 2015; Ford & Courtois, 2009). Multiple, cumulative and prolonged experiences of trauma, including events such as childhood abuse and/or neglect, sexual assault, domestic and political violence, lead to psychological difficulties along several trajectories, which have been described in the traumatological literature as *symptom complexity* (Cloitre et al., 2009). These experiences typically occur against a context of physical, psychological, family/environmental or social constraints where escape is not possible (Herman, 1992).

However, despite the growing interest in complex traumatic stress, McNally (2010) points to the fact that few mental health topics have been the cause of such

intense ontological discussion and emotionally charged debate. Given psychological traumatic constructs exist at the intersection of individual, interpersonal and socio-cultural realms, epistemological questions were bound to emerge in trying to secure a universally agreed construct within this clinical area. Moreover, a number of important schools within trauma psychology have contributed differing viewpoints. The psychoanalytic tradition viewed trauma as a rupture between the inner and outer world of the individual "an extensive breach being made in the protective shield against stimuli" (Freud, 1920, p.31), so trauma could result from either the magnitude of the event or as a consequence of the inadequacy of the clients' ego due to poor development or mental illness. Looking to build a scientific psychology, behaviourism put little emphasis on subjective experience and understood trauma in terms of observable fear responses, which are conditioned through exposure to external fear inducing stressors (Reuther, 2017). The observable nature of behaviourism allowed it to be grounded in empirical methodologies, which formulated trauma, as shaped by external fear stimuli. It should be noted that these traditions have contributed to the categorical approach of labelling psychological trauma within the diagnostic bible of mental health the Diagnostic and Statistical Manual (DSM) (Dalenberg, 2017).

This medicalisation of experience such as psychological trauma within the DSM and ICD has led to reductions of complex phenomena into medical criteria and diagnosis, which align with disease models (Sadler, 2004). Furthermore, behavioural and cognitive approaches within psychological discourse assume an understanding of trauma, which emphasises empiricism and assume a notion of objectivity, linearity and focus on the past influencing the present (Slife, 1993).

Some ontological criticisms by Reuther (2017) have suggested that human experience cannot be objectified in the same way as biological tissue. Contrasting

viewpoints, such as, existentialism comprehend trauma as experience which damage's our sense of belonging in the world, resulting in survivors of trauma having to directly confront the uncertainty of life, their own fragility and the inevitability of death (Schneider & May, 1995). Citing work by Heidegger, Roberts (2017) suggests that an individual's experience of trauma invariably brings an unconscious subjectification as it is embedded within socio-historical contexts, such as technological realms and psychological discourses, which shape an understanding of what it means to be human, our sense of agency, and knowledge of the world. Roberts posits that narratives of human trauma must be viewed with a consideration of the interwoven societal contexts which form the fabric of their meaning making around traumatic experience. These ontological perspectives are often obscured and overlooked within the scientific approaches, which dominate academic discussion around trauma and that focus on symptom reduction.

Although the construct of complex trauma has started to organise around medicalised diagnostic criterion, which will be discussed in more detail in the next section, Weisaeth (2014) sagely points out that psychological trauma can never simply be reduced to a universal individual experience and must be considered against the systemic social, historical and political pressures of a particular society. This has a specific relevance within Irish clinical contexts, given Ireland's history of institutional and clerical abuses, conservative patriarchal culture and the experiences of those caught up in the "the troubles", along the border with Northern Ireland. This study looks to explore these unique experiential aspects of clinical work with complex trauma within Ireland.

2.4 The Diagnostic Criteria of Complex Trauma

Complex trauma differs from other forms of psychological trauma, such as PTSD in several respects. Firstly, it can involve violence that occurs in contexts in which the individual would normally expect to feel safe (e.g. home, school or institutions) (Turner et al., 2011). Secondly, it can combine relational experiences of physical, emotional abuse or neglect (Widom et al., 2014). Third is the experience of betrayal by somebody in a position of trust (Delker & Freyd, 2014), and there can also be the prolonged and intentional violation of bodily integrity (Abrahams et al., 2014). These features comprise a complex set of sequelae, which pose challenges in establishing reliable assessment measures to identify the broad range of psychological adaptions, which correspond with these complex traumatic stressors (Ford, 2017). Both practitioners and researchers have continued to call for a consensual definition in order to empirically study and treat complex trauma presentations (Ford, 2017). The next section will discuss the most important diagnostic frameworks within the field of complex trauma.

2.4.1 Early Definitions

Over the last three decades clinicians have struggled to find agreement on a consistent definition of complex trauma with several varied diagnostic conceptualisations establishing themselves within the clinical debate (Ford & Courtois, 2009). As pointed out earlier, complex trauma evolves out of prolonged and extreme stresses over developmental and/or extended timeframes, which account for its multifaceted disruption of several psychological/behavioural domains. This broad variation of complex symptoms sits at odds with reductive tendencies of mental health classification systems and often confounds efforts to develop precise diagnostic criteria for use in clinical and research settings (Corrigan & Hull, 2015). Some academic

commentators (McFetridge et al., 2017) have argued that the lack of an accepted definition of complex trauma has resulted in a significant delay in its development and left many with trauma-based presentations underserved.

Judith Herman's book *Trauma and Recovery* (Herman, 1992), which outlined her research on victims of sexual violence and child abuse was first to coin the term complex post-trauma stress disorder (CPTSD). Her conceptual framework of CPTSD distinguished a cluster of symptoms which included affect dysregulation, alternations of consciousness, disrupted self-identity, interpersonal difficulties, behavioural challenges and changes in belief systems. Developing on Herman's theoretical framework, Roth and colleagues (1997) formulated disorders of extreme stress not otherwise specified (DESNOS) to provide assessment and diagnostic criteria for the DSM classification system. DESNOS includes several constituents of psychological self-regulation, as well as intra/interpersonal functioning, which can be altered by traumatic stress (a) affect and impulse regulation; (b) somatic self-regulation; (c) consciousness; (d) distorted perceptions of perpetrator(s); (e) self-perception; (f) relationships; (g) systems of meaning (van der Kolk et al., 2005).

However, despite it being considered for inclusion in both the DSM IV and V, it was ultimately rejected by the Diagnostic and Statistical Manual of Mental Disorders committee due to conceptual difficulties (Sar, 2011). A number of issues were cited by the DSM committee, such as a lack of clarity as to whether it would be positioned as a distinct disorder from PTSD, a subtype of PTSD, or an overarching diagnosis which would subsume PTSD (Sar, 2011).

2.4.2 Introduction of Complex Post-Traumatic Stress Disorder (CPSTD) into the ICD-11

Undoubtedly the formal recognition of psychological trauma into the established classification systems of mental health has provided an academic foundation for both clinical progress and the development of a sound research base. As mentioned in a previous section, the diagnosis of PTSD was introduced into the DSM (III) in 1980. The classification of a mental health disorder with an externally caused traumatic stressor was a watershed for both psychiatry and psychology (Maercker, 2021). Building on the contemporary model of PTSD along with incorporating earlier components of complex trauma theory has allowed the World Health Organisation (WHO) to develop a conceptually coherent and validated set of core symptoms, which has culminated in the inclusion in 2018 of the diagnosis of complex post-traumatic stress disorder (CPSTD) within the ICD-11 (Maercker, 2021).

Significantly, the current ICD-11 diagnosis of CPTSD necessitates that an individual was exposed to an extremely threatening or horrific event or series of events and the three traditional criteria for PTSD (re-experiencing, avoidance and hyperarousal) are evidenced. In addition, CPTSD requires core criteria, which are characterised by severe and persistent 1) problems in affect regulation; 2) beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event/s; and 3) difficulties in sustaining relationships and in feeling close to others. These symptoms cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning (ICD-11, 6B41, 2022).

Some questions around the relevance of the construct of CPTSD have been raised by Giourou and colleagues (2018), who suggest that it has considerable overlap

with existing psychiatric conditions, such as borderline personality disorder and PTSD. Furthermore, although some evidence (Marinova & Maercker, 2015) provides support for biological correlates for CPTSD, neurological research remains lacking and more studies are needed to establish this new diagnosis as a clinical entity (Giourou et al., 2018). Despite these concerns, the ICD's new nosological category of CPTSD is a formal acknowledgement of the profound effects of chronic trauma on an individual's ability to regulate their emotions, develop a healthy sense of self and function within relationships.

2.5 The Epidemiology of Complex Trauma

As noted in the introductory chapter, part of the rationale for this study were the high levels of specialist service provision for complex trauma and growing interest in trauma informed practice within Ireland. Although the concept of complex trauma has been informally used in both international and Irish clinical settings, epidemiological research has been hampered by a lack of a recognised diagnostic set of criteria, leaving uncertainty around the true scale of this clinical issue. However, the acceptance of the diagnosis of complex post-traumatic stress disorder (CPTSD) into the (ICD-11) in 2018 and development of the *International Trauma Questionnaire* (ITQ)(Cloitre et al., 2018) has resulted in a rapid increase of complex trauma studies (Maercker, 2021). Amongst this new research is the gathering of population-based frequency data for CPTSD.

In Europe, a German research project (n=2524) assessed the prevalence CPTSD using the ITQ amongst the general population. The one-month frequency was measured at 0.5% for CPTSD (Maercker et al., 2018). This study reported a gender difference (0.7% female v 0.3% male) for CPTSD and an association with childhood sexual abuse, sexual violence. A later study by Kvedaraite et al. (2022) used the ITQ on a

Lithuanian general sample (n=885) to assess levels of CPTSD. This study reported a general rate of 1.8% for CPTSD with female participants four times more likely than male participants (81.3% female v 18.7% male) to meet the diagnostic criteria. A correlation between accumulated lifetime exposure, reluctance to disclose and CPTSD was evidenced during this research.

In a US study, which examined the level of CPTSD within a national sample (Cloitre et al., 2019). Researchers recruited participants (n=1839) using an online research panel that was representative of the US population. There was an overall prevalence rate of 3.8% for CPTSD, with a higher rate of female than male participants meeting the criteria (4.9% female v 2.7% male) within the general population. A dose-response relationship was identified between CPTSD and cumulative traumas. The existing international research on Western populations (non-Irish) of the frequency of CPTSD has evidenced rates between 3.8% and 0.5% with female samples being at higher risk for meeting the CPTSD criteria. This elevation of diagnosis of CPTSD in female populations maybe explained in part by the higher levels of exposure to sexual abuse identified in previous research (Assink et al., 2019; McGee et al., 2019). Other evidence (United Nations, 2015) suggests that long standing societal patriarchal attitudes contribute to higher levels of gender based physical and sexual violence towards women, which has the potential to leave them exposed to an elevated risk of CPTSD (Herman, 1992).

In looking at non-Western populations, Ben-Ezra et al. (2020) sampled participants from three African states Nigeria (n=1006), Kenya (n=1018) and Ghana (n=500) by recruiting participants through internet panels to estimate the frequency of CPTSD. The study showed mean scores for CPTSD of Ghana 13%, Kenya 19.6%, Nigeria 13.7% and overall, 15.9% within the general population with no significant

gender differences. Commenting on the high rates of CPTSD identified within their study compared to Western studies, Ben-Ezra and colleagues (2020) speculated that the distinctive cultural and political contexts, which exist within these African nations, could expose individuals to differing and more frequent forms of traumatic experiences. The researchers reported that 25% of the African samples had experienced traumatic events including: sexual assault, physical assault, life threatening injuries or natural disasters, which contrasts significantly with Western samples (e.g. Germany 0.6-7.7%). They also point to the fact that lower resourced African clinical settings would not have the same support systems in place to treat traumatised individuals, which perhaps contributes to these higher figures. These non-Western studies are worth noting, as some Irish academic commentary by Vallières et al. (2016) suggests that with Western Europe experiencing an increase in migrants and refugees presenting to health systems, the prevalence of trauma related disorders will inevitably rise, and this will require national health systems to build a broader socio-cultural perspective in understanding and treating trauma.

Unsurprisingly, studies using the ITQ to examine clinical populations presenting for support with psychological trauma have demonstrated rates of CPTSD substantially higher than community samples. A Danish study on sexual abuse survivors presenting to a trauma service (n=453) found a rate of 42.8% for CPTSD (Hyland et al., 2017a) with early developmental exposure to trauma a significant contributing factor. While a Scottish study (Karatzias et al., 2017), which examined participants (n=193) from a National Health Service trauma clinic found a rate for CPTSD of 53.1% and an association with accumulations of differing types of childhood traumatic experience.

In Ireland, the first ever epidemiological study by Hyland et al. (2021a) on CPTSD sampled (n=1020) non-institutionalised Irish adults using the ITQ. These research results showed that 7.7% of general population met the diagnostic criteria for CPTSD in the last month (Hyland et al., 2021) with less than half of this figure having accessed mental health services in the past year. This research identified several risk factors associated with the diagnosis of CPTSD in adulthood, such as younger age, experiencing higher number of early traumas, and reporting a greater number of traumas in adulthood. No significant difference was seen between the sexes in the rate of CPTSD. More recent data from a survey on the 'State of Ireland's Mental Health' examined the rate of mental health disorders in a nationally representative sample of Irish adults (n=1110). This survey used the *International Trauma Exposure Measure* (ITEM) (Hyland et al., 2021a) and the ITQ to diagnostically identify the prevalence rate of CPTSD amongst their participants. This research by Hyland and colleagues (2022) reported a rate of 8.8% for CPTSD within this general sample of the Irish population. These research studies on the frequency of CPTSD in Irish samples differ from those on other Western populations discussed earlier in some important respects. There was a considerably higher prevalence of CPSTD in the Irish sample with no significant gender differences. This may be partially explained by the high levels of systemic institutional abuse in Ireland referenced earlier and by the fact that the impact of these institutional abuses tended to be equally evidenced between both men and women (Carr et al., 2009).

Figures from Eurostat (2023) revealed 2.3 million immigrants came into the EU in 2021 and given the current volatile global environment these numbers are expected to grow. However, limited data exists on the scale and the psychological needs of these newly arriving groups. An earlier study by Kelly and colleagues (2008) conducted

within a Dublin Irish psychiatric service on both native Irish and migrant service users, showed an increasing number of migrant service users with histories of significant trauma and experiences of torture and human rights abuses accessing services. The findings of this research found 70.3% of migrant outpatients had two or more traumatic events compared with 47% of the Irish outpatient group. Moreover, the lifetime rates of PTSD significantly differed between both the native and migrant groups (6.1% v 32.8%), with migrants more likely to have to have experiences of imprisonment, murdered family members and torture. The small amount of research in this area indicates that trauma psychotherapists in Ireland will be faced with a stronger transnational dimension to their clinical work, with new requirements needed for interpretative facilities and knowledge of culturally appropriate therapeutic approaches.

In summary, the review of the epidemiology of this research area seems to suggest that CPTSD as a new diagnostic category is rapidly becoming a research focus both internationally and within an Irish context. Although epidemiological research on CPTSD is still in its infancy and must viewed cautiously due to the relatively small number of studies available, it is notable that the frequency rates for the Irish general population are higher than those of other Western populations. It could be speculated that these increased rates of CPTSD might be a reflection of our long history of institutional abuse referenced in chapter one. Furthermore, preliminary research points to a shifting demographic composition of those presenting to the Irish mental services, with diverse experiences of psychological trauma. This review highlights CPTSD as being far from an uncommon clinical presentation within the Irish general population and mental health services and is likely to become an increasingly significant mental health issue for psychotherapists in Ireland.

2.6 The Neurobiology of Complex Trauma

It is perhaps indicative of the growing interest in psychological trauma amongst Irish clinicians that the International Trauma Summit in Belfast, Ireland has continued to be staged biennially since its beginnings in 2018. At the most recent summit in 2024, it was also noteworthy how many of the presentations involved a neurobiological understanding of trauma treatment. Contributions were made by Pat Ogden on Sensorimotor therapy, Ruth Lanius on the neurobiology of complex stress, and Deb Dana on polyvagal theory. This developing emphasis within psychotherapeutic theory on neurobiology is perhaps not surprising given the growth in inter-disciplinary research conducted at confluence of neurobiology and psychological trauma. Studies have consistently demonstrated a relationship with psychological trauma during childhood and a range of detrimental neurological adaptions (Andersen et al., 2008; De Bellis, 2001; De Bellis & Zisk, 2014; van der Kolk, 2000). Nelson and colleagues (2019) suggest childhood traumas disrupt developmental pathways with the timing and intensity of these experiences shaping a process of neurological pruning, which impacts the growth of different psychobiological brain systems. Moreover, a meta-analysis by Campbell (2022) discusses the far-reaching impact of childhood trauma on the developing brain resulting in several negative alterations to the nervous, stress and reward systems, which have implications for several psychiatric conditions and self-destructive behaviours.

Arguably some of the most important work in this field is neurological research by Schore, (2019) on the negative disruptions of relational trauma experiences during attachment. Studies by Schore using fMRI imaging has evidenced adverse effects caused by traumatic attachment experiences on the structural development of the right hemisphere of the brain in early infancy. Schore (2022) argues early chronic

misattunements in the emotional communications of caregivers with infants can lead to levels of affective hyper and hypo arousal during a critical period when subcortical amygdala and hypothalamus are undergoing rapid neural sculpting. This underdevelopment of the architectural neurology of these brain regions in infancy has been correlated in later life with issues of stress regulation, pathological dissociation and disorders of the self, which are consistent with complex trauma (Schore, 2019). Research by Bellis and Zisk (2014) noted chronic traumatic experiences in childhood reset the body's biological stress system by overstimulating the neurology of the prefrontal cortex, hypothalamus and hippocampus to produce elevated levels of cortisol resulting in anxiety, hypervigilance and generalised arousal of the sympathetic nervous system in adult samples.

According to Cammisuli and Castelnuovo (2023) new discoveries within the field of the neuroscience of trauma, and the ever growing need for therapeutic responses in this area has resulted in the emergence of an academic dialogue between neuroscience and psychotherapy. Several therapeutic paradigms based on a neurobiological understanding of trauma have been developed. Schore (2022) outlines an interpersonal neurobiological model of psychotherapy, which sees the therapist facilitate the implicit emotional communication of the right brain mechanisms to allow for the repair of early neurological attachment disruptions. Another influential neurobiological theorist within psychotherapy treatment of trauma has been Stephen Porges (2001) with his introduction of polyvagal theory. This conceptualisation based on his research, sees the vagus nerve supporting different adaptive functions and behaviours through regulating the sub systems of the central nervous system. Polyvagal theory (Porges, 2009) sees a hierarchy of neurobiology influenced behaviours, which are linked to social engagement, followed by fight-flight behaviours and finally

immobilisation. Therapeutic approaches involving polyvagal theory involve using special techniques to control emotional regulation based on Porges neurobiological theory. Ruth Lanius (2015) proposes a neurophenomenological model of trauma that focuses on the dissociative processes that disrupt an individual's experience of self and time. This framework uses a four-dimensional model that works towards integrating aspects of the client's conscious experience of time, thought, body and emotion, through mindfulness exercises, emotional regulation and distress tolerance skills.

At the present time a rapid transfer of research data and redevelopment of theoretical concepts are underway across the disciplines of neurobiology, psychology and psychotherapy. Within the context of this interdisciplinary expansion, new clinical approaches are emerging at the brain-mind-body axis. These neurologically informed therapeutic modalities conceptualise trauma more often as a bodily based phenomenon, which require bottom up strategies and a consideration of unconscious and embodied regulatory processes. The advent of these new approaches necessitates trauma practitioners pay close attention to somatic responses within the therapeutic relationship. This new and growing emphasis on hyper and hypo arousal states of the nervous system may have the potential to leave trauma therapists experiencing new relational and vicarious impacts.

2.7 The Treatment of Complex Trauma

An important contemporary context to Irish psychotherapy treatment has been the increasing influence of trauma informed care. The increasing integration of differing forms of healthcare over the last decade has gradually led to the inclusion of psychological trauma in the conceptualising of physical and mental health responses (Raja et al., 2021). This growing awareness of the role of traumatic events, such as

childhood abuse, sexual assault and domestic violence has led the advent of trauma informed practice within a variety of clinical psychotherapy settings.

The UK body of the Office for Health Improvement and Disparities have defined trauma informed practice as "an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development" (Office for Health Improvement & Disparities, 2017). Despite individuals with complex trauma histories becoming increasingly prominent within mental health services, many current evidence-based psychotherapy treatments have been developed for single event trauma (Melton et al., 2020). Unimodal therapeutic interventions such as EMDR (Shapiro & Laliotis, 2015), Prolonged Exposure Therapy (Hembree et al., 2003) and Trauma Focused Cognitive Behavioural Therapy (Cohen et al., 2011) are favoured within many public health services for trauma treatment (Corrigan et al., 2020).

One of the challenges of developing an intervention for complex trauma has been the wide-ranging and interconnected nature of the symptomology, which impacts clients emotional, social, and cognitive competencies (Hobfoll et al., 2011). Until the acceptance in 2018 of complex post-traumatic stress disorder (CPTSD) into the ICD-11, research on complex trauma treatment has been hampered due to a lack of a consensual diagnostic paradigm (Resick et al., 2012). This has resulted in the dominant psychiatric paradigm used in most Western health systems, tending currently to diagnosis the symptoms of complex trauma into separate concurrent diagnoses (Maercker, 2021). For example, mood disorders, eating issues, substance abuse, and/or borderline personality disorder, regularly overlap with complex traumatic symptomology (Sar, 2011). Indeed, co-morbidity would seem to be the norm in public service provision with 92% of individuals with PTSD also diagnosed with additional

disorder/s (Reardon et al., 2014). This potentially leaves clients faced with fragmented therapeutic responses, as clinicians treat each disorder separately or use time limited models, with an emphasis on top-down and psychoeducational strategies, which do not fully address the needs of those with CPTSD (Corrigan & Hull, 2015).

Nevertheless, a number of important steps have helped to progress the treatment of complex trauma. In 2012, the International Society for Traumatic Stress Studies reviewed the existing literature and surveyed 50 expert clinicians with a view to establishing guidelines for CPTSD (Cloitre et al., 2011). This resulted in the formation of the Complex Trauma Task Force (CTTF), who worked towards the publication of a set of treatment guidelines that endorsed a phased-based approach that could be tailored to the most prominent symptoms of the client presentation. This three phase model looks to (1) create safety, stabilise emotional dysregulation, modify cognitive distortions, and establish a working alliance, (2) process trauma memories, increase self-reflective abilities, and (3) integrate and consolidate new learnings of self-regulation skills, new interpersonal capacities and cognitive work.

Despite a limited research base existing on the effectiveness of psychotherapeutic treatment for complex trauma (Cloitre et al., 2011), the recent acceptance of the diagnostic criteria for CPTSD in the ICD-11 has ushered in a new interest in the treatment of complex trauma field (Maercker, 2021). A recent mixed method systemic review (Melton et al., 2020), which included a mix of a 109 quantitative, qualitative, and mixed method studies highlighted the need to prioritise research on phased based interventions as advocated by the CTTF due to the small evidence base relied upon for these guidelines. While this review showed that trauma focused CBT and EMDR were beneficial to individuals with CPTSD, phased based

interventions which draw multi-component approaches were found to be the most effective within the limited existing research base.

In contrast, other clinicians, for example Voorendonk et al. (2020) have questioned this position of focusing on long term phased treatment and advocate for an intensive 8-day trauma-focused intervention to treat CPTSD. Their treatment programme combines exposure therapy, EMDR, and physical activity and dispenses with the application of a stabilisation phase. In their study conducted on patients with both PTSD and CPTSD (n=308) significant reductions were demonstrated in trauma related symptoms on completion of this intensive intervention.

Other research by Classen et al. (2021) used a 20-session Sensorimotor group psychotherapy to conduct a randomised control trial with women (n=37) diagnosed with complex trauma. Sensorimotor group psychotherapy developed by Pat Ogden uses an integrative treatment that draws on mindfulness-based techniques, along with cognitive, emotion and somatic processing to alleviate traumatic symptoms. The female participants were randomly allocated to either the group psychotherapy or a waiting list condition, which offered information on community resources. The group psychotherapy cohort were found to demonstrate improvements in bodily awareness, interpersonal relationships, and reductions in anxiety.

In concluding, after reviewing the existing literature on the treatment of complex trauma, there is little doubt that this research area is in the early stages of consolidating a strong body of evidence-based research with a recent meta-analysis identifying a lack of quality amongst many quantitative studies and need for qualitative research. Moreover, a number of debates are still to be resolved by researchers around the effectiveness of phased based versus intensive focused models and group versus individual treatments. Furthermore, given the emphasis on understanding complex

symptomology through the non-complex paradigms of PTSD, neurologically based therapeutic modalities developed for complex traumatology discussed in the previous section have often struggled to establish themselves within public health settings. However, within Ireland the increasing emphasis on a trauma informed ethos within service provision is likely to see a gradual increase in the integration of newer neurologically based trauma approaches within client treatment.

2.8 Therapists Working with Complex Trauma

Judith Herman (1992) wrote in *Trauma and Recovery* that "trauma is contagious" (p.140). So, there is little surprise that interest on the impact of those working with traumatised individuals has started to build amongst the research community. Despite the increasing interest in this research area, it has remained conceptually diverse with several terms introduced and a broad range of clinical professions examined (Bartoskova, 2017). Many of these studies have looked to explore the adverse impacts of working with psychological trauma through parallel concepts, such as vicarious trauma, burnout, and compassion fatigue (Kahill, 1988; Pearlman & Mac Ian, 1995; Radey & Figley, 2007). Newer emerging qualitative studies are now starting to identify both adverse and growth factors associated with those who work alongside trauma survivors (Bartoskova, 2017; Tedeschi et al., 2015). While this research direction has proved valuable, qualitative studies remain sparse on those working with complex trauma presentations, especially within Irish clinical settings. The next section will outline relevant research in relation to conceptual frameworks on adverse impacts, growth experiences, along with identifying gaps within the current literature.

2.8.1 Research on Burnout, Compassion Fatigue, Compassion Satisfaction and Vicarious Trauma amongst Trauma Therapists

Research looking at mental health professionals working with traumatised clients has routinely evidenced negative secondary traumatic effects (Baird & Kracen, 2006; Canfield, 2005; Pearlman & Ian, 1995) with these adverse impacts being viewed as an unavoidable hazard of this therapeutic work (Skovholt & Trotter-Mathison, 2016). As noted in the introduction to this section, this research area uses several terms to describe the detrimental effects of working long-term in emotionally demanding health professions. The most commonly used terms are burnout (Freudenberger, 1974), compassion fatigue (Radey & Figley, 2007) and vicarious trauma (McCann & Pearlman, 1990) with these concepts being sometimes used interchangeably by authors (Rzeszutek, 2014). A meta-analysis by Cieslak and colleagues (2014) suggests that the differences between these constructs are subtle with there being substantial overlap amongst them.

The concept of burnout has long been used to describe the detrimental impacts on health-care workers as a result of their clinical work (Collins & Long, 2003). One of the earliest definitions of burnout was offered by Aronson and Pines (1988, p.9) as "a state of physical, emotional and mental exhaustion caused by long term involvement in emotionally demanding situations". Maslach and Leiter (2008) outlined a description of burnout as a process whereby an employee's resources are depleted through their work to an extent, which leaves them no longer equipped with the capacity to engage effectively within their professional environment. Burnout has been characterised by feelings of hopelessness and cynicism (Huggard et al., 2005), along with poor physical health, low mood, job turnover, unproductive work, interpersonal problems and negative attitudes (Kahill, 1988). A survey on burnout amongst psychotherapists by

Bearse et al. (2013) has shown a range of stressors including family issues, personal losses, administrative challenges, suicidal clients and conflict with co-workers, have a detrimental influence on therapist effectiveness and well-being.

Although the concept of burnout has been used to explore the secondary impacts of working therapeutically with trauma, within the research community, it traditionally has been applied to understand the influence of prolonged stress within work environments more generally (Edú-Valsania et al., 2022). A number of other constructs have been developed with a specific focus on working within the health professions. One such term is compassion fatigue developed by Figley (1995), which draws on the criteria of PTSD (re-experiencing, avoidance and hyperarousal) and refers to the negative emotional, cognitive, and behavioural changes for the practitioner of working with traumatised individuals. Figley (1995, p.7) has defined compassion fatigue as "the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced or suffered by a person"

In an extension of the concept of compassion fatigue, Radley and Figley (2007) introduced the contrasting term of compassion satisfaction. They suggest that compassion should also be considered in light of the psychological growth and satisfaction factors, which therapeutic work can encompass, stating "rather than focusing on dysfunction and compassion fatigue, we introduce how clinicians faced with trauma can capitalize on compassion and energy culminating in compassion satisfaction." (Radey & Figley, 2007, p. 213)

Developing a model from these concepts, Stamm (2010) suggests that three components contribute to clinician health: compassion fatigue; compassion satisfaction; and burnout; with compassion satisfaction offsetting the risk of compassion fatigue and

burnout. As a result of developing this model, Stamm produced a 30-item assessment instrument the *Professional Quality of Life Measure* (ProQOL) to assess compassion fatigue, compassion satisfaction and burnout in healthcare workers, which has been used in several important quantitative studies amongst psychotherapists.

In the US, Craig and Sprang (2010) sampled trauma therapists (n=532) for levels of compassion fatigue, compassion satisfaction and burnout using the ProQOL and *Trauma Practice Questionnaire* (TPQ)(Craig & Sprang, 2009). Their results showed that working with heavy caseloads of trauma clients was correlated with compassion fatigue. Moreover, younger age predicted higher levels of burnout and years of clinical experience were associated with increased compassion satisfaction. It was noteworthy that therapists who used evidence-based practices (for example cognitive behaviour therapy and EMDR) demonstrated lower levels of compassion fatigue, burnout and increased compassion satisfaction. A strength of this study was the random sampling which drew from registers of trauma specialists within the National Association of Social Workers and the American Psychological Association. However, as pointed out by researchers, the ProQOL and TPQ questionnaires could only examine a limited number of practice and demographic variables, and it is possible that other extraneous factors may be influencing levels of secondary stress within their study.

A later quantitative study by Sodeke-Gregson and colleagues (2013) in the UK used the ProQOL to assess therapists (N=253) working with adult trauma. This study reported therapists as at high risk for compassion fatigue (70%) but having average rates of compassion satisfaction (53.2%) and burnout (64.2%). Importantly, it noted that being an older clinician, blending therapeutic work with other professional activities, a supportive working environment and perceived supportive supervision predicted higher compassion satisfaction. In contrast, younger age, poor perceived

support by organisational management were risk factors for burnout. Surprisingly, this study revealed a positive relationship between more individual supervision and self-care with compassion fatigue. Researchers speculated this could reflect therapists who were struggling and trying to offset their distress through engaging in these activities. The researchers also pointed out that this survey drew on therapists (86%) who worked within the NHS structure of service provision, and this unique contextual setting is likely to have influenced the responses of the study, and this could impact the generalisability of their results for other types of clinical settings. While these empirical studies using the ProQOL questionnaire provide new knowledge on therapists' impacts, they provide a limited understanding of the complexities, which underpin their results. For instance, the ProQOL questionnaire is unable to take account the subtle differences between differing clinical work contexts or therapist understandings of these negative and positive impacts

Another widely accepted concept in this research area is vicarious traumatisation (VT) developed by McCann and Pearlman, (1990), who also viewed this phenomenon as an inevitable consequence of working clinically with trauma. Using a constructivist self-development theoretical framework, which blends object relations, self-psychology and social cognition theories, McCann and Pearlman (1990) developed a model for understanding the multiple impacts on an individual's self-identity, professional development and psychological adaption to working with traumatised clients. One widely used definition of vicarious trauma is "the cumulative transformative effect upon the trauma therapist of working with survivors of traumatic life events. ... It is a process through which the therapist's inner experience is negatively transformed through empathic engagement with the clients' trauma material." (Pearlman & Saakvitne, 1995, p.31)

Working with negative traumatic experiences have been found to cognitively distort a clinician's perception of themselves, others and their outlook on the social world (McNeillie & Rose, 2021). Cognitive disruptions to a sense of trust, safety and intimate relationships were also noted by Pearlman and Mac Ian, (1995). Pearlman and Saakvitne (1995) theorise that listening to narratives of traumatic experiences can lead to uncomfortable responses of fatigue, guilt, fear, anxiety and sadness, with both intrinsic qualities of the therapist and aspects of the work environment contributing to the complex evolution of these vicarious effects.

Quantitative research on vicarious trauma by Adams et al. (2002) used the Traumatic Stress Institute Belief Scale (TSI)(Traumatic Stress Institute, 1994) to survey clinical social workers (n=185) in the US in relation to their face to face work with traumatised clients. Their results showed participants experienced little disturbance in beliefs or negative intrusive thoughts, as might have been expected. However, higher TSI score were associated with younger age and a lack of perceived social support, but the researchers caution this scale may not be measuring the impact of listening to their client's traumatic material and may in fact be sensitive to work related stressors. This aligns with later research by Devilly et al. (2009) on Australian mental health professionals (n=152), who used the TSI, a secondary traumatic stress and a burnout scale to measure the adverse impacts of trauma work. Their results showed an overlap between secondary traumatic stress, vicarious trauma and burnout with these concepts largely measuring the same phenomenon with little evidence of any impact from exposure to client traumatic material. They questioned the validity of the constructs of secondary traumatic stress and vicarious trauma, and suggest these concepts merely picks up on aspects of burnout, which are related to the working environment rather that indirect trauma from client material.

In summary, quantitative research using the ProQOL questionnaire reveals a correlation between therapist exposure to traumatised clients and compassion fatigue. It is also clear that a number of debates exist in this research area. Some researchers (Devilly et al., 2009) believe vicarious trauma and secondary traumatic stress have issues with their validity as concepts and are more simply understood through the construct of work-related burnout. What is clear from reviewing the quantitative research, is that while it offers new knowledge on the impacts of working with trauma, there are limitations in using questionnaires/inventories to understand relational and contextual processes.

2.8.2 Qualitative Research on Therapists Working with Complex Trauma

The concept of compassion fatigue described earlier in this section has benefited from being formulated from the existing diagnostic criteria of PTSD, which has allowed for easier psychometric measurement due to its emphasis on symptomology (Jenkins & Baird, 2002). Similarly, burnout has tended to be studied through the use of the Maslach Burnout Inventory (MBI; Maslach et al., 1981), which relies on numerical measurements. Consequently, much of the early research literature on therapist impacts has leaned towards quantitative methodologies. Despite this, there has been a recent emergence of qualitative approaches exploring both the negative and positive impacts of working with traumatised clients (Munishvaran & Booysen, 2022; Merriman & Joseph, 2018; Bartoskova, 2017; Sui & Padmanabhanunni, 2016; Possick et al., 2015; Silveira & Boyer, 2015). This newer qualitative research has added a much needed depth to the understanding of individual trauma practice.

Considering the aim of this current study, one of the most important summaries in this research area is a meta-ethnographic review by UK researchers McNeillie and

Rose (2021) which was a response to concerns of poor support for NHS staff. The inclusion criteria for this review only permitted peer reviewed studies, 75% of the sample had to be working with trauma survivors and studies had to be fully or partly qualitative. The researchers synthesised sixteen international studies (three IPA, seven Grounded theory, three Thematic Analysis, one Content analysis, one Open coding and one Field study) on vicarious trauma into a series of themes. Across the studies covered within the review McNellie and Rose identified themes of therapists' view of themselves changing through their work, with thoughts of professional self-doubt, incompetency, and ineffectiveness. Contrastingly, they also experienced a sense of growth through gaining a focus on their clinical skills and resilience, as they witnessed their client's commitment to working through their trauma. Cognitive themes included clinicians feeling personally infiltrated through experiences of nightmares, confusion, hyper-vigilance, recurring images of traumatic client material and thinking about clients outside of working hours. Physical manifestations such as exhaustion, fatigue, pains, tension headaches, and sleep disruption were common descriptions of the symptomatic impacts of working with traumatised populations. Behavioural responses were tendencies to protect loved ones and an overall lack of trust in others with an accompanying experience of hypervigilance, and avoidance of intimacy.

Despite the comprehensive nature of this review, it is important to point out that McNeillie and Rose did not include burnout as a concept, which would have allowed for an understanding of the contribution of environmental work factors. Moreover, the meta-ethnographic nature of this review also calls for the researchers to interpret the data of these synthesised studies, which could have the potential to bias their results. However, it is clear from this review on the qualitative literature on trauma practice that a consistent picture emerges of the multi-faceted negative and positive influences of

working with traumatised populations. Within this review, practitioners' sense of self, interpersonal world and bodily well-being all revealed the profound effects of their clinical exposure to their client's trauma. The qualitative literature also provides an important contrast to quantitative data discussed in the earlier section and offers an opportunity for the vicarious relational impacts and the experiences of participants to emerge.

Of particular interest to this literature review were the small number of IPA qualitative studies investigating therapist experiences of working with complex trauma. A key study by Coleman et al. (2021) investigated the positive and negative impacts of working with complex trauma, by interviewing twenty-one mental health clinicians from NHS trauma services using Interpretative Phenomenological Analysis (IPA). Themes from their findings included clinicians feeling a sense of vocation, holding a sense of tension between needing to be both separated from and connected to traumatised clients, altered perceptions of others and particularly men, facilitating a meaning making process for their clients, being careful not to re-enact any further trauma and a sense of personal and professional development and growth through their work with trauma. Aspects of these findings are consistent with other IPA studies on experiences of complex trauma work with a South African study by Padmanabhanunni and Gqomfa (2022) which interviewed sixteen female psychologists revealing a shift in their sense of safety and view of men. Similar to Coleman and colleagues, a UK| study by Bartoskova (2017) involving ten trauma therapists identified that impacts are not exclusively negative, with clinical practice involving an admixture of detrimental experiences, alongside growth processes.

A seminal Australian study by McCormack and Adams, (2015) investigated four senior therapists' experience of working with complex trauma and their meaning

making around vicarious trauma in a busy medical service environment. Their finding encompassed four major themes including having to sit with horrific narratives and stay connected, struggles to work with the deep-seated relational traumas within limited timeframes and a diagnose-fix-discharge paradigm, their sense of a compromised therapeutic authenticity in the face of the restrictions of the medical model, and a recognition of their own sense of personal and professional development, as they witnessed the courage and vulnerability of clients.

In reviewing the IPA studies, there was a notable trend of growth processes emerging within participants' interviews. Four of these IPA studies (Bartoskova, 2017; Coleman et al., 2021; McCormack & Adams, 2015; Merriman & Joseph, 2018) reported the detrimental effects co-occurring with experiences of professional resilience and personal growth, which mirrors to some degree the concepts of compassion fatigue and satisfaction discussed earlier within the empirical literature. IPA studies on this phenomenon have also tended to be conducted on participants from national health care settings with a specific aim of exploring vicarious negative and/or positive impacts. An exception to this is Merriman and Joseph (2018), who interviewed nine counselling psychologists from a variety of clinical settings, and who explored the clinical influence of the practitioner's use of self on the therapeutic process. Their findings reveal the challenges for participants of using the therapeutic self within trauma work, with struggles negotiating complex interpersonal dynamics, navigating boundaries and the importance of the contexts of the client's traumatic material. Their study also highlights their therapeutic selves undergoing a developmental journey with a sense of acceptance gained around their practice with trauma and through recognising the importance of learning through supervision.

There would seem to be a dearth of literature exploring senior trauma therapists' experiences of long term exposure to this clinical work. This study would seek to address this gap and to illuminate vicarious and other clinical experiences from the perspective of clinical seniority. Given the emphasis within the qualitative literature on recruiting participants from organisational settings with specific clinical cultures, it would seem important for this study to explore this phenomenon within contexts that encompass admixtures of both private practice and/or organisational environments. These blended clinical environments are often overlooked within research and can often be the reality of psychotherapeutic practice with clinicians regularly working part-time on temporary contracts with a need to supplement their work arrangements through private practice.

A search of the existing literature identified only three Irish qualitative studies, which related to therapists' experience of working with traumatised clients. Forde and Duvvury (2021) used semi-structured interviews to explore the experiences of both therapists and clients working and attending a Rape Crisis Centre (RCC) for therapeutic treatment. The study analysed their data using a qualitative thematic analysis to gain insights into experience of psychotherapists using somatic/humanistic approaches when working with complex trauma. Psychotherapists in this study described the application of somatic techniques within their trauma work helped them to identify the nature of clients' emotional difficulties, to assist clients in connecting to their emotions, to recognise dissociative processes within the clinical space and to allow clients to release embodied trauma. Earlier work by Wheeler and McElvaney (2018) interviewed nine therapists and used thematic analysis to explore the positive impacts of working with child sexual abuse victims. Their main findings reported was the sense of professional satisfaction in helping children, learning from children, and the special connection

developed with child clients. While Wheeler and McElvaney's study explored the experience of trauma therapists in Ireland, it focused on positive impacts and exclusively child psychotherapy. An exploration of those working long term across differing sectors of complex trauma treatment and not solely investigating positive impacts may further illuminate experiences within specialised this field.

A similar study by O'Connor, (2019) used IPA to investigate the experience of twelve helping professionals in Ireland (psychologists, psychotherapists, psychiatrists and social workers) working in a specialist public health service with children and families that had experienced childhood sexual abuse. Her findings identified the importance of self-reflective processes, drawing on collective support, containing the work within the workplace and learning through witnessing change as central to the experience of multi layered trauma work. This current study would look to build on O'Connor's findings by solely investigating the experience of psychotherapists working in a wider range of Irish service provision, including both organisational and/or private practice settings.

To conclude this section, the qualitative literature cited in this review identifies a number of important insights into this area of vicarious impacts on clinicians working with psychological trauma. A growing body of qualitative research provides strong evidence for a range of adverse emotional, cognitive, physiological and disturbance of the self and other perceptions. Recently, researchers have increasingly begun to also examine potentials for post-traumatic growth within the psychological trauma work. The research literature on post-traumatic growth, although relatively small, provides the prospect of some mitigation and protection against the unavoidable challenges of working in this specialised area. Only three published studies could be found on working with complex trauma in Irish clinical settings, with none of these exploring

senior therapist experiences. This researcher feels there is a place for a qualitative study, which explores senior therapists' experiences of working with psychological trauma, not just in terms of vicarious effects, but also allows for other aspects of clinical experience to emerge.

2.8.3 Self-care and Supervision for Psychotherapists Working with Complex Trauma

This section will review the existing research literature at the intersection of self-care, supervision and trauma informed clinical work. Similar to the complex therapeutic responses required to assist traumatised clients, some researchers (Knight, 2013; Meichenbaum, 2007) argue for the necessity of an ecological approach to self-care practices in offsetting some of the detrimental influences of those working with trauma. Moreover, several authors have pointed to the need for practitioners within trauma related fields to find their own individual strategies in the management of their self-care and supervision (Collins & Long, 2003; Greenberg, 2020; Knight & Borders, 2018; Meichenbaum, 2007.; Pearlman & Saakvitne, 1995), while other researchers have questioned the value of these practices (Bober & Regehr, 2006).

Few quantitative studies exist on the effectiveness of self-care practices and supervision in ameliorating the vicarious symptoms of working with trauma, with the evidence from existing studies yielding equivocal results. Early work by Bober and Regehr (2006) used self-report psychometric scales to examine the relationship of self-care strategies to the wellbeing of therapists (n=259) working with trauma caseloads. Their results found no evidence that time devoted to leisure, self-care or clinical supervision offered protection against the impact of indirect trauma, with the only variable which positively correlated with lower traumatic stress being less hours per

week of trauma counselling. Likewise, Dworkin et al. (2016) used an online survey on staff members (n=164) at differing rape crisis centres in the US and found no significant benefits to clinical supervision in protecting therapists against secondary trauma.

In contrast, a survey by Quinn et al. (2019) conducted on counselling social workers (n=107) engaged in trauma work in the US revealed a significant relationship between good supervisory relationships and lower levels of secondary trauma. A later US study by Jeglic and colleagues (2022) examined a sample of therapists (n=86) working with sexual offenders, who regularly shared traumatic details of sexual assault and abuse as part of their therapeutic process. The study administered a number of self-report inventories to participants in order to examine a range of coping strategies and trauma symptoms. Their results showed that active coping styles which draw upon healthy problem solving and professional support correlated negatively with low mood scores and positively with lower trauma symptoms.

By comparison, the qualitative literature on self-care and supervision has tended to highlight the necessity for a diverse approach to self-care and for clinical supervision. In a Canadian qualitative study, which has clear similarities to the current study's participant group, Harrison and Westwood (2009) investigated six peer-nominated master therapists with a minimum of ten years of experience of working with traumatised clients in relation to mitigating protective practices. Their findings identified several important themes across the participants' interviews such as the importance of supervision in mitigating risk of vicarious trauma: the use of personal relationships, such as family and friendships contributing to a sense of belonging through a nourishing network of relations; the necessity of mindfulness practice; a habit of consistently challenging negative self-talk; a positive belief in the therapeutic

healing potential of their work; seeking out diverse experiences, such as travelling, joining clubs with contrasting activities and people, and spending time in natural environments.

Similarly, a qualitative American study by Shannon and colleagues (2014) examined the self-care practices of seventeen social work students, who provided exposure therapy to treat traumatised clients as part of their clinical work. This study used journals to track and assess the use of self-care strategies during the course of participants' clinical work at 4-month intervals. Findings from this study showed the social work students during their training drew on a range of self-care strategies to optimise the development of their clinical work. Psychoeducation, mindfulness, and journaling during training were helpful in allowing participants to integrate their own style of self-care routine. The fostering of professional supports, such as supervision, personal therapy, and conversations with colleagues were all seen as central to good self-care practices.

In summary, there is a small but growing international research literature on self-care and clinical supervision and its relationship to therapist secondary trauma. Empirical studies have demonstrated mixed results with some earlier studies showing no evidence for the positive role of self-care and supervision in buffering the negative impacts of working therapeutically with trauma. However, more recent quantitative research has evidenced benefits in maintaining proactive self-care strategies and supervision. In line with these more recent empirical studies, qualitative studies have consistently pointed to the importance of self-care and supervision in mitigating the effects of trauma work.

2.8.4 Training for Therapists Working with Complex Trauma

Academic commentators (Knight, 2013; Meichenbaum, 2007) have advocated for professional training environments to contribute to development of self-protective habits and clinical competency amongst the next wave of psycho-traumatologists, as they begin work within this challenging field. However, over the last 15 years, it is striking to note the number of criticisms by prominent clinical voices, who cite a lack of systemic training in psychotrauma for mental health professionals (Sheehan et al., 2023; Kumar et al., 2022; Brand, 2016; Cook et al., 2011). Moreover, researchers have pointed to the piecemeal nature of training for psycho-trauma, which tends to be taught in a mixture of both academic and non-academic settings and to be viewed as a sub-specialised qualification (Vallières et al., 2017), rather than being embedded within traditional psychotherapy qualifications. Furthermore, the focus on single event trauma often favoured within the medical model has led to issues in practitioner preparedness in dealing with complex presentations within many clinical services (Corrigan & Hull, 2015). These criticisms would seem to be bolstered by a recent empirical US study by Kumar and colleagues (2022), which used a self-report questionnaire to survey licensed health professionals (n=69) after a complex trauma training programme to ascertain their prior trauma training experiences. Their results on early training found that 68% of the participants from this study reported feeling inadequately prepared to assess complex trauma and 75% felt unprepared to treat complex trauma, with 10% stating that they had never received training in this area. A similar trend also seems to be evident within an Irish context with a study by McElvaney and colleagues (2019) using a mixture of surveys and interviews to review Rape Crisis services for young people. Their findings revealed all the therapists within these services supplemented their core

training with additional specialised training to work with sexual trauma and were actively engaged in regular continuous professional development in this area.

In their extensive review of qualitative research on vicarious trauma, McNeillie & Rose (2021) stated "it would seem beneficial to open up the dialogue about vicarious trauma and its effects through…training and reflective practice" (p.437), suggesting that there are still opportunities being missed to use training, as a platform for instilling self-care habits. As Harrison and Westwood (2009) concluded in their findings working with traumatised clients comes at a cost, they argued that training institutions have an ethical obligation to work with therapist trainees around ameliorating vicarious impacts, but also to warn them of the potential risks of working with highly traumatised populations.

Interestingly, the quantitative data on trauma training and vicarious impacts offers a more nuanced set of results than the qualitative studies. Craig and Sprang (2010) who used the ProQOL questionnaire to investigate (n=532) trauma specialists' levels of compassion fatigue, compassion satisfaction and burnout. They identified a significant inverse relationship between more specialist trauma training and lower levels of burnout, higher levels of compassion satisfaction but no significant association with compassion fatigue. This is in line with Sodeke-Gregson and colleagues (2013) who surveyed UK therapists (n=253) and their results showed higher scores on compassion satisfaction and a lower prevalence burnout but not compassion fatigue when participants had undergone specialist trauma training. This positive impact of specialist trauma training on burnout and compassion satisfaction and not compassion fatigue seems counter intuitive. It may be that specialist trauma training allows for a greater sense of agency and control through developing clinical

competencies, which alleviate burnout and increase work satisfaction, but do not mitigate vicarious trauma effects.

In view of all that has been discussed throughout this review, it would seem that the interface of the research on training and complex trauma encompasses a small body of literature. However, this review also identified training for complex trauma to be relatively non-integrated amongst mainstream psychotherapy programmes and remains an untapped source of education for future generations of trauma therapists.

2.9 Conclusion

This chapter outlined the historical contexts of the construct of complex trauma, the ontological issues, along with discussing the contemporary debates, which have led to the recent introduction of CPTSD as a recognised diagnosis within the ICD-11. From the review of the epidemiological literature, it is clear that complex trauma is not an uncommon problem within the Irish general population, with the recent increase of migrants and asylum seekers presenting to Irish mental health services expected to bring new therapeutic challenges. Consideration was given to recent neurobiological advances which have allowed for new insights into the impact of complex trauma on individuals and an overview of psychotherapeutic treatment was detailed.

An examination of the research on therapists working with complex trauma leaves little doubt of the potential negative impacts of this specialised work, with emerging evidence also pointing to potential positive benefits and growth factors. While the overall quantitative literature on self-care and supervision presents a mixed picture. Qualitative studies paint a picture of self-care and supervision playing an important role in buffering the indirect impacts of trauma work, with a lack of training on trauma for therapists still being a significant issue.

Given working with complex trauma is an evolving specialisation within a fast-changing clinical landscape, this review has identified a significant gap in the qualitative research on the narratives of experienced trauma therapists working within Irish clinical settings. It is hoped that the findings of this study will have implications for both clinical practice and supervision within this expanding field, especially amongst Irish trauma practitioners.

2.10 Researcher's Reflective Comments

Reviewing the literature for this study left me with a mixture of feelings. This I feel stemmed from the tension at reading the attempts of many great academic theorists and researchers to capture the elusive qualities of a human experience such as psychological trauma. It made me conscious of the necessity to understand human trauma, but also the persistent limitations in our capacity to fully do so. Examining complex trauma as a construct confronted me with the acute ontological debates at the heart of working with mental health. Both complex and vicarious trauma sit at the confluence of differing epistemological traditions in terms of their conceptualisation, and this makes it difficult to find consistency around what constitutes psychological trauma. This was especially the case around the concepts relating to secondary trauma, which drew on both medicalised and social constructivist ontological positions, which viewed trauma differently. This has made me aware of the need for humility, when taking a position around any understanding of psychological trauma. It has also shaped my own reflections within my clinical work, as I have become increasingly aware of the unique contexts which influence complex trauma presentations. In particular, there has been a growing comprehension of the socio-cultural and historical contexts which underpin any individual's meaning making processes around their trauma.

As a psychotherapist, I am always curious about other people's experiences, so I am naturally drawn to qualitative research as it offers a window into the internal world of the other. My hope is that this study might reflect some of the unique aspects of Irish clinical work which inevitably absorbs sociological threads such as religious patriarchy, the growing pains of a modernising society and influence of global conflict. There have been points on this research journey, when I doubted the importance of exploring this research question. I wondered whether the interviews would yield any new knowledge that did not already exist. I was also concerned whether or not this data would be relevant to trauma practitioners. Working through the literature review gave me a deeper understanding of the field complex trauma with its debates, developments and more importantly the effects on those who make a living from working within this profession. I also experienced excitement at reading the newly emerging qualitative research, which really began to ignite my interest and allowed me sit more comfortably with the reality doing this research.

Chapter 3: Methodology and Methods

3.1 Introduction

This chapter provides an overview of the methodology, methods and an outline of the aim and specific objectives of this study. An epistemological rationale for selecting Interpretative Phenomenological Analysis (IPA) as the research methodology best suited for the question at hand is discussed. A review of the philosophical underpinnings of IPA details the key concepts which influence this approach. IPA as a methodology advocates a particular philosophical stance, so the researcher's reflexive positioning within the study is presented. A comprehensive description is provided of the procedures and methods, which were used to access, gather and analyse the data. The chapter discusses the ethical considerations for this study and a description of the measures taken to ensure its validity and rigour are detailed.

3.2 Research Aim and Objectives

This study sought to investigate the research question: An exploration of senior therapists' experience of working with complex trauma in Ireland: An Interpretative Phenomenological Analysis. The aim of this study was to explore senior therapists' experience of working with complex trauma in Irish psychotherapy settings.

The specific objectives of the study were to explore:

- Participants' lived experience of working psychotherapeutically with clients presenting with complex trauma.
- How participants were impacted in their therapeutic work and personally, while working with complex trauma?
- Participants' experiences and views of what was helpful and unhelpful in working with clients presenting with complex trauma.

3.3 Choosing a Methodology

Epistemology is a branch of philosophy, which enquires into questions of the "nature of knowledge" and "how is it acquired?" (Grayling, 2019). Within the various disciplines of mental health, there has been a great deal of discussion, disagreement and acrimony as to which type of epistemological methodologies offer the best justification in building future knowledge (Bracken et al., 2012). In selecting a research topic in the field of psychotherapy, which often draws on biopsychosocial formulations, every researcher is confronted with a range of ontological understandings and epistemological possibilities in conducting their study. As a doctoral candidate, I faced the dilemma of narrowing down "what methodological approach can best assist me in achieving my goal?"

Research methods have tended to exist in a perennial epistemological tension, which is characterised dimensionally between quantitative and qualitative approaches. The quantitative tradition concerns itself with questions of objective realism and the relationship between variables within populations. Quantitative approaches apply mathematical concepts to analyse collections of measured data using structured research instruments or to manipulate pre-existing statistical data using computer software. Quantitative methodologies require an objective stance from the researcher and allow statistical generalisations to be drawn across groups of individuals (Creswell & Creswell, 2013). In contrast, the qualitative paradigm is founded on constructivist and relativist philosophical principles and uses the analysis of words and meaning to better comprehend phenomena. In the psychological realm qualitative researchers are concerned with accessing the subjective dimension of individual experience to better understand, the motivations, meaning-making processes, which govern human actions (Willig, 2019).

More generally, research within the field of complex trauma has tended to favour quantitative methodologies (Melton et al., 2020), which examine and analyse the relationship between psychotherapy interventions for complex trauma and mental health outcomes (e.g. Classen et al., 2021; Mahoney et al., 2020; Voorendonk et al., 2020). Some quantitative research has also looked to examine indirect effects on therapists of working with complex trauma. A variety of surveys and assessment measures have been used to quantify impacts including compassion fatigue, compassion satisfaction and burnout (Sodeke-Gregson et al., 2013; Craig & Sprang, 2010).

The literature review on this research question unearthed a relatively small body of international research literature, which qualitatively explored psychotherapists' experience of working with complex trauma (Munishvaran & Booysen, 2022; Padmanabhanunni & Gqomfa, 2022; Coleman et al., 2021; Merriman & Joseph, 2018; Bartoskova, 2017; Sui & Padmanabhanunni, 2016; McCormack & Adams, 2015). Only three studies (Forde & Duvvury, 2021; O'Connor, 2019; Wheeler & McElvaney, 2018), which have inquired into the nexus of therapists' experience of working with complex trauma in an Irish context could be discovered during an extensive search of the available literature. In looking at these Irish studies, Forde and Duvvury (2021) investigated simultaneously both therapists and clients use of a particular therapeutic approach. O'Connor (2019) used IPA to explore the experience of the helping professions working with traumatised children and families and Wheeler and McElvaney (2018) looked at the positive impacts for child psychotherapists of working with trauma. The review of the current body of research shows a gap in knowledge base on the subjective experience of clinicians working long-term within this specialised area of psychotherapy. Therefore, an approach which looked to provide a

contrasting epistemological perspective to the predominant positivistic studies while also addressing the gap within the qualitative research was viewed as most likely to provide a valuable contribution on this topic. As the researcher was not looking to gather empirical facts, but rather to explore in depth the internal perspectives of specialist therapists working with complex trauma, only qualitative approaches with a focus on the subjective dimension were considered.

Several well-established qualitative methodologies exist including grounded theory, case study, hermeneutic phenomenology, discourse analysis and narrative approaches (Denzin & Lincoln, 2011). Initially a grounded theory approach was examined as a possible research lens from which to conduct the study question, but it was felt by the researcher that its focus on developing theoretical frameworks would be redundant, given several theories on vicarious negative impacts and growth processes are already well established. A discourse analysis would seek to explore how therapists experience complex trauma work by analysing their use and construction of language and its relationship to broader socio-cultural discourses. This approach was seen by the researcher as not offering access to the deeper meaning making processes required for the present study's aim.

The aim of this study was to investigate therapists' experience of working with complex trauma over a longer-term timeframe, against a background of rapid development within Irish clinical settings as a consequence of sociological pressures. It was felt that a phenomenological approach with its capacity to traverse multi-layered experiences, including feelings, thoughts, behaviours and social contexts (Alhazmi & Kaufmann, 2022) would provide a sound epistemological foundation from which to examine both the intimate and complex space of this therapeutic experience. In exploring the potential of different phenomenological approaches, hermeneutic

phenomenology (van Manen, 2016) and Interpretative Phenomenological Analysis (IPA) (Smith et al., 2022) were considered, as these methodologies allow for a focus on 'the thing itself' or phenomenon, but also there is room for the researcher to develop an analytic interpretation of the data. This allows the researcher to explore the phenomenon under investigation on two levels; firstly, these methodologies give the participants the opportunity to offer rich interpretative accounts of working with complex trauma, and secondly there is the opportunity for the researcher to provide a detailed interpretation (van Manen, 2016; Smith et al., 2021). In exploring the potential of these different phenomenological approaches, van Manen's hermeneutic phenomenology was viewed by the researcher as lacking the idiographic element, which allows for greater analysis of the convergences and divergences between the individual accounts of the participants.

Moreover, Smith and Nizza (2021) argue that IPA is an approach which is sensitive to contextual factors, such as the setting, sociological and cultural sensitivities that surround the topic. This study looked to understand therapists' experience of working with this client base, which encompasses a wide range of background influences, such as organisational cultures, engagement with other professionals and risk management, so IPA was viewed by the researcher as offering an approach which would be sensitive to these contexts. Furthermore, the limited body of qualitative research, which exists on therapists' experiences of trauma work has seen IPA regularly chosen as a suitable methodology (Munishvaran & Booysen, 2022; Padmanabhanunni & Gqomfa, 2022; Coleman et al., 2021; Merriman & Joseph, 2018; Bartoskova, 2017; McCormack & Adams, 2015). This suggests it is viewed as an appropriate approach for exploring this phenomenon by the international research community.

3.4 Interpretative Phenomenological Analysis

IPA as a phenomenological research approach looks to uncover the subjective experience of participants, while also allowing for the researcher's reflective interpretation within the research process (Reid et al., 2005). Developed by psychologist John Smith, as a response to the predominance of quantitative research knowledge within psychology (Smith, 1996), IPA has become increasingly popular within health care and psychological disciplines (Pringle et al., 2011). IPA is rooted in the core philosophical traditions of phenomenology, which allows for the exploration of the 'lived experience', hermeneutics provides researchers with an interpretative lens and commitment at an idiographic level brings attention to the particular within a study (Smith et al., 2022).

3.4.1. Phenomenology and IPA

There have been a number of influential phenomenological philosophers with a differing emphasis in conceptualising human understanding of experience, however, they all fundamentally tend to share a curiosity in the experience of being human and how we make meaning in the lived world. Smith and colleagues (2022) describe IPA as an approach, which draws on the philosophical influence of Edmund Husserl, Maurice Merleau-Ponty and Jean-Paul Sartre.

According to Husserl (1970) phenomenological inquiry is something that should be explored on its own terms, and as it occurs. Husserl looked to develop a philosophical means, by which an individual might examine their own internal experience. According to Smith et al. (2009), Husserl suggests that we should "go back to the things themselves" (p.8), meaning we should endeavour to focus on the experiential content of our consciousness. For those conducting IPA research, Husserl's

ideas emphasise the need for a reflective process that facilitates a systematic examination of the content of consciousness. He also introduced the concept of "bracketing", which sees the enquirer attempt to bracket off their pre-conceptions in order to analyse phenomena through concentration on conscious perception. In IPA, the researcher endeavours to hold a contradictory position by trying to identify their pre-understandings, to better capture a purer comprehension of a phenomenon for a particular individual/group.

The French existentialist philosopher Maurice Merleau-Ponty describes the perceptual and embodied nature of our experience to comprehending the world. He talks of the importance of the individual lived experience being constituted in a moving and sensing body or "body subject" which engages with others in the world (Merleau-Ponty, 1962). Thus, for IPA, Merleau-Ponty brings an invaluable understanding of embodiment to our sense of experience, and brings us toward a holistic phenomenology, which considers physiology in our research.

The French existential philosopher Jean Paul Sartre (1905-80) suggests the presence or absence of others shape the quality of our self-consciousness and emotional experiences (Sartre, 1948). For IPA researchers, Sartre emphasises the importance of interpersonal and social contexts in shaping our perception of our experiences. When we hold a phenomenological position, we must be aware of our perceptual processes being contingent on the textures which human presence provide in defining our lived experience. Thus, the presence of the researcher is implicit within an IPA study and must be considered in the analysis by taking a reflective position within the research process.

3.4.2 Hermeneutics and IPA

The second philosophical thread running through IPA is hermeneutics, which can be defined as "the theory of the interpretation of meaning" (Bleicher, 1980, p.1). Meaning in this context is envisioned, as something, which is fluid and in a continuous flux of revision, new insights and re-interpretation (Tuffour, 2017). In drawing on hermeneutic theory, IPA looks to the influence of Friedrich Schleiermacher, Martin Heidegger, and Hans-Georg Gadamer.

One of the foundational thinkers in the field of hermeneutics is the German philosopher Schleiermacher. For Schleiermacher, the process of interpretation involved an analysis at both a grammatical and psychological level. He advocated an approach to interpretation, which is intuitive, rather prescriptive or rules based in its understanding of a text. He suggests that there is a unique level of meaning, which the writer intends and there is also the level of interpretation of the reader, who endeavours to understand the original context of the text, through differing perspectives. Hence, the IPA researcher brings a perspective to their participant's text, which adds value through identifying connections within larger data sets and creating an analytic dialogue between this data. Smith et al. (2022) also integrates Schleiermacher's attitude of intuitive engagement by advocating for a combination of critical and conceptual thinking, but also playfulness and imagination in working with the layers within the participants' data.

For Heidegger (1927), phenomenology's engagement with the "life world" of an individual is always through a process of interpretation. Hermeneutic phenomenology is also attempting to uncover something, which is partially concealed from our perception. In any examination of a phenomenon, the analyst is never pre-suppositionless and brings their prior experiences and preconceptions or "fore-

structures" to their understanding of a new object. Thus, Heidegger would argue the impossibility of describing a phenomenon in the absence of an interpretative process. From an IPA perspective, Heidegger introduces a re-conceptualisation of phenomenological bracketing, as a hermeneutic process, which includes an acceptance that the researcher brings fore-structured understandings to their data. In line with Heidegger, IPA assumes that researchers will be conditioned by their own psycho-social history and their understanding of the existing extant literature (Smith, 2004). For the IPA researcher, the task of engaging in reflexive practices is an integrated and central aspect in conducting their qualitative study. Although an IPA analysis can never fully step outside the researcher's contextual pre-suppositions, instead it acknowledges this, and seeks through reflexive engagement, to develop credibility and transparency in illuminating the lived experience of the participants (Engward & Goldspink, 2020).

Developing on the hermeneutic sensibility of Heidegger to phenomenology, the French philosopher Gadamer contends that any analysis projects meaning onto a text as it emerges, and this process of projection must be refined in an ongoing process until more clarity is achieved (Gadamer, 1960). Gadamer advocates for a spirit of openness in interpretation, which seeks to emphasise the meaning of the text, rather than looking to understand the intentions of the original author. Therefore, Smith et al. (2022) posit IPA uses Gadamer's hermeneutic perspective in viewing a study as an iterative process between the research data and the researchers' preconceptions, which invariably generates rich understandings of the participant's words.

Within hermeneutic theory, the idea of the "hermeneutic circle" proposes a dynamic relationship between the part and whole. Thus, to comprehend a particular phenomenon within a study, consideration must be given to the overall research or larger data and conversely to fully understand the overall findings or data, one must

look in detail to the particular. Smith (2004) argues interpretation in IPA is a complex activity, with the participants making an interpretation of their experiences, as well as the researcher endeavouring to make meaning of the participants' inner world. The concept of the hermeneutic circle is used to explore the dynamic between the part and whole on a number of levels in IPA. The researcher engages in a micro analysis of multiple relationships, such as the word as it is embedded within a sentence, the extract within the broader text, the text within the oeuvre, and the interview within the study. This leads to a process of analytical interpretation, which is non-linear and operates at different levels in a cyclical fashion (Smith et al., 2022). Ultimately, the participants' recollections can be seen as a first order of meaning making and the researcher being engaged in a second order of sense making, which is referred to as a "double hermeneutic" (Lyons & Coyle 2007).

This interaction between participants and the researcher's experiential horizons can be viewed as a circular and dynamic process. Consequently, Smith et al. (2022) propose that even if the researcher attempts to clarify these preconceptions prior to starting their study, it may only be during the process of engagement with the phenomenon that other biases or preconceptions emerge.

3.4.3 Idiography and IPA

An important theoretical perspective within IPA is *idiography*. Idiography is viewed as a standpoint, which concerns itself with the particular, so for IPA this means an analysis of particular people within the specific context of a study. Thus, in an IPA study, the initial process of understanding the individual accounts of people in specific circumstances before making comparisons across cases, means there is greater

emphasis on detail and depth of analysis, when approaching data (Smith & Nizza, 2021).

This idiographic approach contrasts to the more widely used 'nomothetic' process, which makes claims generally about groups and human behaviour (Bryman 2012). Nomothetic methods have been criticised for attempting to quantify psychological phenomena and generate personality typologies, which are probabilistic and only apply at the conceptual resolution of the group. This domain, it has been argued, works at a level of analysis that offers statistical group averages, which reflect prototypical individuals that do not exist in reality. Alternatively, idiographic approaches value working with a single case with the intention of exploring questions of existence, being and experience (Ridder, 2012). IPA furthers this idea by introducing the notion of drawing individual cases together for a broader analysis (Smith et al., 2022).

3.4.4 Critique of IPA

As IPA matures and gains popularity as a research methodology, it is no surprise that it has become the focus of ongoing criticism. In constructing a qualitative research methodology, which draws upon a number of different philosophical streams, IPA has been proposed by Dennison (2019) as displaying a 'promiscuous epistemology'. As Tuffour (2017) argues, given its eclectic philosophical foundations there was an inevitability that heated academic debates would ensue on several conceptual and practical fronts.

A recent article by van Manen (2018) questioned whether Jonathan Smith's IPA was phenomenological as a research methodology. This article spawned an academic dialogue of rebuttals and rejoinders around the bona fides of IPA as a genuine

phenomenological approach. Van Manen argued that Smith's IPA suffers from conceptual misunderstandings and does not apply the method of phenomenological inquiry in the spirit of its original sense. He wrote that Smith's steps in IPA used to identify "emergent themes", which lead towards meanings that have little to do with phenomenology and are closer to psychological reflections. Earlier similar commentary by Giorgi (2011) suggested that IPA analysis lacks the intuitive grasp of meaning making necessary for phenomenological research. He suggested that IPA tends towards cognitive interpretations of individuals, rather than striving for the unique meaning of an experience as it unfolds for participants.

An article by Zahavi (2019) outlined Smith's defence of these criticisms by Van Manen. Smith argued that phenomenology is a diverse set of philosophies and researchers use these conceptual framings to inform their choices, intuitions and reflections within their IPA studies. He noted that phenomenology is not solely the domain of philosophy and other academic researchers should not be prescriptive or dogmatic in developing rules for its use.

Other criticisms based on epistemological concerns suggest sampling in IPA selects participants with a shared experience of a phenomenon within a specific context. Invariably, this homogenous sample means there are implications for the broader context of the findings (Caldwell, 2008). Nevertheless, Reid et al. (2005) points out that although broad generalisations are not feasible in IPA, commonalities across participant narratives can offer important insights that have wider implications. Caldwell (2008) contends that IPA studies offer context to the wider literature, thereby contributing to "theory" in an area, but with a small "t" rather than a capital "T". Furthermore, Smith et al. (2022) advise that students using IPA should think of theoretical transferability of their findings for other groups in other settings.

3.4.5 Conclusion

Several methodologies were considered for this study, but IPA was chosen, as it offered the researcher the opportunity to explore the meaning making processes of the participants within the study. IPA is underpinned by the philosophical strands of phenomenology, hermeneutics and idiography, which in combination provide a foundation for the in-depth exploration of subjective experiences of participants embedded within social contexts.

Some criticism suggests that IPA at its core is not a phenomenological approach and tends to uncover psychological reflections, which lack experiential depth. This criticism has been countered by the developer of IPA, who cautions against dogmatism in the use of philosophical concepts. Although the IPA's use of a small homogenous sample limits generalisability, it offers context to the broader research literature. The next section discusses the data collection, researcher reflexivity, data analysis, ethical considerations and quality/validity of this study.

3.5 Procedure

3.5.1 Recruitment

IPA studies use purposive sampling, which selects participants with the required experience of a particular phenomenon, in specific contexts. This means participants in IPA share a particular perspective, which makes the sample relatively homogenous. For this researcher's study, the participants had considerable experience of working with clinical populations with complex trauma. This form of qualitative sampling looks to balance an analytic tension between analysing a small number of cases, while still being mindful of the individual experiences within the study (Smith & Nizza, 2021). Smith et al. (2022) advocate a small sample of six to ten participants for professional

doctorate IPA studies, in order to achieve optimal psychological depth. Nine participants were recruited for this study. This number of participants was seen as permitting enough time and reflective space to conduct a detailed analysis, without having too large a data set, which might over-extend the resources of the researcher (Wagstaff et al., 2014).

In order to recruit participants, who shared this 'life world' experience, the following specific inclusion and exclusion criteria were developed.

1. Psychotherapists or psychologists, who have 5 or more years of working with complex trauma in an Irish mental health setting.
2. Complex trauma presentations comprise a regular part of their typical caseload.
3. Fully accredited with a recognised professional psychotherapy or psychology body.
4. Fluent English speakers.

In order to recruit participants with the specific experience of the phenomenon, the following strategy was developed and implemented in phases during 2023/2024:

1. An advertisement (Appendix A) was twice placed in the online classified ads section of the Irish Association of Humanistic and Integrative Psychotherapy (IAHIP), which has a membership of over 1500 psychotherapists. An advertisement and accompanying video (Appendix B) were placed in the monthly e-news and on the research noticeboard of the Irish Association for Counselling and Psychotherapy (IACP), which has over 5000 members.

2. The National Counselling Service and Towards Healing were approached by email (Appendix C) in relation to the study. The managers of these services were asked to circulate an email to their psychotherapists, which included a letter of invitation (Appendix D) to partake in the study, along with a plain language statement with the researcher's contact details.

As the potential participants responded to the IAHIP and IACP advertisements, a plain language statement (Appendix E) was emailed to them. The plain language statement outlined the purpose of the study, what was required in participating, the protection of their data and GDPR measures, confidentiality limitations, potential risks and benefits and their right to withdraw. Those therapists who met the inclusion criteria and agreed to be interviewed were sent an informed consent form (Appendix F). Similarly, the therapists from the organisations who met the criteria and wished to proceed with the interview were forwarded an informed consent form. An issue was encountered with one of the organisations approached, due to their psychotherapists working as independent contractors and not employees. There was an organisational constraint in relation to the circulating of a general invitational email to all their therapists, and it was agreed by the director of this organisation that only management (who were therapists) would be invited to participate in the study and those who met the criteria and agreed to partake in the study were forwarded an informed consent form.

3.5.2 Participants

Given this study focused on a specialised therapeutic community with a relatively small number of practitioners, a table of demographic and work-related characteristics was excluded from this descriptive summary as it could compromise the anonymity of the participants. The nine participants included seven female and two male therapists with an age range (42 to 68). All the participants identified as psychotherapists, except for one, whose primary discipline was a counselling psychologist. The participants' primary therapeutic modality varied with two participants describing their central orientation as psychoanalytic, two worked with CBT, four worked out of a humanistic

framework, and one with a EMDR approach. Despite working out of a core paradigm, all participants spoke of regularly drawing on an eclectic mixture of approaches based on the presentation of their client symptoms.

Three of the participants worked full time within an organisation, which catered to both trauma survivors and non-traumatised clients. One participant was employed within an organisation, which solely supported a client base with complex trauma. Two worked for a trauma organisation but also maintained some level of private practice. One participant worked privately but was also on a panel to work as required for an organisation dealing with complex trauma. Two participants worked exclusively in private practice as specialist trauma practitioners. Participants' years of working experience with complex trauma therapy ranged from (6 to 31 years, m=15), with a percentage of complex trauma work within their caseload of between (20% to 100%, m=66%).

3.5.3 Data Gathering

In gathering data for an IPA study, Smith et al. (2022) recommend the use of semi-structured interviews, and these are carried out with specific objectives. The interview for this study consisted of several questions, which explored the participants' experiences of working with complex trauma (Appendix G). In line with idiographic principles, this style of interviewing allowed for the opportunity to hear and record the individual narratives of the therapists' experiences. In addition, these interviews were used to facilitate an open and conversational dialogic exchange on the participant's recollections of experiences within their clinical work. The openness engendered within this style of interview allows for a greater freedom for the researcher and participants to draw closer to a phenomenological process of rich meaning-making around their work

with complex trauma. Finally, semi structured interviews gave an opportunity to include elements of hermeneutic analysis, by permitting comparisons between interviews due to some of its questions being standardised (Minichiello et al., 1999). Although these features of semi-structured interviews make them useful for other qualitative research methodologies, they are well suited to exploring the experiences of participants in an IPA study.

As the researcher has limited experience with qualitative research, a pilot interview on Zoom was conducted with a fellow doctoral candidate. The pilot interview allowed the researcher to gain some familiarity with time management, the phrasing of questions, and to receive feedback about any shortcomings in the process. As a result of the pilot interview, the researcher was better able to keep the study participants more fully on topic and to facilitate rich participant led responses on the phenomenon. After participants agreed to take part in the study, they were offered an option for an online or face to face interview at a convenient time and place. Oliffe et al. (2021) suggest online interviewing for research can offer a number of benefits with participants able to use the familiarity of their office/homes for interviews, it also eliminates the need to travel for the researcher and participant. However, virtual platforms run the risk of disruptive technical issues and there is a risk that some of the nuance of the interview can be lost. No significant problems were encountered over the course of the interviews, with eight of the interviews carried out via DCU's zoom platform and one interview conducted face to face. Those participants who agreed to take part in the study were interviewed for between 55 and 75 minutes.

3.5.4 Researcher Bias and Reflexivity

As discussed earlier in the chapter, IPA (Smith et al., 2022) requires researchers to take on an interpretative stance in relation to the participants' words. IPA draws upon Heidegger, who argues interpretation is embedded within social contexts, which lead to inevitable biases and presuppositions. This means researcher reflexivity is a core quality within an IPA study (Engward & Goldspink, 2020). Steier (1991) describes reflexivity as the way in which one uses a sense of emergent knowing to shape one's' responses and progress in doing research. Following the guidelines of McLeod (2007) during this study, I looked to maintain a process of reflexive journaling and used the Nvivo memo function to build a trail of my decision making throughout the analysis. There was also ongoing engagement with my research supervisors over the duration of this research project, along with meetings with my fellow doctoral candidates to discuss the emerging issues of conducting an IPA study.

Within the current study, I also used self-reflective processes to take account of my decision in selecting and justifying my research question, choice of methodology, my position as insider researcher, engagement with the participants data and maintaining ethical standards. At the end of each chapter, I have included some commentary drawn from my reflective processes, which covers the core struggles and personal impact for each stage of the study.

3.3.5 Data Analysis

Drawing on Heidegger's hermeneutic principles, IPA looks to comprehend the complexity of meaning within the participant's internal world, which is not explicitly available (Smith & Nizza, 2021). This meaning is garnered by the researcher through sustained engagement with the participants' data and through a process of

interpretation. Smith et al. (2022) acknowledge their guidelines on analysis of data in IPA might sound prescriptive, but in keeping with Schleiermacher's sentiments, they should be applied with a "healthy flexibility" and draw upon deeper intuitive processes. IPA uses a series of seven systemic steps, which provides a record and audit trail of the analytic process. These analytic steps provide a framework to develop experiential statements and themes from each of the participants' accounts and then to identify patterns across cases. This requires an acceptance of the iterative nature of IPA in analysing the participants' words on multiple levels including descriptive elements, linguistic, and conceptual noting.

The researcher used Nvivo software to manage much of the analysis of the participants' data. This software package was developed for working with qualitative research data and offered an efficient set of functions to organise the different themes identified in the study, along with providing an option to write reflexive memos. This IPA study began with a single case and the following steps were taken to analyse the data (Smith et al., 2022).

1. The researcher transcribed the interviews, with efforts made to include differing levels of communication, such as pauses, repetitions, laughter and bodily cues. The data within the transcripts was anonymised and cleaned of identifying information. The first participant's text was slowly read several times, to allow the researcher to immerse himself in the interview data. The interview was also read at least once in conjunction with watching the video-recordings or listening to the audio recording.

2. This step involved the beginning of a process of initial exploratory noting of interesting comments within the interview. As this stage progressed, there was a drafting of a detailed set of comments on the transcript, which focused on three different levels within the interview material. There was a descriptive analysis

describing the contents of what the participant said, a linguistic examination concentrating on the specific use and features of their language. Finally, some exploratory noting engaged the data at a conceptual level, which offered a more overarching, interpretative and reflective stance to the emerging understanding of the participant's words.

3. During this stage, the researcher looked to develop "experiential statements", which look to distil some of the detail of exploratory noting into the most salient features of the participant's experiences. The researcher blended both descriptive and interpretive elements into these statements in order to capture a richer understanding of the participant's words.

4. Experiential statements that strongly represented the participants' experience and were identified as interconnected were drawn together. As these experiential statements formed patterns, they were grouped into clusters and sub-clusters.

5. The main clusters of experiential statements were developed into participants' Personal Experiential Themes (PETs). The Personal Experiential Themes were organised into a table. See a sample of PETs table (Appendix H).

6. The researcher demonstrated a commitment to the idiographic in IPA by completing his analysis for the first participant, before moving onto the next interview transcript. The second participant was analysed using the same sequence of stages, and this continued until there was a table of personal experiential themes for the nine participants.

7. The final stage looked for patterns of similarity and divergence across the individual PETs. Patterns were analysed across cases for Group Experiential Themes (GETs), which highlighted the shared and idiosyncratic characteristics of the experiences of the participants.

The above steps offered guidance for the researcher, as he worked through the analysis stage of the study. However, it has been pointed out, there is no single linear route through these steps (Smith et al., 2022) and the researcher had to maintain an awareness of the philosophical underpinnings of IPA and sit with the multiple levels of interpretation or the double hermeneutic viewpoint, which was central to deep analysis of the material. In IPA, reflexivity means engaging in a fashion, which is "dynamic, interactional, multi-layered, complex, long and often very frustrating" (Engward & Goldspink, 2020, p.4)

Finally, there was a process of "writing up" and the themes were translated into a narrative account (Smith & Nizza, 2021). In the writing up, GETs were expanded upon, explained and nuanced. This process took the form of a narrative argument, which used the words of participants by drawing upon numerous quotations to illustrate their experiences of working with complex trauma. For the researcher the process of writing was the culmination of many months of analysis and where it was hoped the experiences of participants would come alive for the reader.

3.6 Ethical Considerations

Although the researcher was at pains to exercise ethical care throughout the study, there was an acceptance that it would not be fully possible to anticipate some of the ethical issues that could arise over its course. An approach was adopted by Ramcahran and Cutliffe (2001) which proposes a model that sees an ongoing process of ethical monitoring that is based on ethical principles. The researcher was tasked with viewing their research through an ethical lens, which sought to deal with ethical concerns as they emerged over the course of the study. The study looked to build its foundations on

a number of core ethical principles, these principles are justice, beneficence, non-maleficence and autonomy (Beauchamp & Childress, 2001).

The principle of justice seeks to engender fairness and integrity throughout the process of the study. Firstly, an ethics application was approved by Dublin City University Research ethics committee in December 2022 (Appendix L). This application detailed the justification and rationale, gave a brief description of the relevant literature and methodology. This process of application involved a number of clarifications and minor revisions, for example (measures to be taken if more than 10 participants responded to the study during the recruitment process) and was successfully completed before the study was advertised. The researcher also applied this principle by treating each participant who took part in this study with transparency. Care was exercised in a number of ways including supplying participants with plain language statement, the accurate transcription of their words and looking to give equal time to each transcript during the analysis. The researcher was available to answer any of the participants questions in relation to the study, along with giving participants the chance to raise any queries with the Research Ethics Committee at Dublin City University. One participant at the end of the interview asked for a particular section of the interview not to be included in the study, as on reflection, they felt the material shared was too personal. This section of the interview was deleted from the transcript, as per the participant's request. This issue was an illustration of the principle of justice and integrity within the study.

Beneficence refers to the responsibility of the researcher to do everything possible to increase the potential benefits of the study for participants. It was hoped that the idiographic focus of IPA would give voice to a small community of psychotherapists, who had dedicated much of their working life to helping those

suffering with complex trauma. It was noted by the researcher during the opening section of many interviews that participants commented on the need for this research to be carried out, given the rapid developments in therapeutic work with complex trauma. Some participants spoke about appreciating the opportunity to look back over their experience of working with complex trauma and being given the space to reflect on their motivations, the challenges and the rewards of working in this area.

Non-maleficence means researchers must minimise the risk of any harm during the study. The researcher made every effort to adhere to this principle by working to ensure the anonymity and confidentiality of the study participants. However, it was pointed out to the participants that given the small and specialised population which the recruitment strategy of the study targeted, absolute confidentiality could not be guaranteed. Some participants did query whether or not the name of their organisation would appear in their transcript, they were reassured by the researcher that all identifying information would be removed from the data. Their anonymity and confidentiality were protected by the separation of the transcripts from the demographic information. The use of pseudonyms was employed on transcript pages and quotations. In line with DCU guidelines and GDPR requirements, all data was stored on secure storage on DCU's Google drive and an undertaking to destroy all data five years after the completion of the doctorate programme was outlined.

Lastly, the principle of autonomy means participants must be in a position to make an informed decision and give consent based on adequate and clear information. A plain language statement (Appendix E) was supplied to the interested participants at the recruitment stage by email. Prior to the start of the interviews, participants were asked if they needed any clarification around any details of the study. The plain language statement provided accessible information to the participants regarding the

aims of study, along with the potential risks and benefits, what was expected by them in participating, and how their data might be used and protected in the project. They were also informed both verbally and on the plain language sheet that they have the right to withdraw from the study at any time before the Summer of 2024. All the participants made initial contact with me, as a result of the recruitment process voluntarily and the participants who partook in the interview process completed the informed consent form (Appendix F) provided to them, before the interview commenced.

3.7 Quality and Validity in IPA

Smith et al. (2022) advocate using the guidelines of Yardley (2000) for assessing the quality of IPA research. Firstly, Yardley (2000) argues that good qualitative research will demonstrate "sensitivity to context". She suggests a research project must endeavour to situate the research in the existing research literature and be sensitive to the context of the participants' lifeworld within the research. The current study adhered to this principle by the researcher's use of the existing literature to ensure that a complex and diverse overview of the phenomenon was outlined during the literature review and writing up of the study. As discussed in the rationale of the literature review, this study looked to explore therapists' experiences within several contexts including, their seniority within Irish trauma work, the unique aspects of this developing specialisation, and the variety of organisational and private clinical settings in which their work was carried out. The researcher worked empathically with participants to manage the experiential and interactional quality of the interview in order to allow for these contextual elements to emerge. Furthermore, the analysis looked to give a voice to the participants, through an interpretive process, which

illuminated their experience of the phenomenon, and a considerable use of verbatim quotations were used to support the arguments put forward in the findings.

Yardley's second principle is "commitment and rigour". Commitment was shown by the researcher in working consistently through the many processes of the study. In particular the careful navigation of the recruitment phases, which involved differing approaches and negotiations over the course of the study. The researcher demonstrated commitment by attending to the comfort of participants during the study and by the manner in which the participants were listened to and the subsequent analysis of each case.

Rigour was ensured in this study by making sure of the suitability of the participants and that they met the strict criteria, which qualified them to partake effectively. The researcher made every effort to gain the required skills to undertake effective interviews by carrying out a pilot interview to improve his interview technique, attended Nvivo training and worked closely with his supervisors, independent panel member, and other doctoral colleagues conducting IPA studies to ensure accuracy and clarity throughout the duration of the study.

Thirdly, the principle of "transparency and coherence" demands that there needs to be clarity throughout the progressive stages of the research process. The researcher adhered to this principle by describing in detail the process of choosing participants, the interview process and the analytic procedures. Care was taken in the write-up to make sure the study presented a coherent argument along with a full presentation of common themes and contradictions (Smith et al., 2022). Additionally, the study endeavoured to inform its audience of its pitfalls and limitations along with situating the findings and conclusions within the overall relevant literature. The researcher used a master file to contain word documents with the exploratory noting and Nvivo software to store

transcripts, and reflexive thoughts on the development of personal experiential themes and group experiential themes. Examples from these transcripts are provided in Appendix I and J. The Nvivo files include a memo's function, which provide a clear trail of the analytic process.

Finally, Yardley argues for the principle of "impact and importance", she stresses that valid research will tell the reader something interesting or useful about the phenomenon under investigation. The researcher conducted a study in an area of psychotherapy previously given little attention by researchers and on a topic of professional relevance for psychotherapists, given the increasing level of specialised clinical work being done within Irish settings. It is also planned that the findings of this study will be presented at conferences along with submitting for publication as a journal article.

Smith and colleagues (2022) describe validity as "assessing the extent to which the design and methodological approach used in a study are fit for purpose" (p.147). They drew upon the reporting standards for qualitative research produced by Levitt et colleagues (2018) to outline a set of guides for validity in IPA. The researcher ensured that all the following criteria were met over the duration of the study.

1. The study objectives/aims/research goals should have a clear focus on participants' sense-making and the experiential.
2. A clear account of the purposive sampling process should be made including a rationale for this choice, and a practical description of the recruitment phase.
3. There should be clarity around the structure of the data collection and interview process.
4. Commentary should be provided around the data analysis strategies during the process of making exploratory notes, generating PETs and GETS.

5. There should be assessment of the ability of the collected data to capture the experience being investigated.
6. The themes should be illustrated visually and through a dialogue with data, contextualising quotes and with analytic comments on the extracts presented.

3.8 Conclusion

This chapter discussed the process of choosing a methodology with a number of differing methodologies considered for the research question. It was concluded that IPA was the best suited approach as it was viewed as a methodology that privileged the subjective accounts of participants, allowed for divergences and convergences to emerge, was sensitive to the important contextual factors and has been already used in a number of significant qualitative studies in this area. IPA was discussed as a methodology, which draws on a number of important phenomenological and hermeneutic strands within philosophy along with holding a commitment to an idiographic focus. This chapter covered the central criticisms of IPA, while also illustrating the many strengths of IPA methodology, which gave a voice to individuals within this study. An account of the methods used to sample, recruit and analyse the small number of participants involved in this study was provided. As IPA requires a strong consideration of the hermeneutic stance of the researcher, an important aspect of the current study were the reflexive processes undertaken throughout the project. An outline of the measures taken by the researcher in ensuring reflexivity were detailed. Finally, ethical considerations concerning the participants and the measures taken to ensure quality and validity were outlined.

3.9 Researcher's Reflexive Comments

At every stage of the study process, there was challenge, but the analysis process proved to be a long and winding road, as I tried to draw the words of participants together and begin my own process of meaning making. The supervisory experiences proved invaluable in keeping me in an open dialogue within my analytic process between the hermeneutic and phenomenological.

The iterative aspect of the study became apparent during this phase, and I had to attend with increasing care to the reflexive processes, this was especially the case as the participant interviews began and the experience of being subsumed within the data commenced. Each participant impacted me in different ways and there was an internal struggle to dampen my impulses as a psychotherapist and embrace the role of researcher. I found as I asked the interview questions that I had to quieten my own expectations of where I wanted the interview to go and let the participants narrate their experiences. As a psychotherapist myself with a specialist interest in complex trauma, I found myself at times surprised, frustrated and curious about the many differences between myself and some of the participants in terms of our clinical experiences. There was also the challenge of keeping a focus on the experiential within the interviews, as my own biases and the seniority of the participants meant there could be many opinions to share about complex trauma work.

Through my own self-reflection, I learned my own personal opinions, presuppositions and ideas consistently emerged through the participants' interviews. As an insider researcher, I had to confront my biases and expectations, through engagement with research supervision and meetings with fellow doctoral candidates. I learned that I perceived those working within organisations might feel constrained through having to work within limited timeframes, certain modalities and having to

conform within clinical cultures, which proved not to be the case. I was also surprised by the contrasting and diverse use of therapeutic approaches, personal beliefs and motivations drawn upon by each individual participant in working with complex trauma. This on occasion ran contrary to my own expectations of how to work with complex trauma presentations and opened my eyes to the richness of the work within this field.

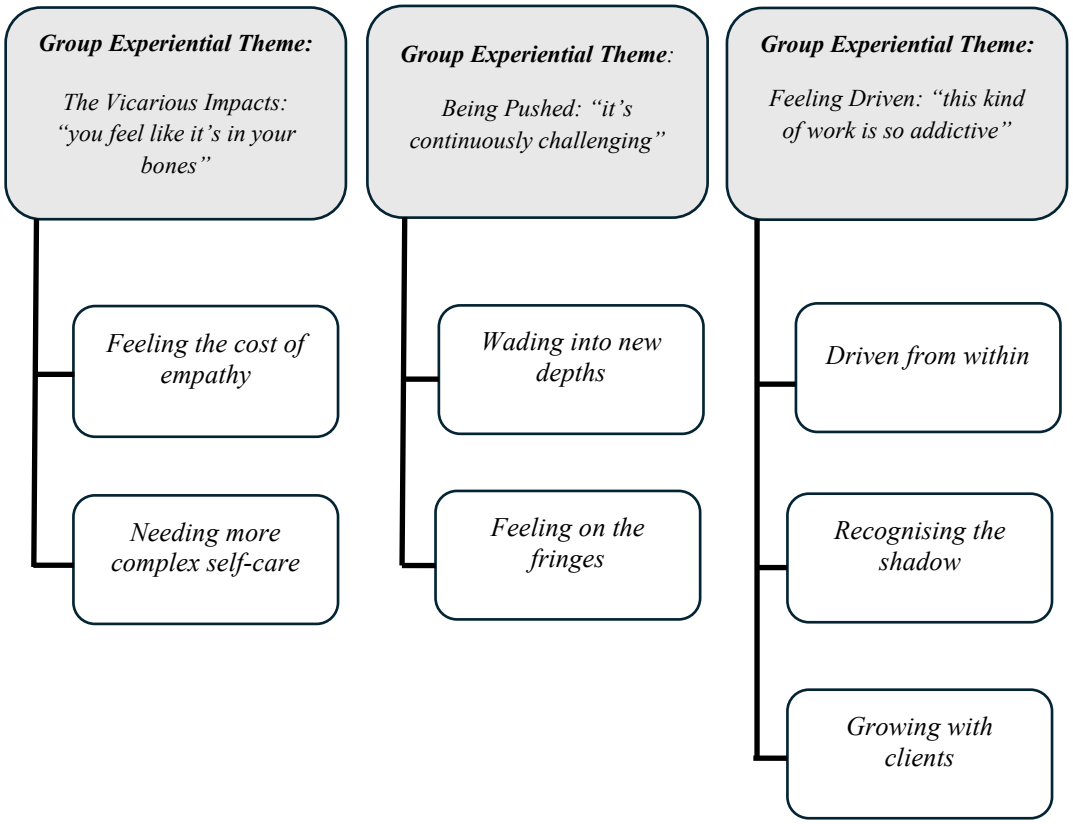
Chapter 4: Findings

4.1 Introduction

This chapter describes the key findings from the nine in-depth interviews conducted for this study. As noted earlier, there were seven female and two male participants with an age range of between (42 to 68). Two worked solely in private practice as specialist trauma therapists. Three worked full time within an organisation with most of their caseload involving complex trauma survivors. One participant was employed by a service which exclusively supported complex trauma presentations. Two practiced within a trauma focused organisation but also worked as private practitioners. One participant ran a private practice but was also engaged by a specialist trauma organisation as needed.

Three group experiential themes were developed from the analysis of the data (1) *The Vicarious Impacts: "you feel like it's in your bones"*, (2) *Being Pushed: "it's continuously challenging"*, and (3) *Feeling Driven: "this kind of work is so addictive"*. Embedded in these group experiential themes are a number of subordinate themes, which illuminate the understanding of the participants' experience of working with complex trauma. These findings represent the participants' experiences of working in this field over several years and a detailed account of these themes are provided in this section. Although the themes are related and possess overlapping qualities, this chapter also discusses the unique and divergent aspects of the participants' experiences.

Table 1: Master table of group experiential themes



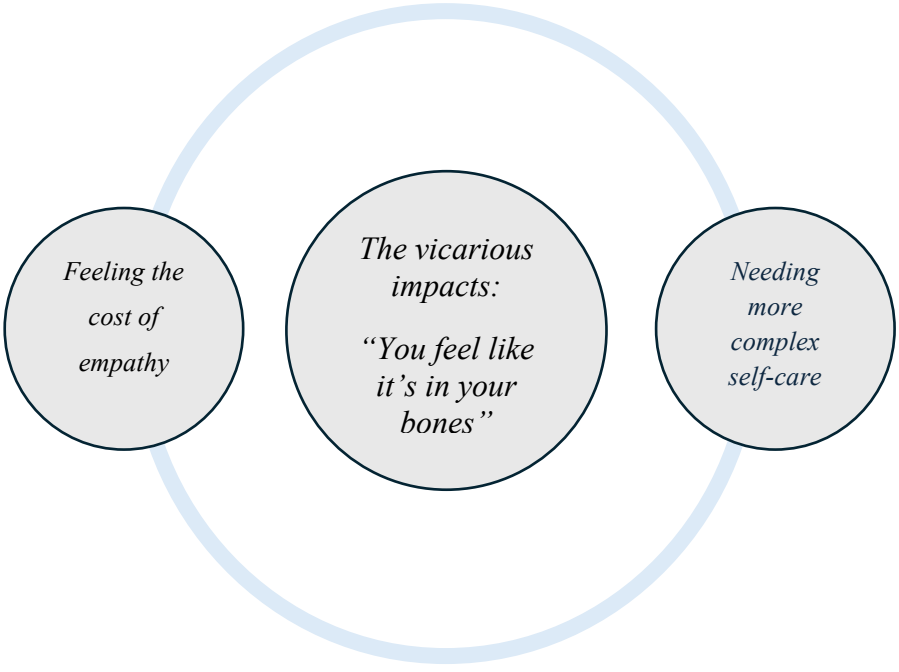
The first group experiential theme, *The Vicarious Impacts: "you feel like it's in your bones"*, illuminates the participants' recollections of the primarily embodied impacts, but also the psychological effects and personal influences of working long-term with complex trauma. Their experiences of weaving a wide range of physical, professional and relational self-care strategies into their professional and personal worlds to allow for career longevity are also detailed. The second group experiential theme, *Being Pushed: "it's continuously challenging"* describes the participants experiences of having to adapt their therapeutic selves and clinical skills to meet the needs of their work with traumatised clients. The participants also talked about challenges in having to manage difficult boundary experiences, longer timeframes, along with the deep

ambiguities of complex trauma work. Participants within this theme recollected the significant struggles they faced in trying to improve their professional development within Ireland. For many, there was a sense of having to continually upskill their knowledge base on complex trauma, due to insufficient core training and the challenge of finding experienced professional support within a small clinical community.

The third group experiential theme, *Feeling Driven: "this kind of work is so addictive"*, elaborates on the deep seated and differing motivations, which interested and sustained participants within this work. Some described feeling complex trauma was deeply entwined with various forms of political and social disadvantage and a sense of injustice for their clients personally motivated them to work in this field. While others spoke of finding the professional challenge of working with psychological complexity elicited a deep curiosity, which almost had an addictive quality. Lastly within this theme, the personal and clinical growth that resulted from witnessing the courage of their clients overcome their painful trauma histories is also spoken about.

4.2 The vicarious impacts: "you feel like it's in your bones"

Figure 1. Group experiential theme one and subthemes



The first group experiential theme outlined is *The vicarious impacts: "you feel like it's in your bones".* This theme details the constellation of physical, cognitive, emotional and behavioural effects experienced by the participants within their clinical work. By way of response to these vicarious impacts, there was a parallel level of complex self-care strategies to allow them to ensure longevity within their therapeutic practice. Of particular importance were the self-care routines involving physical activity, which proved essential in the management of bodily impacts discussed by most female participants within this study.

4.2.1 Feeling the Cost of Empathy

The first group experiential theme *Feeling the Cost of Empathy* illustrates the myriad negative effects, which the participants experienced, as a result of long term work with complex trauma. All of the participants described some features of secondary trauma. However, six female participants described the most prominent impact of this clinical work being embodied effects such as fatigue and physical symptoms. Gillian, who worked mostly in a private capacity, found a marked difference between her work with complex trauma and her non-traumatised clients. She felt working with complexity made many more demands on her at an unconscious level.

> it's much more body work and emotional work and nonverbal work, it takes all… my energy. (L371).

Susan had worked exclusively within a trauma counselling organisation for over a decade. She recognised a sense of feeling chronically tired slowly developing over time. Susan found it hard to make sense of why her work took so much energy out of her physically.

> I wouldn't be mentally exhausted. I would be physically exhausted. I think that's the impact of the work on the therapists. (L294) … I'm not doing physical work, so why am I so tired? (L304)

She remembered feeling more energised in her early career and later described having to cut back on her workload. During the interview, her tone changed to reflect her concern, she stated "It's not normal to feel tired all the time" (L415) and "I kind of wonder at this stage, am I burnt out?" (L361).

In her account, Michelle, who worked in a trauma service, spoke of learning to monitor her internal responses, and she started to use certain bodily signals as a barometer for early signs of burnout. She noticed as the balance of her caseload tilted towards an increasing severity and volume of trauma work that her body began to register changes.

> But when I sit down and if I've had a week with a lot of trauma. I can get a bit stale or something in my body. (L345)

As participants grappled with differing forms of fatigue due to the impact of their work, they recognised that this could gradually translate into other secondary impacts. Gillian expressed how tiredness led to a loss of capacity for enjoyment "I could feel it in my body and my delight or joy in life was gone and I had no energy" (L291). Susan recounted her fatigue led her towards a desire to withdraw socially "a couple of weeks ago, one of the girls was doing something … I went, Ah Jesus, I just would rather stay on the couch now" (L405) Similarly, Pauline who worked within a trauma organisation for survivors of abuse noticed her willingness to be with others reduce and potentially negative forms of self-soothing could start to emerge due to the intensity of her work "you can feel very lethargic, feel tired, kind of desire to drink.. or smoke … You can feel like you don't want to be in people's company" (L295). There

was a sense for these participants of their prolonged clinical work leading to a gradual physical shutting down and a need to detach from the world in order to recover.

In contrast to experiencing a sense of exhaustion, Deirdre and Margaret who both worked within specialist trauma services experienced the secondary bodily impacts of their work differently. They spoke of feeling a variety of physical issues, pains and aches, especially when dealing with physically and sexually abused clients. Deirdre, who had worked for a number of trauma organisations over her career, stated:

> I definitely would have a bit of a physical reaction. My body would tend, suffer a bit, because that physical violence is very much in the room...I found sometimes I actually would feel sore going home. (L318)

During the interview, Deirdre's metaphorical use of the "violence is very much in the room" gave the feeling of the perpetrator almost unconsciously being in the clinical space, with her use of the word "sore" giving a sense of the closeness of the abuser.

Margaret recollected that it was only in hindsight that she learned one of the most important lessons in her career. As she related her account, her face looked noticeably strained. She described her experience of working in an addiction service, which was emotionally turbulent and often felt physically unsafe and this left her feeling increasingly stressed. She recalled starting to register this stress through a series of medical issues in this role. "I developed IBS, and I was getting daily migraines and I didn't connect them." (L162). Margaret remembered that she could be absorbed by her clinical responsibilities and on "auto pilot" (L28) and might not recognise her impending problems.

> Sometimes it takes the body to say stop and that's very much what happened …my body completely shut down so… I didn't couldn't eat for weeks. I started

to have panic attacks, had a huge amount of anxiety… did not feel myself. (L178)

While many participants experienced vicarious aspects of their work through their bodies, others recollected changes manifesting within their cognitive and emotional processes. Mary, who had a lengthy career working in private practice as a trauma specialist, spoke of knowing when she was under strain. Mary articulated "I notice in myself that I get a little bit more scattered in my thinking." (L366). Both Michael and Margaret who worked within an organisation for survivors of complex trauma spoke of a tension between wanting to relieve their client's intense psychological distress but also realising the scale of their client's problems meaning there were no quick fix solutions. Michael spoke of some of his countertransferences leaving him with feelings of inadequacy creeping into his internal dialogue. "it's a kind of a helplessness on the one hand because like you can't just switch a switch or press a switch and that these intrusive thoughts and nightmares will disappear" (L127). Margaret also recognised this a core feature of her clinical work "you pick up on their experiences in terms of that lack of control. That inability to fix this powerlessness that they have felt" (L96).

Working with complex trauma brought some participants into contact with survivors and/or perpetrators of abuse. Three participants who were parents experienced new patterns of thinking around the safety of their children. They started to view them as more vulnerable, after listening to the many accounts of sexual and physical abuse heard through their clinical work. Some participants reported having to actively challenge their emerging assumptions. Gillian spoke in the early part of her career feeling "every man I saw suddenly, I thought they're an abuser … and obviously I had to calm myself on that." (L270).

Michael noticed a gradual shift in his perceptions of his children's safety, as result of his clinical work.

> I'm more protective. I would say around my kids. (L233) it's a tricky one, but it certainly permeates into my own life, and I try as much as possible to not let it and like effect my perception in a negative way. (L242)

He developed a capacity to play devil's advocate with himself as to whether or not he was overcompensating with his own parenting style, when interacting with his own children. For participants, the capacity to learn to reframe their beliefs around the safety of themselves and others, became an important skill in keeping their thinking balanced.

In the earlier stages of their career some participants spoke of working hard to contain strong emotions. They found themselves having to release these intense emotions outside of the clinical space, when they felt safe, rather than let them interfere with their sessions. Sean who worked for over a decade in private practice gave an example of intentionally compartmentalising his emotions with his traumatised clients over his working week. He recognised an experience of giving himself permission to release these emotions at the weekends in his car when his work was finished.

> I would start to feel incredibly angry. I mean rage filled anger. I wouldn't do anything, but it's almost like I could allow it to emerge, because it was activated or triggered all during the week … now in hindsight, it seems like Friday night was a way of allowing that to be released, or to be acknowledged. (L133)

Similarly, Michelle recalled in the early days of her career containing her intense emotional responses until she could express them outside of her therapist's office and not let them leak into the clinical space.

> I was just out of college, and I was working with a lady from quite a war-torn African country, who have been trafficked. I won't go into the details. But I used to go…and sit outside in my car and cry after those sessions, because it was horrific, it was absolutely horrific. (L445)

Sean and Michelle spoke about the early challenges of keeping the emotional impacts of their work contained as they developed as clinicians. Interestingly, Mary described over a long career as a private practitioner actively cultivating the capacity to compartmentalise her work.

> I've had to be very careful to find a way to manage… knowing that knowledge but not holding it actively in my mind once I leave the therapy room. So, I'm very good at a healthy way of compartmentalizing. Where I can put my work away with the lid on it and it doesn't intrude on my day-to-day life. (L344)

It appears for some participants developing ways to contain the emotional intensity of their clinical practice became an important and ongoing skill. For some learning to manage their inner emotions came through hard earned experience, while others consciously fostered the skill of dividing the professional and personal worlds. For these participants using professional supports and emphasising their self-care became central to regulating the painful emotions associated within their clinical work.

Many of the participants found that negative effects could result from differing aspects of organisational responses to their work with complex trauma. Michael recalled:

> it's not necessarily the clients that I'm left … with still swimming in my head. It's either like with maybe a work colleague who is also burning out and lashing out at all of us. (L253)

Margaret spoke of working within a number of clinical services and was always conscious around limitations on resources for complex trauma client work, which could be frustrating for her when dealing with highly distressed individuals.

> if you're responsible for putting in place appropriate rehabilitation for complex trauma, but you're dealing with these additional strains from the organization. It, it can have a huge impact and that was definitely part of my burnout and so the lack of resources, the lack of understanding about complex trauma is huge. (L410)

Most female participants as a result of their clinical work experienced embodied negative impacts throughout their careers. For some in the early part of their development they felt the emotional and cognitive effects needed close attention. While for others work related factors had the potential to interfere with their sense of wellbeing. The intensities of working with complex trauma stretched the internal resources of the participants and brought them face to face with their own physical, cognitive and emotional limits. Facing these limits forced participants to reflect on the quality of their self-care.

4.2.2 Needing More Complex Self-care

> it's kind of a funny business, … If you were an accountant or a shopkeeper, or whatever you wouldn't necessarily maybe have to invest so much in yourself to maintain your resources and keep on an even keel (Michelle L537)

During the analysis it became clear that working with this clinical population elicited a broad range of intense reactions, which forced participants to reflect carefully on their clinical self-management. Of particular importance for most female participants was the need to manage the embodied impacts mentioned in the previous section. The

intertwined vicarious impacts experienced within their clinical work led many participants to prioritise the development of their own forms of multi-layered self-care strategies, which are reflected by the subordinate theme *Needing More Complex Self-care*. The demands of this specialised work meant that many grew to carefully manage their exposure and specifically tailor their self-care to allow them to continue working into the future. As described earlier most female therapists felt the impact of their clinical work at a deep somatic level. Susan articulated "you feel like it's in your bones" (L317) and she felt it was crucial to have a diverse mix of self-care approaches. Most participants reported a sense of the indirect trauma of clients registering with them at the level of their nervous system and thus physical exercise became a central component in resetting their bodily equilibrium. Michelle described her physical activities "I find that that kind of shifts the trauma, and it doesn't get kind of stuck" (L342)

Pauline spoke of noticing her increasing need for exercise, since starting her work as therapist within a trauma related organisation.

> Since I've come to this job… exercise has become just, it's like having lunch. It's become a part of my every day and things get lodged in your body… as a therapist. (L 292)

While Michelle, Deirdre and Pauline emphasised the centrality of physical exercise, Susan had a slightly different perspective, and she highlighted the setting for her physical activity as being a crucial component.

> I have to be very mindful of taking care of myself, so I have to go out walking, and even though...I know that's where I get nurtured, you know. Go up to the forest, go to the mountains, go to the beach. (L472)

Similar to most other participants, she was conscious of her exposure to trauma becoming stored within her body, so a variety of physical activities and the contrast of a natural setting to her indoor therapeutic world offered an antidote to sitting with her clients.

Interestingly, most of the participants reported having to take time off or make changes to their working routines at some point in their career to cope with the ongoing effects of working with complex trauma. As they gained experience, participants had learned through a process of trial and error, how best to regulate their exposure to their trauma work. Some felt that there was a limit to how much work you could do with this client group, which forced participants to cut back on work hours, rearrange work patterns, mix caseloads with other types of work, and move between other professional responsibilities.

Across many participants, there was a clear sense of the importance in working to manage the amount of time working with complex trauma clients. Gillian and Michelle articulated this in simple terms “I don’t think it’s possible to work all in trauma” (L65) and “I would definitely not recommend somebody doing this full time” (L566). Some of the participants in their interviews communicated a gradual recognition of the signals of burnout, which led them towards decisions to reduce their exposure to traumatised clients. Participants spoke of learning many different ways to titrate their complex trauma caseloads.

Michelle gradually learned the importance of knowing when to step to back from her clinical work in a busy clinical service, when she started to recognise a sense of internal pressure.

> I've learned, I think, that if you're going to be working with this client group … if you start to feel burnt out, or if something is kind of getting in on you. I find

that I have to take some kind of action, so either sick leave or tweaking something in my self-care or speaking to somebody. (L368)

Over a number of years within their clinical work, participants had learned through a process of experimentation, how best to professionally sustain themselves.

While many participants made changes that resolved some of the detrimental impacts of indirect trauma, others who chose to cut back their workload experienced little positive improvement. Despite shortening her working week, Susan who worked in a specialist service, which only dealt with complex trauma presentations felt there was no quick fix to regaining her energy levels. Susan spoke slowly and with a number of pauses in the interview as she reflected on her experience of not seeing positive change and her hope that her fatigue would abate in the future.

Do I feel the benefit of it? No, not greatly … I really feel like it's kind of going to take me a year to, I don't know why, I just got this thing it's gonna take me a year. (L385)

For Susan, there was a sense of her feeling intuitively what she needed to do to recover, and this would take time. However, this seemed to be difficult to understand at a cognitive level, which was reflected in her words “I don’t know why”. This seemed to reflect the deep-seated and unconscious nature of the vicarious effects of working with complex trauma.

In contrast, Mary who worked solely in private practice discussed a painstaking process of building her clinical resilience with the scaffolding of specialised supervision, personal therapy, peer support and trainings over many years.

I very gradually increased the number of complex trauma cases I was working with in the earlier years. I was very, very careful to make sure I had a balance that I had people with mild to moderate, presenting difficulties as well as

> complex trauma cases, but with experience…. I've reached a point where I can work completely in this area. (L351)

Participants worked in many different clinical environments, which placed a variety of demands and pressures on them. For those working in private practice, care had to be taken to build a professional network of support, as they lacked the benefits and perspectives afforded through working on a clinical team. Contrastingly, participants working within trauma focused organisations with often lengthy waiting lists, faced having to negotiate changes to work practice and experienced less agency than private practitioners. Of central importance was trying to identify strategies to regulate exposure to complex trauma within each of these unique clinical settings.

Three of the participants Deirdre, Mary and Susan emphasised the many ways in which family helped to provide a psychological foundation and emotional grounding for them in their work.

> I think, really maintaining positive relationships with your children and your partner being very mindful…not to neglect to emotionally neglect other people in your life. (Deirdre L582)

Mary and Susan both spoke of the centrality of their families in keeping a healthy perspective. Mary said:

> I have very healthy personal relationships, we are a close family. I spend one day a week with my grandson, and that's like my anchor in the world is that I can be with a child who is mostly unhurt by the world and knows nothing of these horrors. (L439)

In her interview, Mary expressed her awareness that the dark side of human nature experienced through her work had the potential to distort her view of the world. Mary used the words “anchor” in her relation to her grandson, which suggests her need

to root herself in a healthy personal world and use it as a reference point in her life and work.

Similarly, for Susan it was also important to experience personal time with her grandchildren, as this offered a form of sanctuary away from the pain and distress of her clinical work.

> it's like you have to be present, and you have to see what they do and see the joy and what they're doing and their innocence. (L370)

Susan's use of language such as "innocence" and "joy" was in deep contrast to her earlier descriptions of her clinical work burning her out. There was a sense of feeling that the unspoilt nature of her experiences with grandchildren offered an important perspective in allowing her to function within the emotionally turbulent world of her clinical practice.

Across all the participants the importance of a network of professional support was non-negotiable in being able to work in this specialised field. Due to the unique features of this clinical work, participants spoke of the necessity of having organisational support, supervision and personal therapy with a trauma informed ethos. Mary, who worked with a full caseload of clients with a variety of complex symptomology, felt it was a central component of her clinical work as a private practitioner. She reported that:

> It's talking to somebody who fully understands my experience and my thoughts, who has experienced these things herself, and who has vast experience in dealing with all different aspects of working with complex trauma…I feel like I'm held. There is huge containment, this huge support and understanding and then there's also a sharing of knowledge and an exploration in directions that I would never have thought of going myself perhaps. (L407)

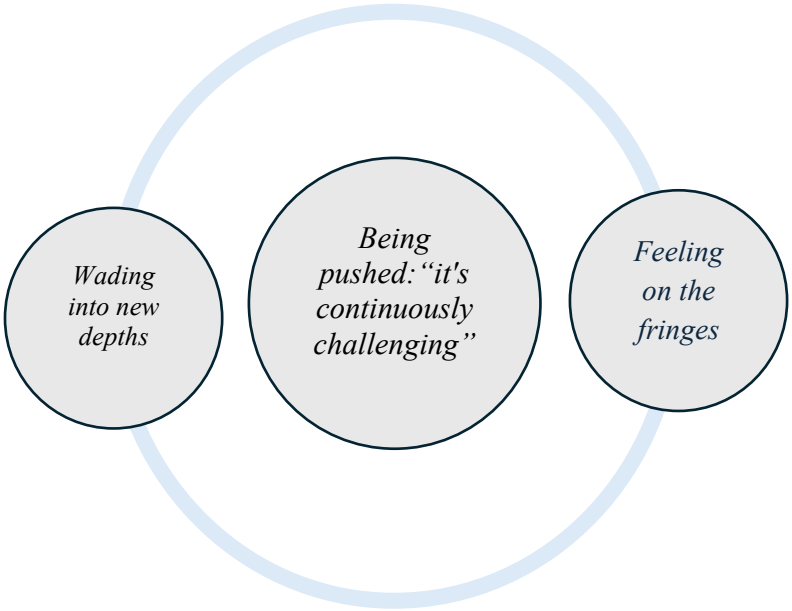
Michelle, speaking about her own philosophy of self-care, captured the overall complexity of the participants' journey.

> I have come to learn that it's a combination of loads of things. So, it's supervision, when things get tough. I go to therapy for little bit, you know nature, hiking, friends, you know movement, hobbies being outdoors, and…doing fun things. (L482)

In summary, many female participants noted vicarious experiences of fatigue and physical discomfort being the primary impacts of their clinical practice, which required ongoing and consistent management. Some reported cognitive and emotional challenges, but with experience they described learning to regulate these effects by reframing their distorted thinking and through gradual exposure to the emotional intensity of their work. The inescapable adversities of this clinical work left them having to develop their own constellations of self-care routines to offset some of these negative impacts. In developing new strategies, participants prioritised physical activities with professional supports and family relationships also contributing to their self-care regimes. For participants there was the need to adapt to the ongoing pressures, with this continuous challenge being part of their attraction to this form of clinical practice.

4.3 Being pushed: “it's continuously challenging”

Figure 2. Group experiential theme two and subthemes



The second group experiential theme *Being pushed: “it’s continuously challenging”* details the participants’ recognition of having to adapt to complexity at multiple levels within their clinical work. The majority reported that the intersubjective realm within complex trauma treatment was a space filled with uncertainties, relational flux and intense transferences which were less common in other types of therapeutic presentations. Working with complex trauma brought many challenges with clinical boundaries. Participants in the study described struggling with time boundaries, length of treatment and feeling a need to rescue their clients. There was also a sense of feeling different to the mainstream of Irish psychotherapy. Having to spend time seeking out niche trainings, sourcing experienced professionals from a very small pool within Ireland and viewing mental health differently to other related professions left some participants feeling on the fringes of their profession.

4.3.1 Wading into New Depths

As participants progressed in their careers, there was a growing recognition of the differences between their clinical work with complex trauma and other types of therapeutic presentations. They spoke of learning to view this specialised work through the lens of theoretical and relational complexity, which is reflected in the subordinate theme of *Wading into New Depths*. Participants reflected on their work with traumatised clients regularly leaving them sitting with uncertainty and an experience of internal turmoil. They grew to recognise this sense of difference as a central part of the symptomology of complex trauma. For all, this meant learning to adapt to the opaque clinical qualities of complex trauma and having to develop a deeper clinical sensitivity as a practitioner. Mary, when asked about what she noticed had changed in her clinical work since specialising in complex trauma work, responded "it's certainly honed my therapeutic skills around nonverbal communication" (L315). Of the many non-verbal phenomena experienced by participants in their practice, most described learning to work with dissociation becoming a central part of their practice with complex trauma clients. Working with dissociation often led to therapists talking about having to adopt a deeper experiential quality to their work, which was characterised by ambiguity and uncertainty. Gillian stated:

> Initially I wouldn't have known about disassociation … I would think they've zoned out or something, … I wouldn't catch the minute things that I can catch now...I didn't have the research behind me or the knowledge (L337)

Many participants spoke of initially being confused in the early part of their career but then educating themselves in the clinical theories of dissociative detachment and self-states or parts when working with the client's personality structure. For Mary, acquiring specialist knowledge about dissociation helped her to make sense of her inner

experience of “confusion” and “feeling deskilled” (L221). Susan described the important skill of keeping the client grounded to allow for effective therapeutic work to unfold. She talked of “It’s in my DNA now nearly” (L224). She said:

> So, if I feel somebody is dissociating …I can bring them back…I could start talking about you know what was on the telly last night… whereas when I was starting off, I would, say, oh, my God! (L238)

Sean and Mary expressed the importance of formulating their work through the concept of dissociated parts and inviting parts into the clinical space. During the interview, Sean spoke in the interview in a light-hearted tone, which may have been demonstrating an intentional lightening of the intensity.

> I am thinking of somebody else who works very, very well with parts, but it took a long time for them to consider it, and she has a number of parts. One of them is 13 or 14 years old, who is really foul mouthed, and we were working on something, and then she'd say that was her… 13 year old, and then we laughed that means the 13 year old is able to come into the room. (L106)

Mary felt her work with dissociative parts involved trying to keep track of the ever-changing intersubjective processes in the room.

> It's like working with a jigsaw where all the pieces are mixed up. You have no picture to follow, to give you a hint, and some pieces are missing. (L251)

She described part of the work was to keep an overview of the client’s unconscious self-states, which she explained is “like mental gymnastics” (L255). Mary’s use of the metaphor of a “jigsaw” gives a sense of sitting within a chaotic clinical picture without much direction, as she works toward integration for her client.

Other participants approached their work with complex trauma through different therapeutic paradigms but similarly experienced a struggle in maintaining a

sense of clinical compass. Pauline spoke of the challenge of working psychoanalytically and having regularly to draw heavily on clinical intuition to comprehend the client's unconscious dynamics. She spoke of this often leaving her uncertain and trying to translate something that is "very nebulous" (L, 440) in its nature to help the client, which could leave her doubting herself. She said:

> How do you measure dynamics? How do you measure? You know, the impact of like of where you might feel like a steam train has rolled over you when the client leaves the room, they might go skipping out of it and you want to like pass out,… they've projected everything that's often quite unconscious onto you and that's relieved them to go… it's deeply unconscious. (L495)

Similarly, Michelle spoke of the intensity of the projections involved in her complex trauma work. She described this as placing demands on her capacity to monitor her internal responses closely, which often left her with feelings of self-doubt and a challenge to fully disentangle herself from the client's unconscious needs.

Amongst participants, there was the experience of having to get used to a slower pace of progress, which often involved longer timeframes to allow clients to incrementally work through deep seated issues. Sean's account captured this longevity as he spoke about a particular client:

> I came up with this image a couple of weeks back from working with complex trauma, it's like walking from Malin head to Mizen head (from the top to the bottom of Ireland) I think if you can't do that, you really need to be in some other area of therapy. (L145)

For Susan, patience was also a clinical virtue within her complex trauma practice. Despite this acceptance of a need for patience, Susan could sometimes question herself.

I suppose it's about being patient, for example, I've one client for eight years, if I was to go by what I see in the room, I would think she hasn't moved … but it's only by what I know of her life outside the room. She has a job. She's driving a car. She's moved in with a partner...how they are with people, how they are in relationships. They're the milestones. (L150)

As well as therapists committing to the arduous nature of complex trauma work, Sean articulated the equal weight in responsibility for the client in holding onto hope along an often tortuous clinical journey. Sean gave an example of a client:

Client speaking: "Yet all I knew was, I have to keep turning up".

Sean: That's the only thing he had, to hold on to…and the work we've done, the work he's done has been life changing. (L163)

Progress with this type of work could be almost glacial, with little visible therapeutic change session to session. During their interview, Sean and Susan emphasised the necessity of the client having faith in the therapeutic process, as clinical progress could plateau, and difficult impasses were not uncommon.

For most participants working with complex trauma meant having to embrace a new clinical culture, with new relational rhythms, working with greater ambiguity and recalibrating of their sense of clinical time. Due to the many emotional, cognitive and relational facets of complex trauma work, participants articulated having to continuously adapt. One central aspect of their clinical work, which elicited a wide variety of dilemmas was the management of clinical boundaries.

For Margaret, Grainne and Michelle, they found that as the therapeutic relationship grew with some of their clients, they became aware of an internal struggle between keeping a clinical boundary and their empathic need to step in to rescue their clients. Michelle spoke about clients with complex difficulties having challenges with

knowing their relational boundaries “people who have a lot of kind of early childhood trauma, sometimes they can kind of draw you in, and almost wanting to be in a very enmeshed relationship” (L511). For Michelle this meant there could be a struggle in knowing when to “step back” (L531).

> I think there are times, when I have gotten emotionally kind of too invested and so that would have been in the past. But I don't think any of us are immune. (L497)

During her interview, Margaret described working with clients who not only suffered with severe psychological trauma but also lacked proper accommodation, had limited financial resources and were dislocated from their families and culture. Sitting with this client group made her conscious of the many advantages that she enjoyed in her life, and this could leave her reflecting on thoughts of fixing their problems. Despite being a very experienced practitioner Margaret remembered that some clients could still impact her, and she gave an example of a client who had been separated for a number of years from her children. She recollected:

> I’ve been working with this person for a long time at that point and we were very close. It was very much a challenge to not just step in and say here, I’ll give you the money…let’s get these kids over, you know, some things are bigger. But I didn’t, you know, but I did talk to the team and see if there was any other agencies where we could appropriately raise funds. (L142)

Margaret was aware of the therapeutic alliance being fundamentally about human connectedness and this could make it difficult to hold an objective stance. Likewise, Gillian was conscious of the unfairness of childhood traumatic experiences, and she could find herself tempted to “get a bit more directive at times than I would normally” (L179) or to accommodate her traumatised clients.

It's the one area where I have to really watch my boundaries, even with something like keeping time with the client… I really have to hold myself to that because, I just feel for them. … sometimes I think I'd make a better therapist if I was a little bit more… clinical isn't in the word, but kind of allowing people to find their way on their own. (L176)

Like other participants Pauline noted that working with complex trauma often meant clients presented with challenging interpersonal dynamics, so communication was crucial. She stated:

Communication is very important and communicating clearly and kindly but holding and also naming that you know if someone is upset … if they maybe feel annoyed at me. (L410)

Pauline spoke of recognising some of her clients could experience strong feelings of abandonment, and tendencies to hold unrealistic expectations of others, so discussions to develop healthy boundaries were an important part of the therapeutic work.

Invariably, working to hold boundaries meant on occasions that clients could misinterpret the intentions of a therapist. Gillian remembered working with a female client by phone, who had a long history of complex trauma. She spoke about having to put a time boundary in place with this client, due to having other client calls. Gillian related this incident in sad tone, which indicated her sense of regret. She described this client not returning to continue sessions and sometime later this client went on to die by suicide. Gillian spoke of still reflecting on her decision not to give the client more time at their last session.

I really got her wrong and I really feel sad about that and cross with the system, she was in care… she ended up taking her own life. You know, I really struggle

with that. I can get very angry about that, and I had my part to play as well… I timed it badly and I had to finish up the last two calls… I think she took that as a shutdown. (Gillian L222)

Throughout their interviews participants articulated their continuous struggle to adapt to the multi-faceted nature of their complex trauma work. This placed a constant demand on them in adjusting to deeper relational uncertainty and to become increasingly clinically skilled. Participants also spoke of the necessity of setting firm boundaries to enable the healing process of their traumatised clients. One of the natural qualities, which drew participants to this client group was their empathy and it was this humanity for others that could generate yet more clinical struggles, as they worked to set healthy boundaries amidst the complexity of their client's trauma. These contrasts between this specialised therapeutic profession and general counselling work could leave participants with a sense of feeling different to the other sectors of psychotherapy.

4.3.2 Feeling on the Fringes

I think there's a load of us lagging… I think that's changing now. (Gillian L165)

Over the years, participants began to recognise their work within a specialised field meant they travelled a different and more demanding path to others working more generally within the psychotherapy profession. This experience of *Feeling on the Fringes* represents another important subordinate theme. Most participants reflected back over their beginnings in psychotherapy and could not recall any specific academic training in complex trauma. Despite complex trauma having a lengthy history, training in this area was something they had to develop for themselves as a sub-specialisation. Likewise, participants spoke of being challenged to find supervision and personal

therapy, which could support them in working in this unique clinical environment. In her interview Susan recollected her own psychotherapy training lacking specific trauma components. As somebody who was also involved in educational settings, she recognised the inadequacy of training for psycho-trauma practice in contemporary Irish academic settings “I think they need to do more trauma training for students, because nobody knows who's coming into the room” (L587). This resonated with other participants, Mary and Sean spoke of the central importance of having a broad range and distinctive clinical skills to address the complex symptoms of clients. Mary, who had worked within this field for decades, reflected on psycho-trauma training, “it's becoming more familiar to people. But it still is neglected in core trainings, and that's a major major deficit” (L494). Similarly, Gillian was aware through her clinical work with traumatised clients of the idiosyncratic nature of this practice.

> It's actually the one area that I think is specialised. The other actually is addiction… I think, more than any other area. It needs specialised training. (L322)

Sean recognised a mismatch between his own early psychotherapy training and his experience of trauma work. He recounted that:

> when there is complex trauma, and there is sexual abuse of various kinds in childhood or young adulthood, and transference and counter transference gets enacted in the therapy session that's an area that I felt had to do to work there myself, research and read about it and work through with various clients over the years. (L285)

For Sean and Mary, the absence of core training components left them looking to remediate their knowledge base. This lack of early training instilled a sense of responsibility for regular levels of upskilling and additional trainings around ongoing

developments within this field. Sean in this interview raised his voice, which seemed to emphasise his sense of responsibility in keeping himself highly skilled within this specialisation, as he stated, “I'm actively and consciously deciding, I need to keep learning I need and want to keep learning” (L186). Echoing these words, Mary speaking about her professional training “I constantly sought CPD or whatever to increase my knowledge, I'm still doing that” (L488).

One positive for Mary of having to take on her own supplementary training, was she could fully draw on the newer waves of international literature, theory and practice research, which have developed at the intersection of psychotherapy, trauma and neurobiology. She discussed this contemporary academic training giving her an important empirical dimension to her work as a clinician. She said:

> In this current day the desire to make everything measurable and quantitative... I found it incredibly useful to have a scientific underpinning for understanding psychotherapeutic knowledge of trauma, and my experience in the room, and how I could share that knowledge, how I could speak about that knowledge with other people who maybe didn't have a psychotherapeutic background. (L182)

Central to being able to sustain this clinical work was the role played by supervisors, personal therapists and peer support. Participants talked about the crucial nature of having good support in place to maintain oneself within the work. Despite this, many participants articulated difficulties in finding suitable clinical professionals within Ireland. This was especially true for those participants who mostly conducted their work in private practice.

In Deirdre’s and Gillian’s experience, most supervisors were qualified for general counselling environments, and while they might be very competent supervisors,

they lacked the particular knowledge and skill sets needed to support supervisees with complex trauma work. On recollection, Deirdre who worked within an organisation spoke of there being a lot of experimentation with supervisors, “The external supervision can be hit and miss.., I'd be really careful who I go to” (L547). Gillian, who worked mostly in private practice, described past experiences of working with non-specialist supervisors leaving her feeling that her professional needs were not being met.

> I wasn't processing stuff. I was coming away a little bit dissatisfied…I heard him say one day something about the body. He says, ‘God, I didn't really realise about the body being so important in trauma’ or something and I thought, yeah, we're definitely on different pages a bit here. (L148)

Mary found it difficult to find the right professional fit in working with differing therapists and supervisors over her career. She worried about the impact of the material that she presented as a supervisee and discussed as a client.

> I looked for a long time to get a therapist that was able to… able to match my needs. An example would be, I know I had a therapist previously, and I had a supervisor previously who were totally overwhelmed by the content of what I was bringing, and the supervisor said she had such a headache after talking to me in supervision sessions that we need to stop because she couldn't bear it…Yeah, and a therapist also just became very overwhelmed and was crying in sessions…and I found I was minding her. (L430)

For those working at the extreme edge of the trauma continuum, it could be challenging to find professionals that could sit with the disturbing nature of the material being presented.

Gillian, Sean and Mary spoke of their experience of having to secure personal therapists and supervisors from overseas, mostly from the United States and the United Kingdom due to a very limited pool of experienced professionals working in Ireland. A backdrop to this trend was the increasing availability and usage of technological platforms, which allowed for international professional relationships to develop.

Interestingly, Gillian, the most experienced clinician in the study, articulated her experience of starting to work with psychological trauma. In her account, she stated "there was very little peer support and not even peer support supervision because it was new enough" (L266). She noted a recent trend in Ireland of professional influence from larger countries with strong clinical traditions of working with trauma starting to share their therapeutic experience and knowledge. For Gillian, these were important academic voices, who could inform the Irish clinical environment.

> They're bringing in speakers and with some on zoom from America and with an English speaker actually from the Manchester. I think we'll get more aware of, we need to be learning more…not just the trainers or therapists. (L166)

For Mary technology had allowed her to connect with a broader international community with a specialised knowledge on dissociative disorders. She spoke of these international forums having a deep well of clinical knowledge, which she could tap into and integrate into her clinical work.

> I'm in peer groups. I also take part in a clinical forum run by [international trauma organisation] once a week, which is invaluable, it's a group of psychotherapists working with complex trauma…, and somebody brings a clinical dilemma, and for an hour everybody discusses it. (L454)

Apart from the challenges of finding suitable professionals within psychotherapy, some participants found that there were additional challenges, due to a

lack of knowledge amongst other related caring professions, which drew on a medicalised understanding of mental health.

> It would probably help them if the wider staff were just more aware on some level of the impact of trauma … even more of an understanding and compassion (Deirdre, L572)

Deirdre viewed there being benefit to staff in related professions being increasingly trauma informed, as this might allow them to more fully comprehend the behaviours of clients or patients presenting to services. Gillian reflected back on attitudes to complex trauma at beginning of her career and she recognised some progress but still felt there was a substantial level of improvement needed.

> What is better now than it was say 20 years ago, is people aren't giving us medication as often. …it's I think more confidence that the work we do, can benefit maybe more than medication. (L188)

Participants came from differing clinical settings with some working solely in organisations, others working with a mixture of both private and organisational work and two participants now working exclusively in private practice. Unlike those working with the 'worried well', most participants found the treatment of complex trauma was best suited to a multi-disciplinary approach due to regular issues of legal reporting, the requirement of medical interventions, the risk of violence/suicide and the need for specialised social supports. Gillian worked mostly as a private therapist and felt the impact of working by herself.

> I think the disadvantage of working on your own as well, is the lack of team…., sometimes the client obviously doesn't want you to talk to a GP or psychiatrist or anything, so it's very confidential. (L412)

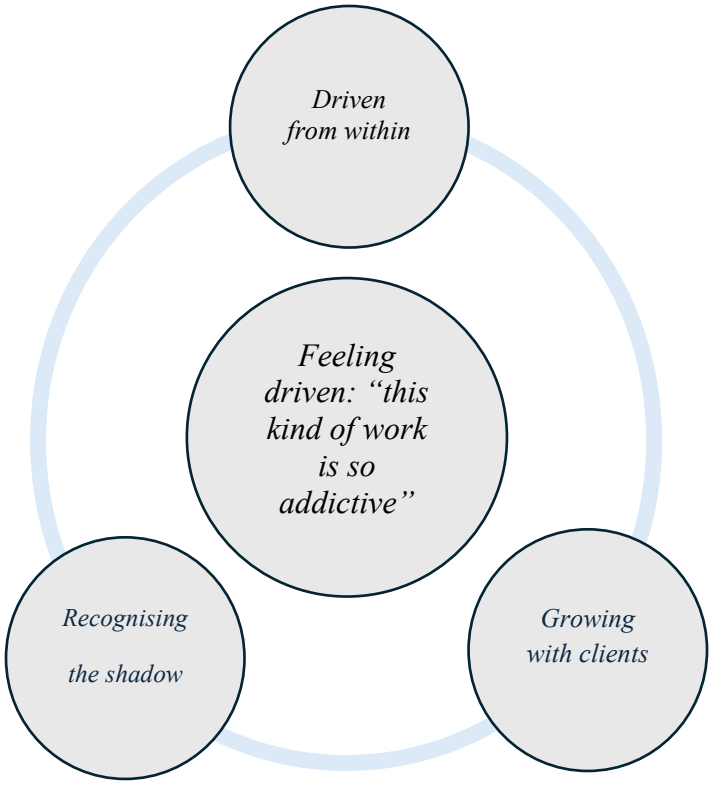
Margaret, talking about the originator of the phrase complex PTSD, said, “I think it was Judith Herman spoke about the importance of never working with complex trauma alone” (L 108). In her work, she experienced complex trauma as often accompanied by many additional challenges, which were beyond the bailiwick of her role as a psychotherapist.

> There should always be a team of people, when working with someone with complex trauma because it’s never just about the therapy, you know, there’s so much like social need, there’s medical need, there’s possibly legal need, all of these needs to be taken into account, one individual cannot take on alone someone’s rehabilitation journey for complex trauma. (L109)

In concluding, participants spoke of having to adjust to new depths within their work with complex trauma, as a consequence of working with the multifaceted symptomology of their clients. Working with complexity meant them having to sit with dissociative, somatic and unconscious processes, which could lead to participants struggling with uncertainties and self-doubt within their practice. This clinical complexity also left them navigating many boundary dilemmas as they tried to balance the needs of their traumatised clients with their own natural empathy. Working within a small and emerging Irish trauma community left them feeling on the fringes of Irish psychotherapy practice, due to challenges in securing adequate professional support and limited core training in specialist trauma approaches. Despite having to respond to the continuous complexity of this clinical world, there were also personal motivations that drove participants within this profession.

4.4 Feeling driven: "this kind of work is so addictive"

Figure 3. Group experiential theme three and related subthemes



The third group experiential theme *Feeling driven: "this kind of work is so addictive"* reflects the differing personal motivations, beliefs, and passions, which inspired the participants to work in this area. Some became acutely aware through their early work of the social disadvantages faced by this client group and felt obligated to work in services with free access. Most recognised the abuses of power inherent within their client's traumatic experiences and felt a responsibility to respond therapeutically and advocate through their professional role. While for others, a deep fascination with the human mind and the intricate nature of complex work drew them towards a career in psycho-trauma. Interestingly, some participants experienced these motivations as having a darker side. Overextending themselves through working long hours and

feeling a need for constant upskilling left some participants questioning the limits of their passion for this work. While all the participants grappled with the differing stresses of this specialised work, they were also acutely conscious and appreciative of their own personal and professional growth as they spent time working with clients.

4.4.1 Driven from Within

The first subordinate theme, *Driven from Within* demonstrates the sense of awareness around the internal drives which drew participants towards and fuelled them in their work with complex trauma. Participants throughout their accounts referred to personal aspects of their practice of which they were only dimly aware of early in their career, becoming important in providing an impetus in giving their work meaning.

Across many accounts, participants spoke of their early careers making them conscious of the influence of societal disadvantage as a contributor to complex symptomology. Pauline, speaking about her work within a specialist service, reflected: "You become very aware of the underbelly in society and in human nature, as well the resilience on the other side" (L595). She spoke of years working in this area being a strong influence in shaping her as a person, "It gives you a different perspective…it would massively inform my values and how I choose to live my life." (L602). Pauline narrated that due to her personal values, it was important to work in a clinical setting which provided free psychotherapy and was accessible to all sectors of society.

Gillian grappled with similar concerns in relation to individuals with complex trauma having access to therapeutic support.

> I hate charging people who are going through PTSD CPTSD…. Oh God, I wish the system could support these people more. (L181)

Gillian in the interview, spoke in a tone of irritation, which reflected her internal stress. She was mindful of the limited financial circumstances which many survivors of complex trauma are often faced with due to the chronic nature of their problems. Her work mainly in private practice left her holding an internal dissonance, due to the long-term nature of treatment for complex trauma and the potential for clients of years of expense.

The accounts of Deirdre, Margeret and Michael reflected a changing clinical environment with therapists now having to respond to the needs of different groups within Irish service provision. The dire circumstances faced by traumatised individuals fleeing political and economic instability provoked a strong sense of advocacy amongst some participants in their interviews. Deirdre was conscious of the increase in people seeking asylum and those fleeing differing types of persecution.

> they're arriving here and they've no money, you know, so I feel strongly that we need to be just very caring and aware of people who aren't Irish. (L656)

Working with asylum seekers, survivors of domestic violence and child abuse for many years, Margaret found therapy with this group left her feeling helpless at times. Margaret's experiences of working with the fundamental abuses of power and betrayal amongst survivors meant that her work often left her with a strong need to seek social justice. She described feeling compelled to take an active stance as part of her work as a therapist, "it piques your interest, and it drives your kind of human rights or advocacy needs... It's bigger than just a job". (L273).

For Michael, who also worked with those seeking international protection, he recognised the many obstacles that his overseas clients faced and felt obligated to support in non-traditional therapeutic ways in his work. He gave a recent example of helping a client seeking asylum, who faced numerous socio-cultural challenges:

> I'm doing a lot of maybe psychosocial stuff… like writing to ministers and stuff like to try and help him…it wouldn't be like necessarily typically a therapeutic thing. (L 210)

He was conscious of an internal pressure to re-conceptualise his role as a psychotherapist. He experienced his asylum seeker clients as having many additional needs compared to native clients and this left him with doubts around the boundaries of his role.

Deirdre noticed being moved by client experiences of childhood trauma, which she felt could be overlooked within our society.

> I have an interest in people out there in society..., especially around sexual abuse, because there's such an amount of shame and secrecy within the family culture, probably that they're in, and it's not something people say to their friends. So, I'm interested in it coming out of the dark a bit more. (L202).

In using the expression "coming out of dark", Deirdre seemed to feel there was a sense of taboo holding back this client group in coming out openly and seeking help. She felt that they ran the risk of remaining a hidden community and it was important to offer a response through her clinical work.

The many complex sociological contexts and clinical challenges of trauma work elicited differing personal responses in driving participants within their professional lives. Central to their professional identity as practitioners were the personal values and their social justice and political beliefs, which became a crucible in energising them within this challenging profession.

4.4.2 Recognising the Shadow

A number of the participants described working with complex trauma as having an almost addictive quality, which is represented in the subordinate theme *Recognising the Shadow*. While participants found their personal motivations catalysed their working life with traumatised clients, this passion for their work needed to be carefully channelled. Mary, Sean, Deirdre, Michelle, and Margaret spoke of a mixture of curiosity, professional interest, a necessity to upskill and a sense of responsibility leaving them endlessly over-extending themselves within their work life. This stretching of themselves within their clinical work could have almost a compulsive quality or as Deirdre put it:

> I think a possible negative is this kind of work is so addictive and interesting you can go down all kinds of rabbit holes, and I have to be careful (L433)

During the interview, Sean found it hard to fully articulate his interest in complex trauma, so used the metaphor of a film. He expressed a sense of identification with a character in the film 'The Deer Hunter', who is traumatised by his experiences in the Vietnam war.

> The Christopher Walken character who goes back to Vietnam and engages in Russian roulette. I do recognize an element of that in myself, that if I have a client who that's, let's say, relatively speaking, simple trauma or adult-onset PTSD or it's an awful phrase, the worried well, I just find myself not really interested…I need the really distressing and challenging… there's a slight, it's dark side to it. (L331)

Sean wondered whether his unconscious attraction to working with complex trauma was a result of his years working with a client group with histories of traumatic

experiences. For him there was a sense of re-enactment within his practice and an interest in severity which he found hard to fully comprehend.

Mary expressed a similar pull towards working with complex trauma treatment and could always remember her sense of deep-seated curiosity for complexity and dissociation within her clinical practice.

> I am inclined to overwork. I'm inclined to take on more…the work fascinates me. I should say no... I'm getting a lot better in recent years (L348)

In her interview, Mary spoke in an energetic tone, which indicated her passion for the work and that her struggle to rein in this curiosity had been ongoing. For her, the challenge of having to push herself to learn new complicated theories and integrate new knowledge into her clinical practice was professionally stimulating.

Deirdre also felt there was a difference between working with complex trauma and other types of therapeutic practice. They recognised a continual need to build their knowledge and skill base, due to the rapidly expanding nature of complex trauma theory and treatment. Deirdre felt this drive to learn and was considering doing another university qualification currently but felt a tension around this.

> People mightn't be always really into their work. Whereas I think in this line of work, because it's so interesting, I have to be careful about decisions like that, because …I suppose it's been careful that the work doesn't ripple too much into outside of the workplace. (L438)

For Mary, she remembered initially feeling a discomfort at her deep fascination with human suffering. Talking about a conversation with her supervisor, she stated:

> My own supervisor at the time, and I was kind of half ashamed of saying that this work… I'm working with somebody who is so distressed and has such a horrific life history… but I have this huge curiosity… and he laughed, and he

was saying, yes, he shared my curiosity,… curiosity how do people's minds work? And how are minds shaped by life, experience? How can repair come about? So that was my fascination that brought me into it. (L188)

Mary's use of the words "half ashamed" illustrates her having to hold a duality between her own positive experience of fascination and her awareness of her client's suffering, which could jar with each other. Similar to her clinical work with clients, she learned to integrate these uncomfortable shadows within her psyche.

For Margaret, she could start to become all consumed by her work, due to her tendency towards political advocacy. There was a strong sense of overwhelm and becoming lost within her complex trauma work:

just filling up every single moment and so you can really get consumed by that world and because of the need that seems to be attached to working with complex trauma. It's not often something that you can just leave. (L239)

Margaret learned from experience that working with complex trauma also revealed a shadow side. Her passion to help others contained the potential for self-destructive tendencies.

it's definitely a double-sided sword because it's something that drives you, motivates… you definitely need a passion and a motivation if you're going to succeed in working in that area.…it drives you and you just have to make sure it doesn't consume you. (L,290)

Passion for their clinical work was an important feature of participants' professional identity as practitioners. However, participants found they had to work at the edge of where their passion could be channelled positively or move into darker waters. Working at this edge was an experience which had to be navigated carefully.

4.4.3 Growing with Clients

Although all participants detailed many adversities, they were also keen to point out the positive changes resulting from their trauma practice, which included improvements in their overall outlook on life, personal resilience, and development as professionals. The subordinate theme *Growing with Clients* reflects the development of these growth processes. All the therapists in the study reported experiences of personal growth and a sense of satisfaction through sharing in the healing processes of their clients. Michelle, Sean and Pauline described a sense of finding their work with complex trauma clients professionally rewarding.

> It can be a wonderful experience… it's quite rewarding when you see somebody with massive challenges starting maybe to trust and open up for the first time and you know… I really admire these clients because it's so hard for them to come to therapy. (Michelle L331)

For Michael, sitting with his clients as they worked through their trauma left him experiencing an internal satisfaction.

> It's brilliant even when you see somebody actually working at trying to overcome their own irrational fears on their own and… blossom in a way and become more independent and less dependent…the best one is where somebody says I'm not coming to therapy anymore because I'm doing okay. Thank you for everything that you've done for me…it's a lovely rejection. (L286)

Michael viewed his role as to move the client towards functioning independently in their own lifeworld. He smiled during the interview as he used the word ‘blossom’ and seemed to make sense of the therapeutic process as something which facilitated inherent growth potentials for both him and his clients.

Some participants' experiences of their clinical work trickled into their perspective in other dimensions of their life, most notably family. For Gillian in her interview, she described working with trauma shaping her development in a number of areas of her life "personally, it's really helped me…more generally as a therapist, and as a mom with kids. It's helped me hugely" (L395). Michael recollected sitting with the horror and trauma of his client's narratives, left him reflecting in a deep way on his own family "I cherish my family a lot more" (L233). Michelle noted as she repeatedly watched her clients transform through a commitment to overcoming their trauma histories, it led to a positive shift in her mindset.

> I think it has left me with a kind of a hope and an optimism. …[I've] been on some wonderful journeys with people and so that's the rewarding piece. (L548)

Pauline who had worked with many clients from disadvantaged social backgrounds, noticed a gradual awareness growing of the many advantages, which she enjoyed in her own life. She spoke during her interview of the growth in her personal beliefs and how she viewed others:

> Gratitude, huge gratitude for all the privileges that I've had in my life and have, it fairly puts things into perspective (L308)...I suppose my spiritual life has been impacted… in terms of trying to make sense of the world and what the world is about, as for me, that we're each one of us, are precious and unique, and that that there's nobody else in this world like you. (L330)

Working with a client population who struggled with affective, cognitive and relational dysregulations exposed participants to an intersubjective intensity, not found in their personal worlds. Acclimatising to this intensity over time meant participants gradually built what seemed to have been a healthy desensitisation to the emotional swings and distorted perspectives of their clients. This also allowed some participants

to tolerate the stresses of everyday life more comfortably. Gillian spoke of the process of learning to sit with strong emotional reactions within her work.

> I find if I can slow down enough to be with the client with where they're at, I learn a lot, because their reactions can be very strong at times….so I find that very helpful to become more sensitive generally to people, clients or people in my own life. (L37)

For Gillian this process had allowed her to be more mindful in her personal life and attune to important others. Similarly, Sean spoke of working with complex trauma helping him to build an emotional resilience, which he saw as something that permeated across all spheres of his life.

> I get less disturbed or distressed by non-complex trauma events in people's lives. So, if somebody I know says that something happened, and they get quite worked up… I think, yeah, not nice, it's unpleasant…. but I don't get as distressed or disturbed about relatively speaking, everyday problems or issues or concerns (L194)

Deirdre and Gillian described their work as something that engaged them at a deep emotional level, and they developed a real love for their work with clients. During their interviews, both spoke with apparent enthusiasm about their work and how this impacted other family members. Deirdre articulated "I absolutely love it. So that's good, and that's good for my family. There is a parent who really enjoys their work" (L429) and Gillian laughingly recounted her daughter's words in a conversation.

> My daughter …was saying to her boyfriend. 'my mum loves going to work every day. Can you imagine that?' (L434)

Through her many years of clinical work with complex trauma, Susan was acutely aware of how much it took for her clients to confront the current impacts and

memories of their chronic abuses. She was filled with obvious admiration for her clients:

> The courage and the strength, and I can't think of the word for people, what they have gone through… they're still standing some of them, so it gives me great hope…and people's capacity…. to survive.. and to live … for some to have a good enough life. (L355)

As well as gaining a personal satisfaction and emotional resilience from their clinical work, participants spoke of growing professionally as the years passed and they gradually built knowledge and worked with large numbers of diverse traumatic presentations. The participants in their interviews gave a sense of the hard-earned growth gained through thousands of hours of clinical work. Despite all of his specialist trainings, Sean had learned the relationship was the fundamental building block of all therapeutic work or as he put it "the importance of establishing a therapeutic alliance, a relationship precedes any kind of trauma work" (L19). He felt this simple lesson learned from feedback over the years from his complex trauma clients had allowed him to keep humble in his work and grow as a practitioner and he stated that he regularly 'goes back to basics' (L68).

When Mary was asked about her sense of growth as a result of her years working with complex trauma. She recollected:

> It has deepened my understanding of interpersonal interaction, where there is rupture. It has given me a much deeper appreciation of relationships... and a greater tolerance when things go wrong. It certainly has helped me develop a much deeper insight into myself. (L503)

Some participants spoke of their personal therapy as a central part of their practice with complex trauma, given the complicated nature of their client's symptoms.

Both Sean and Mary interestingly described their work with complex trauma forcing them into a process of self-examination of their own internal worlds. This led them to reflect on their own adult attachment patterns. For Sean there was an experience of recognising his avoidant attachment style and using it to benefit him by learning to detach from difficult clinical experiences. Through her personal therapy work, Mary recognised that her mixed attachment style was something that she was able to cultivate to her advantage. She spoke of developing her attachment patterns, allowing her to cope more effectively within her demanding clinical work.

> I think it's part of me growing up that I always had that ability to compartmentalize and to cope with my emotional needs, not being fully met, being good enough, but not being fully met. I found I already had a capacity to say I just need to put that away and not look at that for the moment, then it took practice to make it very secure. (L471)

As Sean sat with the last question of the interview, he reflected on a long career working with complex trauma. Sean spoke of having a sense of deep satisfaction in his chosen career. He acknowledged that therapeutic work with complex trauma might not suit everyone, but he encouraged others to consider a career in the profession.

> if you're able for it, if you have the physical, intellectual, personality qualities, I say, go for it. It's just fantastic. It really, really is, it's continuously challenging…. it's like you're playing three-dimensional chess (L316)

The use of the metaphor "three-dimensional chess" illustrates how Sean's clinical work stretched him on multiple levels. While he was conscious of the centrality of the relational within his work, the intellectual challenge of this complex world fuelled his passion, while also providing healthy objective perspective and clinical distance from horrors of this clinical work.

Personal motivations became a keystone of the participants' therapeutic identity with a sense of being driven by the importance of offering services to disadvantaged sectors within Irish society and by personal curiosity. These drives also had a darker aspect, which participants had to learn to integrate. Sitting with clients overcoming their traumatic pasts, led to experiences of growth and development for participants.

4.5 Conclusion

This chapter presented the findings of an analysis using an IPA methodology to explore nine senior therapists' lived experiences of working with complex trauma in Ireland. All the participants experienced the costs of empathetic engagement with most feeling these impacts at a visceral level. While some reported feeling that work related factors contributed to their negative effects, most felt it was the impact of sitting with their clients' trauma, which led to a host of physically related symptoms. For some participants, there was the experience of being affected cognitively and emotionally, but with experience they learned to respond to these challenges. Each participant developed their own ecosystem of self-care, which nourished them on a holistic level. Of central importance were the many physical activities that they learned to integrate into their self-care routines. These experiences of vicarious embodied effects, which were only experienced by the female participants within this study, may warrant future investigation, given the increasing emphasis of working with somatic and neurobiological approaches within complex trauma treatment environments.

Participants spoke of having to adapt to deeper complexity at every level of their clinical work. Many were challenged to develop the multi layered clinical skills needed to work with the many transferences and dissociative states that presented in the room. Sitting with the extended timeframes and the many uncertainties of trauma

treatment became part and parcel of the clinical complexity of working with this client base. There was also the challenge of getting used to the ambiguities around boundaries, which tested the participants clinical decision making, resulting in a struggle to maintain perspective within their practice. The intense countertransferences of working with complex trauma often made it difficult to find a balance, between knowing when to offer necessary support and keeping a healthy limit in the best interest of the client. While participants reflected over often lengthy histories of working with complex trauma, many aspects of this specialised work left them feeling at the vanguard of a new clinical culture, but this also left with as sense of being alienated. Participants reported regular challenges in finding suitable professional support for their trauma practice and a sense of having to remediate a lack of early training in specialised trauma theory and treatment.

Central to the participants' therapeutic work were the personal motivations, which drew them towards offering their clinical skills to often disadvantaged or hidden segments of society, who historically had been underserved. Therapists also reflected on the compelling nature of the work, which fuelled a deep curiosity and challenged them on a professional level. These drives were also shadowed by tendencies, which often ran the risk of consuming the participants' lifeworld. Having established themselves within their professions, all the participants spoke of how personally rewarding the experience of working in this field had been. Witnessing their clients grow in their own lives was a central motivation for therapists in doing their work and led them towards maturation in their own personal and professional lives.

4.6 Researcher's Reflexive Comments

The presentation of the participants' data came with the responsibility of wanting to reflect their experiences in way that was helpful and fair. I was aware of the openness of my participants and the sense of risk there was in sharing so openly within such a small community of practitioners. I was also conscious of doing a study on complex trauma, which has a strong connection to the darker aspects of an earlier Irish society while also reflective of a quickly changing and unstable world. As a researcher conducting the interviews, I was conscious of the socio-cultural influences in my own life that could play a role in my study. I grew up in a particular era which was characterised by a catholic religious authority, less affluence, and with little ethnic diversity or recognition of minoritised communities. These early developmental experiences contrast dramatically with the current Ireland in which I now practice with its openness towards mental health issues and new attitudes to inclusivity. These personal reflections allowed me to consider the importance of the participants' personal histories in understanding their own clinical work. My reflective practice also allowed me to consider the impact of being a male researcher and how this might influence my own interactions within the interviews. I considered whether or not white Irish middle-aged male participants would be as open with a male researcher, given the male tendency to shrink from showing emotional vulnerability. I endeavoured to try to balance these contexts within the study, in a way in which I hope was 'good enough'.

It was only in writing up of the findings and working with the words of the participants that a fuller sense of meaning within the study began to take form. As I wrote the quotations within the finding, I could remember the interviews with the participants, and it reminded me how far I had come and how much I had learned through the different iterations of the study. The writing up phase forced me onto many

steep learning curves, with the challenge of sharpening up my academic writing, and having to read hundreds of journal articles. I feel in the doing of the study, I have submerged myself in the experiences of other professionals within my community. This has changed my perspective in some ways. On reflection, I am now more mindful of my own vulnerability as a professional, but also appreciative of the positive dimensions of working within this field. There is also the feeling that complex trauma practice is starting to be viewed with increasing importance and concepts within this field are beginning to influence other related professions and society. It has made me acutely aware of the important therapeutic role trauma practice will have over the years to come.

Chapter 5: Discussion

5.1 Introduction

This chapter situates the key findings of the lived experiences of senior therapists working with complex trauma in Ireland within the relevant theoretical and academic literature on therapist practice with complex trauma. Nine psychotherapists with several years of experience of working with complex trauma were interviewed and these accounts were analysed using an Interpretative Phenomenological Analysis (IPA) methodology. Three group experiential themes were identified; (1) *The vicarious impacts: "you feel like it's in your bones",* (2) *Being pushed: "it's continuously challenging",* (3) *Feeling driven: "this kind of work is so addictive"*. These group experiential themes were generated through the use of an IPA analysis process and are the researcher's interpretation of the subjective accounts of the participants' experiences of working in this specialised field.

This chapter examines the extant literature in relation to the three central findings of the participants' lived experience of working with complex trauma and makes noteworthy contributions to understanding how this work impacts on psychotherapy practice. Firstly, participants' experience of long-term clinical exposure to clients with histories of chronic and prolonged trauma resulted in a variety of adverse effects. Most referenced by the therapists were the physiological impacts, and to a lesser extent cognitive or emotional disturbances, which required a corresponding tailoring of self-care regimes to maintain equilibrium within their work. The second finding were their experiences of adapting to the ongoing pressures of complex trauma practice. This meant learning to work with a greater relational ambiguity, grappling with holding clinical boundaries and feeling a sense of professional distance from the

general world of psychotherapy. Thirdly, the participants described a diverse mix of internal motivations drawing them into their clinical work in an almost compulsive fashion, which possessed both a light and dark side. There were also the many positive experiences of growth, which tempered this challenging work. This study reflects a journey of personal and professional acclimatisation to adversity, new clinical challenges, and an experience of recognising and tapping into their own personal motivations in an effort to develop within their clinical practice.

5.2 Working with Secondary Traumatic Stress

Early pioneering work by McCann and Pearlman (1990) and Figley (1995) has long identified the perils to those working with complex trauma. Due to the relational sequelae of complex trauma, Boulanger (2016) argued that working with survivors invariably means having to build a strong relational bond to enable the therapeutic repair of interpersonal dynamics and damage to self-concept. These intensive interactions leave therapists exposed to ongoing experiences of secondary traumatic stress. Thus, it was not surprising to hear the participants in this study offered many accounts of experiencing negative impacts, due to years spent in this intense clinical environment.

Although as discussed earlier in the literature review, the terms *Vicarious trauma* (VT; McCann & Pearlman, 1990) *Secondary Traumatic Stress* (STS; Stamm 1995), *Compassion Fatigue* (CF; Figley, 1995) and *Burnout* (Maslach & Leiter, 2008) have conceptual differences, these definitions are often used interchangeably within the research literature. Of the four major concepts, which describe vicarious impacts, the findings of the therapists' experience overlapped most with burnout, with most participants describing a sense of fatigue, depletion, physiological impacts and needing

to reduce their workload. However, the participants' experiences did align to a lesser degree with some aspects of VT and CF, such as emotional disturbance and struggles with distorted beliefs in the earlier stages of their career.

5.2.1 The Physical and Emotional Impacts

Most notable amongst the female participants of this study were the predominance of embodied symptoms which resulted from their clinical practice with complex trauma material. Negative physical impacts such as fatigue, aches and pains, tensions and a sense of lethargy were reported in the majority of the female participants' accounts, with an accompanying need to reduce their client load and seek professional support to manage these physical effects. Moreover, participants discussed developing regular habits around physical activity to mitigate the somatic impacts of their long-term clinical work.

In a foreshadowing of the words of the participants within this study, Merleau-Ponty (1962) asserts in talking about human experience "it is precisely my body that perceives the body of another" (p.412). The sense of absorbing their client's trauma through their bodily experiences was a strong finding within the study, which has resonance in prior research. Findings by Killian (2008) in a US mixed method study found trauma psychotherapists (n=20) recognised vicarious stress via bodily responses, including "muscle tension" and "headaches". Similarly, in a review of the qualitative literature on therapists and vicarious trauma by McNeillie and Rose (2021), a number of "physiological experiences" were identified. Most female therapists within the current study presented an image of their clinical work, which was comparable to the descriptions by McNellie and Rose of 'exhaustion', 'lack of energy' and 'tiredness'. Participants within the current study also reported physical symptoms, such as

migraines, IBS, pain and muscle soreness, especially when working with physical and sexual abuse survivors. This is consistent with a previous IPA study conducted with South African female trauma therapists by Sui and Padmanabhanunni (2016), which reported experiences of "tensions in the neck and shoulders", "headaches" and "sore muscles". It appears the current study builds on a growing evidence base in regard to the embodied vicarious impacts of working with traumatised populations.

This finding on physiological impacts accords with newer psychobiological theories of complex trauma survivors. In his groundbreaking book on psychological trauma, *The Body Keeps the Score*, Bessel van der Kolk (2014) talks about the psychobiology of trauma. He suggests that psychological trauma is often captured at the level of human physiological systems. Given the established evidence reviewed earlier in section 2.6 on the increasing development of the neurobiology of trauma, it would not seem to be a stretch to suggest that those working regularly with experiences of chronic relational trauma would experience adverse effects via the central nervous system. All the participants articulated experiences of working with unconscious aspects of their client's trauma, which were often experienced through the therapists' internal physiological responses.

Allied to this is the growing emphasis within contemporary trauma treatment of focusing on somatic symptoms with a number of approaches including Somatic Experiencing (Levine, 2010); Sensorimotor Therapy (Fisher & Ogden, 2009) and Bodily Based Techniques (Rothschild, 2000) working with the physiology of clients. In their book *Help the Helper* Rothschild and Rand (2006) describe "bodily-centred countertransference" as a phenomenon in which trauma therapists unconsciously take on internal somatic experiences of their clients. An Irish study by Carr and colleagues (2010) used their own scale *the Egan and Carr Body-centred Countertransference*

Scale (2005) to measure bodily symptoms in female trauma therapists (n=58) working in a service providing counselling for survivors of childhood abuse and neglect. Their results showed tiredness and muscle tension as a common countertransference amongst participants, with headaches, aches in joints and stomach problems also evidenced to a lesser degree. Within this current study, participants emphasised the deep relational nature of trauma, and often having to identify the unspoken or somatic fragments of early life trauma of their clients. Many described experiences of strong countertransferences and projections, which left them with feelings of fatigue and physical depletion. This, it could be argued, puts specialist trauma therapists in a direct line of fire for negative somatic impacts and could account for the participants' negative bodily experiences.

A further important finding within this study was neither of the two male therapists related any experiences of physical impacts. In contrast, the participants that reported the most bodily symptoms were exclusively female and worked most frequently with survivors of childhood abuse. Brown (2017) notes that women are disproportionately overrepresented in all types of interpersonal and sexual violence figures, with female therapists often sought out for sexual assault and abuse treatments (Moon et al., 2000). Herman (1981) pointed to the higher prevalence of sexual trauma within specialist services having the potential to lead female therapists to over identify with female survivors of abuse and sexual assault. Feminist psychological perspectives have taken a systemic perspective on the development of trauma with institutional hierarchies and patriarchal cultures viewed as facilitating many types of trauma (Brown, 2004). According to Brown (2017) systems of power influence marginalised individuals, such as the socially disadvantaged, women and minoritised groups in their ability to cope, their sense of well-being and their level of exposure to trauma.

It is worth noting that within an historical Irish context gender roles have tended to be viewed through a traditionalist lens with a religious ethos shaping attitudes towards women's working environments (Patterson, 2001). Arguably, this has provided patriarchal norms that perpetuates the continuance prejudicial gender-based attitudes within Irish public life and institutions (Griffin, 2019). According to Hochschild and Machung (2012) this cultural normalising of emotional labour as something to be expected and not rewarded is created through a societal conditioning, which encourages women to adopt nurturing stances and relational support, which can lead to negative impacts. This issue was highlighted by Bearse et al. (2013) who hypothesised that female therapists may experience "stronger caregiver responses", which could make it more challenging to keep therapeutic distance within their work. Within this study female participants regularly described being motivated to work with vulnerable groups, it could be speculated that their own lived experience of growing up in patriarchal society could predispose them to overinvest themselves in their clinical work leading to negative impacts. This aligns with the present study and the wording used by some of the female participants "I just feel for them", "too invested" and "consumed" and their descriptions of this leading towards experiences of physiological symptoms of burnout. While there were only two male participants within the current study, which limits the potential of any conclusions, these findings on gender difference within complex trauma work could provide a fruitful area for further research.

As mentioned at the start of this section, conceptually burnout aligned most with the reported experiences within the present study. A similar finding in an Australian survey by Devilly and colleagues (2009) conducted with mental health professionals (n=152) offering therapy to traumatised clients found burnout to be the

most relevant concept in understanding indirect effects of trauma work. Devilly and colleagues used questionnaires to measure work related variables, average time spent with trauma clients, STS, VT, and burnout. They identified that exposure to trauma work had no significant effect on levels of STS, VT or burnout. Instead, negative impacts could be related to external work-related stressors including, level of experience, lack of support, role conflict and unreasonable workloads. To some extent the findings of the current study are consistent with Devilly and colleagues, as participants described their experiences of working with heavy caseloads, organisational pressures, and strains with fellow colleagues leading to negative influences. However, the findings of this qualitative study differ to Devilly and colleagues in some important respects. Devilly and colleagues quantitative approach focused primarily on measures of secondary trauma and work-related variables with little examination of the clinical characteristics of this specialised work. The purposive sampling of the current study looked at senior therapists working with an often-high frequency of sexual and physical abuse and/or domestic violence on their caseloads, which exposed participants to potentially severe levels of indirect trauma. This prolonged occupational exposure, along with the participants' reports of engaging in deep therapeutic work using specialised paradigms showed a different profile of indirect effects. The participants in this study, while acknowledging the effects of work-related factors on their experience, also understood their adverse impacts as being a direct result of sitting with their traumatised clients. This is important in furthering our understanding of how these embodied symptoms arise from clinical practice with complex trauma clients, given the challenges empirical approaches have had in parsing out the underlying processes of indirect trauma.

A recent review by Fernández et al. (2024) examined 22 articles in relation to the protective and predisposing factors in the vicarious traumatisation of psychotherapists. They suggest based on their results, that burnout may in fact be a precursor to both VT and CF by priming therapists working with trauma in a way that leaves them more vulnerable to other forms of indirect trauma. The findings from this current study would find this a plausible framework, as participants spoke of experiencing somatic symptoms during busy periods of their working life, but many made sense of their symptoms as directly related to intense sessions with challenging clients. It would seem that the dynamic between environmental/work related factors and the contagious nature of client trauma is a multi-layered phenomenon for clinicians. This research provides additional evidence that vicarious impacts on therapists are a multidimensional phenomenon resulting from an interplay between experiences of work-related stressors and indirect trauma from clinical work leading to negative bodily reactions.

One surprising or unexpected finding was the low levels of negative emotional impact discussed by participants in their current trauma practice. This challenges previous theoretical models, such as CF which predict indirect emotional symptoms. Moreover, a meta-review by McNeillie and Rose (2021) discusses a wide range of emotional impacts amongst therapists working in this field, with sadness and anger being the most common examples reported. Findings in an IPA study by Merriman and Joseph (2018) described some of their participants becoming "desensitised" and "switching off", due to heavy caseloads of trauma work, but learning to regulate the amount and type of work to maintain their well-being. This is consistent to some degree with the present study, while participants shared experiences of anger, anxiety, sadness and emotional overwhelm, these were confined for the most part to earlier stages of

their careers. This suggests most of the therapists within this study had learned through experience to sit with the intense affects of their clinical work and effectively use their own internal resourcing and professional support systems to emotionally regulate themselves. Some of the participants outlined their experiences of developing a tolerance, rather than a defensive desensitisation, in dealing with intense emotions, as they matured as clinicians "I'm very good at a healthy way of compartmentalizing" (p.344). Therefore, this is important in furthering our understanding that their long careers allowed participants to develop coping strategies, including drawing on professional support, caseload management or taking time off work in the face of emotional stress.

One of the strengths of an IPA study is that the phenomenological thread allows for nuances to emerge. One such nuance was the unexpected finding amongst some of the participants of developing an emotional resilience with experience, which sits at odds with many of their descriptions of their somatic impacts. Participants vicarious embodied effects seemed not to diminish and to require continuing and intensive self-care and management. Given that a trauma informed philosophy is only gradually emerging into supervisory and organisational support systems, there may still be an emphasis on the emotional, cognitive and relational processing of indirect adverse effects, rather than exploring therapist bodily symptoms. It is also noteworthy that descriptions of working with dissociative processes were common in many participant interviews. Dissociative processes are regarded by some theorists (Costa, 2020; Dalenberg et al., 2012) as unconscious defences against overwhelming and painful emotional responses. Complex trauma clients who dissociate commonly experience a hypo-arousal of the central nervous system (van der Kolk, 2014), which can result in numbing and emotional detachment. It is possible that therapists, who regularly work

through the lens of dissociative processes, learn to attune more often to physiological cues, due to their client's inability to directly access their emotions. This could have left the participants within the current study less likely to experience emotional impacts and more at risk of bodily based counter transferences.

In summary, it would seem the female participants in this study described experiences of negative physiological impacts resulting from their clinical practice, with hypoarousal responses, such as fatigue, numbing, and physical symptoms most cited. While these adverse impacts are consistent with symptoms of burnout, they also align with psychobiological theories of complex trauma symptomology amongst survivors such as dissociative detachment and psychosomatic complaints. The trauma therapists within this study spoke of working regularly with dissociation, it is possible this might lead them towards prioritising clinical attunement of somatic signals, which could partially account for their experience of elevated adverse physical reactions and lower levels of emotional impact. Moreover, female therapists are likely to be working with differing forms of gender-based violence, which may resonate with their own experiences. Irish societal expectations based on patriarchal norms of women as nurturers and caretakers may place female trauma therapists under additional strain.

There would also seem to be a connection between the experience levels of the participants which allowed them to develop effective ways to manage the emotional impacts of their work. These findings have implications for psychotherapy practice with those who seek help due to complex trauma.

5.2.2 Distortions in Self and Other Perceptions

Within this study, a number of participants spoke of gradual distortions creeping into their thought processes, which they actively had to work to counter. This is a relatively

unsurprising finding, given the early construct of VT developed by McCann and Pearlman's (1990) suggests cumulative experiences of indirect trauma within clinical environments lead to cognitive disruptions in areas of self-perception, trust, power dynamics and intimacy.

This present study aligns with the construct of VT, with roughly half the participants identifying an increased concern over the safety of others and at times their overall trust in the world. As one participant described after starting to work with child abuse survivors "every man I saw suddenly, I thought they're an abuser". These changes, for the most part, took the form of participants worrying about the safety of their children or grandchildren, with a general sense of questioning the welfare and the motives of others. It was notable that the participants within the study had considerable experience of working in this clinical area and had learned to develop a process of challenging these internal distortions. This is consistent with earlier research by van Minnen and Keijsers, (2000), who found that although therapists working with trauma could experience negative cognitive distortions, they were able to reframe these beliefs positively. Similarly, most participants within the present study developed self-reflective skills, which allowed them to recognise and modify the disruptions to their thinking and belief systems. As one participant who worried about being overprotective in his parenting stated, "I learned to play devil's advocate with my thinking". This broadly supports previous work (Munishvaran & Booysen, 2022), which identified similar themes amongst clinical psychologists working with both survivors and perpetrators of sexual abuse, with participants experiencing a loss of faith in humanity, a lack of trust, viewing others as potential abusers, and becoming "an over-protective nurturer" (p.4).

Other findings within the study found that some participants experienced internalising a sense of helplessness from their clients, this was especially prominent amongst the two participants practicing with refugees and asylum seekers with exposure to conflict and political abuses. Qualitative research by Duden and Martins-Borges (2022) on therapist experiences in a Brazilian study reported that working with refugees left participants experiencing a sense of helplessness, fatigue and burnout, with the needs of this client group extending far beyond the typical competencies of therapists. Duden and Martins-Borges' (2022) research, mirrors the experiences of therapists within the present study, with participants using words such as "helplessness" and "powerlessness" in describing their clinical work with asylum seekers.

In conclusion, participants' experiences in the current study aligned with the theoretical framework of VT and with a previous study by Munishvaran & Booysen (2022) with exposure to narratives of child trauma leaving them with distortions in their beliefs around the safety of others. Consistent with prior research by van Minnen and Keijsers (2000), participants in this study gradually learned to work towards reframing these shifts in their beliefs and attitudes through using self-reflective processes. Two participants working with those seeking asylum reported experiences of counter transferences, which reflected a sense of powerlessness, and a need to be proactive in their role as therapist. These counter transferential phenomena would seem to reflect the unique trauma profile of a new group of traumatised individuals increasingly presenting to Irish clinicians.

5.2.3 Restoring the Self

Given the impactful nature of working with complex trauma, an unsurprising finding was the high levels of self-care discussed by participants in their interviews. The importance of their self-care routines grew as their careers progressed, and they gained knowledge and learned valuable lessons through trial and error. It appeared that participants developed a unique ecology of personal, professional and communal strategies in dealing with the multi-faceted effects of their work. Each participant described having to find their own formula of self-care habits. This typically involved building a foundation of self-care practices which supported them in maintaining their physical and mental health. There was also a need to develop a series of options, which could be implemented in the face of emerging negative impacts. Through experience participants spoke of strategies including, taking leave, linking in with supervision, cutting back on caseloads, increasing time with family or communal activities when they began to recognise signals of vicarious effects. This aspect of the findings corroborates earlier findings from an IPA study by Bartoskova (2017) conducted on trauma therapists, which discussed the importance of a broad spectrum of social support, including supervision, family, friends, and organisational team, with participants finding their own individual self-care regimes.

In looking more closely at specific self-care measures developed by participants in this current study, as might be expected given the high levels of physical impacts reported, one of the most cited forms of self-care was physical exercise. In a prior mixed method study by Killian (2008), it was noted most trauma therapists drew on a wide range of outdoor activities to salve the impacts of their work with traumatised clients, with many using the gym as a way to reset bodily equilibrium. This reflects the understandings gained from this current study, with participants using an array of

physical activities including exercise bikes, hiking, walking in natural settings, and participating in communal activities, which all contributed towards shifting the fatiguing nature of their trauma work. One participant commented on the routine nature of physical exercise in her life stating, "It's like having lunch". These findings identified that many participants felt working with complex trauma could often involve dissociative processes, which could lead to a sense of numbing or 'staleness' and this required a process of counterbalancing through physical activity to restore their vitality.

Another coping strategy that emerged in the current findings was the use of different modes of arranging, mixing and cutting back on caseloads. Changes made around caseload management by participants generally occurred in the face of ongoing negative impacts, which were a consequence of intense periods of clinical work. This study found that about half of the participants described cutting back on their workload of traumatised clients due to a sense of burnout or negative impacts. This makes sense given a prior meta-analysis by Lee et al. (2011) reviewing the literature on psychotherapists and burnout indicated a positive relationship between long working hours and burnout syndromes. One participant described feeling the necessity to limit her exposure to trauma work in order to maintain the quality of her practice, which is supported by Killian's earlier study (2008), who identified the need to be able to regulate clinical workloads, when stress starts to emerge, as an important self-regulation mechanism.

This study also reported another form of caseload regulation with participants describing decisions to mix their caseloads in a variety of ways, such as blending in general counselling work and differing professional responsibilities into their work hours. A recent study by Rayner et al. (2020) used an online questionnaire to examine STS and trauma caseloads amongst Australian psychologists and social workers. This

study found no significant association with the percentage of traumatised clients on therapist caseloads and STS. However, this study measured mental health workers perceived level of trauma on their caseload, without any consideration of actual trauma diagnosis or assessment of trauma symptoms. In contrast, a previous US study (Craig & Sprang, 2010) used the ProQOL (Staam, 2005) and Trauma Practices Questionnaire to measure clinician's burnout, CF and workload patterns. The mental health practitioners (98%) within this study reported working with formally diagnosed trauma presentations on their caseloads. This study revealed a "dose response" effect, with elevated frequency of secondary stress correlating with higher levels of trauma work, which aligns with the current study findings.

A recent systemic review (Sutton et al., 2022) on organisational factors, which influence vicarious trauma, recommended the diversification of caseloads and responsibilities of clinicians within clinical services. The current findings of this study found seven participants spoke of blending caseloads and/or mixing different responsibilities to give them a break from direct practice and to support them in their self-care. Participants in this study found this offered them the capacity to manage vicarious distress as it arose within their work. It would seem that therapists develop regulatory strategies to manage the adverse impacts of their clinical work, as they progress through their professional life.

One further finding were the differences between private therapists and those therapists working within non-profit or state organisations. Those participants in this study working within organisations reflected on the value of working in a team environment as being a central pillar in their capacity to sustain their work with complex trauma. An important part of working within an organisation was the experience of being part of a multi-disciplinary environment, which reassured,

supported, and kept participants safe within a myriad of clinical, risk management and legal reporting duties common in complex trauma work. Melaki and Stavrou (2023) compared the vicarious post traumatic growth and adverse experiences of trauma therapists working in private practice and those working in organisations. Their findings describe those working within clinical teams feeling a sense of security, with the opportunity to be able to immediately talk with a team member being a protective experience in dealing with secondary stress. This has been a consistent finding with Sutton et colleagues, (2022) review also having identified practitioners working in well supported organisational cultures feeling valued and less likely to experience secondary stress.

Within the present study, those that predominantly worked independently in private practice, cited having to spend more time and effort in seeking out and building a professional network, which at times could leave them feeling isolated and unsupported. This resonates to some degree with findings by Melaki and Stavrou (2023) in which private therapists working with trauma survivors reported experiencing more VT, with symptoms of intrusive images, bodily tension, and a sense of social isolation compared to those working within organisational workplaces. Some participants in private practice within the current study spoke about feeling professionally isolated, due to a lack of a clinical team environment. However, most reported their sense of isolation was largely driven by feeling different to other segments of the psychotherapy and mental health profession and with them finding it harder to access adequate professional support.

A further important finding from the current research was the value of therapists having strong relationships to draw upon outside of the professional world to mitigate the emotional and psychological strain of working with complex trauma. A previous

qualitative study by Hou and Skovholt (2020) found experiences of current unconditional love provided at home as one essential component in maintaining a fulfilling career as therapist. In the present study, three participants spoke about spending time with children within their extended family, providing a contrast to the clinical workplace and this helped to keep a positive and more balanced outlook on the world. Interpersonal connections offered opportunities to spend time in socially healthy environments, which were an antidote to the dark side of their professional practice.

Unsurprisingly, central to nearly all the participants functioning within professional practice was the support of supervision and to a lesser extent personal therapy. With complex trauma presentations involving multiple dysregulations, complex psychodynamics and regular risk management issues, a strong professional ecology was seen as vital in sustaining clinical practice. As outlined earlier in the literature review, Bober & Regehr (2006) in their study found no evidence of supervision offering protection against secondary trauma. However, a recent review of organisational factors mitigating STS by Sutton and colleagues (2022) examined twenty-three quantitative, eight qualitative and five mixed methods studies and found those that were in engaged relationally oriented supervisory alliances felt most supported and were protected from indirect trauma. This is consistent with the current study with participants relying on supervision at times of increased occupational pressure and clinical self-doubt. Complex trauma work was viewed as being too complicated in terms of its therapeutic approaches, counter-transferences and risk profile not to have regular expert supervisory input.

Interestingly, all three of the participants, who worked primarily in the private sector with complex trauma were engaged in personal therapy in addition to clinical supervision across the entirety of their careers, with no participants in organisational

setting reporting working actively with a personal therapist. Those in private practice detailed the importance of having an appropriate clinical space to be able to maintain personal clarity around aspects of their own personality within their work.

5.3 The Growing Pains of Working with Continual Complexity

The participants in this study offered many examples of having to adapt to the clinical depth of working with complex trauma. Complex trauma work challenged the participants to work with greater experiential depth and extended timeframes, which could run into years. This could mean for example having to sit with many psychological dysregulations, interpersonal frictions and self-destructive behaviours during therapy. Thus, participants were thrust into a clinical world with few certainties and many ambiguities as they navigated the clinical waters of complex trauma practice. There were also the anxieties of managing complex boundary dilemmas and a sense of having to continually strive and push themselves, due to the specialist nature of the work. This will be further explored in the next section.

5.3.1 Working with Intersubjective Complexity

Participants within this study spoke of working within general therapeutic practice and as their interest in psychological trauma grew, they moved into the specialised field of complex trauma. This narrower focus within their clinical work required them to adjust to complex symptomology, as illustrated in the sub theme *Wading into new depths*.

As discussed earlier in chapter two, guidelines around working with complex trauma usually requires a longer term phased approach, which comprises of three phases; (1) a stabilisation phase, which requires supporting clients with different forms of psychological regulation, (2) a reprocessing phase, which looks to work through

traumatic memories, (3) a final integration phase, which consolidates the different strands of the treatment (ISTSS, 2012). This form of psychotherapy usually demands high levels of competencies from the therapist with a use of specialist paradigms, which are carefully integrated to address the various facets of the clients' presenting symptoms. It is unsurprising therefore that participants within the current study went through a process of adapting to the intensity and clinical intricacies of this form of psychotherapy.

Little academic research or commentary exists on psychotherapists transitioning into and through specialist therapeutic practice, so the current study sheds a light on this developmental trajectory. One important finding was the participants' experience of learning to attune to the unconscious dimensions of their clients' trauma. Many stated this required them to "hone" their understanding of non-verbal aspects of client trauma, especially unconscious dissociative phenomena. Sands (2010) in a journal article on trauma practice, describes a clinical process of using nonconscious dissociative attunement to clinically engage with chronically traumatised clients. This form of work sees the development of a realm of unconscious communication within the therapeutic relationship in which the therapist accesses their own internal and visceral reactions in order to symbolise aspects of clients' dissociated trauma to allow for repair and integration. Likewise, participants within the current study spoke of working towards a deeper understanding and integration of dissociative processes for their clients. However, this paradoxically left them experiencing a sense of "ambiguity" and "confusion", which they began to understand as part of their client's unconscious trauma. This is consistent with Hopenwasser, (2008), who argues dissociative communication often involves a deep synchronization within the clinical dyad or a "two-person unconscious", which sees the therapist experiencing the shifting

dissociative self-states of their client. According to Hopenwasser, this "dancing the dance with dissociatives" (p.354) can leave clinicians with a sense of mental confusion as they work within this disorganised intersubjective space towards healthy integration.

A qualitative study by Strait (2014) which interviewed therapists working with trauma and dissociation, identified the clients' dissociation having a "powerful impact" (p.325) on the clinician with this phenomenon having both the potential for client healing and vicarious impact for the clinician. As Strait points out, working in this way requires a "cat like perception of non-verbal cues" (p. 325), which has echoes within this study with one participant comparing trauma sessions to "mental gymnastics". Within the current study there was a sense of balancing a tension between working with the fragility of the client's internal process, and a need to maintain a safe working alliance, in order to allow new integrative processes to unfold. The findings suggest that perhaps many of the participants had to adjust to sitting on the constantly shifting intersubjective sands of the dyad, which left them describing the sessions with trauma clients with words such as "nebulous" "confusing" and "three-dimensional chess".

Participants in this study spoke of learning to adjust their expectations, with clinical progress often unfolding in tiny increments and with little evidence of significant change week to week. Given that psychological injuries to clients across early developmental windows can lead to deep-seated symptomology (Cloitre et al., 2009), work with complex trauma as mentioned earlier in this section tends to be protracted. Participants described having to use a broader chronological lens to gauge client growth. They spoke of impasses having to be explored and a struggle to hold onto hope in the therapeutic process, with courage needed to bring lessons from the clinical space out into the client's external world. Ganzer (2019) writing in *Reflections on Long-term Psychotherapy and Psychoanalysis,* speaks of the necessity of allowing

trauma to metabolise at its own pace during long term treatment. Likewise, in a journal article by Van der Hart and Boon (1997) in which they detail the clinical treatment of two Dutch clients with complex dissociative symptomology, they argue the clinical process should be "fractionated/gradual" (p.162). Within the present study, participants spoke of this longer focus of the treatment leaving them at times questioning progress and describing the need for clinical stamina and patience. One participant described having to recalibrate his clinical expectations when working with complex trauma and compared it to walking from "Mizen head to Malin head" (the most northern and southern points in Ireland).

It is worth noting that no research could be found at the time of this study on therapists' experiences of adapting to the complex nuances of their clinical trauma work. The developmental pathway of participants within this study working with complex trauma is significant and suggests an experience of adjusting to sitting with relational ambiguities, due to dissociative processes within the clinical dyad along with having to build a tolerance for an often long and painstaking pace of clinical growth. This finding on therapists adjusting to the challenges of complex trauma treatment would seem significant and warrants further research.

5.3.2 Working with the Intensities of Complex Boundaries Experiences

Most participants in this present study experienced greater pressures when managing their clinical boundaries with complex trauma clients compared to their general clients. Managing clinical boundaries brought several challenges, with participants experiencing internal dialogues around, running over time, the length of treatment and a desire to rescue clients. While all participants recognised the need for boundaries, deep feelings of empathy for the unfairness and injustice of the abuses suffered by

clients could leave participants feeling a desire to rescue them or being too fluid with boundaries.

Within the accounts of the current study, participants spoke of facing within their complex trauma treatments many complicating factors, such as histories of sexual abuse, complex psychodynamics and current self -destructive behaviours which required careful management and added several facets to the decision-making process around boundaries. There has been a paucity of research around "how counsellors and psychotherapists understand and experience" clinical boundaries (Blundell et al., 2022, p.4). Moreover, no evidence base could be identified currently on the experiences of therapists working with complex trauma and clinical boundaries. This study offers a novel understanding of the phenomenon of working with clinical boundaries within complex trauma therapy. It is perhaps unsurprising that clinical boundaries pose such a challenge to trauma therapists, with a review of the existing research literature by Nieuwenhove and Meganck (2019) on the interpersonal patterns of complex trauma clients revealing schemas, such as mistrust, worthlessness, and sensitivity to rejection being a regular feature of this type of therapeutic treatment. Within the current study, participants described their client's relational patterns within the treatment evoking strong countertransferences and empathic responses, which could impact their decision-making processes on boundaries. Participants were aware through clinical experience of the risk of becoming too enmeshed within their alliances with trauma clients. However, some reported still at times grappling with feeling over-responsible for the treatment, not wanting to accept payment, and regularly running over time. One participant felt, regardless of experience level, there could be a risk of becoming "too invested" and learning when to step back in the therapeutic alliance was viewed as an important skill. As Bromberg (2013) suggests trauma therapists must inevitably engage

with the dark nature of trauma work and in doing so, they risk vicarious contagion from the relational aspects of the clients' psychological injuries. Participants in this study learned to recognise the relational unease, which could emerge in their work and gradually learned to use supervision and peers to find a sense of balance within their clinical work.

One manifestation of this relational enmeshment leading to boundary dilemmas was the desire to "step in" and rescue their suffering clients. Participants were aware of the disadvantages their clients faced, due to the impact of traumatic experiences and this could leave them with fantasies of intervening in their client's life. In *Trauma and Recovery* (1992), Judith Herman cautions therapists working with complex trauma around the temptation to assume the role of rescuer, which can restrict client capacity to build their own sense of agency. Friesen and Casella (1982) suggest that if the need to save clients is not explored by therapists it can lead to frustration within the treatment and potential burnout. Within the current study, two participants described having fantasies of wanting to offer financial or practical support to their clients or recurring thoughts of wishing clients who had dropped out of treatment would contact them again. However, these thoughts were tempered by the clinical reality of their work, with participants drawing on professional support and supervision to keep their perspective.

Clinical boundaries became especially important when dealing with suicide risk, the tension had to be navigated between the responsibility of informing others or sitting with the anxiety that the client might harm themselves before the next session. When working with suicide or other types of risk, participants spoke of experiencing conflicting emotions, as they liaised with other professionals, tried to be clear and collaborative with their clients as well as having to sit with not always getting these

clinical decisions right. This is in accord with Levy et al's. (2019) study which found that therapists can experience considerable anxiety as they grapple with a collaborative balance of trying to empower a suicidal client around their safety and exercising their own power to be responsible as a therapist.

An interesting finding of this study were the clinical experiences of some participants reflecting on the changing face of complex trauma work in Ireland. As has been discussed earlier in chapter two, much of the complex trauma work in Ireland has emerged out of need to address the historical impacts of institutional, clerical abuses and other instances of chronic abuse and neglect experienced within previous decades of a conservative Irish society. Two participants reflected on their clinical experiences of working with asylum seekers as having distinct challenges. Clients coming to Ireland seeking political protection often faced multiple challenges including legal issues, lack of accommodation, grief at leaving their family and culture behind, and personal trauma histories due to political abuse. In an article by Speight (2012), she argues that clinical boundaries should be considered in the context of cultural differences within clinical work and not solely through the prism of risk management, as this runs the risk of creating an unhelpful distance within the therapeutic relationship. Therapists in the current study were conscious of their internal struggles to balance compassion, empathy and risk, while still being sensitive to the stark cultural differences of their clients' experiences. This balancing act around clinical boundaries could leave them at times with an internal sense of helplessness, failure and a temptation to over-identify with the plight of clients. Participants spoke of a need for the perspective of supervision and organisational team members to re-orientate them within clinical boundary dilemmas. This appears to be in line with findings in an Australian qualitative study by Apostolidou and Schweitzer (2017) which interviewed nine practitioners working with

asylum seekers. Apostolidou and Schweitzer's study revealed supervision offered therapists an opportunity to build a multicultural understanding of their client's issues and to comprehend feelings of "powerlessness" and "impotence" within their clinical work with this group.

Moreover, the two participants also felt that working with those seeking asylum often required practical support due language barriers, lack of knowledge of the health and legal systems, which often led to therapeutic work blurring into advocacy. A review of the qualitative research on therapeutic boundaries with asylum seeker clients by Davoren and colleagues (2024) revealed a number of themes, which overlap with the current study. This current study supports the finding by Davoren and colleagues (2024) in highlighting the need to reconceptualise psychotherapy in this area as "clinical-political" (p.20), with clinical advocacy a relevant component of trauma work with asylum seekers. Furthermore, they emphasise the importance of "psychodynamic processes" (p.1) such as countertransference being carefully monitored, due to the emotional intensity and traumatic narratives, which accompany this work. Although this study only interviewed two participants working regularly with asylum seekers, it would appear that new multi-cultural perspectives and additional support systems are required to work within this newly emerging clinical environment.

5.3.3 Feeling on the Outside

Another novel finding in the current study was the experience of many therapists feeling on the fringe of their profession. Many felt they had to work harder than most doing general therapy work, due to receiving insufficient core training in trauma and struggling to find trauma informed peers, personal therapists and supervisors. A partial explanation for this was cited by one participant who felt that the small scale of the

Irish trauma community could not generate the same level of highly specialised professionals or clinical expertise compared with the larger populations of the United Kingdom and United States.

Across many of the participants was a familiar experience of having to take on the responsibility of upskilling their clinical practice, due insufficient training in psychological trauma in their core qualification. This echoes previous research (Brand, 2016; Cook et al., 2011; Dunkley & Whelan, 2006) which highlighted the absence of professional trauma components on therapist training programmes. Two participants, who currently worked on training programmes, commented that the lack of education on complex trauma was a "major deficit", which put novice therapists at a considerable disadvantage. However, given the recent increase of trauma informed awareness amongst the clinical professions, this deficit amongst Irish psychotherapy training programmes is likely to be rapidly changing.

A recent systematic review discussed earlier by Sutton et colleagues (2022) identified the importance of trauma training in mitigating indirect impacts of secondary trauma. They recommend psychotherapist training should not only include education on the theoretical aspects of complex trauma, but also information on managing the adverse impacts of this clinical work. Participants within this study spoke of trying to compensate for their sense of deficit in early training through continuous professional development (CPD) in order to build a specialised knowledge in complex trauma theory, assessment and treatment. Despite the descriptions of some participants of limited early training, most felt this specialisation required ongoing education given the continuous and fast paced theoretical advancements and new practice modalities emerging for complex trauma work.

Recent interest in trauma informed care in service provision has been gaining traction within clinical supervision literature (Jones & Branco, 2020). Despite some development towards trauma informed supervision internationally, this current study paints a picture of supervision in Ireland within this specialised field still being in a fledgling state. About half of the participants experienced difficulties in sourcing adequate supervision to support them in their complex trauma work, this was especially problematic for the private practitioners. Accounts within the study viewed the clinical relationship with supervisors as a core component in functioning as a trauma therapist. This is in accordance with studies (Peled-Avram, 2017; Dagan et al., 2016;) which found that participants who evaluated their supervisors as effective were more resilient to indirect trauma. Within the present study, a consistent finding was participants found that many supervisors were adequately trained for general counselling, but this did not make them suitable for complex trauma work. One participant reported supervisors could be overwhelmed by the graphic nature of severe trauma material. A number of participants found that their supervisors did not meet their needs, in the earlier part of their career, due a lack of experience and knowledge on psychological trauma. Of the three participants in this study who worked primarily within private practice, all of them worked with supervisors from the United Kingdom, as no supervisors with requisite levels of expertise could be found in Ireland. It was also of note that the three oldest participants worked in private practice. A survey by Rønnestad and colleagues (2024) on psychotherapist development suggests that senior practitioners are more likely to work in private practice and this can leave them in relatively isolated and lonely working arrangements and potentially deprived of collegial support and interaction. They argue that supervision is a particularly relevant resource for senior therapists, given their potential for vulnerability. These findings by Rønnestad et

colleagues (2024) are of particular interest as this could suggest the participants in private practice in the current study, are not only more likely to be isolated due to seniority, but also as a result of their specialisation. Moreover, although not exactly comparable, a survey by Bearse et colleagues, (2013) examined the obstacles that psychologists faced in accessing their own psychotherapy. One of the results of their study identified that as psychotherapists become more professionally established and experienced, it becomes more of a challenge to engage a potential therapist with the capacities to meet their needs. It could be speculated that the participants within the current study, who possessed specialised clinical competencies and extensive experience within this field, would find it hard to find a suitable professional at or above their clinical level.

5.4 Inner Motivations

A surprising thematic avenue, which emerged out of the interviews, were the differing motivations, which drew participants towards a deeper professional focus on complex trauma practice. For most of the participants, they described exposure to individuals with psychological trauma in the early part of their careers provoking differing internal drives, which gradually led them towards increasing professional investment in this clinical niche. While many of these motivations were conscious and grew as the participants matured into their clinical work, some accounts reflect a darker quality to these internal drives, which had an unconscious quality. There was also the experience of the compelling nature of this professional field leading towards experiences of growth and resilience.

5.4.1 Inner Motivations and their Shadow

A novel finding of this study were accounts of a growing awareness of their personal values, beliefs and motivations playing a significant role as a catalyst in their clinical work. McBeath (2019) points to the paucity of research existing on psychotherapist motivations and he cites the continuing relevance of Norcross and Farber's (2005) statement that, "if the professional silence on the topic is not quite deafening, it sure is conspicuous" (p.940). In an online survey of psychotherapists (n=540) in the UK by McBeath, he identified most therapists feeling their motivations to enter the psychotherapy profession were unconscious and changed over time. For the most part, participants within the current study felt they were aware of their motivations and reported several diverse sources of impetus within their clinical work. Complex trauma was viewed as having a socio-political dimension, which disproportionately impacts those who are socially disadvantaged and those seeking political asylum in Ireland. This became an important driver in the work of some participants, who spoke of free access for these groups being of fundamental importance and, as one participant articulated, it was "something philosophically that was important to me".

Aspects of these findings resonate with a recent UK IPA study by Coleman et al. (2021) which interviewed twenty-one psychotherapists working in NHS trauma services. Their study revealed a theme of "Called to the Work", which discusses their participants' feelings of being drawn to complex trauma practice, due to a need to respond to social inequality and a sense of vocation. This study by Coleman and colleagues cited participants feeling interested in supporting those with histories of abuse and motivated by their own minority status towards working with traumatised clients. They also developed a framework from their research, which identifies a key milestone in a trauma therapist's development, being the capacity of the clinician to be

"in touch with and re-evaluating their motivation to do this work". It was noteworthy in the present study how often participants referenced different types of motivation as being central to their development as trauma therapists. Participants spoke of experiencing their clients as suffering different forms of political and social injustice, along with experiencing clinical neglect due to the complexity of their presentations, and these contexts could often inspire an energy within their practice. A model of altruistic caring developed as a guide for the social professions by Curry et al. (2009), suggests altruism can emerge out of a diverse range of motivations including early life adversity, belief in social justice, and empathic perspective taking. These motivations converge with the accounts of the participants within the current study, who spoke about being acutely conscious of the plight of disadvantaged or those abused in childhood.

Four participants spoke about their professional "fascination" with the complex trauma field, with some relishing its professional intensity. There was a sense of there being a marked difference between general counselling and complex trauma work and they described a fascination with the deep complexities of the work, which could border on obsessional. This aligns to an extent with research in an Indian mixed method study by Duggal and Sriram (2016), which interviewed sixteen psychotherapists in relation to their motivations in becoming therapists. Participants reported an interest in the human mind and academic reading leading them towards entering the psychotherapy profession. An early study entitled *Public and Private Lives of Psychotherapists* by Henry et al. (1973) interviewed clinical psychologists on their motivations and found the role of "intellectual curiosity" and fascination with "human behaviour" were important factors in their career choice. Within the current study, participants used words including "curiosity" "so interesting" and "fascinating" to

describe their clinical work. It appears the specialised nature of complex trauma with its growing CPD sector, inter-disciplinary research base, multiple new theories and challenging client presentations left participants constantly stimulated and striving to develop themselves within their work.

Another finding that stands out was the sense of a shadow side that was generated through the participants passion for their clinical work. Participants became aware of the tendency to be drawn into overextending themselves or being 'consumed' by their professional life. Some described a constant temptation to get lost down a number of "rabbit holes", due to the constant opportunities to train in specialist approaches, read new academic material, or their interest in clinical work leading to heavy caseloads. These tendencies could invariably begin to encroach into their family time and personal life. Many alluded to the dire circumstances of some of their clients making it more difficult to boundary their personal and professional lives. Within clinical environments supporting sexual abuse survivors, asylum seekers and refugees, the scale of the clients' challenges often made strong demands on the participants inherent empathy. New clinical support systems for overseas refugees seeking protection meant the line between conventional psychotherapy and advocacy could become blurred and, as one of the participants stated, "It's not often something that you can just leave". As Killian (2008) concluded from his study, a combination of therapist characteristics and organisational cultures can lead to 'workaholism', given the intense demands within services working with trauma.

Another aspect of this shadow side were two participants' descriptions of being drawn to the most severe end of work on the complex trauma treatment continuum and having little interest in the "worried well". This at times left them questioning their motives and their attraction to such a deep level of human suffering, with one

participant making sense of this attraction as a fascination with the complexity of the human mind. The other participant questioned whether this pull towards working with severe trauma could be some form of a repetition compulsion, due to years of prolonged clinical exposure to trauma. The Jungian analyst Guggenbuhl-Craig (1971) wrote of therapists' motivations possessing light and dark aspects and spoke of the impossibility of "pure" motives. Writings by Norcross and Farber (2005) and Jennings and Skovholt (2004) in a similar vein describe therapists' motivations as always as a mixture of unconscious personal motives and altruistic drives. Within the current study it would seem that the notion of the "wounded healer" has some resonance with one therapist expressing a sense of their own personal history drawing them towards the healing of others. The participants in this present study illustrated their sense of feeling motivated in doing their work, through a mixture of social justice, empathy for survivors and a clinical fascination in the workings of the human mind, but which could also lead to compulsion.

5.4.2 Growth and Resilience

Research, although still in its early stages, has started to reveal not only the ways in which working with complex trauma detrimentally impacts therapists but also leads to secondary experiences of vicarious growth (McCormack & Adams, 2015; Arnold et al., 2005). Within this current study, every time the participants outlined descriptions of the vicarious detrimental effects, there was also a corresponding reference to the personal and professional gains accrued through the years of their clinical work. This aspect of building resilience is reflected in the theme *Growing with clients.*

Newer IPA research has begun to re-conceptualise the vicarious features of complex trauma work as a co-occurring blend of both adverse impacts, alongside

personal and professional experiences of growth and resilience (Bartoskova, 2017; Coleman et al., 2021). This aligns with a recent review of the literature on Post Traumatic Growth (PTG) by Sanki and O'Connor (2021), which suggests post traumatic growth emerges out of efforts to leverage learnings from personal adversity and turn them into experiences of wellbeing. For participants in the current study, despite the tragic nature of many of their clients' narratives, there was a sense of deep attraction to this work, with them using words such as 'love', 'interesting' and 'compassion' as they looked back over the experiences of their professional lives. These positive feelings allowed them to endure the emotional and physical discomforts of their work and allowed for self-healing and development, enhanced attitudes towards relationships, positive outlook on life and an ability to tolerate the psychological intensities of their clinical work. This mirrors a previous framework by Tedeschi and Calhoun (1995) on traumatised individuals which outlines changes in self-perception, interpersonal relationships and philosophy of life.

Based on their qualitative research of participants' experiences, Coleman and colleagues (2021) conceptualised complex trauma treatment as having the potential for negative impacts but also being a "dynamic process of expansion and growth", which moves through a series of key milestones over the clinician's lifespan. With therapists developing a connection with their motivation to do this work, an ability to maintain the alliance in spite of the complexities of the work, a tolerance to the darker aspects of work, and self-reflective capacities, which allow for a growth mindset. Having accepted the reality of the negative physical and emotional wear and tear of their clinical trauma work, participants in this study began to foster a sense of "optimism", "gratitude" and "hopefulness", as they witnessed their clients working through the painstaking process of slowly rebuilding their lives. The current findings resonate with

a qualitative study on twenty-one trauma therapists by Arnold et colleagues (2005), who found their participants learned to draw on the courage and determination of clients and use it as an emotional salve in strengthening their own sense of resilience. For some of the participants in this study, the unique perspective of their work with traumatised clients often led to a deep sense of gratitude. Witnessing their clients overcoming intense suffering and numerous psychological challenges could lead to a re-evaluation of their own personal circumstances. One participant articulated that they had a "huge gratitude for all the privileges that I've had in my life and have, it fairly puts things into perspective", which echoes Munishvaran and Booysen's (2022) similar findings in an IPA study with their participants gaining a deeper appreciation of "there are other people who have had it much worse than I" (p.4).

While some aspects of vicarious growth almost emerged organically over the careers of the participants, some found that they had to carefully cultivate the learnings and new insights into their clinical work to keep on gradually building emotional resilience. For many this meant taking on the responsibility of cutting back on their caseloads and drawing on their support systems. However, for one participant this meant gradually titrating her exposure to complex trauma over time, until an emotional and psychological tolerance developed. By using supervision and personal therapy as a scaffold to build a strong sense of differentiation and healthy detachment, this participant experienced the capacity to work solely with a severe trauma caseload. Arnold and colleagues (2005) also describe a small cohort of their participants developing a therapeutic distance, with one clinician describing his supervisor stating that "you probably have to have a certain amount of callousness" (p.249) to survive in this work. Interestingly, this form of compartmentalisation parallels Bowen's (1978) concept from family therapy of the interpersonal dimension, which consists of

navigating a relational dialectic of intimacy and independence, to allow for optimal wellbeing. As the participant in the current study articulated "if you feel too much, this is not work for you". For all the participants it was important to find a level at which they could tolerate the intensity of their workload.

A novel finding of this study, which may indicate an important area for further research, was the description of two participants adapting their attachment style as an aid to their work with complex trauma. Racanelli, (2005) has identified an avoidant attachment as a risk factor for burnout amongst health care providers. In contrast, this current study found that attachment styles with insecure avoidant components could be positively adapted to assist in their clinical work. As part of their self-development and through personal therapy work, these participants were not only able to move towards a secure style, but they were also able to positively draw upon their attachment pattern for the purpose of healthy compartmentalisation and holding of boundaries within their clinical practice. This resonates with a study by Cologon and colleagues (2017), which investigated the relationship between self-reflective capacities and attachment style in mediating therapist effectiveness. Their findings suggest that high levels of reflective functioning amongst therapists help to transform attachment styles from a negative to a positive factor in terms of therapeutic effectiveness.

In contrast to many qualitative research studies in this area, the current study explored the experience of senior therapists, who had at least five or more years of experience of working regularly with complex trauma (mean=15 years). As previous quantitative studies have reported, duration of career as a mental health practitioner was also predictive of compassion satisfaction (Devilly et al., 2009; Craig & Sprang, 2010). More recently, a phenomenological study by Wang and Park-Taylor (2021) interviewed eleven trauma psychotherapists at differing stages of clinical development and found

their careers tended to follow a U-shaped trajectory in relation to their ability to cope with vicarious stress. Wang and colleagues identified that the most seasoned therapists within their study were able to engage in trauma therapy with low levels of emotional lability compared to those with less experience. It was noteworthy that the present study showed that a period of clinical struggle and grappling with self-doubt was a typical developmental trajectory for most participants, with them taking on important lessons from these experiences. The findings of the current study partially accord with the results of Wang and Park-Taylor's (2021) research with participants developing through CPD, developing self-care strategies and through a process of ongoing self-reflection, which allowed them to use their clinical skills and experience to manage their emotional responses effectively. However, the current study revealed, despite their seniority, most female participants within the present study found their vicarious embodied symptoms did not diminish with clinical experience and required ongoing and intensive management.

5.5 Conclusion

This discussion chapter located the finding of the present study within the relevant literature on therapeutic work with complex trauma. The findings of this study add to the rapidly expanding field of complex treatment by building on previous findings, highlighting novel phenomena and suggesting future directions for research in this area. A key finding of this study revealed working with complex trauma affected female participants primarily at a somatic level with fatigue, muscle tension, soreness and stomach complaints being the most commonly cited symptoms. Given that contemporary complex trauma treatment regularly draws on the neurobiological understandings and somatic approaches, which emphasise non-verbal aspects of client

trauma, it would make sense that therapists would be more exposed to bodily transferences, and this may partially explain the high levels of physiological impacts found in this study. Interestingly, neither of the two male participants spoke of somatic impacts, and this gender difference may warrant further research in the future. Although participants made sense of their vicarious symptoms largely as due to clinical interactions with clients, work related stressors also emerged as influential. One unexpected finding was the extent to which participants reported little negative emotional impact from their clinical practice, which contradicts much previous research and theory. This could be partially explained by the focus on emotional regulation amongst professional support systems.

In line with previous research, descriptions of distorted thinking around the safety of others were experienced by some participants, but gradually they learned to reframe these thoughts and beliefs over the course of their careers. Participants reported addressing adverse impacts through pro-actively taking responsibility for holistic self-care regimes and making decisions to adapt/manage their workload. A diverse range of physical activities were prioritised to allow for longevity within their clinical work. For the most part organisations were viewed as offering a strong sense of safety to participants working within them, but they could also be a source of work-related stress.

Prior to this study little research existed on the experiences of clinical development, clinical boundary issues and professional identity amongst trauma therapists. This present study found therapists were challenged to adapt to the relational depth and gain familiarity with embodied communication, dissociative processes and intense counter-transferences within their work with complex trauma. This meant having to balance feelings of uncertainty and self-doubt, while still maintaining

therapeutic progress within a long-term treatment process. This required a combination of patience, stamina and high levels of clinical dexterity during their work with complex trauma. Clinical boundaries also posed greater challenges, due to the complex psychodynamics and inherent risk management within complex trauma treatment. Some participants experienced intense counter transferences around needing to rescue their clients or a desire to be too fluid in holding their usual practice boundaries. There was also the need for trauma therapists to consider the socio-cultural contexts within their decision making on boundaries and to reconceptualise some aspects of their professional role, when practicing with asylum seeker client bases.

It would seem from the descriptions within this study, this first generation of senior trauma therapists in Ireland have experienced a sense of working within a developing specialisation, which is slowly finding its way in the midst of the growing demands for therapeutic responses to complex trauma. This has left some participants feeling professional isolation with a sense of having to look beyond Ireland for professional support and specialised training, which has been both a challenge and also a source of professional growth.

Although a small research base exists on therapist motivations, there would seem to be no published study on this phenomenon amongst experienced trauma therapists. This study found that participants described a range of internal motivations, personal interests and beliefs, which generated an impetus within their clinical work. Descriptions of motivations included needing to respond to the disadvantage of social inequality, working with client groups who could have their needs overlooked, and professional fascination. However, many participants were careful to point out that these motivations possessed a shadow facet, which had the potential to become destructive or lead to a sense of unease. It would seem the inherent qualities of

complex trauma practice spring from both conscious and unconscious motivations, which are multifaceted.

This study significantly underscored previous findings with participants speaking of both personal and professional growth processes resulting from their work. The experience of working alongside clients as they healed from chronic traumas, left participants with a positive outlook on their personal life and a sense of personal gratitude for the positives in their own lives. Professionally, there was a sense of developing an increasing emotional resilience, through gradual exposure to their client work, along using their personal therapy and supervision to develop personal characteristics to assist them in working effectively.

5.6 Researcher's Reflexive Comments

The writing up of this discussion section and situating of the findings within the current literature proved an arduous process. There was a struggle to present the convergences and differing experiences of participants in a meaningful way within the study. It was rewarding to see many of the participants experiences are recognised within previous studies, but it was also gratifying to hear their unique voices emerge through the idiographic threads of the current study. As an insider researcher, the words of the participants reflect the many changes of a profession, which is very important to me personally.

In the past as a society, perhaps through a sense of collective shame, we have tended to deny those who suffered with complex trauma the opportunity to be heard. Those who suffered with complex psychological injuries would often have to contain a deep sense of shame and endure or act out their emotional pain. We have made many leaps forward in responding to the many diverse experiences of those who suffer with

complex trauma in Ireland. However, maybe some of this tendency to cloak some of the darker aspects of our past has resulted in the lack of academic scrutiny around those who work with traumatised clients. Psychotherapy is a solitary profession and unlike other types of occupation it is conducted behind a closed door with little to see and with practitioners rarely able to discuss their practice publicly due to its confidential nature. My hope is that this study will be a small stepping stone in recognising the important work of this therapeutic community.

6. Conclusion

6.1 Introduction

The chapter summarises the core contributions of this study, the strength and limitations are examined, along with the implications of the findings for psychotherapy practice, supervision and training. Some concluding reflexive thoughts will provide a coda to the overall study.

6.1.1 Strengths and Limitations of the Current Study

A strength of this study was that it achieved the aim of illuminating the experiences of psychotherapists working long term with complex trauma in an Irish context. The study objectives elaborated a number of key issues and highlighted both convergences and divergences in the participants' experiences of working within this clinical speciality. In making a rationale for this study, the researcher highlighted the recent escalation in research studies, due to the introduction of a definition of complex PTSD into the ICD-11. However, many of these studies, as noted earlier, have tended to be quantitative studies and with a focus on client epidemiology and treatment outcomes. There has also been a small but growing interest in qualitative research on therapist experiences of complex trauma work (Coleman et al., 2021; McCormack & Adams, 2015; Merriman & Joseph, 2018; Munishvaran & Booysen, 2022). The present study, however, has some differences to much of the previous qualitative research, such as, this study investigated the participants through the lens of long term clinical work. Therefore, this current study extends knowledge within the body of international qualitative research through documenting and illuminating other experiences of this specialised clinical work within an important developmental context. Moreover, in Ireland the establishment of a number of therapeutic trauma services and growing numbers of

private practitioners working with complex trauma, mean that this study addresses the need to develop evidence-based knowledge in this field. At the time of writing this thesis, three published studies could be found on this phenomenon in Ireland. In researching Irish trauma practice, Wheeler and McElvaney (2018) explored the positive impacts on child psychotherapists, Forde and Duvvury (2021) investigated working with a particular therapeutic approach and O'Connor (2019) looked at experiences of a variety of mental health professionals working with children and families. The present study sought to give a voice to senior psychotherapists and psychologists in Ireland, who have spent many years working with this clinical population. It explored not just professional and personal vicarious impacts, but also what was helpful and unhelpful, along with their experiences as senior practitioners within this challenging specialisation.

Both a strength and limitation of this study was its use of an IPA methodology, which like all approaches is open to critique (Tuffour, 2017). Van Manen (2018) for instance, argues IPA tends to reveal psychological reflections, rather than the phenomenological experiences of its participants. It has been pointed out that phenomenological concepts have the potential to be applied in a "more user friendly approach" (Pringle, 2011, p.22) as in IPA, and do not have to adhere to the strict roots of the original philosophy (Smith et al., 2009). Within this study, the phenomenological aspect of this approach allowed participants to fully express the experiential nature of their struggles and growth, and the researcher could then view their words through an interpretative process, which led to rich findings. IPA offers a blending of flexibility for participants to openly respond, but also the semi-structured nature of the interview format brought an opportunity for careful analysis of the phenomenon under discussion. Care was taken in using the software package NVivo to

organise the analysis of the participants words into relevant themes along with reflexive commentary (example in Appendix K). This use of NVivo along with reflexive journaling provided an audit of the researcher's thoughts and decisions during the study process. However, this same phenomenological quality which emphasises the subjective experience, also offers limits in the generalisability of its findings compared to positivist methodologies (Caldwell, 2008). Although the researcher made careful use of an audit trail during study, the interpretative nature of IPA means that the data can inevitably be subject to some level of bias by the researcher.

In recruiting participants, the researcher was conscious of the fact that the reality of complex trauma practice in Ireland often means straddling roles, which encompass a mixture of work within mental health charities, government funded services, and running a private practice. Rather than solely recruiting from specialist trauma services, the study advertised initially with two Irish psychotherapy accrediting bodies, which meant participants could be drawn from a variety of clinical settings. Some participants worked in specialist organisations, some worked in private practice and others worked with an admixture of both organisational and private practice. A number of specialist trauma services were also directly contacted in a later recruitment phase of the study and five participants volunteered in this way. Even within these specialist trauma organisations, most participants split their caseload between non-trauma and complex trauma presentations, with some also working privately. The researcher had to make a decision around what constituted a representative set of inclusion criteria in recruiting a "fairly homogenous sample for who the question will be meaningful" (Smith et al., 2022, p.43). These professional admixtures within this purposive sampling could be viewed as an arguable weakness of this study, however,

they also allow for insight into typical contemporary work patterns with trauma in Ireland.

The participants recruited were comprised solely of white therapists and this study mainly collected demographic information on clinical background details. A study which considered demographic information such as ethnic and relationship status could have added additional facets of understanding of the participants' experiences. It is also important to note that the participants within the study were older due to the focus on long term practice with trauma and most likely would have experienced growing up in an Irish society, which was conservative and homogenous, and this could differ from the experiences of newer cohorts of trauma therapists. Future studies might focus on recruiting samples, which reflect the shifting demographics within Irish psychotherapy.

The researcher was conscious of his position of also being a trauma therapist. As Costley (2014) argues, being an insider researcher invariably means having an advanced level of knowledge within a practice area, which must be managed responsibly when using methodologies which privilege the subjective. From this researcher's viewpoint, it offered a simultaneous advantage of being familiar with the specialist language, dilemmas and contexts of this clinical world, but also the challenge of having to engage in greater reflection on the use of the hermeneutic stance within this IPA study. The robustness of this reflexive position was held by using a number of both internal and external resources. Along with maintaining a personal reflexive process of writing, the researcher attended monthly research supervision meetings along with receiving input from an independent panel member over the duration of the study, which allowed for the development of decision making of the emerging interpretative processes. Additional perspectives and opinions were offered on the

researcher's dilemmas, quandaries and decisions, through a series of on-line conversations with fellow doctoral candidates, also conducting IPA studies. These multiple perspectives within the study process allowed the researcher to maintain awareness of his reflexivity for the study duration.

6.2 Implications and Recommendations for Psychotherapists, Supervisors and Training

6.2.1 Implications and Recommendations for Psychotherapists

This study looked to be the first to illuminate the lived experience of the first generation of senior therapists working regularly with complex trauma in an Irish clinical context. The study highlights the unavoidable hazards of working within the field of complex trauma, alongside the many ways in which senior therapists learned to sustain themselves within ongoing clinical practice. There was the experience of needing to constantly push themselves to meet the needs of their clients, and the experience of feeling an almost compulsive quality in working with complex trauma treatment. Moreover, as complex trauma work is starting to be viewed as less of a specialisation and with theory and treatment strategies increasingly being absorbed more fully into the world of general practice, it is hoped that this study will increase the academic knowledge of both specialists and non-specialists alike.

Undoubtedly, the most important finding of this study were the reports of the embodied impacts on female practitioners working long term with presentations of complex trauma. Given that trauma therapists work with aspects of the client's trauma, through the bodily sensation, dissociative fragments and unconscious traumatic transferences, it is unsurprising the effects of this work were experienced deep within the physiology of participants within this study. The concept of Secondary Traumatic

Stress suggests a mirroring of client symptoms and with complex trauma being viewed through the lens of neurobiology, vagal responses and the workings of central nervous system, it is becoming increasingly important for therapists to recognise the physiological toll of this work. One contrasting note within this finding on embodied impacts was the gender difference with the male participants not experiencing physiological effects through their clinical work, it is possible female trauma therapists may be more vulnerable to these cumulative effects through a combination of sociological, psychological and neurological factors.

For clinicians who wish to practice regularly with traumatised clients, it seems important to emphasise the need to restore a sense of physical and emotional wellbeing. One of the hallmarks of conceptualising clients with complex trauma is to observe the many layers of their interconnected symptoms, it would seem important therefore that clinicians adopt a similar mindset in reflecting on their own self-care needs. This study cautions against reductionist approaches to self-care. Therapists would seem to be best served by developing constellations of deep personal and communal support, sourcing expert clinical supervision, peer group communication and personal therapy, while also finding ways to harness the body's physical ability to recover from ongoing stress. The findings of this study suggest that trauma clinicians can benefit from monitoring the cumulative negative cognitive effects of long-term practice and learning to reframe beliefs, thoughts and attitudes. It also appears that experiences of clinical adversity have the potential to be channelled into growth processes, which can bring many positive personal and professional benefits. While a growing emphasis is beginning to develop around the awareness and management of the detrimental indirect impact of complex trauma work, vicarious growth processes would seem to be an untapped resource yet to be fully explored within practice. This research indicates that there are

potentials for trauma practitioners to harness personal motivations, develop gratitude and to build emotional resilience. Using supervision and personal therapy to explore and integrate the personal shadow, which emerges out of the complexities of working within trauma practice, also offers the prospect for continuing professional growth.

Compared to those working within organisational settings, trauma therapists primarily in private practice would seem to have to invest a considerable amount of time and effort in establishing supervision, personal therapy arrangements and peer networks within this specialised field. These professional networks provide an essential foundation for those working independently with complex trauma, given the broad array of clinical issues, such as suicidal risk management, underlying psychiatric conditions and complicated dissociative processes, which are often a feature of this type of practice. This study highlights the importance of those within the private sphere of complex trauma practice, to pro-actively work towards mitigating any potential for professional isolation. Findings from this study supports the value of building connections with specialist peer forums, trauma organisations and using technological platforms in accessing appropriate expertise.

The following recommendations are made for clinicians.

1. Attend appropriate continuous professional development, which allows for a comprehensive understanding of vicarious trauma symptoms and managing of its impacts.
2. Develop self-reflective skills to identify the early signals of the negative impacts of complex trauma practice, with a particular emphasis on physical symptoms.
3. Expand self-care routines to include physical activities to mitigate the cumulative embodied impacts, this may be of particular importance for female trauma therapists.

4. Use personal therapy and supervision to explore the adverse effects and the potentials of vicarious growth processes.
5. Build a network of both Irish and international professional peer support in relation to complex trauma practice.

6.2.2 Implications and Recommendations for Supervisors

Trauma psychotherapists within Ireland are facing increasingly severe and complex presentations, due to the growing recognition and treatment of the impact of early life trauma, alongside the arrival of an increasing number of individuals seeking political protection. This study highlights a deficit in specialist knowledge and experience amongst supervisors and personal therapists in Ireland. Of particular note is the amount of effort needed to source supervisors within Ireland with the requisite clinical profile and the specialist knowledge of the multiple facets of complex trauma work. A recommendation from this study is the establishment of a listing within Irish accreditation bodies of specialised supervisors with a clinical background in complex trauma.

Given the developing nature of clinical supervision as a discipline within Ireland, this study suggests that trauma-informed issues are included within supervisory training programmes. Some of the participants within this study described challenges with recognising vicarious impacts in the early part of their career, as these impacts could gradually develop over time within busy clinical environments. It would therefore seem important that supervisors would include elements of psychoeducation for supervisees on the signs and management of indirect trauma.

Other findings suggest that having to adjust to a therapeutic alliance using relational and bodily informed approaches, and managing complex boundaries were

substantial developmental hurdles, when working with complex trauma. A supervisory space, which would take account of these developmental challenges could also provide important support for supervisees. It was notable that participants reported learning to cope successfully with the emotional strain of complex trauma practice, while bodily based impacts had to be consistently managed. This might reflect a lag in trauma informed knowledge amongst supervisors, who traditionally have focused their supportive energies on emotional, cognitive and behavioural effects, with less emphasis on bodily based countertransferences and this may warrant further research investigation.

Part of the reason for choosing the methodology for this study was its sensitivity to the participants' contexts. One such participant context was the work being undertaken by those engaged with refugees and asylum seeker clients. It would appear this is a growing clinical population, which to some extent presents its own unique signature of vicarious impacts on trauma therapists. It would therefore seem a reasonable approach for supervisors to upskill themselves around the socio-cultural challenges of therapeutic work within this niche area.

The following recommendations are made for supervision.

1. Include dedicated modules on trauma informed practice and working with asylum seekers/refugees within supervision training.
2. Engage in training which helps to identify the somatic, cognitive, emotional and behavioural signs of secondary traumatic stress amongst supervisees. Along with highlighting the potential vulnerability of female practitioners to embodied vicarious trauma.
3. Facilitate supervisees in developing their own unique philosophy of self-care and in learning work related regulatory mechanisms for managing secondary stress.

4. Adopt the use of relational models within supervision to enhance supervisees self-reflective processes and understanding of complex interpersonal and bodily based dynamics.
5. Create a supervisory alliance which emphasises relational openness in dealing with the challenging emotional responses and clinical boundary dilemmas of complex trauma work.
6. Highlight the role of working environments (private practice vs organisational setting) on the development of indirect trauma.
7. Establish a listing of supervisors with specialised knowledge of complex trauma within Irish psychotherapy accrediting bodies.

6.2.3 Implications and Recommendations for Training

As was highlighted earlier, each society develops its own individual signature of complex trauma experience, which is influenced by its own history and newly emerging demographics. With this in mind, no training programme can fully respond to the variation in presentations encountered within the many differing clinical environments across Ireland. This study also recognises that the international trend of a trauma informed ethos within service provision is also likely to be enhancing previous limitations with training programmes within Ireland. Moreover, the expansion and range of specialised trauma training that can be availed of privately or through specialist organisations via online platforms has allowed opportunities for therapists to enhance and upskill their core training.

However, it was worthy of note that the seniority of the participants within this study meant some commented on both their own early training experiences and as contributors to contemporary psychotherapy programmes. It was clear from their

reported experiences that there was a sense of a "major deficit" in the level of training and preparedness of current students in working with complex trauma. It is recommended that psychotherapy programmes offer modules that address the sequelae, symptomology and therapeutic strategies/approaches for clinical work in this field. This study raises the importance of training courses preparing trainees for the unique characteristics of complex trauma practice, including working with dissociative processes, complex relational and bodily transferences, and developing a clear framework for decision-making on clinical boundaries. For trainees, personal therapy could also provide an invaluable foundation in learning to understand their own internal reactions and interpersonal patterns, when working with traumatised client bases. Furthermore, a primary finding of this study were the unavoidable negative impacts which accrued from clinical practice in this field. It would therefore be important for training programmes to caution student therapists on the hazards of this type of specialised work and allow them to make an informed decision around working with traumatised populations.

Psychoeducation on self-care for clients experiencing complex trauma, has long been established as a staple in their recovery. An emphasis on the regulation of a constellation of bodily, affective, cognitive, interpersonal, behavioural and a fostering of a deeper relationship to their socio-cultural environments is often part of guiding clients to increased experiences of well-being. It would seem logical therefore that therapists working with trauma, should be encouraged to develop their own ongoing philosophy of self-care, which tailors a broad range of internal and external resources within their early training environments. It is recommended that students be encouraged to grow the habit of self-reflection within their clinical practice, in order to

recognise and respond to the potential vicarious impacts of trauma work and for this to be included as an area of focus within clinical supervision during training.

It is also becoming evident that the refugee crisis is a growing international issue. This has the potential to increase demands on those working therapeutically with complex traumatic presentations. Thus, training which is culturally sensitive to the varieties of socio-cultural contexts of newly arriving individuals seeking political protection would be helpful.

Recommendations for training.

1. Within training programmes highlight the inherent risks of complex trauma work to novice therapists.
2. A specific focus on preparing trainee therapists in recognising and responding to the adverse vicarious impacts of complex trauma practice.
3. Include specific modules on complex trauma theory, specialised practice, management of clinical boundaries and socio-cultural contexts within core psychotherapy training.
4. Encourage trainee therapists to develop their own unique philosophy of self-care, which recognises the multi-faceted impacts of complex trauma work.
5. Attend regular continuous professional development on complex trauma practice.

6.3 Future Research

This qualitative study provides the first window into the lifeworld of senior psychotherapists working both privately and/or with non-profit organisations long term with complex trauma in Ireland. It provides a number of contributions, as well as raising important questions within this study area. The therapists who participated within this study were experienced trauma clinicians, and this study offered a glimpse

at some of the developmental issues faced over the duration of their clinical work. It would seem that the experience level of the participants allowed them over time to manage the emotional intensities of complex trauma work. This was achieved through a process of regulating caseloads, a gradual desensitisation to the affects of working with clients and in some cases using attachment patterns to compartmentalise the powerful emotional effects of complex trauma practice. Contrastingly, while female participants built self-care strategies to cope with vicarious embodied symptoms, these adverse physiological effects remained a central and continuous struggle within their clinical work. Moreover, working with complex trauma meant gradually adapting to working with non-verbal, dissociative and unconscious processes within the working alliance. This left the participants in the earlier part of their career as trauma therapists challenged in navigating a sense of ambiguity and uncertainty within the therapeutic process, which they had to learn to adapt to. The complexity and intense countertransferences of this specialist work also led to difficulties in managing clinical boundaries. Future research studies exploring trauma therapists' experiences could look to more firmly establish some of the developmental phenomenon highlighted within this study.

Literature indicates that female psychotherapists are at higher risk of secondary trauma (Fernández et al., 2024; Wozencroft et al., 2019). The current study found that male therapists reported no physiological impacts, which were commonly discussed by most of the female therapists. This is surprising, as male socialisation is typically viewed as limiting men's outlets for emotional expression, which could leave them more vulnerable to vicarious effects. It is also possible that Irish socio-historical factors, which have reenforced patriarchal attitudes within institutions and work life, could leave women more prone to indirect effects within their practice. A more in-

depth examination that specifically looks to better understand and illuminate the experiences of gender and vicarious trauma may be helpful, as this may have important implications for self-care.

Some recent US qualitative research by Borders et al. (2024) conducted on the trauma-informed supervision of trainees identified emotional regulation as a primary target for supervisors in supporting novice supervisees. The current study explored the experience of senior trauma therapists and revealed bodily based symptoms as a central concern within their work, rather than emotional regulation. This contrast in findings may suggest that the supervisory needs of trauma therapists shift over the course of their development with accumulating exposure to complex presentations leading to bodily impacts. An additional layer of understanding could be added by future research studying trauma informed supervision of senior therapists to gain a perspective on trauma therapist development.

Given the differing traumatised populations now seeking professional support within Ireland for different forms of psychological trauma, qualitative studies which explore the impact of various sub-types of complex trauma may yield valuable new knowledge on secondary impacts. Despite the small number of participants within the current study, it appeared to some degree that experiences of vicarious effects were mediated by working with specific client groups. For instance, those working with asylum seekers with histories of political torture/oppression and socio-cultural dislocation reported some subtle differences in the experiences of their counter-transferences around power and questions around their role as therapists. These impacts were less referenced by those therapists treating Irish survivors of institutional and childhood abuse. Future studies within an Irish context could seek to explore these differences in vicarious phenomena.

6.4 Conclusion

This study set out with the aim of gaining a deeper understanding of senior therapists' experiences of working long term within the specialised field of complex trauma. Both the aim and the objectives of study were achieved through a detailed analysis, which generated a comprehensive set of findings, which advance academic knowledge on this phenomenon.

Over the course of their interview participants took their time to explore and describe how they made sense of their experiences of working with complex trauma over the many years of their career. *The Vicarious Impacts: "You feel like it's in your bones"* illustrates the variety of ways their work took a personal and professional toll. It represents their experiences of gradually learning new skills in caring for themselves as professionals and balancing the need to live full lives outside of their working worlds. Of particular significance were the physical and somatic symptoms common amongst the female participants, which required ongoing and intensive management. This finding may reflect the growing emphasis on non-verbal and somatic approaches to working with complex trauma, and also a potential gender difference in the experience of vicarious trauma, which warrants further study.

Participants found there were experiences of the numerous adaptations, which the complexity of their therapeutic work continuously demanded. This required a process of clinically acclimatising to a dynamism within the intersubjective realm, which called for constant reflection, made significant cognitive demands, and needed continuous upskilling over and above typical continuous professional development requirements. Due to the regular interpersonal challenges resulting from complex trauma, clinical boundaries regularly became a source of internal struggle and self-doubt for therapists within the study. The participants, as they reflected, described the

ways in which working with complex trauma felt different to other types of therapeutic work with a sense of having to strive harder to grow within their professional specialisation. Training, supervision and support had to be often sought out internationally rather than through the usual channels of Irish psychotherapy. These differences in complex trauma practice left participants with a feeling of *Being pushed: "It's continuously challenging".* This finding emphasises the need for a trauma informed ethos amongst organisations, training programmes, and the discipline of supervision, which is sensitive to the unique developmental trajectories, clinical boundary challenges and the difficulties faced by those working with complex trauma in private practice and organisations.

A further finding was a sense of *Feeling Driven: "This kind of work is so addictive".* Deriving a sense of energy through a process of harnessing their beliefs, values and personal motivations gave participants the opportunity to sustain this continually demanding clinical work. The passion generated by these motivations could also encompass a duality of self-destructive tendencies, but also the seeds of both professional and personal growth. Participants were conscious of the dialectic of being stretched while also growing in their emotional resilience, in their outlook on life and in developing a foundational set of values as professionals. These motivational and growth processes would seem to be relatively unexplored resources within developmental frameworks, psychotherapy training and supervision provision for trauma therapists.

6.5 Final Reflective Thoughts

It has always been my hope for many years to one day complete a doctorate and it would seem this academic finish line has finally been crossed. Central to this research

process were the reassuring voices of my supervisors and fellow doctoral candidates, so these conversations will be missed. The process of working through this study has taught me many lessons professionally, academically and as an individual. This research study has created an awareness of the richness and diversity of this clinical work, and the deeply embodied nature of human experience and psychotherapy work. The words of the participants have certainly permeated into my own psyche, and I have noticed my tendency to engage in physical activity has increased with regular running, going to the gym, and my ongoing struggle to include daily mindfulness.

The finding within the study around gender difference has also increased my awareness of my lived experience as a male therapist within a predominantly female profession. The study made me more conscious of the fact that much of the trauma caused to clients is a result of the actions of male perpetrators, but there is also my sense as a male therapist of trying to use my gender in a way that offers a corrective experience and a differing perspective within the profession going forward. I feel that this study has also sensitised me to the ways in which growing up and living in Ireland shapes our working lives. I hope the study reveals something about the complex nature of our motivations, attitudes and beliefs as clinicians and how they are all subtlety being moulded at a level that is not always apparent at first glance.

As this study concludes, I am grateful to the senior therapists who took time in the midst of busy caseloads to partake in this study. As I conducted their interviews, I was conscious of most of the participants wanting to contribute something to future cohorts of trauma therapists. My wish in deciding to study senior therapists working with complex trauma was to generate some academic attention around a group of therapists, who take on the arduous task of therapeutically addressing the societal legacy of our traumatic past and who offer their skills to those seeking refuge from

brutality of war and oppression. I hope that the findings of this study will spark some reflection on trauma informed practice, supervision and training within Irish clinical circles. But also, reflection at the level of the individual therapist, as they consider the adversities of this work, the passion it generates and the growth it promotes.

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Appendices

Appendix A: Recruitment Wording for Online Advertisement

Research study exploring psychotherapists work with complex trauma.

My name is Gerry Meehan and I am researching senior therapists' experience of working with complex trauma, as part of my Doctorate in Psychotherapy at DCU.

I am looking for participants who:

- have 5 or more years of working with complex trauma
- have complex traumatic presentations as part of their typical caseload
- are accredited psychotherapists
- would be willing to share their experiences of working with complex trauma in an interview lasting 45 – 60 minutes approx.

Your experience is important to me and in particular, I want to hear about the following:

- your first-hand understandings as senior clinicians of the positive and/or negative aspects of working with complex trauma
- your insights into what has been helpful and unhelpful in working within this specialised area
- if and how working with complex trauma has influenced you personally and professionally

If you're willing to take part in a 45 – 60 minute interview either in person or by Zoom, I would be delighted to hear from you.

This video gives a brief summary of the study.

For further information please contact Gerry Meehan, Doctorate in Psychotherapy candidate

E: gerard.meehan3@mail.dcu.ie

or Tel: 085-1417173

My warmest thanks for your support

Gerry Meehan

Appendix B: Recruitment Video

https://drive.google.com/file/d/1-5fKGWI19UcGdrF9-7aq6A_P37uJTPPF/view?pli=1

Appendix C: Letter to Directors/Organisations

Dear Director

I am a candidate on the Doctorate in Psychotherapy at Dublin City University. As part of this programme, there is a requirement to complete a research project related to the field of psychotherapy. I intend to study senior therapists' experiences of working with complex trauma in Ireland.

The purpose of my study is an exploration of senior therapists' experience of working with complex trauma. I wish to further investigate this topic by using a qualitative study to add to the primarily quantitative research which predominates within this area, and to research this phenomenon within an Irish context. In particular, the study will explore in detail the impact both personally and professionally of working with complex trauma, as well as the positive and negative aspects of working within this specialised area.

I am looking to include clinicians, who regularly work psychotherapeutically with complex trauma for my study. I would be grateful if you could circulate an email to senior therapists in your organisation (that is those who have five or more years of work with complex trauma presentations) regarding participation in my research. Should you require any further information you can contact me at 085 1417173 or email at gerard.meehan3@mail.dcu.ie.

Yours sincerely
Gerry Meehan

Appendix D: Letter to Participants

Dear colleagues,

I am writing to invite your participation in my upcoming Doctoral study, entitled 'An exploration of senior psychotherapists' experience of working with complex trauma in Ireland. An Interpretative Phenomenological Analysis'. I am a candidate on the Doctorate in Psychotherapy at Dublin City University, as part of this programme, there is a requirement to complete a research project related to the field of psychotherapy.

The purpose of my study is to explore senior therapists' experience of therapeutically working with complex trauma within an Irish context. Research suggests that working with complex traumatic presents unique challenges and benefits for clinicians. This research will look to explore the experience of therapists in Ireland working within this specialised area in order to examine in detail their experience and how they make sense of their work with complex trauma. In particular the study wants to explore how you are influenced both personally and professionally by working with complex trauma, as well as exploring the positive and negative impacts of working within this specialised area.

You may be eligible to participate in this study if you have regularly worked with complex trauma for over five years in your clinical practice. You will be invited to take part in a 45 – 60 minute interview at your office or on Zoom. No contact details will be shared with any third party. Your participation in this study will be completely voluntary, you will have the right to cease the interview process or to withdraw your data up until submission of the study in Summer 2024.

If you would like to learn more about this study, please contact me at gerard.meehan3@mail.dcu.ie or if you would like to talk with me directly call me at 085 1417173. Thank you for your time and consideration.

Yours sincerely

Gerry Meehan

Appendix E: Information sheet

Plain language statement

Research title: An exploration of senior psychotherapists' experience of working with complex trauma in Ireland. An Interpretative Phenomenological Analysis.

Supervisor: Dr. Aisling McMahon
School of Nursing, Psychotherapy and Community Health
Dublin City University
Collins Avenue Dublin 9
aisling.mcmahon@dcu.ie

Supervisor: Dr. Denise Proudfoot
School of Nursing, Psychotherapy and Community Health
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Researcher: Gerard Meehan
Doctorate in Psychotherapy Candidate
School of Nursing, Psychotherapy and Community Health
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Purpose and rationale of study

This research intends to study in detail senior therapists' first-hand experiences of complex trauma work. In particular, the study would like to know, how your experiences of working with complex trauma has influenced you personally and professionally in positive and/or negative ways. Your subjective insights into what was helpful and unhelpful in carrying out your work with this client group would also be of interest. Your interview data will be analysed for important themes in relation to your work in this area. This research will build on a small body but growing body of work, which examines therapists' understanding of working within this specialised field. No previous research has exclusively investigated clinicians' experiences of working with complex trauma in Ireland.

What does participation involve?

Your participation would involve a 45 – 60 minute interview at a convenient location, which would be recorded digitally. The interview would contain questions regarding your experience of working with complex trauma. Should you agree to participate in the study, you would be asked to sign a consent form, which confirms your willingness to partake in the study. A short debriefing will also take place in order

to give you the opportunity to discuss any questions or concerns that may arise as a result of the interview.

How is your privacy protected?

Every effort will be made to remove all identifying information from your interview data and the use of pseudonyms will be employed on transcript pages and quotations. However complete anonymity cannot be guaranteed, given the method of face to face interviews, the small number of participants and use of direct quotations. The transcripts will be identified by an allocated number and a list of the participant names with the identification numbers will be stored separately on an Excel spreadsheet. The Excel spreadsheet will be stored on the researcher's secure DCU Google drive.

How will data be used and disposed of?

Interviews will be typed up from the digital recordings, and these recordings will be erased after submission of the research study to DCU. All digital transcripts/data/coding information stored on DCU Google drive will be stored for a five year period after the completion of the study and then deleted by the researcher.

Limits of confidentiality

Confidentiality cannot be fully guaranteed and can only protected within the limitations of the law, (- i.e., it is possible for data to be subject to subpoena, freedom of information claim or mandated reporting). In the event of a disclosure of information, which sees a risk to you as participant, another person or if there is a child protection issue raised, Children First guidelines will be adhered to.

Potential benefits

There will be no direct benefits to your participation in this study. However, the opportunity for you to reflect on your own experience of working with complex trauma, may provide an indirect benefit by aiding in your personal and professional development.

Potential risks

There may be a small risk for you to become distressed, during the interview, as you discuss recollections of your clinical work. Should this arise, you will be made aware that you can take a break at any point during the interview and you will be reminded that you have the right to stop the interview and withdraw your personal data from the study. You will also be encouraged to discuss these issues with your own supervisor.

Do I have a right to withdraw from this study?

The choice to participate in this study is completely voluntary and you are free to cease participation during the interview and to withdraw any of your data up until submission of the thesis to DCU in Summer 2024. You can withdraw from the study by contacting the researcher Gerry Meehan at gerard.meehan3@mail.dcu.ie or alternatively the research supervisors: Dr. Aisling McMahon at aisling.mcmahon@dcu.ie or Dr. Denise Proudfoot at deniseproudfoot@dcu.ie.

How will I find out what happens with the project?

If at any stage you have any questions regarding the study findings contact the researcher, Gerry Meehan at gerard.meehan3@mail.dcu.ie or alternatively the research supervisors: Dr. Aisling McMahon at aisling.mcmahon@dcu.ie or Dr. Denise Proudfoot at deniseproudfoot@dcu.ie. The Doctoral dissertation will be available on completion in the DCU library and online as part of the DORAS academic repository. It is hoped that the findings will be presented at a psychotherapy conference and a paper based on the findings will be submitted to an international psychotherapy journal for publication.

What measures will be taken in relation to GDPR compliance and who do I speak with concerning any GDPR compliance questions?

A number of measures will be in place to meet the EU's 2016 GDPR compliance and related Irish legislation. All researchers/supervisors have completed a training module on data protection. All of your data will be stored in folders on DCU's secure Google Drive. Only the named researchers/supervisors will have access to your data and no data will be stored on any devices. Your data will not be shared with any third parties.

If you have any questions regarding GDPR compliance contact the researcher, Gerry Meehan at gerard.meehan3@mail.dcu.ie or the research supervisors: Dr. Aisling McMahon at aisling.mcmahon@dcu.ie or Dr. Denise Proudfoot at denise.proudfoot@dcu.ie. Alternatively, you can contact the DCU protection officer, Mr. Martin Ward at data.protection@dcu.ie, Tel. 01-7005118/7008257. You also have the right to lodge a complaint with the Irish Data Protection Commission at 01-7650100 or https://www.dataprotection.ie/en/contact/how-contact-us.

If participants have concerns about this study and wish to contact an independent person, please contact: The Secretary, Dublin City University Research Ethics Committee, c/o Research and Innovation Support, Dublin City University, rec@dcu.ie, Tel. 01-7008000

Appendix F: Informed Consent Form

Informed Consent Form

Research title: An exploration of senior psychotherapists' experience of working with complex trauma in Ireland. An Interpretative Phenomenological Analysis.

This study will be being conducted by Gerry Meehan, a candidate on the Doctorate in Psychotherapy programme and supervised by Dr. Aisling McMahon and Dr. Denise Proudfoot at the School of Nursing, Psychotherapy and Community Health, Dublin City University. The purpose of this study is to illuminate senior therapist experiences of working with complex trauma in Irish context.

If you agree to participate in this study, you will be interviewed and asked a series of questions in relation to your experience of working with complex trauma.

If you consent to being part of this research please complete the following:

I have read the Plain Language Statement (or had it read to me)	Yes ☐	No ☐
I understand the information provided	Yes ☐	No ☐
I understand the information provided in relation to data protection	Yes ☐	No ☐
I have had an opportunity to ask questions and discuss this study	Yes ☐	No ☐
I have received satisfactory answers to all my questions	Yes ☐	No ☐
I am aware that my interview will be audio/Zoom recorded and that direct quotes will be used in the study write-up	Yes ☐	No ☐

I am aware that my participation in this study is completely voluntary and that I am free to withdraw for any reason, at any stage.

My data will be kept secure at all times, and my name will not be divulged to anyone. My name will be anonymised to protect my identity. However, given the small number of participants and interview process and use of direct quotes, I am aware my anonymity cannot be fully guaranteed. Furthermore, this study will be subject to legal limitations, which have been explained to me. It is also my understanding that all information gather during the research will be deleted and shredded five years after the completion of this Doctoral project in accordance with DCU guidelines and GDPR requirements. I understand, the results of this research may also be published in a future journal article.

I have read and understood the information in this form. My questions and concerns have been answered by the researchers
and I have a copy of this consent form. Therefore, I consent to take part in this research project.

Signature:

Participants Signature:_____

Name in Block Capitals:_____

Witness:_____

Date: _____

Appendix G: Interview Schedule

Interview Schedule

Name:_____ Sex/Gender: _____, Age: _____

Professional discipline:_____ Therapeutic approach: _____

Client base: (adult/adolescent/child/mixture)_____

Current practice setting/Organisation :_____ Years working with complex trauma:__

In your opinion, what percentage of your work is with those who have experienced complex trauma? ___

How do you understand complex trauma?_____

1. Why is this study of interest to you? /complex trauma?
2. Tell me about your experiences of working with complex trauma as a psychotherapist?

    -Prompts (Is there a time recently? As part of your recent caseload?

    What does it look like? How did you feel? What did you do?)
3. In what way does working with complex trauma impact on your work as a therapist?

    -Prompt (Can you give me an example of your early/recent practice)
4. In what way does working with complex trauma impact on you personally?

- Prompts (career/families/relationships/existential beliefs/values/future trajectory

    both positively and negatively)
5. What has helped you to work with clients with complex trauma?

-Prompts (How did this help? Role of supervision? Have you completed any specialised training on the topic (how do you know you have enough training?)
6. What was unhelpful in working with complex trauma?
7. Is there anything we haven't covered which that you feel is important to say about your work with these clients or complex trauma in general?

Appendix H Pauline's PETS table

Name
THEME 1 WORKING IN THE FOG
Clearing a path for the client to heal
Bringing mindful awareness to client's experience p.11 *you know, resources we have within ourselves that we are disconnected from or don't realise we have and our breath is a huge resource, you know and our body being able to move uh, you know the idea of you know going for a walk being we're across the road from a lovely little park here regularly encourage clients to go for a walk in the park, you know, just let things land, you know, take time, be present to yourself. Notice whether that it's possible to do that or you know, and what happens if it doesn't feel possible? What comes up for you? And notice the capacity to increase your ability to be present to yourself, because it's only in our capacity to be present to ourselves that we can actually be present to other people*
Helping clients love themselves p.12 *And notice the capacity to increase your ability to be present to yourself, because it's only in our capacity to be present to ourselves that we can actually be present to other people and also, the idea that whatever I'm looking for is actually within myself and so if I'm looking for love, for example, companionship, you know to be loved, you know, I have to find that within myself first.*
Instilling curiosity within the client p.6 *trying to foster a curiosity about what is happening for them before the sessions. After the sessions during the sessions… for what… so trying to help them to connect to themselves, to notice what happens in their body, to notice if they're having dreams or their sleep, what's that like? What their appetite might be like and to begin to foster a sense of awareness and with the benign curiosity….is the….so without any criticism or judgement, but just to kind of go now that's interesting and wonder about the timings of things and to try and help them and that's also in doing that, I'm trying to assess the clients capacity for insight, you know, because some clients obviously would have, uh, a deep capacity for insight and others this might be a whole new language*
Need for challenge and accountability p.16 *I can be quite challenging my clients, you know, not confrontational, but just quite challenging about, you know, like, say, awareness isn't enough, you know, what do you do with the awareness then? And that's your free will. But sometimes I end up finishing my clients. Well, we've come as far as we can for now, you know. This isn't a chat. We're here to do work and you know….and it's a valuable space and I'm a valuable resource and this is a valuable resource, so I have to you have accountability. I have accountability and the client has accountability. So if the client isn't attending for uh consistently, or if I feel they're messing me around like they're ultimately messing themselves around*
Pacing session and allowing the unconscious to emerge organically p.5 *because timing is very important and finding the language and may not be able to find the language for it at that time because I don't understand it,*

Name
so I can't interpret it or translate it. Also an interpretation wouldn't be helpful because that would generally be too removed from where the person thought they don't know it's unconscious, so it's an unconscious phenomenon really generally
Preparing client for work ahead p.6 *I would spend a lot of time in the early stages of…trying to establish the relationship with the client, trying to foster a curiosity about what is happening for them before the sessions. After the sessions during the sessions… for what… so trying to help them to connect to themselves, to notice what happens in their body, to notice if they're having dreams or their sleep, what's that like? What their appetite might be like and to begin to foster a sense of awareness and with the benign curiosity….is the….so without any criticism or judgement*
The reassurance of psychoeducation p.9 *You know, something might have that you can help the client gain a sense of control and so you can do some educational work with them. Also, you can explain to them what are common impacts of trauma and that can be very normalising for people, so and that can be massively reassuring to say, oh, it's not just me, because people often feel there's something wrong with me and going on, you know, the what you are describing or what is happening to you*
Making sense within the relationships of trauma work
Flow of reverie between client, therapist and supervisory dyads p.8 *in my notes the whole act of writing up my notes is the beginning of me, beginning to process because I'm externalising something that has been in me and so that starts there, and then often I will take a note of something that I might bring to supervision, or that I might think about or I might write some points that I'll go oh, I didn't think about that in the session. That didn't strike me and I'll put a note on it for next week to raise it in the session with the client or I'll just think about something more theoretically, really….. and so….and think about…it it's like it basically, it's like reverie, you know, space of reverie, which is something I think is really important and so it's, it's that space of just well reverie is a dream like state. You know of like it's just…it's like spices in a dish. They're finding their level, you know, and some flavours will come out strongly than others, you know and they'll find their way….so it's sort of like….you know, you,….(pause) you'll be identifying themes, identifying just what might be a repetition. What might…. what you might you bring to supervision*
Managing fantasies p.12 *if you're working with somebody, maybe who has a borderline personality disorders and yeah, it's very intense em…and managing boundaries are really important and consistency is very important. Communication is very important and communicating clearly and kindly but holding it, you know, it's very, very important. Em and also naming that you know if someone is upset with you or you know they may not be upset that for themselves if they maybe you're maybe you feel annoyed at me. Maybe you feel a bit abandoned and, you know, sit in a way that it isn't accusatory or critical. But of course, of course, you know course….you know, and what do you think…..you know, there off swanning away for two weeks and you know,*

Name
Therapeutic relationship is central p.4 *I think that ultimately it's the relationship that heals and your child. I've been hugely challenged and how to be present to people.* *The one to one is more like the mother child, the kind of oceanic oneness of the intensity of that. It's a much more intense presence, you know, and it can be engulfing, you know and you know…….that's part of it as well..that's part of the healing*
Unhelpful fantasies p.12 *Well, if you're working with somebody, maybe who has a borderline personality disorders and yeah, it's very intense em…and managing boundaries are really important and so, so and consistency is very important. Communication is very important and communicating clearly and kindly but holding it, you know, it's very, very important. Em and also naming that you know if someone is upset with you or you know they may not be upset that for themselves if they maybe you're maybe you feel annoyed at me. Maybe you feel a bit abandoned and, you know, sit in a way that it isn't accusatory or critical. But of course, of course, you know course….you know, and what do you think…..you know, there off swanning away for two weeks and you know, maybe I am.* *I explain to clients at the beginning,……, I will give you notice of time off unless an emergency occurs. You know, people can go into all sorts of fantasy. As I have once with the client I had a client who I saw for about two years and he used to come every single week at the same time and he drove a motorbike…he was….he never didn't attend without notice, you know, and we did a lot of great work together and then we'll make he didn't attend and he didn't call after or cancel. And my fantasy was that he had been knocked off the motorbike on his way, you know, and em I really. That that's where I went to my head. I said ohh, he's….you know, because I never heard from him. But then you have your procedure of following up, and then what something had happened anyway that he had been on route but something happened. And anyway whatever it was, he never thought to call and it could have been acting out as well of some sort, which is fine. It's healthy I think. But you know, it was interesting where I went in my mind as well. You know, the catastrophe, you know? Yeah. So it works both ways. Yeah.*
Using bodily informed approaches p.4 *it can get communicated energetically and nonverbally. And so it's meant that I've, em… I've become much more interested in body work and breadth work and it and built on my trainings in that regard* *I've just moved way more towards body work and my own interest anyway. We would have been introduced to yoga when we were in college and as a stress management, for stress management. So I've just ended up like I have ended up training to be a yoga teacher and I don't formally teach, but I use the principles of yoga and breath work here in in my work with clients so and helping people to, you know, movement, you know, the movement of energy. You know how things change so you know.. so actually the client before you we were doing some breath work in terms of being able to self-regulate when feeling overwhelmed*
Working outside of the room p.5 *so it's an unconscious phenomenon really generally, and that that's what I'd understand it as, and but…then. So that's where the work happens outside of the session, either in clinical supervision in my peer group, or as just in my own thoughts, my own experience*

Name
I'm trying to assess the clients capacity for insight, you know, because some clients obviously would have, uh, a deep capacity for insight and others this might be a whole new language or they may not……It might be like…double Dutch, you know, so it depends. So you're trying to you're you're trying to assess what level do you go in and so you do an awful lot of work on your own. You know, outside of the session *the whole act of writing up my notes is the beginning of me, beginning to process because I'm externalising something that has been in me and so that starts there, and then often I will take a note of something that I might bring to supervision, or that I might think about or or I might write some points that I'll go oh, I didn't think about that in the session. That didn't strike me and I'll put a note on it for next week to to raise it in the session with the client or I'll just think about something more theoretically, really….. and so….and think about…it it's like it basically, it's like reverie, you know, space of reverie, which is something I think is really important and so it's, it's that space of just well reverie is a dream like state state. You know of of like it's just…it's like spices in a dish. They're finding their level, you know, and some flavours will come out strongly than others, you know and and they'll find their way….so it's sort of like….you know, you,….(pause) you'll be identifying themes, identifying just what might be a repetition. What might…. what you might you bring to supervision*
Working with ambiguity
Challenge of prioritising intuition over rational p.6 *It's very unique and it's not very scientific. So this can be part of the difficulty in this type of work, which is so hard to measure, you know like how do you measure those? How do you measure energy?* *How do you measure dynamics? How do you measure? You know, the impact of like of where you might feel like a steam train has rolled over you when the client leaves the room, they might go skipping out of it and you want to like pass out, you know. So it's, you know, because they've projected everything that's often quite unconscious onto you and that's relieved them to go. The ideal is that you're going to have to grab hold of that in some way, help to spread it out between the two of us and be curious about it and help the client to reintegrate whatever it is they're they're, you know, the idea of projective identification, you know, to reintegrate whatever it is that that is unmanageable for them, you know. But this is, you know, for trauma, you know, it's it's deeply unconscious* *you're trying to help people to em…. to open up to the energy to how they are and like that can be a whole foreign language to people and….and people some people might think that's a load of rubbish*
Inhabited by the client's energy p. 4 *Literally inhabited. By…so a person could be speaking to me in uh with some vitality or they may have some vitality, but the energy I'm experiencing is a very flat energy and so that might might feel like I might feel tired. I might have difficulty concentrating or I might lose my concentration and kind of….or find it hard to follow sometimes.*
Reintegrating projection within alliance p.6 *the impact of like of where you might feel like a steam train has rolled over you when the client leaves the room, they might go skipping out of it and*

Name
you want to like pass out, you know. So it's, you know, because they've projected everything that's often quite unconscious onto you and that's relieved them to go. The ideal is that you're going to have to grab hold of that in some way, help to spread it out between the two of us and be curious about it and help the client to reintegrate whatever it is they're, you know, the idea of projective identification, you know, to reintegrate whatever it is that that is unmanageable for them, you know *It can be deeply unconscious, very and very threatening to people. It can be, but sometimes it's not. Sometimes people get such relief when you kind of might draw attention to notice and energy change or, you know, do you notice that or you know and? And you know, does that happen for you in other places, or do you? Have you ever noticed that? And then sometimes go Oh yeah, that happens to me a lot.*
Sitting with uncertainty p.6 *I have learned it's is that it's better to be present to it in the here and now of the relationship as much as that as possible. But if you do that too quickly…..before you have kind of been able to grab hold of what might be occurring because you don't actually know what's occurring, but something is happening and you don't know what that is. It's some sort of repetition. But what exactly the trigger for that has been, you know, or how to work through that isn't clear. You have to work that like, I don't have the answer for that, as a therapist, all I can do is reflect back what the patient is bringing to be seen. And so to try and translate that together.*
The puzzle of countertransference p.8 *you'll be noticing your own kind of counter transference with with the client of whether you're drawn to them whether you like them, whether you feel the warmth for them, or whether you find them particularly difficult to be with or you know, challenging or you know, so it's interesting and interesting how that evolves and what what of….because everything that's happening between me and a client happens for the client and all their relationships to…. in some form or another. But the only difference is that in our relationship we have the opportunity to actually really talk about that from a place of curiosity and and ideally growth and expansion of what happens in relationships, so it it it depends and it depends on the level of the relationship*
Translating the unspoken p.6 *But how to reflect that back in a way where it isn't overwhelming for the client or shaming or in any way critical that… so…. I would spend a lot of time in the early stages of…trying to establish the relationship with the client, trying to foster a curiosity about what is happening for them before the sessions. After the sessions during the sessions… for what… so trying to help them to connect to themselves, to notice what happens in their body, to notice if they're having dreams or their sleep, what's that like? What their appetite might be like and to begin to foster a sense of awareness and with the benign curiosity….is the….so without any criticism or judgement, but just to kind of go now that's interesting and wonder about the timings of things and to try and help them and that's also in doing that, I'm trying to assess the clients capacity for insight, you know, because some clients obviously would have, uh, a deep capacity for insight and others this might be a whole new language or they may not……It might be like…double Dutch, you know, so it depends.*

Name
Using emotional energy to guide work p.4 *I like one of the things that I would do before I meet every client is I would just take stock of my emotional temperature is what I call it and notice how I am and myself what my energy levels are like and myself, what I'm anticipating the session might be particularly in an ongoing relationship with the client. What this session, you know, what themes we might be working on, what we might be exploring and so then the client comes and then just you can feel the energy sometimes. Sometimes it's very flat and you can feel that for me the way that that manifests is sometimes I can feel a very flat energy like I can feel inhabited. Literally inhabited. By…so a person could be speaking to me in uh with some vitality or they may have some vitality, but the energy I'm experiencing is a very flat energy and so that might might feel like I might feel tired. I might have difficulty concentrating or I might lose my concentration and kind of….or find it hard to follow sometimes.*
Working in the dark p.6 *what I have learned it's is that it's better to be present to it in the here and now of the relationship as much as that as possible. But if you do that too quickly…..before you have kind of been able to grab hold of what might be occurring because you don't actually know what's occurring, but something is happening and you don't know what that is. It's some sort of repetition. But what exactly the trigger for that has been, you know, or how to work through that isn't clear. You have to work that like, I don't have the answer for that, as a therapist, all I can do is reflect back what the patient is bringing to be seen. And so to try and translate that together*
Working with nebulous states p.5 *I might have missed a point or kind of uhm, or to get clarity on something and so something is happening between us, that is very nebulous and has to be translated, and so the timing…. so, so….and I know that that's happening between us because I've taken my own emotional temperature beforehand. And so that you're going OK, something is happening in relationship and then it's about trying to uncover what that is, and that doesn't always happen there and then right, you know, because timing is very important and finding the language and may not be able to find the language for it at that time because I don't understand it, so I can't interpret it or translate it.*
THEME 2 FEELING THE SHADOW OF THE ORGANISATION
Being powerless
Black and White in the face of therapeutic complexity p.18 *My difficulty is in the black or whiteness of the law. You know that it's…..there's no……..previously, if we had some challenges in relation to things you you might discuss it on a case by case basis with your manager and you'd work out. Or does that need to be reported? There will be a clear clinical reason, if it wasn't being reported, you know, and that would be recorded and it would be transparent. But that autonomy is gone.*
Feeling imposed upon due to strict policies p.18 *Feel suffocated. I feel trapped… eh I feel angry. I feel frustrated. I feel disrespected as a clinician and my clinical judgement. You know that I don't have the autonomy to use my clinical judgement, which I would have previously.*

Name
it's not straightforward, but there's there's no room for negotiation when it's law. I'm mandated under Children's First.
Not being allowed to be adult in the clinical space p.18 *previously, if we had some challenges in relation to things you you might discuss it on a case by case basis with your manager and you'd work out. Or does that need to be reported? There will be a clear clinical reason, if it wasn't being reported, you know, and that would be recorded and it would be transparent. But that autonomy is gone. That's not there anymore. So it's the loss of that…. and so for me as a clinician, yeah, it's definitely a question in my capacity to be able to continue to work in…..in in this environment?*
Shadow of legal entities on alliance p.17 *I have to pass on that information regardless of whether the I have any identifying information, then I would explain to you that it's your choice whether you, if Tusla make contact with you, which they won't, em… but, but I can't say they won't because I can't speak for the behaviour of another agency. But it's very unlikely they would, then Tusla or gardai, because Tusla are supposed to share it all with the gardai.*
Feeling internal conflict
Feeling split between legal obligations and therapeutic process p.19 *It feels kind of thoughtless. Yeah. So that's a shame. Because Reverie and thought is so important in the presence as well. They're all. It's not just it's a split. It's a split in the system and it's them and us, you know. And that's not healthy.*
Financial need versus clinical ethics p.18 *so that's a huge conflict because on one hand I have a very good job, you know, you know, I have a lot of experience of, you know, a very fair appeal of very fair salary. I feel very good terms and conditions appeal are treated fairly…..supported uh, lovely colleagues. Nice office. You know, all of these things that as a professional you would, you know, hope to have and, and I feel grateful that I do have it. And, but I'm grappling, you know, and I have financial responsibilities myself and, you know, quality of life. And then you go uhh, you know, in my own values and how I want to be, you know, can I? Can I? find some way to be present in the way that…you know my own values so it's it's an ethical thing. It's very difficult you know, so that's very challenging.*
Left frightening clients p.19 *it's a huge loss. Yeah. And also it means that some clients disengage. And it can be retraumatising for clients. Very frightening for them…..*
Split between legal obligations and therapeutic process p.19 *It feels kind of thoughtless. Yeah. So that's a shame. Because reverie and thought is so important in the presence as well. They're all. It's not just it's a split. It's a split in the system and it's them and us, you know. And that's not healthy.*
Tension between policy and therapeutic safety p.19 *it means that some clients disengage. And it can be retraumatising for clients. Very frightening for them*

Name
THEME 3 LEARNING SELF-CARE
Need to cut back on work p.10 *I'm limited, limited and all that I can do…. and so I've reduced my working week because I realise that exposure to trauma over time it it takes its toll and I'm very aware of the importance of my self-care. Sleep. I need sleep I need, you know I need regular sleep and like to eat well.*
Physical activity as an antidote to trauma work p.9 *since I've come to this job like I have, like, exercise has become just. It's like having lunch. It's become a part of my everyday and things get lodged in your body, you know, as a therapist. So I find for me exercise as a way of moving that along that physically.* *So for me, exercise has become just a part of my life, which it wouldn't have been in the same way previously*
Signals of burnout p.9 *so you can feel very lethargic, feel tired, kind of desire to drink, you know, have a drink or smoke, you know? Ehm. You can feel like you don't want to be in people's company or there is certain. There is certain things you just don't want to be exposed to, like terms of, you know, some things on TV I just won't watch that, you know*
THEME 4 EVOLVING PERSONAL BELIEFS
Becoming socially aware of dynamics of trauma
Becoming aware of different sides of human experience p.9 *You become very aware of the underbelly in society and in human nature, as well the resilience on the other side, so your worldview definitely gets impacted…(pause) and your lifestyle, you know, so it's not a positive or negative*.
Becoming aware of the social contribution of trauma p.1 *I suppose again came in contact with them having experienced trauma but coming from very socially disadvantaged backgrounds and where there was addiction and different issues, so again, just more generalised trauma and also just the difference between like trauma, I suppose. How trauma is classless, really? It can be classless. Although it's not always and I was interested in being able to be of better service to people, and so I did a psychotherapy training* *All of them would have had some sort of trauma like family breakdown, addiction, poverty, uhm, educational disadvantage, just a different, Em….relationship breakdown. So just those general areas and from working with children and families, I recognised that children are very limited in terms of their sense of agency. They're very dependent on the adults in their lives, and I suppose they want to make more of a difference and so I moved into working with adults, and the idea that adults could affect change they have choice*
Curiosity around the impact of early trauma p.3 *I suppose it was more my psychoanalytic training, like being interested in seeing how, how… Em….how patterns get laid down in childhood and how*

Name
that impacts us for the rest of our lives. So I was more drawn to that way of working that way of understanding things than…..em, something that was more than solutions
Early work leading to interest trauma work p.1 *I did my training in my late 20s and got my degree. And my first job out of getting my degree, which was in applied social studies and social care, was uh, uhm, in residential care centre for teenage girls and I suppose again came in contact with them having experienced trauma but coming from very socially disadvantaged backgrounds and where the was addiction and different issues, so again, just more generalised trauma and and also just the difference between like Trauma, I suppose. How trauma is classless, really? It it can be classless. Although it's not always and I was interested in being able to be of better service to people, and so I did a psychotherapy training and uhm, in that just and in working just, I've always worked in either xxxx or voluntary agencies just meeting people coming through the door, so all of them would have had some sort of trauma like family breakdown, addiction, poverty, uhm, educational disadvantage, just a different, Em….relationship breakdown. So just those general areas and from working with children and families, I recognised that children are very limited in terms of their sense of agency. They're very dependent on the adults in their lives, and I suppose they want to make more of a difference.And so I moved into working with adults, and the idea that adults could affect change*
Needing to work in public services, which has access to all p.2 *I just feel that it's an area where you can genuinely make a difference. I mean, I did some private practise, but uh. And while private practise was interesting, the difficulties that people brought or their challenges were more existential rather than kind of, em ……(pause) Well, there were more existential. Yeah. And so. And I was just interested in in working with like, I I believe in, I believe that like our education and our health services should be free. So to work in the service where people can access it for free with something philosophically that was important to me and, you know, in our service, like the training that all of us have, we're trained to a very high level and we get an awful lot of support and so any of the clients who attend here, if they were to access….like an hour of my time outside of here would be a minimum of 100 or an hour*
Bringing personal values in view
Gratitude for an ordinary life p.9 *gratitude huge gratitude for all the privileges that I've had in my life and have it fairly puts things into perspective. If you're upset about things, you kind of go first world problem. Em….It gives you a different perspective, I suppose really. Well, for me would be massively inform my values and how I choose to live my life.*
Shift in belief systems p.10 *Well, I, I mean, I suppose like for example, you know, being raised Catholic in Catholic culture where, seeing abuses, terrible abuses within that system and that institution and that institution, and from my experience of working with people, has vilified and abused young people. Not all, of course.* *I suppose my spiritual life has been impacted and.eh, and in terms of trying to make sense of……the world and what the world is about, as it was for me, it's brought me towards Buddhism and Buddhist teaching, you know, in and the inevitableness of suffering. But then how? How do we be present*

Name
to that? And I suppose away from the idea of sin and more towards kind of suffering and the idea of healing and hope and more agency and autonomy, and so em….and also that we're each one of us, are precious and unique, and that that there's nobody else in this world like you.
Knowing your therapist red line p.15 *I came in contact with a paedophile once, and I just the way he spoke about things and held the child responsible and that the child wants something to happen. I like this happened by default. I was doing an assessment some of this information came out, like I I wasn't able to compute that in my brain, you know? So I know, say, for example, one in four work with actual sex offenders. I know I couldn't work in that area because it just I I just can't compute it, you know.*

Appendix I: Sample of transcript from Mary's interview

Raw Data	Descriptive - What	Linguistic - How	Conceptual My sense of it	Emerging themes
Interviewer: I'm wondering that you mentioned dissociation and your development around working with that…. I wanted to…..If I could ask you to look more currently around your work and maybe an example of what it's like to work now.				
Mary 11:24:49 P: Oh, yes, here's a good example of what it's like to work now I'm working with somebody. And this person mentioned to me, we're on camera. We're working online. And this person mentioned that he noticed he's seeing himself as well as he is talking to me, which is kind of a little bit….. I'm actually writing a paper about this at the moment, and he noticed that he smiles a lot when he's talking to me, and he's usually incredibly guarded. And that kind of encapsulates, my experience of somebody who has a full, a dissociative identity disorder, a diagnosed DID….. (speech fast) is that….. I have to adjust to whatever part of him presents, and in working with him it's like working with the jigsaw. I often used to use this as a as a metaphor, it's like working with the jigsaw where all the pieces are mixed up. You have no picture to follow, to give you a hint, and some pieces are missing, and you also have other pieces from different jigsaws thrown in there, working with somebody with a dissociative disorder is like	Online work, gives client dual perspective, subject and object. Does online work give therapist and client a different sense of self-concept? Adjusting to parts of personality in order to keep engaged with client. Tracking unconscious states	Pace of speech almost as reflection of intensity of working being described. Metaphor of jigsaw, where all the pieces are mixed up'. Highlights the level of the disorganisation with severe trauma. Suggests solving a puzzle, which is unclear to client	A sense of working at multiple to integrate unconscious traumas. Learning to work with uncertainties of practice.	Sitting with and trying to make sense of the chaos of the client trauma.

trying to sort out that jigsaw and make sense of it. So what? What? I depend on very much is my counter transference. What I'm feeling myself in response to the person and the presence that they have in that moment, because it can change from moment to moment, and I have to adjust, depending on who is who is fronting what what self-state is presenting, so it's very much. It's like mental gymnastics, because I'm trying to hold what I know of the big picture which can often feel very, very confused sometimes it's really difficult to hold on to what I already know, because there is such confusion and such fog for the person themselves around parts of them that they don't know about… (Pause) Em, It's also, It's like being on high alert all the time, I'm in almost a hyper aroused state of sensitivity, so that I can track what the person needs in any one moment. In in my response, or in my presence within that intersubjective space.	Describing the puzzling nature of working with shifting counter-transference to work with parts of dissociative symptomology Tolerating the confusion of shifting self-states and slowly building the 'big picture' Having to work with client's fog and uncertainty Working in a hyper aroused state of sensitivity. Sounds very intense. Looking to track counter-transferences moment to moment. Reported in a number of transcripts.	'It's like mental gymnastics' Seems to enjoy challenge. gives a sense of having to hold multiple aspects of trauma in room. Use of word gymnastics suggests constant movement, while trying to hold onto precision. Brief silence. Contrast between client's 'fog' and her 'high alert'. Important to try to make sense of client. Aware of uncertainly 'fog' forcing her to work in in state of hyper arousal.	Working in the dark and trying to piece together an puzzle of a dissociated personality There is sense of trying to gain an understanding within the chaos of alliance. Reflection of clients inner world. Having to enter clients trauma?	Being pushed Attuning to the flux of relationship Bringing order to chaos Having to accept the confusion
Interviewer 11:27:41 R: Hmm!				
Mary: What is needed from me as therapist… It's very…. It can be very frustrating. I could feel lost…. sometimes I get it wrong. And there is a reaction and I have to do…. then I often I often talk. I do a lot of psych ed. at the beginning. So I talk about rupture and repair I'm going to make mistakes, and I will…. I will say sorry and hopefully, you can let me know. But there's also the most wonderful moments of connection (animated tone) when, like that smile that doesn't….. that came very, very infrequently at the start… when I was talking to somebody who was very, very blank in expression and very monosyllabic and very monotone in their	Having to work without a clear direction frustrating 'I could feel lost' and accept inevitability of making errors Looking to lay down a foundation of psycho-education around the imperfection of the therapeutic process (Rupture/repair) important in developing as the capacity for connection.	Starting to speak in animated tone during interview process 'Wonderful moments of connection' a stark contrast to previous comments about difficulties of work. Use of wonderful almost suggests feels like compensation for hard work. 'like that smile' 'very very blank' contrast of language suggests life force breaking through a defence.	Psychoeducation helps to feel grounded in midst of uncertainty with client. Importance of integrating small moments of connection. In trauma literature, experiences of severe neglect leave individuals with limited capacity for positive	Managing the countertransference Working slowly towards integration

speech….. and then every so often this smile would break through, and it would be the first time I experienced it, it felt like, I'm looking at this person as a 9 year old, and this was before I knew the the story, the full history, a 9 was a very significant age. And like Hmm! Where am I going with this? I'm using….. I'm thinking of this person as an example, so there are these tiny little increments of connection… there are tiny little increments of….. what we used to call integration, seeking integration. But now I would work more from a notion….. I know I got it for Valerie Sinnison… I'm not sure she got it from somebody else. Multigration, where it's helping somebody, be able to cope with day-to-day life in a relatively comfortable way, that you're not necessarily seeking integration. So it's the joy of having those little moments of connection where you know that a repair has happened.	Describing traumatised child part emerging Views working with early development states pathway to integration Working towards increasing tiny little increments of connection, rather than fully integrated personality Goal it to work towards internal coherence Rewarding for therapist to see small victories.	'9 year old' emphasising the developmental aspect of work and evoking strong image child within 'tiny little' emphasising painstaking nature of work. Repeated use of 'integration' suggests working with chaos Little x2 childlike 'Joy of having those little moments of connection' emphasisng the asymmetry in the emotional temperature of work.	emotion Therapist and client growing together?	Vicarious growth?
Interviewer: No, there is so much in last. Thank you, xxx, and I suppose just to pick up, maybe on a aspect, what is it like when you're sitting with that client that you were talking about, there's a kind of…… you're working between these shifts in states. What does that feel like for you?				
Mary: If I'm up to speed with it, if I notice it instantly, I can instantly change, because, depending on the part that's there. Some parts might be very open and responsive. Some parts might be very closed, some parts might be very aggressive and angry so, and the whole idea of working with dissociated parts is that every part is welcome. So, if the angry defensive part comes forward, I will just say, Oh, my goodness! (maternal voice) I notice you know that. Yeah, something has	Welcoming every part into therapeutic process an essential for work Having to hold complex formulation of parts structures simultaneously.	'up to speed' suggest having to keep a high level of vigilance. 'Parts' repeated Tone sounds maternal during interview "Oh, my goodness!" "has something made you really	Working with speed and complexity. Work places demands on therapist concentration, emotionally and requires holding intricate formulations	Need for Intellectual challenge?

made you really angry, and I would love to know what it is. And is it something I I have said or done that I need to change? Or is there something I can help you with right now, because you do a really important job in protecting. So it's that way of working that, recognizing the shifts, recognizing what each parts where each parts, or getting to know where each part's distress is held, and coping mechanism is held within that, and how to respond appropriately to that coping mechanism, whether it's anger withdrawal and infantile state. So it's learning, learning the intricacies of somebody's mind that has been incredibly brilliantly clever in protecting them and helping them survive and I think holding that in mind…. I do a lot of supervision as well I'm one of the things I always emphasize is how incredibly clever is this person's brain… that all these parts are holding distress, but also holding a coping mechanism that has kept them alive psychically. Yeah, so in switching, yeah, sometimes, if there's a switch, and I'm slow to recognize it, I'll feel the miss-attunement. It will come to. I will feel the miss-attunement in myself. I'll say something, and it won't land or there'll be an expression that will be that will, I think…. Oh, that's not what I expected. So then I scramble in my mind to think what's going on, and what have I missed.	Introducing curiosity to client through empathic inquiry Work requiring high levels of attunement with multiple levels of psychological defence. Time has to be taken to learn intricacies protected child parts holding anger or withdrawal. Feeling out sync with client as sign of new state Moving from attuning with client to reflective position to gauge alliance Moves between Supervisory and therapeutic Having to scramble to organise a meta position within relationship to guide process.	angry" sound almost parental.	Carefully working with clients' defences Learning defences and adaptions Use of internal responses central to work, highly experiential	Working with depth, pacing and delicacy Using the self as a barometer Working with parts of personality
R: Super, and I'm wondering, I'm just listening to you and probably a lot of these questions will overlap. But I'm wondering in what way does working with complex trauma impact your work as a therapist. Now, I know you've come from a different place at the start….				

Yeah, yeah, it is deepened. My understanding of human distress and human survival. It until I specialized in this work. It really gave a really informed my work, working with more general the presentations, maybe where there wasn't as much trauma it increased my sensitivity in terms of becoming attuned to somebody. It's certainly honed my therapeutic skills around nonverbal communication, and hugely increased my awareness of transference and counter transference…Em and that informed all my work. It is also hugely informs me, in terms of supervising other cases, because in supervision I listen to the non-verbal, pay attention to the non-verbal communications, and I pay attention to transference and counter transference between myself and the other therapist….. What else?....(pause) I feel, I'm missing something big, and I can't think what it is.	Understanding work through survival/defence system Working with trauma changed approach to work Learning the sensitivity to levels of attunement and honing of skills around non-verbal communication part of benefits of working with trauma Trauma communicating through behavioural, bodily cues and the felt. A sense of something central to work, but can't recall for the moment.	'all my work' influence of trauma work transfers through professional roles 'Pause' seems agitated, as about to begin to talk about something important, but it has slipped her mind. This is almost a reflection of the chaos of work	Shift from emphasis on cognitive to non-verbal. Much of complex trauma work is unconscious/ somatic approach	Working at deeper levels. Importance of the body within work
Well there's no problem to circle back, if…. It might come up in as part of an answer to another question, and suppose to just to develop on that, I just…. in what way does working with complex trauma impact on you personally, and I suppose that can be… you spoke to career for instance. But even relationships, family, beliefs, values, future going forward.				
P: Hmmm. It's a really important question, because I think that's it's vital that if you're working in this area, you need to look very closely at yourself and your own life and the impact, I'm not even going to say potential impact because there is an impact. But you're not only holding somebody's enormous distress, you also holding the horror of what has been done to them and the things that perhaps I know when I started off first, how one human can	Need to scrutinise yourself an important quality Inevitability of impact of working with complex trauma. Holding onto another's distress changes you.	Seems to be arrested by question 'to look very closely at yourself and your own life'. Looking away seems to be in a deeply reflective space 'Holding a massive amount the horror and pain', 'how one human can hurt another' emphasising the darkness of	Psychological holding comes at a price. Careful monitoring, and personal therapy	Unavoidable vicarious impacts

can hurt another in ways that I've never imagined so you're holding a massive amount of horror and pain, and that needs to be very carefully monitored and looked after…. so what I have is, I'm in personal therapy, permanently…. It's not not a short term thing…. I have personal therapy where I can explore my own process. What I'm holding, and pay attention to where that resonates within my own life. So I'm very closely looking both at what I might bring to a therapy session, and also what I what what might be left within me, that I need to process and let go of, so that my personal therapy is hugely important and equally as important is specialist supervision because of the level of trauma I'm working with. I've had specialist supervision for that past 10..15 years. Actually from the UK. Because I wasn't able to find anybody in Ireland with the depth of knowledge, particularly around the more severe end of complex trauma around dissociative disorders, and because I would have been working with people who've been trafficked people apart paedophile rings. Okay, I work with children and adults and a lot of very complex sexual abuse cases….(pause) I've had to be very careful to find a way to manage… knowing that knowledge, but not holding it actively in my mind once I leave the therapy room. So, I'm very good at a healthy way of compartmentalizing. Where I can put my work away with the lid on it and it doesn't intrude on my day to day life… Em, I have to constantly watch self-care because I am inclined to overwork. I'm inclined to take on more… you know, work that fascinates me, that I should say no to. I'm getting a lot better in recent years, because that whole self- element has has… I become…. I wasn't so aware of the need for the	Surprised in early work the by capacity of people hurt one another. Importance of having an ongoing experience of therapy to self monitor impacts. Feels self knowledge is vital part of therapeutic knowledge. What I bring and left with. Using personal therapy and supervision important Very complex monitoring of inner experiences, once you have knowledge of the darkness of trauma, it cannot be forgotten. No supervision expertise in Ireland. Irish clinical environment lagging. Healthy compartmentalising. Importance of finding ways to separate professional and personal life psychologically. Ironic, dissociation often seen as a form of compartmentalisation/split off. (conscious v unconscious) Inclination to overwork, due to fascination with trauma work. Need for self-care. Having to build tolerance for current	human nature. 'Holding' emphasising depth of exposure during work 'permanent' and 'not a short term thing' emphasising importance of personal therapy in understanding self 'Knowing that knowledge, but not holding it actively' suggests traumatic knowledge has toxic quality 'fascinates' almost sounds obsessive ' not holding it actively in mind' Sounds like it is neutralised.	'permanent'. Process of holding needs to work with or it will damage professional and personal self over time Constant work in personal therapy to manage vicarious impacts of working the severely traumatised. Does therapist risk absorbing identity of client/abuser. Projective identification. Process of letting go of client's distress has to be actively worked with.	Need to manage impact of trauma carefully Feeling vulnerable to impacts Development of specialist self care regime. Can not get professional needs met in Ireland. Developing nature of Irish trauma community Development as trauma therapist different to other therapy? Building tolerance and finding ways to manage exposure.

extent of self-care that's needed, and the need to…. I very gradually increased the number of complex trauma cases I was working with. In earlier years. I was very, very careful to make sure I had a balance that I had people with mild to moderate, presenting difficulties as well as complex trauma cases, but with experience and with my ability to cope with the fallout of hearing somebody else's huge distress and what has happened to them. I've reached a point where I can work completely in this area… but even at that I mix my clinical cases with supervision, and with some teaching. So I'm constantly keeping a balance that I do other work, that it's all around complex trauma…. I teach about complex trauma and dissociative disorders and disability psychotherapy, which is all trauma based. But the teaching is just a engages a different part of my mind, so it it's a balance within me. I also, I look after myself in terms of doing things I like doing, and I, my weekends are totally empty, which they weren't for a long, long time.	caseload. Couldn't do this in earlier career. Learned through experience Gradually exposing her self to work and build a tolerance Need to mix work Supervision, teaching important almost an external multiplicity of roles, reflection of her client's inner world. Learned to cut back on working weekends. Creating a time without any contact with trauma work, a necessary component.	Self x 2 Put my work away with the lid on it. Sounds like intentional choice.	Desensitisation or healthy compartmentalisation? Separating knowing from holding Cognitive versus emotional Learning to boundary her personal world and important lesson Titrating exposure to build resilience	

Appendix J Sample of transcript from Margaret's interview

Raw Data	Descriptive - What	Linguistic - How	Conceptual My sense of it	Emerging themes
Interviewer: Sure, yeah, absolutely. And I suppose you've spoken to this already xxxxx, but if you want to add anything to it, that'd be great. In what way does working with complex trauma impact on you personally and that could be career, family, relationships and beliefs, values. Positively or negatively?				
Margaret Hmm. It's maybe very much aware of the role that values play in my own life and the type of life that I want. So seeing how severely people have been impacted by trauma to the level where it's a complex trauma and working so closely with that, I suppose, picking up a lot of that vicariously, has and the kind of the burnout that happened as a result of all that has made me make huge changes in my own personal life for the better, I hope in terms of slowing down. (noticeable shift pace and tone, speaking in measured way) So being able to step back and realize that the little things really don't matter. You know, getting pissed off with someone in traffic is just not worth it and that it's only doing additional damage to your own body. The kind of life that I thought I wanted versus what I feel I need has changed. I was always very ambitious and very busy and I was doing, you know, a hundred things at once. So. Even when I was working in the the torture rehabilitation centre full time I was also doing a full-	Work caused her to assess personal values. Experience of burnout made her reflect and make changes in personal life. Experience of burnout brought to a realisation of values and need to slow down. Very driven personally.	"slowing down" "step back" "changed" x 2 Emphasising a pivot in life Tone of interview reflecting language 'slowing down' emphasising pace of professional world and her need for reflection. 'damage to your own body' form of self harm?	Crisis forcing her to re-evaluate her work. Professional values informing personal experiences Bodily counter-transference?	Becoming lost in the intensity The flame that burns twice as bright Forced to look at what is fundamentally valuable

time PhD was also doing lecturing. I was also, you know, I mean there was just all of this and also have my son at home that was just filling up every single moment and so you can really get consumed by that world ad because of the need that seems to be attached to working with complex trauma. It's not often something that you can just leave. After you leave the day's work, you know, it's something that continues to impact you. Especially when it's connected to world events. And that was the case for you know torture and asylum process but also for You know, the work I'm in now, which is around, you know, religious abuse. So..making huge changes in that I no longer fill up my days like that. I no longer take on more work than I feel, I want as opposed to feeling this driver need….to do something because the opportunity is there but also because I can and I feel like I could help. It's about kind of stepping back and kind of going, no…and so yeah, that's that's definitely changed as a positive way in my life. The negative, again, the burnout, I suppose, but then again, a lot of the reading I've done around, and what I'm starting to see is that sometimes it's a it is a positive because it's and necessary stopping block. You know, because I wouldn't have stopped. I would have, I would have kept going. I mean, even at the end of the PhD and you know, while I was on a block break before starting this job, I had only signed up to 3 other things that I was planning to do. You know, it was just craziness. So don't have that answers that probably, but that's it.	Tempering ambitions and personal life. Trying to unsuccessfully balance work and personal life. Seemed to lose this balance gradually, as she took on more Work following her. No escape. Work has international dimension, so comes through media, making it hard to ignore Turning point in her life. Driven by something beyond her agency Learning to regulate work. Upside to burnout, it allowed her to confront problem. It took burnout to stop destructive pattern.	'hundred things at once' Sense of absorbing other's chaos "filling up every single moment" 'Consumed by that world' describing almost addictive patterns World x2 'Feeling this driver' almost being controlled by something beyond her "necessary stopping block". Emphasising lack of agency 'Craziness' sense of being out of control	Almost obsessive attitude to work Difficulty finding boundary due to the needs of complex trauma work Found her boundary due to burnout Crisis causes her demarcate professional and personal world. Wisdom hard earned. Jung's shadow side Unable to stop overwhelm of work demands. Important life lesson Only burnout could have stopped overworking, very like addiction/compulsive behavour.	Complex work makes multiple demands on therapist resources. Having to boundary on several fronts. Education, family, workload, professional responsibilities. Complex counter-transferences The shadow side of passion? Almost addictive Rock bottom?

Interviewer. And just something that struck me there. I wonder, do you feel there's something? I think you kind of referenced a little bit in some of your comments. Something kind of unique about kind of this type of complex trauma work that kind of draws you in sense. And I don't know how you described as you put it, you're aware of the kind of constant need.				
00:49:05.000 Margaret Yeah. Often when someone is experiences complex trauma is generally in a something in a wider sense. So something that's part of a bigger issue. So for example, you know, domestic violence or refugee trauma or child abuse or you know any of these things that are part of these bigger political issues. So if you're working in this area, there's possibly a part of you and definitely for me that has a very strong human rights perspective and the need to be an advocate and to do something about these atrocities that are happening in the world and I want to one sense, but also a bigger sense, you know, as part of the bigger picture of what's going on and that's what draws you in. So it's very hard to let go of that because you're not just dealing with that one person. It's it's a bigger issue that you're surrounded by all the time because it's generally the stuff that's on the news. It's generating the stuff that's affecting the country at that period of time. So it piques your interest and it drives your kind of human rights or advocacy needs and it becomes part of that. It's bigger than just a job.	Complex trauma for participant is a manifestation of broader political issues, which draws on human rights Personal values bringing her towards this work Moving beyond the traditional role therapist towards advocacy. Work is part of global problem Hard to avoid trauma work due to constant news coverage	Tone of interview shifting from personal to broader political issues "wider" "bigger" sense of scale contrasts to insular world of therapist space. 'part of you' multiplicity 'bigger' x 3 'bigger than just a job' sound transcendental element to work bringing universal rights to individuals. 'piques you interest' sounds personal	International experiences shifting the profile of trauma work Strong human rights beliefs a driver in work Micro and the Macro Scale of issues has the potential to draw you into darker places in your work	Political entering into psychotherapy Changing face of trauma in Ireland.

Interviewer Hmm.				
00:50:30.000 Margaret So I think that's. Well, that's my experience anyway with working with complex trauma, you know, whether it's true addiction or mental health in general or you know different things that are happening politically in the country. It's bigger, it drives you and you just have to make sure it doesn't consume you. Which I think it did for me a little bit.	Not viewing her work as a set of symptoms, but rooted to political and social issues.	'doesn't consume you' lost in the sheer scale of issues	Almost sounds like a counter-transference. Universal scale of problems/ transferences "consuming her"	
Interviewer And it sounds like there's a kind of a challenge to compartmentalize some of the work. As it kind of interfaces with other aspects of your life, so to speak.				
Margaret Yeah, I mean it's definitely It's a double edged sword because it's something that drives you, motivates you. You know, you definitely need a passion and a motivation if you're going to succeed in working in that area. But also it can consume you and Yeah, it can make it very difficult to let go of.	Passion is necessary but sees the dangers after burnout	"double edged sword" a duality, which is unavoidable 'difficult to let of' suggests wanting to hold	Striking a balance between the passion needed and knowing when to let go. Needing to get close to do therapeutic work, but it can burn you	Getting too close All consuming fire

00:51:32.000 Interviewer Sure. And then I suppose the next question I have for you, xxxx, is what has helped you to work with clients with complex trauma. But you can, that can be supervision, training or whatever you feel or even if it's personal qualities you feel you possess.				
Margaret Hmm (Pausing to reflect)				
00:51:50.000 Interviewer That make the work more bearable.				
00:51:53.000 Margaret I do think that my psychoanalytic training. Definitely helped me be suitable for the work in that, there's something about when you're trained in psychoanalysis, it's a way of looking at people without over diagnosing them, you know, it's a much more simplistic view. That just makes a huge amount of sense in the world, you know. And the amount of analysis that you need to do throughout your training. So for example when I was training my attitude 3 years twice a week on the couch with very strict psychoanalysis, you know, like to the point where they were barely speaking, you know, they might say, a word during the whole session, you know, so a huge amount of my own analysis and processing that made sure that I sorted through my own shit and I wasn't bringing that into the room. Whereas when I was, you know, supervising the therapists or especially training counsellors kind of training to psychologists that be coming in from the colleges. I could see that they didn't have that. Or not didn't have that to the level that I would see in other people who had gone through the	Psychoanalytic therapeutic approach avoids labels and pathologizing Less jargon, diagnosis detrimental? Psychoanalytic approach requires a lengthy and rigorous experience of personal therapy, which prepares therapists Necessity to know thyself Self reflection allowed for self knowledge	"simplistic view" contrasting term for complex work	Working on your own personal history through a deep therapeutic experience a good foundation for trauma work Need to be able to differentiate your own issues. Personal drive and interest in human right a strong motivation for work.	Not becoming lost in labels/symptoms Need to be able to hold some clinical distance Personal therapy allowing differentiation within work

psychoanalytic group and I also worked with other psychoanalysts or psychologically trained people and working in complex trauma and I could definitely see a difference there in terms of their capacity to be able to manage what they were hearing. So I think there's something to that. I don't know exactly what it is, but I think there's something there. Also, like I said, previously I think having a passion for human rights and when it's part of that bigger picture, that can be a driving force and it can help. Because you feel like you're doing something. And often very empathetic people and people who would be therapists have a sense of not being able to do enough. So being feeling like you're part of something bigger and on the right side maybe of human rights issues…..can, whether that's mental health or whether it's something more political can help. And then in terms of the work in the torture rehabilitation centre, it was definitely the clients getting to meet those people and how incredible and seeing the level of survival possible in people. And just the strength of the human spirit and how amazing these people are. And also you know been exposed to other cultures and all that was just you know wonderful and fascinating and such a privilege. But being able to see that strength. It's just something that I will never ever forget and to just It shows me that people can come through this. I've seen it. I've witnessed this. Doesn't, you know, the worst circumstances. People can get through the other end of this.	Feels training for complex training is wanting in some aspects. Psychoanalytic perspective allows for therapeutic distance? Contrasting herself to other therapists due her motivation Rewarding to experience the strength of the 'human spirit' in the face of the darkest side of human nature.	"passion" "driving force" sounds like a catalyst for work "being part of something bigger" connecting on a broader human level "bigger" referenced throughout giving a sense of universal dimension. 'human spirit' transcendent? 'Privilege' gets to do something others don't. Rewards of experiencing other cultural experiences. "witnessed" importance other in healing.	Important to feel like she is contributing something Personal values contribute to work, different to other types of psychotherapy? Does she see other therapy as passive? Personal growth through seeing people survive "worst circumstances"	Complex trauma work driven by personal ideals and bigger issues Personal growth through witnessing client overcome worst circumstances

Appendix K: PET and Subordinate Theme Development for Deirdre

PET 1 **Learning complex self-care**

Deirdre found that her work exposed her to the varied and intense forms of the trauma, which impacted her primarily at a physiological level, and on occasions risk management could leave her with feelings of anxiety. She emphasised the need for building an ecological approach to self-care, which allowed for a broad spectrum of resource to recover her psychological balance. Embedding herself within family relationships, specialised supervision and investing into physical exercise all helped Deirdre to function within her work.

Deirdre described being conscious her specialised work having the potential to make strong demands on her emotional, physical and personal resources, which she had to be careful manage. She spoke of complex trauma having the potential to become "addictive" and she developed high levels of self reflection to keep her stable within her professional world.

Subordinate themes: Importance of family
Supervision
The physical side of trauma

PET 2 **Walking a clinical tightrope**

Working with complex trauma required Deirdre to make regular clinical decisions around the balances, which needed to be struck in order to progress treatment. Although Deirdre worked long term with her clients within an organisation, her time was bounded by a finite number of sessions, which she felt helped her keep on track and focus on the client's trauma. Deirdre used the metaphor 'a bit of tightrope' to describe the decision making around balancing the need to contain the client's trauma and work through it. Her experience over career had developed her clinical timing and balancing differing aspects of complex trauma work. She described her progress in knowing when to hold boundaries, when to confront avoidance, building an alliance versus autonomy and translating unspoken emotions/physical sensations into language. These are advanced experiential skills, which have been referenced throughout other interviews. These seem to be a contrast to the often manualised approaches common in general psychotherapy.

Subordinate themes: Balancing decisions
Holding a healthy flexibility
Translating the unspoken

PET 3 **Working with Violence**

Deirdre talked about the experience of being impacted by vicarious aggression in her clinical work. Her specialised work could bring her into contact with victims of domestic violence, resulting in specific type of countertransferences. She spoke in a metaphorical sense of 'violence being in room' and a parallel process of experiencing the impact of her client's abuser. This could result in bodily countertransferences leaving her feeling physically tense, sore and tired. There was also the challenge of working with risk to the client and others. Deirdre spoke about the necessity to quickly link in with other professionals, when violent risk becomes a worry. She experienced this connecting in as both supportive and it allowed her to spread out risk amongst other professionals in order to manage the risk more effectively.

Subordinate themes: Feeling the shadow of violence
Feeling the client's trauma within body
Managing risk

PET 4 **Professionally developing**

Reflecting on her journey through a career in complex trauma work, Deirdre noted her early experiences in addiction counselling piqued her interest around the influence of trauma on mental health. She was aware of a lack of trauma informed approaches after qualifying in her core training and felt the was something that she had to compensate for in later training. She spoke of feeling that her interest in complex trauma ran the risk of her taking on excessive training or being lost down 'rabbit holes', which had the potential to interfere with her family life. At times over her professional life accessing adequate supervision proofed to be a challenge with general supervision lacking the specialist knowledge of unique aspects of trauma work.

Subordinate themes: Becoming interested
Lack of training
Finding the balance with upskilling as a specialist
Challenge of finding suitable supervision

Appendix L: Ethical Approval

Ollscoil Chathair Bhaile Átha Cliath
Dublin City University

DCU

Mr Gerard Meehan
School of Nursing, Psychotherapy and Community Health

15th December 2022

REC Reference:	**DCUREC/2022/209**
Proposal Title:	**An exploration of senior psychotherapists' experience of working with complex trauma in Ireland. An Interpretative Phenomenological Analysis**
Applicant(s):	**Mr Gerard Meehan, Dr Aisling McMahon, Dr Denise Proudfoot**

Dear Colleagues,

Thank you for your application to DCU Research Ethics Committee (REC). Further to expedited review, DCU REC is pleased to issue approval for this research proposal.

DCU REC's consideration of all ethics applications is dependent upon the information supplied by the researcher. This information is expected to be truthful and accurate. Researchers are responsible for ensuring that their research is carried out in accordance with the information provided in their ethics application.

Materials used to recruit participants should note that ethical approval for this project has been obtained from the Dublin City University Research Ethics Committee. Should substantial modifications to the research protocol be required at a later stage, a further amendment submission should be made to the REC.

Yours sincerely,

DCU
Research & Innovation

Taighde & Nuálaíocht Tacaíocht
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Chairperson
DCU Research Ethics Committee

Note: Please retain this approval letter for future publication purposes (for research students, this includes incorporating the letter within their thesis appendices).