The Journey Out
Of Childhood Relational Trauma

Adult clients and therapists consider the usefulness of the therapeutic relationship in mediating childhood abuse and childhood relational trauma.

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Abstract

Childhood abuse and trauma are pervasive problems in Aotearoa New Zealand creating concern for all. Consideration is currently given to children in relation to childhood abuse and trying to eliminate this in New Zealand society. However the broader effects of childhood abuse for the individual as they traverse through teenage years and into adulthood is given scant attention both in relation to treatment for children and families and for teenagers, young adults and adults. This research sought to understand at an overarching level that particular journey for individuals and also any mediating effects to the original abuse.

To gain the broadest possible understanding of the problem adult clients were sought in relation to completion of a significant therapeutic journey to moderate the effects of childhood trauma. From a position of resolution the client group discuss the abuse they experienced or exposure to abuse as a child, the personal and relational effects on themselves over their childhood, teenage years and adulthood, entry into and the effects of the therapeutic relationship in moderating the life-time effects of trauma.

Therapists were also sought in relation to the therapeutic journey and ‘what works in treatment.’ The purpose of this was to corroborate and also identify any dissonances in relation to the client narrative and to identify the elements contained within the therapeutic relationship which assisted in moderating childhood abuse and trauma. A multi-discipline selection of therapists was chosen to compare elements cross-discipline in terms of therapeutic delivery. A cross-discipline literature review was also undertaken in relation to historic and current research on the topic.

The research was centrally concerned with the client narrative and how that lined up alongside therapeutic delivery and therapeutic outcome. The research noted the gap between initial interventions and a therapeutic process and the inter-personal, relational, social and cyclic difficulties of family violence in Aotearoa New Zealand. The research indicates that to ignore this issue and treatment pathways for this group of people enables the perpetuating problem of family violence and subsequent consequences in Aotearoa New Zealand.
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Glossary of Abbreviations

AACRT  Adults Affected by Childhood Relational Trauma
CRT  Childhood Relational Trauma
NGO  Non Government Organisation
PTSD  Post Traumatic Stress Disorder
AOD  Alcohol and Other Drugs
CYF  Child Youth and Family
CHAPTER ONE
Introduction

This thesis presents the results of a qualitative study of the usefulness of the therapeutic relationship for adult clients affected by childhood relational trauma.

As a clinician in the field for 25 years I have worked as a DAO (Duly Authorised Officer under the mental health act), mental health and health social worker, counsellor and therapist. I currently work in a therapeutic practice and work largely with adults affected by childhood relational trauma.

While working in the mental health system I noticed disparities between what the client was saying was the source of the problem and the treatment given in relation to the presentation. Further juxtapositions included: inter-disciplinary conflict in relation to treatment; the distress of some clients at feeling not heard in the mental health system; shorter term interventions appearing to be driven out of funding requirements rather than efficacy in treatment and the increasing marginalisation of social work as a valuable component in the process for the client.

These conflicting anomalies led me to be more interested in what the client said was helpful in treatment and hence what I wanted to further understand in undertaking this research. Added to this came the idea of considering narratives across the life-span from the beginning of the trauma and what therapists who were working in medium to longer term therapy had to say from a cross-discipline perspective. I increasingly considered the disparity between systems, professional parameters and what the client thought and would actively seek articles and anecdotal feedback from both clients and professionals relating to this disparity.

In my reading over the years I have noted ongoing discrepancies in treatment and agreement on how to treat individuals with childhood trauma. I have wondered how individuals can get the treatment they require with multiple juxtapositions in treatment understandings and approaches and I have pondered how we can view the field in a more progressive and unifying way.

In choosing this topic I have been particularly interested in the client voice and client experience of treatment pathways and therapeutic process. I became interested in giving ‘air’ to the client voice as a way of considering the client themselves as a valuable player in development of treatment pathways. I was interested in considering the value of the client participating in a co-relational way within the process and what their specific experience and feedback of relational client centred approaches were.
Clients were sought who had completed their therapeutic journey. The natural starting point to get an over arching view was to start at the clients beginning i.e. from the point the original trauma began and track the trauma and effects over time including interventions and effects of the therapeutic journey.

Therapists were also interviewed in relation to understandings of trauma and therapeutic process and where therapist knowledge of treatment sat in relation to client understandings.

A bio-psychosocial approach was considered as the widest encompassing view of individual personhood including the development and problematic manifestation of trauma and subsequent interventions and treatment.

**Research Questions**

The research question posed was: What was it about the therapeutic relationship that assisted in mediating* childhood relational trauma?

An open ended approach to the research was chosen because the narrative of the individual was sought as the key to achieving this goal.

Some broad questions were posed as a guideline to the emergent narrative, they included:

What was the original abuse/trauma?

What effect did this have over your lifetime?

What were the interventions that occurred as a result?

How did you meet your therapist?

What was the therapeutic journey like?

What was helpful/unhelpful about your therapy?

**Thesis outline.**

Chapter 2 provides an overview of relevant theory and research via the literature review.

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*In the context of this project mediation and mediating relate to the process in which the client and therapist are participants.
The literature review assisted in seeking parameters for the research, development of understandings from other researchers who had considered similar topics and establish a coherent overview in relation to the literature and individuals affected by childhood relational trauma.

Chapter 3 being the methodological chapter explains the methodology chosen most suited to emerge the client narrative including insights or phenomenon contained therein.

The method; chapter 4 discusses the method by which the process was conducted in order to achieve the aims of the methodology and the research.

The client findings emergent within the research is presented in chapter 5 and chapter 6 presents the therapists findings as they reflect and mirror the client findings.

The discussion chapter: 7; considers the client and therapist findings in relation to each other including any disparities and congruencies contained within the research. The literature review is also considered in relation to the findings of the client and therapist including any commonly reflected themes or juxtapositions.

Chapter 8 reflects on conclusions and recommendations. A model is suggested in this chapter as a way of understanding the journey and treatment pathways in relation to adults affected by childhood relational trauma.
CHAPTER TWO

Literature Review

Historical context

It is generally acknowledged that modern understandings of psychological ill health began with Freud and the development of psychoanalysis. Freud’s early research highlighted the effects of interpersonal trauma in the development of hysteria as a result of alarming rates of sexual abuse in Victorian women (Herman, 1992). However the unacceptability of these ideas at the time subsequently led him to reject these early findings in favour of ideas around internal representations and drives as the cause of psychological dysfunction in the patient.

John Bowlby (1969) acknowledged Freud’s opus but decisively highlighted the effects of context and environment and placed these concepts firmly back in the arena for consideration in the development of psycho-pathology and well-being. Bowlby noted the importance of attention to context and environment particularly when considering the symptoms of trauma (Bowlby, 1969; 1973; 1980). Bowlby’s research led him to insist that socialisation, environment and family interactions be considered in the development of problematic psychopathology in the individual.

However Bowlby’s theories posed too great a shift for fledgling psychoanalysis to consider and so his views were largely ignored by the psychoanalytic community for the next 50 years (Slade, 2008). Bowlby himself later noted that for several decades his work was used primarily to advance the field of developmental psychology rather than be used by clinician’s in the field as he had hoped. (Bowlby, 1988; Slade, 2008)

The question between scientific validation and usefulness to the field has also been raised by David Bohm (1985). Bohm notes that the desire for scientific validation of the field has led to increasing fragmentation in treatment. This tension has also been considered by Peter Fonagy (2003). Fonagy criticises traditional quantitative research over the previous century for feeding the belief in professional and lay people that the onset of psychopathology related predominately to the genetics of the individual. Fonagy also raises the issue that increasing statistical sophistication and advances in research genetics has developed a consequential and corresponding elimination of the place for classical socialisation theories with an emphasis on parenting and relationship such as attachment theory.

John Briere (2006) also questions the way research in relation to adults affected by childhood relational trauma (AACRT) is conducted citing Bradely, Greene, Russ, Dutra and
Western (2005) in noting that results of randomised clinical trials provide less guidance to clinicians working with people in the field than might be expected.

Early fragmentation of research and subsequent treatment paradigms has continued over time from the beginnings of the field creating difficulties in consistency and effectiveness of clinical assessment and treatment (Fonagy, 2003). The effect of this has been the development of an often piecemeal approach to treatment for individuals with complex presentations as a result of childhood relational trauma. (Bowlby, 1988; Bohm, 1985).

**New Zealand contexts and childhood abuse**

*There can be no keener revelation of a society’s soul than the way in which it treats its children*.  


New Zealand has increasingly upward trends of childhood abuse and neglect including infant deaths. The Child Health Monitor (2011) notes childhood maltreatment includes acts of commission (overt abuse) or omission (covert abuse) by a parent or other caregiver which result in harm, threaten harm or create a potential for harm to a child.

Acts of omission are noted as including physical and emotional neglect and acts of commission being invasive and including physical, sexual, emotional abuse (Briere & Scott, 2006; Briere & 2012; Briere & Lanktree, 2013).

Briere and Lanktree note that acts of omission and commission over childhood create the genesis of a particular set of traumas identified as complex trauma. As Briere and Scott assert that complex trauma involves ‘highly invasive traumatic events, usually of an ongoing interpersonal nature, frequently including exposure to repetitive childhood sexual, physical, and/or psychological abuse’ (as cited in Briere and Lanktree, 2013, p.1).
He Mana to ia tamati/Every Child Counts coalition including Barnardos, Plunket, Unicef, Save the Children and Te Kahui Mana Ririki cite Lievore and Mayhew (2007) in defining child abuse and neglect including:

- Children witnessing inter-parental violence
- Physical discipline and physical abuse of children
- Childhood sexual abuse
- Child injury, mortality, homicide and suicide
- Child neglect (ECC Discussion paper No. 1 June 2010)

ECC estimates the annual cost of Child Abuse and neglect in New Zealand is approximately two billion dollars.

The effects of Child abuse in New Zealand resonate across personal, interpersonal, family, community, civil services, policy makers and commissions of enquiry. These multiple layers can be considered at Micro, Meso and Macro levels:

- Micro level: As a relational issue of inter-personal/family violence, child abuse and family violence.
- Meso level: As a social and community issue involving communities in relation to policing, justice, Child Youth and family (CYF), emergency services and mental health services.
- Macro level: As a socio-political issue relating to how we care for, protect and nurture our young including government policy and funding in relation to resourcing and protecting the most vulnerable.

Bio-psychosocial development of personal difficulties in context over time

‘It is just as necessary for analysts to study the way a child is really treated by his parents as it is to study the internal representations he has of them, indeed the principal form of our studies should be the interaction of the one with the other, of the internal with the external’.

(Bowlby 1988a)

John Bowlby first noted the bio-psychosocial significance of disruption in early attachment relationships and difficulties over the life-span. He also noted quality and consistency of the child’s primary relationships in the development of the healthy self (Bowlby, 1969, 1973).
The development of distress, anxiety and trauma as a result of inadequate or traumatic care-giving was also noted by Bowlby (Bowlby, 1969, 1973, 1988). Increasingly researchers are considering the link between abuse and well-being, noting effects on self esteem, self confidence, interpersonal relationships, decision making, peer relationships, socialisation, scholastic achievements, daily living/work activities. (Brick, 2005; Briere & Scott, 2006; Briere & Lanktree, 2012; Fonagy, 2003; Schore, 2000).

Bowlby (1969, 1975, 1980) noted the significance of environment, attachment relationships, personality considerations and genetic factors over time in the augmentation of difficulties arising for the individual. Furthermore variations in development as a result of context and environment require constant consideration by the clinician (Bowlby, 1969). Bowlby notes that the contribution of the family environment is significant in contributing to psychological difficulties of the individual (Bowlby, 1973).

Bowlby’s model included understandings of the development of well-being and/or difficulties for the individual arising within the context of the person’s environment and significant relationships over time. Bowlby insisted that clinician’s consider relationships, context and environment over time in the development of psycho-pathology in the individual. Allan Schore (2000) in reviewing John Bowlby’s work argues that current research and clinical models need to return to Bowlby’s integration of psychological and biological tennants.

In the last 10 years with developments in neuroscience there is increasing emphasis by researchers in the bio-psychosocial development of personal difficulties over time. Current research indicates that it is useful to view complex trauma over the life span form a bio-psychosocial perspective. This allows the context and relational aspects to be considered in the development of ongoing difficulties for the individual (Brick, 2005; Briere & Scott, 2013; Daniel, 2006).

**Relational trauma over the lifespan**

The invisibility of the traumatised child (Atwool, 2000) might lead professionals to conclude that the effects of childhood abuse do not travel with the individual into adulthood, rather staying at the border of childhood. Lenore Terr (1991) invited researchers and clinicians to consider childhood trauma in a more organised and coherent way including cognitive and emotional changes as a result of childhood trauma and the effect of these changes on the individual over the life-span. Terr particularly noted the intra-psyhic difficulties for the adult as a result of childhood trauma which included: distortions in thinking; violence; self destructive behaviours; extreme passivity and anxiety (1991).
In this century understandings of the need to develop more coherent understandings of lifetime trauma is being considered by researchers (Brick, 2005; Fonagy, 1999; 2003; Green, Hayes et al, 2002). Briere and Scott (2013) note in their extensive research on lifespan effects of childhood trauma that it is becoming clear that childhood victimisation is a significant and substantial risk factor for the development of later mental health difficulties.

Neil Brick (2005) notes that the effects of childhood sexual abuse reflect a pervasive disturbance of self involving relational disruption and intense or inappropriate reactions and behaviours. Furthermore Brick notes that this group of people are traditionally diagnosed with personality disorders across Axis-II diagnosis band of the DSMIV. More recently some researchers of the current century reject the limitations in treatment of a personality disorder diagnosis instead citing Complex Trauma as a more useful diagnosis as it links to an essentially hopeful approach to treatment outcomes for the individual (Briere & Langtree, 2012; Briere & Scott, 2006; Briere & Scott, 2013).

Brick (2005) unpacks the raft of personal and social problems as a result of childhood relational trauma (CRT) which are essentially intra-personal and inter-personal in nature and include: ‘conflict resolution difficulties; interpersonal sensitivity; adult attachment issues; feelings of isolation and stigma; social alienation; difficulty trusting others; relational imbalances; tendencies toward revictimisation; unstable personal relationships; the victim-perpetrator cycle; social introversion and violence’ (Brick, 2005, p. 4).

The issues for the individual as a result of CRT noted by Terr and Brick are not isolated to a single event instead creating vulnerability for further difficulties to develop over the individual’s lifetime. Briere and Scott (2013, p. 17) note that ‘child abuse and neglect not only produces significant, sometimes enduring, psychological dysfunction’, but that it can create a greater likelihood of abuse later in life through teenage years and into adulthood. Briere and Lanktree (2012, p. 1) note that ‘the impacts of complex trauma are substantial, ranging from anxiety and depression to posttraumatic stress, interpersonal problems, and dysfunctional or self-endangering behaviours.’

As CRT crosses the developmental years it is increasingly being noted by researchers that due to the involvement of the individual’s growing years personal coping systems are compromised as a result. For the individual this creates distortions in understandings of self, others and the world creating interpersonal and intrapersonal disruptions and disorganisation (Bowlby, 1969, 1973, 1980; Briere & Scott, 2006, 2013; Schore, 2000; Slade, 2008).
Relational trauma and the development of problematic internal working models/psychopathology over the lifespan

‘Trauma in childhood may become a central focus around which the child’s growing takes place, shaping their perception of themselves, the significant adults in their life and their world view.’ (Atwool, 2000)

There is a growing body of literature indicating the development of problematic internal working models as a result of CRT creating difficulties in an individual’s sense of self and relational ability (Fonagy, 2003; Holmes, 2001; Schore, 2005). Briere & Scott (2013) note the particular vulnerability of an individual’s neurobiology when abuse occurs early in life and that abuse has an effect on enduring internal representations of self, others and the world due to acute developmental sensitivity (Atwool, 2000; Bowlby, 1969, 1973, 1980; Briere & Scott, 2013; Fonagy, 2003).

For the individual this manifests as intra-personal (intra-psychic) and relational difficulties over time (Fonagy, 2003; Holmes, 2001; Schore, 2005; Slade, 2008). These problematic manifestations compromise the individual’s ability to self manage thoughts and feelings creating a range of difficulties effecting mental health and well-being (Atwool, 2000; Bowlby 1973; Birere & Lanktree, 2012; Birere & Scott, 2006; Briere & Scott, 2013; Fonagy, 2003; Holmes, 2001; Sable, 2008; Schore, 2003). In essence there is an intrinsic undermining the secure base development within the developing individual.

For adults affected by childhood relational trauma (AACRT) disruptions in the secure base or deficits in the development of the secure base provide a pivotal entry point for disorganisation within the cognitive and emotional self contributing to: personal distress; anxiety and depression; difficulties in interpersonal relatedness; vulnerabilities around insecure and abusive or disrupted attachments; risk taking behaviours and perpetuating cycles of violence. (Bretherton & Munholland, 2008; Fonagy, 1999; Schore, 2000)

Difficulties over the individual’s lifespan are increasingly being noted by researchers who agree that the link between interpersonal trauma and the development of a traumatic predisposition creates multiple and complex difficulties for the individual. These difficulties relate to subsequent inadequate or maladaptive relational paradigms as a result of relational trauma. (Bowlby, 1973; Briere, 1996; Buelow, Lyddon and Johnson, 2002; Daniel, 2006; Fonagy, 2002; Holmes, 2001; Lopez, Brenan & Kelly, 2000; Renn, 2009; Sable, 2008; Schore, 2003; Siegel, 2001; Thorberf & Lyvers, 2010).
Daniel Siegel (1999, p. 70) notes that ‘the developing mind uses the states of an attachment figure in order to help organise the functioning of its own states.’ Therefore if the attachment figure is the cause of distress or trauma this creates a disruptive and irresolvable problem for the developing individual, contributing to problematic ways of understanding self and the world.

**Attachment theory**

Attachment theory was developed by John Bowlby (1969, 1973, 1988) in relation to observations with infants and their significant caregivers. Bowlby noted the distress in the infant in relation to ruptures in the care giving relationship; his research also noted the difficulties over time for the growing child in relation to these disruptions, separation or abuse as a result of disturbed, disorganised or abusive care giving. Bowlby noted the significant impact on the growing individual as problems or deficits in care giving became manifest as mental health and social difficulties across the individual’s life time. Correspondingly the helpful effects of Secure Attachments on the individual’s mental and emotional well-being and social relationships were also noted by Bowlby (1967; 1973; 1988).

Bowlby defined Attachment Theory as a biological instinct in which proximity to an attachment figure is sought for protection, nurturing and comfort. Furthermore attachment behaviour anticipates a reciprocal response in meeting the emotional, physical and safety needs of the individual (Bowlby, 1967; 1973; 1988). Significantly childhood attachment patterns define and shape the child’s understanding of self in the world, how they emotionally regulate themselves and carry out relationships with others. (Atwool, 2000; Bowlby, 1988). Bowlby also contended that Attachment relationships continue into adulthood and over the life time as a secure base support structure assisting in emotional security and well-being (Bowlby, 1969, 1972, 1988).

Mary Ainsworth through her research in relation to the ‘strange situation’ noted emerging categories of relational disturbance in the child’s interactions (Atwool, 2000; Daniel, 2006; Fonagy, 1999; Fonagy & Target, 1997; Schore, 2000; Siegel, 1999; Slade, 2008). Ainsworth linked children’s relational distress and trauma to relational difficulties which could be observed within specific categories and included anxious, avoidant or ambivalent.

Mary Mains further developed the ideas of attachment theory noting a further category being disorganised attachment (Daniel, 2006; Fonagy, 1999; Main & Goldwyn, 1993; Siegel, 1999; Slade, 2008; Sonkin, 2005). Mains also developed the AAI (Adult Attachment Interview) a feature of which is adult narrative coherence. Narrative coherence being the marker for secure attachment and well-being (Bretherton & Munholland, 2008; Sable, 2007; Slade, 2008).
Relational approaches in the development of the healthy self

Contemporary literature indicates that working therapeutically with the concept of relationship and attachment assists in the development of the adjusted and relationally competent individual (Brick, 2005; Briere, 1996; Daniel, 2006). Researchers of Neuroscience, psychology, clinical social work and psychotherapy agree that the hallmarks of a mentally well-adjusted human being relate to Bowlby’s ideas of adaptive internal working models or the secure base of the individual which includes: reflective function (Bretherton & Munholland, 2008; Fonagy, 1999; Schore, 2000; Slade, 2008); proximity seeking (Fonagy, 1999; Sable, 2007; Schore, 2000); affect regulation (Bretherton & Munholland, 2008; Fonagy, 1999; Sable, 2007; Schore, 2000); emotional attunement (Fonagy, 1999; Sable, 2007; Schore, 2000; Slade 2008), secure base (Bretherton & Munholland, 2008; Fonagy, 1999; Schore, 2000; Slade, 2008); and narrative coherence (Sable, 2007; Slade, 2008).

Briere (1996) discusses that it is in working through disturbed relatedness that the development of the capacity for attachment emerges. Furthermore Briere notes that when working with people therapeutically it is the relationship constructs that determine positive growth outcomes. Daniel (2006) also notes the relationship in treatment as pivotal to positive outcomes noting that the relational approaches of Attachment Theory provide an empirically grounded framework for understanding important aspects of interpersonal functioning in children as well as adults. Holmes (2001) and Lopez, Brenan and Kelly (2000) also note the link between attachment and the healthy and effective self in their counselling and psychology study.

Relational approaches and treatment

Attachment Theory offers a relational paradigm for clinicians to consider, in the treatment of adults affected by disruptions and disturbance as a result of childhood trauma. In relation to working with AACRT Attachment Theory informs the role of early relational experiences in the development and complexity of relational trauma (Briere & Scott, 2013; Fonagy, 2003). As a result of complexities in the development of difficulties, corresponding treatment pathways and interventions require multi-faceted consideration by the clinician.

Researchers indicate there are particular considerations involved when working with the adult affected by childhood relational trauma (Bowlby, 1969, 1973, 1988; Daniel, 2006; Fonagy, 2003; Holmes, 2001). Firstly consideration of the therapeutic approach, the therapeutic encounter and the skill set the therapist brings in working with AACRT is pivotal.
to outcomes (Briere & Scott, 2013; Holmes, 2001; Mains & Goldwyn, 1993; Sonkin, 2005). Secondly the particular set of dynamic’s operating within the therapeutic relationship which assists in mediating the effects of AACRT for the client requires consideration (Briere & Scott, 2013; Daniel, 2006; Holmes, 2001; Mains & Goldwyn, 1993; Sonkin, 2005).

I have noted that the literature tends to privilege the position of the therapist but as this research is based around the client’s experience I will talk about client perspectives first.

**Operational dynamics of relational treatment for AACRT.**

*Client lifespan relational experience*

Researchers note that relational approaches are essentially collaborative involving the understandings and perceptions from the adult client’s perspective in treatment (Mains & Goldwyn, 1993; Daniel, 2006). Current understandings of the adult in treatment inform the therapist as to parameters of treatment. Mains & Goldwyn’s (1993) research notes that the adult narrative and their understanding of early relationship is essential to treatment. Daniel (2006, p972) ‘All measure of attachment patterns in adulthood rely in one way or another on the person’s current mental representations of attachment relationships rather than on relationship behaviours in infancy’. In working with AACRT it is the client perspective of relationship and relationality which informs treatment pathways and parameters of treatment (Mains & Goldwyn, 1993).

*Essential collaboration of the relational approach*

The development of a collaborative relationship between the client and therapist forms the basis of the therapeutic alliance thus facilitating the ability for the work to be undertaken (Daniel, 2006; Holmes, 2001; Sonkin, 2005). The individual narrative contains information in relation to well being including understandings of self, others and the world which assist in informing treatment parameters (Mains & Goldwyn, 1993). The role of the therapeutic intervention is to develop an authentic ‘attachment type’ relationship as the collaborative relationship is noted by researchers as the key to healthy development (Briere & Scott, 2013; Brainwave Trust, 2014; Holmes, 2001; Roisman, Padron et al, 2002).

*The therapeutic relationship as the secure base*

Once established the therapeutic relationship provides a secure base for re-working
problematic internal working models, attachment disturbance and disruptions. (Briere & Scott, Holmes, 2001; Sonkin, 2005). Fonagy (2003) notes the importance of the therapeutic alliance, noting that in working with adults it is not attachment categories but that attachment occurred that is important.

**Processing trauma**

With the establishment of the collaborative therapeutic relationship and development of trust and safety processing of trauma is able to occur (Briere & Scott, 2013; Daniel, 2006; Slade, 2008). Part of the therapeutic task is to progress toward minimisation and elimination of ongoing emotional, cognitive and physiological disruptions in relation to the trauma. (Daniel, 2006; Renn, 2009)

**Development of self capacities**

Researchers agree that relational competence includes the ability to reflect on one’s own mental state and that of others, affect response and attunement, emotional regulation, validation of self in personhood and development of self capacities (Daniel, 2006; Schore, 2000; Slade, 2008; Sonkin, 2005). Hence development of self capacities forms an essential part of treatment furthermore reflective function is noted by researchers as contributing to self regulation and relational competence (Schore, 2000).

**Re-storying/ developing a new narrative**

The development of an abuse free narrative is the final phase of the therapeutic work when a future focus is able to be developed which is free of an abuse lens. (Brainwave Trust, 2014; Mains & Godlwyn, 1993; Riesmann, 1993).

**Recommendations for therapists working with relational approaches**

**Inclusive language**

In working with AACRT there are some subtle but significant variations in the language used by the relational approach of Attachment Theorists. This relational approach to language
assumes an inclusiveness of the individual in treatment for example; psychopathology, intra-psychic difficulties and psychological dysfunction become disruptions to the secure base, problematic internal working models and problematic interpersonal relationships. (Bowlby, 1973; Holmes, 2001; Sable, 2008). In essence the language of Attachment Theory considers relational functioning rather than individual or isolated psychopathology (Sonkin, 2005; Daniel, 2006; Renn, 2009).

*Relationship as pivotal*

In working with attachment theory in treatment consideration of the therapeutic relationship is held in mind as the vehicle for mediating trauma (Sonkin, 2005). Daniel (2006) notes the importance of the therapist’s role in developing a secure base attachment for the client and the pivotal aspect of relationship in this task.

*Secure Base*

The therapist provides the secure base which underpins the therapeutic relationship and work to be undertaken holding secure base tenants mindfully while engaged within the therapeutic relationship (Daniel, 2006; Sonkin, 2005). Furthermore Sonkin 2005 notes that non-verbal communication of primary emotions and contingent communication is important between the therapist and the client forming the basis of the therapeutic alliance, which is the key to positive therapy outcomes.

Schore (2000, p. 32) states that to be securely attached means that there is an ‘encoded expectation that homeostatic disruptions will be set right’. Science and especially neuroscience can now clearly demonstrate reflective function and self regulation as a result of securely attached relationships (Schore, 2000; Sonkin, 2005). The secure base relationship between the client and therapist provides the forum for re-working problematic internal working models (Fonagy, 2003; Holmes).

*Therapist relational attunement*

Sonkin (2005) notes that the therapist working with AACRT must be keenly attuned to the client signals to build relationship and that it is also important for the ‘therapist to be attuned to their own internal/emotional body experience’ (Sonkin, 2005, p. 4)
Renn (2009) notes that working therapeutically with attachment paradigms alerts the therapist to listen for themes of attachment trauma in the form of loss, neglect, rejection, abandonment and abuse in the client’s narrative: ‘From an attachment/trauma perspective the clients symptoms, destructive and self destructive behaviours are understood as expressing unprocessed traumatic experience imprinted in implicit procedural memories’ (Renn, 2009, p.1). For the therapist working with AACRT, disruptions in care as a result of turbulence in the individual’s environment require regularity and consistency in treatment, particularly as hypersensitivity due to trauma can create difficulties in trust and engagement.

*Re-working problematic internal working models & co-creating a new narrative.*

A further component of therapy with AACRT is noted by Daniel (2006) and requires re-working or supplementing client’s existing working models. So that the development of coping and relational abilities are part of the therapeutic change process.

The final stage of therapy is consolidation of new gains and the development of a new future focused abuse free narrative (Holmes, 2001).

**Summary**

For several decades of the last century mental ill health has predominately focused on the genetics of the individual in terms of diagnosis and treatment. Since the late 1990’s and up to present time researchers and clinicians are increasingly embracing John Bowlby’s ideas of context and environment and the link to negative effects on mental health for the individual.

In New Zealand awareness of problematic family violence statistics is juxtaposed along-side current understandings from neuroscience in relation to brain development and well-being. There is a growing body of knowledge between the link to psychological difficulties for the individual over the life span as a result of socialisation in family violence and correspondingly the link between therapeutic relationships and well-being.

Attachment and relational approaches note the development of problematic internal working models as a result of abuse and trauma. The significance of relationship in the development of capacity for secure base attachment including: emotional regulation; reflexive function and relational dexterity and competence via the therapeutic relationship is being increasingly noted by researchers (Holmes, 2001; Daniel, 2006; Sonkin, 2005).
Working therapeutically with individuals affected with multiple traumas creates multifaceted issues for consideration in therapeutic assessment and treatment. Consideration of multiple traumas’ over the lifespan and their subsequent connectivity to complex presenting symptomology requires clinical consideration for treatment outcomes. (Briere & Scott, 2006; 2013)

More recently and particularly over the past decade contemporary researchers and theorists are returning to the idea of the primary relationship as the central tenant for the healthy development of ‘self’ (Holmes, 2001; Sonkin, 2005, Daniel, 2006). This provides an important inroad for professionals in relation to assessment and treatment (Briere & Scott, 2013; Roisman, Padron et al; 2002; Holmes, 2001).
CHAPTER THREE

Methodology

In considering my choice of methodology I reflect on my engagement in the therapeutic field, the rationale for my chosen methodology, location of myself as a researcher engaged in the research and ethical perspectives in which this research is grounded. My choice of methodology has facilitated consideration in collecting and representing the data and also a way of thinking about and analysing the data (Crotty, 1998).

Locating myself

Quantum physicist David Bohm (1987) proposes that when engaging in research the researcher’s pre-suppositions require consideration. This allows the ground of enquiry to be clarified and emergent themes to arise in a natural way. In consideration of this I reflect on myself, what has contributed to my personal and professional lens and why I am undertaking this research.

I come to this research as a 52 year old pakeha woman with Danish and Spanish ancestry alongside the usual British Isles ancestry common to early settlers in Aotearoa New Zealand. On reflecting over my lifespan I recognise particular signposts along my journey. These markers have had important bearings on locating me at this particular point in writing this thesis.

I was raised in a large family and extended family in a small rural southland community. My catholic socialisation via a large family and convent boarding school of my adolescence provided a strong education and consequently a strong sense of family, community and identity as a girl and woman.

Being whangaied as an infant also had an important bearing on the shaping of the lens through which I view the world: as did my family link via marriage to tangatawhenua over 35 years ago. At this time I became aware of cultural relationships and corresponding tensions in an overt way. This in part is what led me to considering and wanting to understand cultural relationships in Aotearoa New Zealand including the Treaty of Waitangi and led me into my studies in social work. Social Work, being client-centric and grounded in context provide another important analysis that I bring to this work.
I have two adult children and two grandchildren and I live in the area where my maternal, Danish ancestors first arrived in the Wakatipu Basin 150 years ago. My maternal grandmother brought narrative via storytelling to me, in a way that engaged the whole person. It was from her that I carry the value of understanding people and their experience via narrative.

Narratives are the way we create meaning and come to shared understanding which links with both my therapeutic work and the essence of the relational component of this research (Reisman, 1993).

Today, looking back I have accumulated 25 years experience in mental health, health, therapy, social services and family violence. I have previously been a DAO (Duly Authorised Officer) under the Mental Health Act while working in the mental health system and also as a group therapist and psychiatric social worker. I have supervised Family Violence, health and social service workers and organisations for 20 years. I have worked therapeutically with the ‘whole’ person in context i.e. a bio-psychosocial approach since the mid ‘90s. As an ACC registered counsellor I work therapeutically with clients to provide therapy in the sensitive claims area and mental trauma due to physical injury.

Medical model vs: relational models

While working as a mental health social worker and Duly Authorised Officer within the public mental health system I increasingly became aware of elements that seemed to be inherently missing in treatment within a medical model frame of reference. It seemed that the ‘person’ and context was often missing in treatment, reduced to a set of symptoms and diagnosis to be managed. Consequently this had complex and bewildering consequences for the individual. Subsequently difficulties in patient compliance with treatment or lack of patient understanding of ‘fitting’ the medical model were often referred to the medical social worker for ‘sorting out’.

Medical treatment geared toward managing presenting symptomology, although helpful in initial relief of symptoms appeared to fail in the permanent treatment of the ‘underlying’ problem instead exiling the patient to the restrictions of permanent disability of mental health diagnosis. The individual rather than gaining control over symptoms, issues and problems that created a presentation to mental health continued cycling back into mental health services.
As a psychiatric/mental health social worker I had begun working therapeutically with individuals from the mid 1990s on what it was that they identified as the problem to be worked on. The exclusion criteria for the model of working included psychotic illness and schizophrenia. The themes that arose during therapy included: complex grief; CSA (childhood sexual abuse); religious indoctrination; life stage resolution; depression; childhood physical, emotional, psychological abuse, and so forth.

In 1996 I was part of the development of an idea to work therapeutically with groups in the mental health system alongside a psychotherapist who was the team psychiatrist and a Tangatawhenua practitioner also working in the mental health system. The idea of the group therapy programmes hinged around a phenomenological approach of setting aside medical model diagnosis, thus allowing the person to emerge within the therapeutic frame. The programmes ran for a full year over a period of four years. Alongside the four year group therapy programme ran a four year therapeutic conversation with the therapists and four years of clinical supervision with a European trained Family therapist. This European Family therapy and individual therapeutic approach all assisted in forming my therapeutic lens and my way of working from a bio-psychosocial model with the ‘whole’ person in the context of their life over their lifespan. The work was subsequently presented to a health and mental health conference in Finland (Roldan, Wilson & O-Hinerangi, M., 2001).

**Positioning myself within triangulated perspectives**

My development as a professional in the mental health system contained triangulated perspectives that I had to work with and within; firstly the scientific positivist position of the medical model working with DSMIV diagnosis and treatment of patients as a Duly Authorised Officer under the Mental Health Act. In conjunction with this sat my role as the mental health social worker working within the diagnostic psycho-social band within the DSM IV diagnostic criteria.

Secondly the constructionist and postmodern feminist position of the mental health social worker considering the individual struggling to maintain autonomy within the hierarchically powered system simultaneously noting a parallel disparity in power in relationships as a contributing factor to the development of the original diagnosis; and thirdly the relational model of the therapist endeavouring to keep the ground swept clear in order to work therapeutically with the client. As these three positions have had an important bearing on shaping my professional approach I reflect on where each of these positions is sitting in relation to this research.
The research I am conducting in relation to the therapeutic experience is from a relational approach. This relational approach is a hermeneutic phenomenological approach and parallels the relational approach I use in therapy. Phenomenological ‘bracketing’ will assist in keeping positivist and researcher’s perspectives aside, allowing the individual narrative/phenomena of the research participants be illuminated. Figure 1 notes the methodological research categories in relation to the research undertaken (Crotty, 1998). Following Table 3.1 Methodological discussion will maintain consistency with client centred processes of this qualitative study.

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Table 3.1

**Client centred approaches**

Client centred approaches are central to this research project holding the participants’ subjective experience as central to emergent understandings and arising phenomena (Ivey, Ivey and Morgan, 1997; Kensit, 2000).

The analysis of the research material will remain client-centred honouring the narrative from the client perspective to gain new insights into how we understand and view the issues arising (Crotty 1998).
Attachment perspectives

In considering Attachment theory in relation to this research I reflect on Attachment Theory in several ways: Firstly where attachment sits in the relationship between the participant and the researcher given the sensitive nature of the research material and the parallel between this and the relationship between the participant and their therapist. Secondly the individual’s personal relationship history which may feature both positive and negative relational and Attachment experiences of other significant individuals. I reflect on how these entities and dynamics interrelate for sensible meaning to emerge from the research (Bohm, 1985).

Current theorists, researchers, clinicians and neuro-scientists note the significance of attachment relationships both in the genesis and as a mediator of relational trauma (Bowlby, 1998; Briere & Scott, 2013; Holmes, 2001; Schore, 2001; Sonkin, 2005). Hence I seek to understand from the client their subjective experience in relation to the mediating effects which link to the therapeutic encounter.

Contemporary literature indicates working therapeutically with the concept of attachment assists in the development of the adjusted and relationally competent individual (Briere, 1996; Daniel, 2006; Lopez, Brenan & Kelly, 2000). As such this research assumes the competence of the individual post-therapy and hence the ability to subjectively participate in the research undertaken.

Central tenants of attachment theory including: secure base; affect moderation; re-storying; development of internal an working model; reflexivity and mentalisation; are simultaneously considered both within the relationship between the researcher and research participant, the participant and their relationship to their therapist and the participant and their relationships within the contexts of the subjective experiences which contained the genesis of the problem.

Relational approaches

Relational approaches are used in this research which parallel the relationally linked development of childhood trauma and subsequent mediation via therapy (Bowlby, 1969, 1973, 1988; Briere & Scott, 2013; Holmes, 2001). As the researcher is also part of the research process in qualitative research, relational approaches assist in ‘getting along-side’ to assist in illuminating the emerging phenomena (Crotty, 1998).

Bohm (1987) notes relational approaches to dialogue assist in the development of awareness which embraces a larger understanding than simply asking questions can
provide: ‘...the general picture it suggests is a stream running between two banks. It’s the stream that counts. The two banks merely give form to the stream – the stream is common to the two banks. So there will be a stream of thought or perception, or some sort to energy flowing between; unfolding, and that would be the meaning of the dialogue’ (Bohm 1987, p34). In this research the relationship between the researcher and research participant will facilitate the flow of dialogue and subsequent shared understandings.

As the importance of relationship as an effective intervention for childhood relational trauma is noted by many researchers and clinicians (Briere & Scott, 2013; Holmes, 2001) the research will parallel this in considering relational approaches as a way of gathering, understanding, and interpreting client narratives in this research. Relational approaches strongly acknowledge and hold the value for the client’s perceptions, understandings and experience contained within the narrative (Crotty, 1998; Riesmann, 1993).

**Professional Ethics and Safety**

Professional Ethics and Safety remained in mind over the whole project particularly given the content of historical abuse in relation to a vulnerable group of people. Hence client safety and professional ethics were given consideration over the entire project and particularly from the outset in setting a safe frame should clients choose to participate.

In undertaking this research reflection of ANZASW standards of practice and code of ethics are considered in relation to respect, autonomy, human rights and other relevant acts e.g. Health and Disability Code of Consumer rights and the privacy act which note the participants’ rights during participation including respect of participants’ information and how this is collected and stored.

Professional ethics are considered in relation to working with people in a way that is participatory and allows them to find their own voice, and so their piece of ground to stand on. In considering the process of interviews with clients in relation to their healing journey, consideration is given to respect and care of the client and client information in the interview process.

The clients reveal issues in relation to trauma which affected their life/stage developments across their lifespan and created significant personal distress including consequences e.g. mental health diagnosis, police and AOD (Alcohol and other Drugs) involvement and difficulty in relating and systems at micro, meso and macro levels. The sensitivity of this particular topic cannot be overlooked in relation to the process of gathering data, nor can the privileged position of the researcher in hearing the individual experience.
Bio psychosocial perspectives

Social epidemiologist Nancy Kriegger (2001) discusses the link between socially inflicted trauma, the relationship to ill health and how we come to understand this. In considering the links between vulnerability and ill health including psychological distress Kriegger (2001) notes that speaking of society and biology is to speak of personal embodiment. In terms of this research that translates to the embodiment of context, socialisation, biology and personhood within the individual.

In consideration of individuals and personhood Factor (1985) notes that approaching a problem from a traditional scientific perspective can create further fragmentation and less understanding or solution to the problem but also more problems than solutions, ‘the mechanistic world-view that seems to dominate contemporary science and society has led to a state of increasing fragmentation both with the experience of individual human beings and in society as a whole’ (as cited in Bohm, 1985, p. x ). Ongoing fragmentation of the individual is avoided by a bio psychosocial approach which allows consideration of the research participant’s embodied understanding of self via their individual narrative.

Crotty (1998) insists that to approach human science in part is inadequate. Furthermore the ‘whole’ requires consideration in research. Therefore considering the ‘person’ in context and unpacking their understanding and experience from their perspective is a way of coming to understand the embodied experience of the person from a bio psychosocial perspective.

Hermeneutic phenomenology

Hermeneutic Phenomenology is a natural choice for methodology in relation to this research as it provides a way of listening to the research participant’s narratives while simultaneously bracketing away social pre-suppositions thus allowing the embodied experience to emerge (Crotty, 1998).
Phenomenology

Phenomenology allows a way of ‘listening without chasing after any kind of result’ (Therapist 1, 2013). Phenomenology acknowledges that the individual’s subjective experience may sit outside of usual cultural and social norms. This research intends to honour the individual’s subjective experience in order to illuminate any new understandings that may arise.

Crotty (1998) noted that phenomenological approaches require focus and effort to notice, understand, emerge and maintain the integrity of the subjective experience of the research participants. Crotty also notes that these approaches require us to engage with phenomena in our world and make sense of them directly and immediately. Furthermore that phenomenology is ‘an attempt to return to the primordial contents of consciousness, that is, to the objects that present themselves in our very experience of them prior to our making any sense of them at all’ (Crotty, 1998, p 79).

As Rilke (1929) notes in ‘Letters to a young poet’; ‘Things are not all so comprehensible and utterable as people would mostly have us believe, most events are unutterable, consummating themselves in a sphere where sword has never trod,…’ (Rilke, 1929, p. 11).

Hence it becomes the phenomenological researchers task to unfold embodied information for the purpose of emerging new understandings (Crotty, 1998).

Hermeneutics

‘I climbed up to a hole in a bank in a hill above the sea, and there fell into the attitude of listening out of which poems may rise – not to the sound of the sea, but to the unheard sound of which poems are translations’.

(James K. Baxter, 1965; TMH 124)

In considering hermeneutics Crotty (1998) reminds us of Heidegger’s (1949) ideas around phenomenological noticing via poetical thought; ‘the poet reaches out with poetic thought into the foundation and the midst of being’ (Heidegger 1949, p289 in Crotty p.99)

However, although traditional hermeneutics derives from interpreting biblical texts Crotty argues that modern hermeneutics is pragmatic meaning making stating that it ‘is a matter of practical judgement and common sense, not just abstract theorising’ (Crotty 1998p. 91)
Furthermore, Crotty notes that emergent hermeneutic meanings are able to be shared between individuals and communities. Importantly, this sharing of meaning ‘is to situate hermeneutics within history and within culture’ (Crotty 1998, p. 91).

Underpinning hermeneutics remain concepts of articulating, translating and describing things which are located outside or separated from usual social norms and understanding (Crotty, 1998). Crotty’s hermeneutic circle parallels the therapeutic process where the client already has a hunch but develops a larger understanding of self in relation to the problem. Simultaneously, the researcher and the research provide another or more fully encompassing understanding of the arising phenomena and corresponding emergent solutions.

**Bracketing**

Phenomological ‘bracketing’ assists in maintaining the clearing to illuminate the emergence of the individual experience. Crotty (1998) notes that assumption that arises as parts of everyday cultural norms require setting aside; thus allowing other understandings and insights to emerge. Hence careful attention must be given to the bracketing away of researcher’s paradigms and values to allow the client’s narrative to be illuminated.

In this research, I will be using bracketing to hold aside medical model, feminist postmodern and my own personal ‘lens to ensure that the themes pinpointed in the data do in fact arise out of the data and are not imposed on them’ (Crotty 1998).

**Social constructivism**

Social Constructivism notes that an individual’s way of understanding and interpreting events is socially constructed. Experiences and the context they were experienced in create personal understandings within the inception of experience (Crotty, 1998). Social constructivism is the making of meaning and Crotty notes meaning is not discovered but rather socially constructed by individuals, groups and communities as a way of coming to understand and order human interactions (Crotty, 1998). Just as meaning is understood by each participant in their individual lives, I as the researcher will be constructing the meaning out of the collective meanings contained within the research interviews.
Postmodern feminist approaches

The complexities and polarities of Postmodern Feminist epistemologies assist in awareness and critiquing the grand narratives of Enlightenment and modern era. Postmodernism challenges the traditional ways of viewing and understanding traditional understandings and knowledge while feminist constructs hold central the concepts of selfhood and agency of the individual (Butler, Cornell & Fraser, 2013, Mazza, 1991).

Mentalisation and reflexivity

Mentalisation and Reflexivity are considered within the spectrum of Attachment constructs as mentioned earlier. Mentalisation and Reflexivity of the researcher within the research process is also considered as an ingredient to notice, analyse and give voice to emergent information within the research process.

Siegel (2001) notes the mind develops at the interface between human relationships and with reflexivity the researcher strives to understand and illuminate the individual’s subjective experience to facilitate a wider more encompassing understanding of integration and well-being in relation to this group of participants (Siegel, 2001).

Narrative approaches

Bohm (1987) notes the tendency for research to create divisions and fragmentation which are then misleadingly viewed as absolutes rather than ways of thinking and that no point of view is complete in itself. The use of narrative approaches in this research will assist in understanding the whole and not fragments of the parts (Bohm, 1987). Hence the use of narrative will assist in limiting partial understandings.

Narrative approaches are used in the collection and analysis in this research. This will assist in identifying intersections between social, contextual and personal entities which have particular and precise meaning to the participant at the time of the narrative interview (Riesmann, 1993).

Narrative approaches do not require the participant to fit the particular lens of the researcher but rather requires the researcher to use a collective process of thought to understand the particular experience, world view and significance of the narrative in relation to the client (Bohm, 1987). This will provide enrichment to emergent understandings.
Researchers continue to note that narrative is used as a way to understand and explain the individuals embodied experience (Reismann, 1993; Bohm, 1987; Holmes, 2001; Labov and Waletzky, 1967). In using narrative the research parallels the therapeutic process which uses narrative to understand the individuals subjective experience as they describe it and re-storey and co-author the narrative via the therapeutic process. Reismann (1993) notes that a narrative can be viewed from several vantage points, the narrative told by the individual about their experience, the understanding of the story interpreted by the researcher and the insights gained by the reader of the research.

In using narrative the researcher not only shares the original story but becomes part of a new story which forms a larger narrative, new understandings and becomes part of a broader dialogue between individuals and across communities (Reismann, 1993). This then allows the reader to engage with in a way that is accessible and becomes part of their relationally formed narrative understanding.
CHAPTER FOUR

Method

In answering the research question about the usefulness of the therapeutic relationship in mediating trauma in AACRT careful consideration was given to client safety and their ability to participate in the interview process freely and safely. The ability to offer participation ground to clients affected by childhood trauma was extensively discussed with therapists in the field and both my academic and clinical supervisors. Some therapists resistance in discussing research participation with completed clients raised the question as to who the therapist was protecting and so an extensive conversation around safety and participation was held with each client participant as names and contact details came forward. Clients were very clear about communicating their wish to participate as a way of educating and giving back (as discussed in subsequent chapters). The method became one of considering the research ground from the widest and encompassing position in order to glean all information in relation to the ground from the outset embracing client centred, relational and narrative processes as guided by hermeneutic phenomenological approaches. This approach was essential to the authenticity and value of the emergent data.

Parameters for safety and participation in the research

As a mental health professional I came to this research with an understanding of risk and planned for that across the research project. Considering the delicate nature of the subject matter recruitment of participants was given careful consideration which began a naturally flowing qualitative research snowball process as follows:

The initiation of client recruitment began with a personal conversation with each therapist in which they were invited to consider any previous clients who had completed therapy and would like to voluntarily participate in the research.

The level of control accredited to the therapists in the process was for the following reasons:-

  a) To allow no names to be put forward if the therapist felt it would be detrimental to client well-being.
  b) To allow clients to freely say no via their therapist if they felt they did not want to participate i.e. a free engagement in the research process was sought.
It was also decided in conversation with therapists that including completion of client therapeutic journey and the therapist professionally assessed the client to be emotionally ‘robust’ or had sufficient ego strength enough to participate and the client was unlikely to enter therapy again.

The availability of the therapist should the client wish to de-brief or require support following the interview process was also given careful consideration prior to recruitment of adult client participants and the original therapist was available to the participating client.

Parameters in recruitment of therapists included a cross-discipline approach covering: clinical social work, counselling, psychotherapy and psychology. The exclusion criterion was limited to therapists who had a minimum of 10 years experience of working therapeutically with adults affected by relational trauma within a therapeutic process to reflect the complexity of AACRT.

**Recruitment**

Recruitment began with contacting local therapists working with adults affected by childhood relational trauma. The design was to contact local therapists in the first instance working in the Queenstown Lakes, Central Otago and Southland regions. If recruitment proved difficult and there were not enough participants then consideration of recruitment would be given to the Otago and Dunedin region and then the Canterbury and Christchurch region.

Recruitment was via local knowledge and word of mouth following the previously mentioned qualitative snowball research approach.

**Number of participants**

Initially it was thought that 8 clients would be recruited and 5-6 therapists. The actual number recruited in the end it was 5 clients that were interviewed and 4 therapists.

It transpired that after interviews with 5 clients there was enough information to analyse in terms of the research question and that there had been a saturation point reached in terms of themes and threads of individual healing journeys.

The rationale for the number of therapists was to provide a broader range of therapeutic experience cross-discipline. The reason for this was to ascertain if there were any particular synergies and differences in relation to varying disciplines to. It was hoped that a multi-disciplinary approach would offer more insights into working with this particular group of people.
**Difficulties in recruitment**

Difficulties were encountered with therapist engagement in the process. Therapist participation in and engagement in the process took time, effort and skill to achieve. For some therapists approached I developed a sense they were apprehensive about the motives of the research and some personal defence mechanisms were encountered in engaging some therapists in the research. This may have been due to funding cuts and changes that were having broad and considerable effects across the health and social service sectors at the time. It may also have been related to historic criticism of longer term therapies in favour of funding shorter term therapies and brief interventions.

Hence an elongated process occurred in order to gain therapist participation which included: introduction of project, a face to face meeting which involved an in depth discussion of the project including, my professional development, course of study and my professional focus, and rational for study. Although information in relation to the project was supplied within the requirements of the university ethics committee the therapists requested further information in writing from me including: what I was going to ask them; how the interview would unfold; and the rationale for the project including what I was aiming to achieve from the project.

In essence the therapists requested a therapeutic explanation rather than an academic explanation for the project.

Difficulties in recruitment of clients were in slowness of recruitment due to reluctance of therapists to engage clients in the process. It seemed that the therapists were the over protective parent and would not allow the client the benefit of making the decision for themselves. Hence both therapist and client participation in the project was slow and a great deal of determination on behalf of the researcher was required to get momentum in the research process.

**Separation of client and therapist narrative.**

The client and therapists recruitment was a separate process and so the therapists dialogue does not refer to any clients that participated just the same as the client group are not necessarily reflecting on any particular therapist who participated. Both client and therapist participants remained confidential from each group and indeed from each person within each group. Strict confidentiality in relation to the Privacy Act was adhered to in relation to everyone who participated. This approach allowed all parties to be free to talk of their particular specific experience.
Holding a research frame similar to the therapeutic frame of ‘keeping the ground clear’ in order for the individual to emerge their own information was the process adopted by the researcher. This approach allowed the emergence of the phenomenological information contained with the embodied experience of the individual.

**Demographic of participants.**

Client participants included 5 people, 4 women and 1 male. The male participant received his therapy in New Zealand but experienced the abuse in another a commonwealth country of Great Britain with similar welfare approaches and systems to New Zealand.

Four therapists participated including 1 male and 3 female. The Male participant had completed psycho-analytical training in Europe and the women had completed training in New Zealand including, psychology, psychotherapy and social work. All Therapist participants were working either full-time or part-time in private practice, 1 had recessed private practice while she was the full-time manager of a child and family organisation.

All therapists had a minimum of 10 years working in the mental health, child and family, psychological, clinical social work and therapeutic field and so contained a vast knowledge and experience of working therapeutically with individuals, adults, children and families.

**Ethics and Safety**

As a professional therapist who considers safety at every therapeutic session (i.e. prior to therapy, during therapy, throughout the therapeutic session, pre-closing of therapy sessions, close of therapy sessions, following therapy and the time between the next therapy session) safety was given careful consideration at each step of and across the entire research project. Parameters for this project were approved by the university ethics committee which also considered safety of client participants. Safety was particularly important for the client participants given their abuse history and history of difficulties with interpersonal relationships. Client names and any identifying data has been changed for protection of their privacy. Participating therapists are referred to as Therapist 1, Therapist 2,.. etc; also for privacy.

The Health and Disability Act, Privacy Act and Human Rights Code were held in mind at each step of the process. The ANZASW code of ethics and standards of practice was adhered to by the researcher.
**Obstacles and difficulties encountered in the process**

As mentioned earlier recruitment was one of the obstacles in getting the research started. The journey to find the answers to the research question also became an odyssey along which I encountered things that I had not expected.

I had not expected that the client transcripts would be as emotionally gruelling as I have worked in this field for many years. Completing each of the 5 transcripts was emotionally gruelling and heart wrenching and I wondered at times if I could have chosen an easier topic. I reflect on two reasons for this. Firstly: when working as a therapist the information emerges slowly over time between the client and the therapist, so that the therapist and client are working through the emotionality over time. But as the researcher, interviewing the individual from their reflexive position of knowing and resolution the transcribing became a very difficult and challenging task which engulfed me at times.

Secondly it is difficult to learn that the client had attempted to seek help multiple times over their lifetime but failures by individuals either working individually or in organisations kept the client trapped in their trauma.

The other thing that I had not expected to happen was the criticism by the client in relation to initial, first, brief and mandated interventions. Having interviewed and transcribed 5 client interviews this criticism has emerged as a phenomenon which is considered in depth and development of a model is proposed in relation to this phenomenon.

**Terminology and language**

During the process of analysing the data terminology naturally developed to assist in describing the phenomenon that was emerging. Hence adults affected by childhood relational trauma became AACRT and references to childhood relational trauma (which may include single or multiple events of childhood abuse or neglect) became CRT.

Furthermore as this research takes a relational approach relational language is used. This assisted in adding coherence to the various language used across multiple-disciplines e.g. defence mechanisms encountered in therapy became attachment activation. This also assists in making the research accessible to a wide variety of professionals and also client groups.
Analysing and representing the data

Client emergent themes

Narrative is a useful tool for individuals to make sense of trauma. Furthermore narrative is inherently multi-disciplinary in its approach as it crosses linguistic and cultural understanding that it originates from (Riesmann, 1993).

Using a phenomenological hermeneutic approach themes were extracted using a numeric and colour coding system in relation to themes understandings and language (Riesman, 1993). Crotty’s (1998) assertion that the researcher is required to exercise discipline to reduce the researcher’s own appearance in the data is held in mind throughout the entire process.

Initially themes were coded as each new theme or thread occurred within the data. New themes were added and coded as they arose within the transcripts.

Client identified themes are as follows:

1. Trust, truth, trusting, courage.
2. Time-span in therapy.
3. Finding the therapist, journey into therapy.
4. Variation in counselling experience and mandated interventions and techniques e.g. ACC, police, Mental Health, CYF.
5. Development of insight and reflexive function.
6. Abuse and disclosures
7. Self identified issues
8. Relationship and client experience of the therapist and therapy. Therapy as a resource for change.
9. Client identified cognitive and emotional process as a result of abuse.
10. Coping mechanisms (as a result of the abuse), AOD, shoplifting, not engaging in life (disassociation)
11. Negative belief systems as a result of the abuse.
12. Surviving, boundary setting, self soothing, self care.
13. Relationship with therapist and others e.g. children, others, partners, mother, father etc.
14. Now – What are things like now for the client in their lives as a result of therapy.

The client themes were then collated in relation to the emerging themes excluding some dialogue that did not add to the parameters of the research e.g. ‘would you, like a cup of tea?’ Or interruptions to the interview which included telephone calls, family members, or others interrupt the transcript to engage the participant. And other information which was not the focus of the interview e.g. if someone had moved to Australia and they discussed
the town, area and life style of Australia but that this did not have relevance to the interview as agreed and was more a ‘social conversation’ as a way of building rapport than linked to the specific area of research.

Client themes were then ‘excavated’ several more times i.e. closely considered for elements that did not add to research parameters. Also pauses or repetitions in discussion were reduced or removed where relevant to assist with legible written English as expected to be presented in an academic document but also to make them accessible to all readers. This process reduced the data down to 5 overall themes:-

1. Client experience of trauma.
2. Effects of trauma over the life span
3. Entry into services and first interventions
4. Therapeutic experience
5. What is different on completion of therapy?

Therapist emergent themes

The therapist data was expansive and a long and arduous task to analyse. The reasons for this relate to the multiple disciplines interviewed and so there were individual variances in disciplinary language, style and approach with each interview. Also the therapist had expansive knowledge and experience and so the conversation was in a great deal of depth and ranged in a broad spectrum from techniques to philosophical reflections.

Therapist’s transcripts contained over 28 themes and so it was decided to make sense of the research therapists transcripts would be extracted to mirror the themes emergent in the client transcripts. This was in keeping with the therapist mirroring within the therapeutic process and it adhered to the purpose of the research i.e. seeking the client experience of the therapeutic relationship.

A further rationale for this being that the researcher is holding the frame of the research and the therapist and adult client are held within that frame much the same way as a therapist would hold the frame for the client within the therapeutic session.

Therapist reflection of client themes extracted within the data:

1. a) Client experience of trauma
   b) Therapist understanding of trauma
2. a) Client effects of trauma over the life-span
   b) Therapist understanding of the effects of trauma over the life-span

3. a) Client entry into services
   b) Therapist understanding of engagement and entry into therapy

4. a) Client experience of the therapeutic relationship
   b) Therapist understanding of the therapeutic relationship

5. a) Client reflections and understandings of what is different for them on completion of therapy
   b) Therapist understanding of effectiveness of the therapeutic process

As the interviews took a client centred relational narrative approach the data emerged as a conversation with many themes and threads across the participants life or professional life. This approach made analysing and the data a complex process but it adhered to the phenomenological and relational approaches of the research process.

**Development of a model**

As each client participants narrative was grouped into identified themes the phenomena emerged within each category which is discussed within each section of the client chapter and the findings chapter. Some themes were not surprising as would be expected e.g. relational difficulties over time. What was surprising was the power and clarity of the client narratives in relation to the effects of trauma over the lifespan and the usefulness of long term therapy in moderating the problems as a result.

Another point of note was the clarity in relation to interventions which were not felt to be helpful to the client. As these experiences emerged as a distinct phenomenon within all client narratives it posed the difficult problem of understanding how this phenomenon fits within the client healing journey. What started as an exploratory approach to the research project emerged as a gap that required addressing.

At this point a further objective emerged; being the development of a model to understand how the various phenomena in the client journey fit together. Also how the client could be referred to therapeutic services at an earlier point in their life-span thus short-cutting multiple years in exile as a result of the effects of CRT. This is put forward tentatively clearly a lot more research would be needed. But the model is proposed as way of formulating and understanding the data within the research.
CHAPTER FIVE

Client Findings

Childhood trauma

Participant narratives of childhood trauma reflected themes of their particular abuse experience. Themes included: experience of the abuse; the effects of the abuse on the individual; contact and intervention with various agencies; and pathways to finding a therapist and the therapeutic journey.

Interviews were loosely structured and were of a conversational style. The process followed the theme that the participant introduced, consequentially a natural flow developed throughout the interview. The pattern that emerged included noting the development of the original trauma and effects of this over the life span, any interventions mandated or otherwise and the therapeutic involvement that assisted in mediating the abuse and trauma.

Two distinct facets of the interviews emerged: firstly the type of trauma and the corresponding physical, behavioural, cognitive and emotional manifestation of this over the lifespan. And secondly, the therapeutic journey, the effects of therapy on the original and subsequent traumas; and on the individuals life on completion of their specific therapeutic journey.

Questions that naturally arose during the interview included: what was the childhood trauma? When did it start and how long did it go on for? What problems did this create for you over your life span? What interventions occurred as a result of the problems that developed? When did you enter therapy, how did you find the therapist that you completed your therapeutic journey with? What was that journey like and how did it help mediate the initial trauma and any subsequent traumas? What have been the positive and negative aspects of your experience of help/intervention? What is your life like now having completed your therapy in relation to childhood trauma?

Individual experience of childhood trauma varied in several ways including: overt and or covert abuse and/or neglect, context, age the abuse began, developmental period the abuse spanned and the type of abuse experienced.

Participants identify the effects of childhood abuse on themselves across the lifespan linking effects to personal, social, emotional, behavioural, cognitive/thinking and physical aspects of the self.
Individual experience of contact with health, social services and NGO’s as a result of the abuse included: first contact with services; type of help sought/offered/mandated and the effect on the trauma issues as perceived by the individual i.e. personal reflections/insights in relation to the effect of the intervention on emotional, social, spiritual, cognitive, interpersonal aspects of self.

Finding the right therapist to work on the issues of childhood trauma presented its own problems. Some individuals had previously had several counsellors before finding the one they went onto complete a therapeutic process with. For some, finding the therapist to work with was a serendipitous process e.g. As it was for Craig and Gaynor. Others note going into therapy had its own difficulties in some cases as Joan notes, ‘I had to force my hand to go into counselling, it was the time and place.’ For others the waiting had been a long and difficult process as Raylene notes, ‘I was feeling quite desperate and I tried again and got in.’

**Experience of trauma**

All participants verbalised their individual experience of childhood relational trauma and abuse. Each narrative was distinct to the individuals’ particular experience and relational style. The question linked to the abuse experience was; ‘what was your experience of childhood abuse and trauma?’ The individual experience of childhood trauma varied for each person including; age of onset, duration over time and type of abuse that was experienced. Despite the original abuse history being up to decades ago; participants’ narrative of their experience held a distinct clarity in relation to the abuse. Individual understanding included nature of abuse and elements surrounding the trauma which enabled and continued to perpetuate the abuse or trauma.

Craig

Craig’s trauma included covert and overt abuse beginning from the age of 13 months when he was placed with child welfare authorities. Craig lived in 18 different homes and foster homes up until the age of 16 years. For four years from age 11 years until the age of 15 years following placement with his aunt and uncle by child welfare authorities Craig’s abuse became overt and included psychological, physical and sexual abuse:

‘..they had an old hay barn and there was a wooden feeder that the hay was put into and I had my hands tied to that. ...he (uncle) would give me a choice, it was either a bamboo cane or a strap or I could be dragged through the brambles naked’ (Craig).
Gaynor

Gaynor’s trauma was as a result of her socialisation by domestic violence within her family home. The domestic violence occurred between Gaynor’s mother and father; Gaynor’s mother also gave her (Gaynor) ‘hidings’. Gaynor notes the fear associated with being raised in a home with domestic violence and feelings of not being wanted by either her mother or father. Gaynor continues to wonder if the hidings she received from her mother were her mother’s way of venting frustrations and anger at the (domestic violence) situation she was in:

‘I was the vent, I don’t know if it made her feel better’ (Gaynor).

Gaynor was also sexually assaulted by an extended family member at the age of eight years old.

Loren

Loren’s trauma included sexual, physical, and psychological abuse at the hands of her adopted parents. Loren also notes a spiritual element to her abuse:

‘... it’s not just the sexual abuse, it’s the physical, psychological the spiritual as well. All of it’ (Loren).

Socialisation via abuse was ongoing spanning Loren’s entire childhood and teenage years until she left the family home at the age of 17 years. The abuse Loren experienced was from three individuals; her adoptive parents and her adoptive grandfather. Being a victim of childhood multiple abuses Loren notes that she was susceptible to other perpetrators of abuse including flashers in parks and genital exposure by males at local swimming pools on several occasions.

As a teenager escaping the sexual abuse from her family home Loren reflects on the violence that continued:

‘There was a lot of violence and violent people I was involved with. There was a lot of violence and crime and there was absolutely no way out.’

‘You know, I just had victim written all over me. I was a target and they knew it’ (Loren).
Raylene

Raylene’s trauma was as a result of sexual abuse over a period of five years starting from about age five years. At that time her family moved to another town to be part of a church group. Following re-location she was raped regularly by a cousin, she was also sexually assaulted by four other extended family members who were part of the church group.

‘It was two of my extended family members and one of my foster sisters, and two of my older male cousins’ (Raylene).

Joan

Joan’s trauma developed as a result of growing up in a household of domestic violence over the developmental years of her childhood. She noted the volatility in the family home between her mother and her father. Joan reflects on her father’s role as instigator of the domestic violence in the family home:

‘He would read things into things that weren’t happening, he was very controlling’ (Joan).

When Joan was 14 years the physical violence occurring within the family home ceased. However Joan notes that the psychological abuse continued for many years until she left the family home.

Other abuses noted by Joan included sexual abuse by a neighbour which began when Joan was five years old and discontinued when at seven years the family moved to a different part of town. Joan also experienced bullying at school across her schooling years which she links to the ongoing conflict within the family home.

Summary

The narratives reflect the helplessness and isolation of the child in the situation of abuse. In all cases the abuse presents as a cluster i.e. where there is one type of abuse operating other forms of abuse also feature.

The participants note that the abuse operating in their life as a child created fear and undermined development and socialisation, creating difficulties, scholastically, with peer groups, self perception, and self worth.
For some the idea of asking for help was impossible, for Craig he was disbelieved when he told a care worker about the abuse. Bewilderment in relation to the abuse created a subsequent issue in reading social norms, creating self perpetuating abuse patterns. As a result of the childhood abuse a perpetuating cycle of abuse developed effecting individuals across the developmental life-span.

A further factor is that the significant adults in the children’s life failed to notice and protect the child from witnessing or experiencing abuse. Inappropriate adult boundaries created environments of risk for the child. Adult lack of understanding and empathy for the plight of the child was also a problem which perpetuated the abuse.

‘Scouting’ by a paedophile and a paedophile group in relation to Loren who was adopted and Raylene who’s family re-located to another town to be part of a church group was an additional dynamic in their abuse.

Craig whose abuse included torture was also placed with paedophiles, who were sadistic and enjoyed the torture and pain inflicted on Craig as a child. Loren’s abuse also has featured elements of torture.

For Gaynor and Joan where domestic violence was the primary issue in the family the domestic violence appears to have created a particular vulnerability for the child which then led both of them to being sexually abused.

In all cases the individual had a clear understanding of the harm the abuse had created for them and how the original abuse linked to other abuses and multiple difficulties in their life.

The effects of childhood abuse and trauma on the individual across the lifespan

All participants articulated in detail the effects of the abuse over their life-span. Each individual’s understanding of the personal effects of abuse spanned their childhood, teenage and adult years.

Narratives echoed the despair, isolation and emotional distress at being childhood victims of physical, psychological, sexual, spiritual abuse and domestic violence. Acting out the despair of childhood abuse either overtly or covertly is a common theme in the narratives and includes: undermining self talk, risk taking behaviours in relation to alcohol and drugs, violent relationships, perpetuating cycles of violence, negative self image, failures scholastically and work/career, difficulties with intimate relationships, getting along with people and socialising also suicidal ideation and attempts.

Living in silence and isolation with the abuse created distortions of perception in relation to self and others. Functional disruptions included intra-personal, inter-relational and social
Distortions in perception included a fundamental sense of being intrinsically bad, wrong and unlovable, misunderstandings in communication and intentions in relation to non-abusive interactions. Cognitive and emotional confusion in relation to expectations of others, family, peers and the community was also a problem created as a result of childhood abuse.

Raylene

Raylene reflects on the ‘profound effects’ that the sexual abuse has had on her life:

‘The effects of the abuse were huge. It’s always hard to explain to people the depth and subtleness that abuse effects people’ (Raylene).

Living notes that living in fear was the norm for Raylene. Furthermore she reflects it took years to recognise how deeply the fear permeated her life. This included a fear of men which effected choosing a life partner and relationships with men. Over her lifetime Raylene also developed a growing sense that it was her responsibility to protect others from her abuse:

‘I felt like I had to protect others around me from myself. I had a belief system that people who had been abused were ‘screw ups’, they are victims, they have victim mentalities, they ruin their families lives because they are constantly unstable, or they have a good period and then they lose it again, and that horrified me’ (Raylene).

Raylene developed a self that was separate from the child who had been repeatedly raped over her childhood developmental years in order to protect others from her abuse. This continued to perpetuate the original disconnection she felt in relation to the abuse:

‘I remember consciously,… remember purposely thinking that you (I) have to portray something that is different to what is real. And that’s when I took on my shell, or my bubble, yeah’ (Raylene).

An overdeveloped sense of responsibility in doing things ‘right’ was also augmented within Raylene over the years:

‘Like sex before marriage was wrong. But I felt really cut off from myself too, I lived with a sense of numbness but I was quite cut off from myself and the world’ (Raylene).
Hiding the abuse from family was a skill that was also well developed:

‘I think in my early teens I hid it really well. In my late teens and early adulthood I became hypersensitive to things and everything. And I have only realised in the past year just how bad that was’ (Raylene).

An extreme distrust of people was another issue that developed over the years of abuse. Raylene developed a technique of carefully watching people’s body language and expressions for clues as to her personal safety:

‘I was always seeking people’s body language and eyes, for the truth. Are they telling me the truth? I was really hung up on the truth’ (Raylene).

Raylene also had difficulty at school and interacting with her peers and came to believe that she had limited scholastic ability:

‘I felt quite nervous and anxious with my peers. And in school, especially maths, I don’t know why, my mind would just go blank, like, even if you asked me something like 2 plus 2, I just couldn’t tell you’ (Raylene).

When Raylene was an adult she was diagnosed with Post Traumatic Stress Disorder. This diagnosis increased Raylene’s panic attacks and she notes that she became anxious and paranoid that someone was going to take her children into care.

Doubt in her ability to make a decision that was not affected by CSA became a constant problem and she became increasingly fearful of being admitted to a psychiatric hospital. But in the end Raylene had to admit to herself that it would be better to go into a psychiatric hospital than not be there for her children as she had been having increasing suicidal thoughts:

‘I had a lot of anxiety, I was scared of failing’ (Raylene).

Loren

Loren notes that PTSD has been a major problem for her which has had a disabling effect on her life. At times the PTSD prevented Loren from being able to work or maintain relationships. Loren notes that she is still unable to comprehend how much damage has been done to her as a result of the abuse and compounding this were many years of denial around the abuse.
Fear was a perpetual element in Loren’s life:

‘throughout my childhood I was just constantly living in fear, waiting for the next attack’ (Loren).

From her teenage years Loren used alcohol and drugs to cope with PTSD, fear and emotional pain. Loren’s socialisation by abuse led to expectations of abuse in her life and so she became a victim of further abuse:

‘I was, brainwashed, so brainwashed it took me to other abusers. You know, when I left the family home I just went to other abusive men and so sexual assaults continued.’ ‘I was just a piece of meat. I was there for men to do whatever they wanted’ (Loren).

When Loren left home she moved to Wellington and thought that this would help but the PTSD and fear became debilitating:

‘Living in Wellington, I would just sit in my flat and cry. And I would take on jobs and that but I couldn’t maintain them, I would just crash’ (Loren).

Fear permeated all aspects of Loren’s life:

‘It was so frightening because I had lived this, this life of violence and drugs and crime in my teenage years and had met some nasty people. And I mean, all around the country, yeah and so when I got to Wellington it was, my god, I will have to defend myself from these people if I come into contact with them’ (Loren).

The consistent fear of further attacks and the trauma from the childhood abuse onwards created a constant and disabling effect. Loren struggled to move forward in her life:

‘So it was just everything, (in my life) the PTSD was just exacerbated. It was going all the time. So seriously, I haven’t really had time away from it (PTSD) and I’m 42 years old now’ (Loren).

Loren developed suicidal ideation and had a failed attempt at suicide when the memories of the abuse started to come back:

‘All of the memories came back to me. I just walked into the ocean with my handbag and all of my important papers and documents, I walked into the ocean and stayed there for some time and it became obvious that nothing was going to happen to me. So the next day I phoned mental health’ (Loren).
Loren notes that there is a lot she doesn’t remember due to disassociation:

‘I was a ‘non’, (non-person) for 30 years. It was just this person pretending, mimicking people, because I didn’t know how to behave’ (Loren).

Loren had difficulty trusting which included her birth mother when she met her and her first counsellor in Wellington:

‘I didn’t trust my birth mother and I didn’t trust that woman (counsellor) although she was very qualified. But it had to all come out because I was going absolutely crazy, assaulting cops and yeah, not functioning’ (Loren).

During this period Loren amassed multiple convictions for assaulting police officers as a teenager and young adult:

‘Yeah, all assaulting police; that’s my convictions. And yeah, my abuser was a policeman. The only people helping me were the therapists, the police didn’t help’ (Loren).

Loren continues to have flashbacks of the abuse and has self-mutilated over the years.

Craig

Craig reflects that he had a lot of anger as result of abuse:

‘I nearly killed a boy in a respite home. I was expelled from school, I was an absolute tearaway. I would get into trouble with the police, petty crime, violence, drugs’ (Craig).

Craig also went to jail once. Craig notes the technicality of this as when the judge asked Craig to pay for the dry-cleaning of a police officer’s uniform (as a result of the charges) or go to jail. Craig refused to pay for the dry-cleaning and so he was sentenced to a period in prison.

Craig notes that he was verbally and physically abusive in his ways of interacting with people and particularly authority figures from his teenage years on:

‘People used to say don’t mess with Craig Soper because he will kill you. Oh I remember going to school when I was in first form and the older guys in form seven; I found the biggest guy I could find and I beat the shit out of him’ (Craig).

Craig also notes difficulty with relationships, choosing people that have been verbally and mentally abusive. There have been several broken relationships. Craig has also been affected by anxiety and has had difficulty relaxing. He also has ongoing thyroid problems.
Joan

Joan links her choice of violent, alcoholic partners as a result of her childhood trauma. Joan also reflects that growing up in a violent home that included verbal and mental abuse developed a predisposition to start a fight in her intimate relationships:

‘You know I was the instigator 90% of the time’ (Joan).

Joan also notes difficulty in staying in relationships as a result of her upbringing:

‘I’ve never been in a relationship that has lasted longer than 2 years. And there have been four of them that have been like that. ‘I have casual (relationships), that’s easier’ (Joan).

In reflecting on difficulty in relationships over the years Joan notices a need to be in control which she notes is the motivation for ending relationships:

‘I always wanted the upper hand, to be in control and I called the shots. So it was me that ended it’ (Joan).

Promiscuity has also been a problem for Joan. She identifies the contributing factors as a combination of being raised in an environment of domestic violence and the sexual abuse by a neighbour in the development of her promiscuity.

Joan developed low self-esteem, which created difficulty in looking people in the eye and asking for her needs to be met in a way that did not involve abuse. Joan also notes that she had a lot of anger:

‘I was very angry, very, very, very, angry. Yeah, very angry, very controlling, and I had no confidence, no self esteem and no self worth.’ ‘I was also a people pleaser’ (Joan).

Joan reflects that she also used anger in her parenting relationships with her children as a parent herself and she has some regrets about this.

Gaynor

Gaynor notes the effects of her abuse have included drug use, marijuana and drinking. Also violence:

‘I was really reactive, really staunchly reactive. I got trespassed once from WINZ cause I lost my temper at the WINZ office. It was like fighting for my rights but I would get out of hand’ (Gaynor).
Gaynor reflects that her anger links to being overlooked in the domestic violence and feelings that both her mother and father did not want her:

‘I think the anger came from not being heard, not being valued, not being respected. And of course, I was never respected anyway particularly when I would do the pakeha haka’ (Gaynor).

Gaynor’s mother eventually left the family home and her father developed the family motto: ‘trust no cunt’. Gaynor reflects she was very defensive, like her father and learned not to trust anyone, reflecting the family motto her father had taught her.

Gaynor notes the emotional pain of her childhood and that even with drugs everything was ‘too’ painful and she had suicidal thoughts and plans from the age of nine years. Her first plan was to use her father’s cyanide to suicide but she was interrupted in the process of enacting it:

‘It hurt. Everything hurt so bad. And then I heard his car come up the road and I thought I would get a hiding because I got into the cyanide cupboard. So I quickly put it back. Kids logic!’ (Gaynor).

Key themes

Participants note the direct correlation between childhood abuse; the trauma they experienced and the difficulties that ensued over their lifespan. The narratives are stunning in their coherence and clarity in explaining the individual internal and external process of difficulties directly corresponding to the abuse experience. Participants also verbalise how these difficulties were enacted in their lives, relationships and social contacts.

The working model of abuse contained within the parent/caregiver or perpetrator which appears to have been imprinted on the child created intrinsic internal discord in relation to integrity of personhood. This internal discord created and maintained interference in the normal development of the child. The abuse imprinting and the developmental disruption and distortion manifested as acting out behaviours when the child moved into the teenage developmental years. This acting out continued over teenage years and into adulthood encompassing the 20 year-30 year decade and 30 plus years and beyond.

The other factor of significance in the interviews is that the abuse experienced is mirrored in the acting out behaviours of the teenager, young adult and adult e.g. Joan describes a controlling father in a family of domestic violence and she is able to identify her own controlling patterns and anger in relationships. Also the violence that Craig experienced is
reflected in the violence he used at times on people in order to protect himself from perceived threats e.g. the school yard beating of a larger boy.

The participants are as clear about their inappropriate acting out as they are about the inappropriateness of the original abuse they experienced and the circumstances they endured as children.

The internal processes of difficulties as discussed by the participants include; low self esteem, difficulty understanding self and others, PTSDs, numbness, disconnection from self, confusion, self doubt, anger, difficulty with concentration and suicidal thoughts.

The external processes of difficulties include: anger and violence; difficulty getting along with people and maintaining work; AOD abuse; police and justice intervention; promiscuity; and difficulty in intimate relationships.

**Initial intervention**

Initial intervention came from a variety of sources but primarily government mandated agencies e.g. CYF, Policing, Justice and Mental Health. For others the initial intervention was self motivated contact with a counsellor. Agency involvement and the type of intervention administered varied with each person in relation to the issue that brought them to the attention of the agency in the first place.

For Craig that was in relation to AOD charges, petty crimes and theft. Loren’s charges linked to assaulting of police officers, Gaylene came to CYF attention in relation to her children, Raylene and Joan sought assistance as adults through counselling.

Loren

Loren has had a variety of contact with services and agencies; firstly the police and justice systems due to violence and assaulting police officers. Then voluntary contact with mental health services following a self harm attempt.

Loren also attended an AOD treatment programme and follow-up with an AOD counsellor. This was by a tangatawhenua organisation on relocation to a city in the South Island. In 2006 she had follow-up with a clinical psychologist for a period of one year.
Craig

Craig’s first contact with services was from the age of 13 months when he first went into care. From then to the age of 16 years he had been in 18 different homes and foster homes. He has also had multiple health and helping agencies involved over the years including various counsellors, social workers and psychologists since being placed in care at a young age.

Craig recalls telling the child welfare agencies of the abuse and not being believed:

‘I told them what was going on. And they said no, no, no, that couldn’t happen and they dropped me off. I still remember that night, it was snowing. They didn’t want to know that something like that could happen. So you know, .....you (I) can still remember that as if it was yesterday’ (Craig).

As a teenager Craig has had a conviction which included a period of incarceration in prison. Craig also had a period of time in a mental health unit as an adult when he was sectioned under the Mental Health Act for a period of 8 weeks when his partner at the time miscarried at 36 weeks with Craig’s son:

‘You know I was pretty messed up, being sexually abused and everything that has happened, loosing Jamie was the hardest thing that I’ve had to cope with in my life’ (Craig).

Raylene

Raylene’s contact with services was mainly via a counselling process. The time period of therapy spanned various blocks of time over a period of 5 years. The search for the right person to complete a therapeutic journey with led Raylene to trying multiple counsellors in the search for the right relational ‘fit’ for her:

‘Different types of counselling became very evident to me. One thing I will say strongly to this day is that I hate counsellors who ask you a question but will never give you an answer. Or that you ask them a question and they will ask you a question back. It just did my head in. It felt sterile, I guess. Like I understood there needs to be a professional boundary. But it felt very clinical and sterile and therefore unsafe. Yeah, that’s how I felt, yeah’ (Raylene).
‘Another person I tried was through a church. Because I was brought up in a Christian Family, but I found that was just more probably focused on one aspect of life and I needed a more holistic approach.’

‘I think I knew what I wanted. And there was another guy I tried who was more black and white, very absolute about his theories, I guess he may have been more behaviour based, I’m not sure. But like one thing he said to me was that it was acceptable for my parents to feel angry and let down by me because I had a child out of wedlock’. ‘I guess he was a bit consequence based. But for me I didn’t choose to be abused, that was something I was left to pick up the pieces from. And so that was very heavy handed and just added to my condemnation I suppose’ (Raylene).

Raylene had a historic Sensitive Claim but for many years did not know she had a right to choose a counsellor that she felt comfortable with. She found the psychiatrist’s assessment very scary and thought it was about taking her kids off her.

Gaylene’s first contact with agencies was a CYFs intervention in relation to her children:

‘My first experiences were of me being told to go to counselling, so I would go. Some of them (counsellors and counselling experiences) were horrible’ (Gaylene).

Later on, as a mature student Gaynor studied Social Services at polytechnic and she reflects in the light of her studies a sense of not being validated in her counselling experiences:

‘.. some of them (counsellors and counselling experiences) were just so unethical what they told me about my rights, their professionalism and how many sessions’.

‘One lady, a counsellor, and it was at her home, we had to use her personal bathroom and her laundry was in there and it just felt icky, it just really felt icky. And, um, she would tell me what to do and she would even call me names, you know just about being “stupid” for even think something like that. So for me I just stopped saying anything in counselling’ (Gaylene).

Gaynor recalls the level of control in the counselling sessions and continues to be irritated about this:

‘And there was another lady, she’s where I get the ‘weet-bix’ counsellor label from, you know? “.. got a counselling certificate - came out of the weet-bix box.” I think she got it at the community college, she did tell me that. She was never really, um, she always got me to do what she wanted me to do’.
‘I remember her getting me to draw one day but it was what she wanted me to draw, she wouldn’t just let me draw. And so I became the token client, (and mechanically say) ‘yeah, that’s great, thank you very much’.

When she passed away I thought – ‘that’ll teach you for fucking up people’s lives. She also made my eldest daughter feel guilty about a lot of shit. And I would make my daughter go to counselling, I would say, ‘no, you’ve got to go, you’ve got to go’. So she had that (dying) coming’.

‘It wasn’t helpful, nothing changed. Nothing changed for me. Nothing changed. I would reflect on that when I was getting in my car and I would think, oh, I’m just as fucked up as when I went in. But I won’t say anything because then I would have to go more. It was like I had no rights, because if I didn’t go, they would tell someone who would come into my world again, like ‘she didn’t complete that or something’.

‘When I moved down south and started doing a social services course I took the opportunity to request my family’s CYF’s file. – It was a lot about judgement, like no one ever really talked to me about what was going on in our home. And I was an angry person. Yeah, I wouldn’t let people in’.

‘My daughter had an ACC (sensitive claims) assessment by herself recently, yeah, she did. I was very proud of her. So she did that and she really enjoyed that process with, a man. It was a man she saw from (North Island provincial city). And she even said to me if I could have him, I would go to counselling. And she said, it was because she felt that he didn’t judge her, he didn’t tell her that she was crazy. He understood.’

‘The lady that died told her (Gaynors daughter) that she would become a burden on society when she grew up’.

‘To me it was abuse all over again, it felt yuk, It made me feel powerless’ (Gaylene).

For Gaylene and her daughters the undermining aspects of her counselling experience became another issue to manage in their lives.

Joan

Joan’s first intervention was with a counsellor that she initiated. She tried a few counsellors to get the right fit for her:

‘I’d seen a couple of counsellors. One of them I didn’t like and that was probably my stuff as well’ (Joan).
Joan did not have any other interventions with either government or NGO agencies her entry into counselling to work on her abuse was her own motivation.

Summary

Interventions that were mandated occurred with the participants over their teenage years and early adulthood. Intervention as children is absent for most of the participants. The sole intervention as a child was in relation to Craig who had been placed with child welfare services. But Craig’s intervention was not around protection from abuse but placement as an unwanted child. Although he was in the care of social services as a child, when he told the social worker of his abuse he was not believed.

There were no other interventions for the participants as children that would have assisted or protected them from further abuse.

For some of the children the perpetrators held positions of social standing and trust e.g. Loren who was adopted by a CYF worker and a police officer reflects that she would not have been believed even if she asked for help.

Where there was a high level of violence including torture in the original abuse there is a corresponding level of violence in the ‘acting out’ behaviours of the individual. Violence witnessed as a result of family violence became intrinsic in partner relationship patterns. In narratives where the sexual abuse did not contain overt forms of violence the victim internalised the abuse creating a particular set of ongoing difficulties.

The participants note that as teenagers and adults their ‘acting out behaviour’s’ in relation to their abuse was the issue that instigated attention and intervention from Justice, CYFs and Mental Health. These interventions occurred in relation to any incidents to personal and public safety, e.g. assaulting police officers’, CYFs intervention in relation to children, mental health intervention in relation to suicidal attempts.

In some cases intervention created confusion for the individual particularly when childhood socialisation involved the use of violence. Violent acting out behaviours as teenagers and adults created a direct conflict with social expectations, and laws. Subsequent intervention created a particular bewilderment for the individual as there had been no consequence in relation to the perpetrators and violence in relation to them as children. The various interventions from police, justice, CYFs and Mental Health were related to behavioural modification of the presenting problematic behaviour in society. Interventions were
isolated to the particular organisation that was enacting a behavioural modification for example Justice intervention for assaulting police officers; mental health admission and treatment in relation to self harm attempt and CYFs involvement in relation to monitoring children.

The various interventions have been completed in isolation without a ‘whole’ person approach in relation to the individual but remain consistent with the current mandate in relation to Policing, Justice and CYFs. Hence the narratives around intervention lack a therapeutic component which encompasses a bio-psychosocial model in the interventions the participants note the difficulties this approach created.

Where there has been no risk to public safety the individual has tried various counsellor’s until they have found the right person to work with.

The journey out – the therapeutic relationship

The journey out contained its own distinct facets which included: finding the right therapist; committing to and completing therapy; the differences for the individual following completion of therapy and what life is like now for the individual. Finding the therapist to complete the therapeutic journey with had its own difficulties. For some was an accidental process, for others they found their therapist via word-of-mouth.

Committing to and completing a therapeutic journey presented both challenges while simultaneously paralleling relief at both intra-personal and relational level. Trust emerged as a difficulty as not trusting was a highly tuned defence mechanism developed over the years of abuse. On entering therapy issues in relation to trust posed an internal confrontation at both the intra-personal level and relational levels. So having to trust the therapist in order to embark on a therapeutic journey created distress and anxiety. Fear was an issue that created juxtaposition on entering therapy as fear was a constant dynamic operating in relation to interactions with people. But to enter therapy required the individual to contain and not respond to the fear in order to engage in therapy.

Aspects that were immediate gains on engagement with a counsellor were: feeling validated by the therapist; a sense of relief at being believed and understood; and development of a palpable sense of safety within the therapeutic process. These early gains were what encouraged the participant to continue to attend therapy.
Craig

Craig found his therapist via a health and disability organisation with which his disabled daughter was involved. The therapist was temporarily in the organisation on a locum completing her psychology registration:

‘It was actually quite rewarding to meet my therapist and realise she has worked for woman’s refuge and battered woman and bullshit and everything else, and to hear a woman say, “Craig I believe you”. It was quite nice’ (Craig).

In reflecting on what it was that made the difference Craig notes relational aspects of the therapy that were validating to himself as a person and also his preparedness to accept help:

‘I think it was the counsellor herself and how she approached things because both of them, the psychologist and the counsellor, it was the way they made you feel; like a person and the way they would listen and not be judgemental. And it was because they wanted to do it (work therapeutically) and not because they had to do it. And also I was probably at the stage where I wanted to accept some help’ (Craig).

Craig holds some scepticism about the motive that people have in relation to working with children and adults:

‘I think for some counsellors it’s just a job but you need an element of a little bit of sensitivity and you know, you have to be able to understand. If you don’t then you are just doing it for the money, and some counsellors are. You might not believe that but I’m a firm believer in that, you know’.

‘It’s like some social workers, and even in the past, they don’t give a shit about you, like (name), when I told her about the (childhood abuse from uncle and aunty) abuse, they (child services) didn’t give a shit’ (Craig).

Gaynor

Distress in relation to her daughter’s behaviours led Gaynor into therapy:

‘I found my therapist via supervision when I was working for a Rape Crisis organisation. It was because of my youngest daughter and all of the trouble she was in that led me into therapy’ (Gaynor).
Gaynor had previously doubted her ability to ever go into therapy again because of negative experiences in relation to feeling put down and judged in earlier counselling:

‘I knew that, with my life history and with the events in it and with previous experience of counsellors in the North Island, it was a huge trust thing. I really didn’t think I would ever go into counselling again’ (Gaynor).

Gaynor realised that she had to take a risk and trust to move forward in her life. But trusting a therapist again was emotionally challenging as it was counter to her abuse survival. Gaynor came to understand that to move past her abuse history she had to develop a relationship with at least one person, even if it was only her therapist. Gaynor reflects on her new ability to value herself and engage in life as a result of her therapy:

‘I think I just,... I think I just learned that, if I could take the risk of being honest then that is when change occurs. Because then that’s when I get something out of what I am investing in, and actually, oh, this is going to make me cry, (tears) actually having trust in the therapeutic process and the relationship with my therapist. And I think at the early stages, that’s when I felt that I could do that, even if I developed that relationship only with my therapist.

Then that was all that I needed to do’ (Gaynor).

Gaynor links trust and integrity within the therapeutic relationship to learning to value herself over time:

‘And like a leap of faith, that’s what’s kind of fed the value for me, which I have learned through the process. The therapeutic relationship has opened all of these doors about life that I can explore and feel. I’m in life now, its full and rich and alive, that’s what therapy did for me.

But I had to do it with somebody’ (Gaynor).

Raylene

Raylene had tried several times to get into her counsellor and was not sure about her right to choose her counsellor:

‘I didn’t understand the system (sensitive claims) and how it worked along-side me until I met the counsellor I did my therapy with"
My therapist was probably the fifth person that I went to see. Mum had originally asked but she had a long waiting list. And I tried again later on when I was feeling quite desperate and I got in’ (Raylene).

Concerns about her mental health and safety motivated Raylene to keep trying to get into therapy. She sensed from the beginning that the therapist was a whole person and her narrative reflects a development of trust and a therapeutic relationship:

‘I started feeling that if I didn’t get help I, you know, I was going to lose it’.

I tried again and again to get into my therapist and I finally got in. I could tell straight away that she was a whole person. And that while she always maintained a professional relationship she, just had the ability to see the person where they were at and where they needed to go, I suppose. Yeah’.

‘But she always remained humanistic too. It wasn’t so clinical that it was just all about what she had learned and how you get the person from here to there. She was always very practical about life and how life, I suppose’ (Raylene).

Raylene is reflective on the internal conflict in relation to the abuse and that the energy used in hiding the abuse was making her feel ‘split’ as a person. Raylene sensed that she was no longer able to hide the trauma or solve the personal problems in isolation. The value of therapy to Raylene is evident in her narrative; she describes the relationship with respect and care:

‘Yeah, and I was becoming a split personality I think, I was trying to I guess, take a step outside myself and put it in a box and learn how to manage it because I didn’t think I had the tools to open the box and deal with it. I guess that’s why my therapist worked because she just started giving me tools, you know, it was interesting.

And now I think that’s why she (therapist) was so great because, um, she’s honest, too and she allows you to understand things and not just – you should do this, you should do that, she’s like,, why? What? When? How? You know?

I remember drawing a picture, that was marvellous for me. Because my mind was so overworked, the drawing therapy I think was a major key for me, the colour’s and the,...cause I couldn’t get it out. And I guess I’d learnt, unless I felt it was safe or I’d jigged it around enough to know that it might be what other people might like to hear, I couldn’t say it or do it.
But I remember drawing this massive cloud that really encased me. But there was so much in it was like a tornado. And I just couldn’t get out of it everything was overwhelming; it was bigger than me, um. Yeah, so that was where we started.

She basically gave me permission that it was okay. Like, ‘you’re here right now, as you are and its okay.

She wasn’t just another person trying to tell me ‘this is how I define you’. It was more like – ‘I’m here to help you. It was just, well I knew I could work at my own pace and find out how to begin that. Yeah, it’s hard to explain.

I often think about it to this day. I am who I am because of her. I survived because of my therapist.

She taught me how to counsel myself I suppose’ (Raylene).

Joan

Joan entered therapy as an adult after trying a few counsellors, ‘some of them I didn’t like and that was probably my stuff as well.’. At the time of entering therapy she hadn’t talked about the difficulties in her childhood and adult life with anyone. She had to challenge herself to attend counselling:

‘...and because I hadn’t had, I didn’t talk to anybody about it, it probably was time, yeah, I really honestly can’t say what triggered it, I had to go, it was time and place’ (Joan).

It was a friend who recommended Joan’s therapist to her, Joan reflects on her thoughts at the time and the start of her therapeutic journey:

‘I thought, oh, well, I will give her a try. And so I saw my therapist for about two to three years. I would stop and then go back again. I did a block of counselling and then would try on my own and then would go back and do another few from time to time’ (Joan).

Entering therapy proved to be challenging and Joan reflects on the challenges of sitting with her therapist and looking at her:

I didn’t realise how hard it would be. It probably took me a few months to look my therapist straight in the eye, instead of averting away.

I went back again, counselling last year, but I think, some aspects of counselling has helped a lot, this time more so, I’ve had a lot of ‘Ah hah’moments. And my counsellor
was really up front, (laughs) really up front, yeah just a lot of things I was doing hadn’t changed, but now they have.

She challenged me, she didn’t mince her words, yeah, she was good.

I honestly don’t know what was helpful or unhelpful because I think it depends on where you are within yourself. If you find it helpful or unhelpful it depends on your state of mind and how open you are to the advice that’s being given or hearing what they have to say.

So it’s all been helpful because I’m not the same person that I was when I started counselling, yeah.

I was with my therapist for three years; two years for a start and then every time I thought something wasn’t going right I’d re-check with her and do another few, six sessions or 10 sessions. Yeah.

I couldn’t have done it in any less; the initial six sessions is not long enough because you are only just starting to establish a rapport or a relationship with your counsellor. So I don’t think I could have done it any shorter or quicker, it’s just part of the process really. And I think you know within yourself if you need more or you are just not getting what you need’ (Joan).

Loren

Loren went into therapy in 2011 when her childhood trauma created triggers that debilitating her daily functioning:

‘I was just being triggered left right and centre and yeah, I crashed again’ (Loren).

Loren found the therapist she completed her therapy with on recommendation from someone:

‘Someone recommended my counsellor to me. And she was the one that I did my therapy with’ (Loren).

Loren’s counsellor specialises in recovery from childhood trauma and Loren found therapy, the therapist’s approach and level of skill was a safe environment for her:

‘It was a safe environment to tell somebody who is qualified to understand, yeah what,......, what’s going on. And understanding my behaviour’s and why things happen. Yeah.
The only people helping me were therapists, the police didn’t help.

I’d be dead or in jail if I didn’t find my therapist, or else somebody else might be dead. Because I didn’t give a fuck.

Seriously, if it wasn’t for therapy. And I couldn’t have afforded it either. So ACC, I’m very grateful. Because if I had to pay for it I couldn’t have done it’ (Loren).

Summary

Participants emotional and cognitive presence in the dialogue is tangible which directly contrasts the invisibility of the child victim of abuse whose emotional, developmental, cognitive, physical and sexual safety needs were negated by the perpetrator and the perpetrator’s support system. For some the therapy resolved the issues of childhood trauma. But for Loren the crippling effects of her abuse are apparent in her dialogue. While therapy may have provided some relief to her symptoms there is an element of disability in relation to her personhood.

Within the participant’s conversation about their therapist and therapeutic journey the dialogue differs from earlier sections in that there is intra-personal consolidation and a relational element emerges. This relational element mirrors the ‘actual’ relationship between the participant and their therapist. Participant’s dialogue reflects an integration which contains emotional and cognitive aspects of themselves, aspects of their experience of the therapist and the therapeutic experience. This part of the narrative is emotionally and cognitively harmonious and reflects an integration of the ‘whole’ person in context.

What is it like now?

Joan

Joan is no longer promiscuous, is planning to do future study in social services and is considering the development of a career pathway. Joan is grateful for her therapy and wanted to participate in the interview as a way of ‘giving back’. Joan is enjoying parenting her teenage son without anger and is involved in school fund raising to assist with his scholastic activities.

Joan is now able to set boundaries to her critical family members and also challenges critical or undermining behaviour in her extended family. Joan notes that she doesn’t wear masks
now, is honest and up front with people and her family. Joan laughs as she notes her aunties are still getting used to this.

Raylene

For Raylene therapy assisted in her gaining control over her thinking, emotions and development of autonomy in her life:

‘therapy and my therapist gave me my autonomy back and my ability to be in control of my mind’ (Raylene).

Raylene is now in her final year of studying nursing and had just completed her psychiatric in-patient unit placement prior to our meeting. Raylene notes with humour that she did go to the mental health unit in the end ‘but as a student’. Raylene is focused and optimistic about her and her children’s future;

‘That is one of my biggest regrets, that is has taken me to this age to realise that, I’m not stupid, or there is something wrong with me, it’s just the effect of trauma.’

‘..that was a huge thing for me actually (to study) to be quite honest. Last year was a hard year for me cause I suddenly got a lot of anxiety, I was just scared of failing. I feel like this will be the first success, sort of you know? But if I can graduate then I will have proven to myself that I have crossed a line’.

‘And this book up to this point of my life will close and I can start a new one. Not a new page or a chapter, I can start a whole new book’. (laughter)

‘One of the biggest battles after being abused is to trust yourself.’

‘It can get easier if you are committed to the hard yards (therapy), and that’s what I say to people (who ask me); Are you willing to make the hard yards? You have to do the hard yards until you think it’s going to kill you. That’s how hard it is. You know, it’s like living on a cliff, or not living on a cliff, but pushing yourself to the edge of the cliff and then realising there is no cliff.

It takes a lot of courage because you have to desensitise, you have to learn new norms and then desensitise, what had previously become a normal reactions’ (Raylene).
Gaynor now enjoys the person she is, she is studying social work and working in supporting people with mental health difficulties. Gaynor has maintained and enhanced her relationship with her children and now is a grandmother. She understands and values relationships and takes time to enhance relationships with all the people in her life. Gaynor exudes a sense of delight in her life and a deep enjoyment of all aspects of herself, her family and her life:

'I had to develop a relationship with myself and I think that’s what I got out of my therapy.

Like I can walk past a window now and see my reflection and I can give myself a wink. (laughter)

And it’s that thought, ‘you’re doing okay’. And I would never do that before. I wouldn’t do that before. And I enjoy life now, with me in it because I’ve got to be in it. It comes from that therapy.

Being a grandparent is just magic. I find there is something so magical about little people. And what they can teach us without even knowing they are teaching. Um, I had my little granddaughter every two weeks from when she was two months old. And it is her time, you know, nothing gets done pretty much. Because that’s something that I didn’t do with my own kids. I was busy trying to prove to everyone that I was an okay mum. I was doing this and I was doing that, but with my granddaughter, it’s about forming a relationship. (tears)

‘It’s about forming a relationship’.

The therapeutic relationship has opened all of these doors about life that I can explore and feel’ (Gaynor).

Gaynor works in supporting people who have had mental health and addictions and reflects on this work now:

‘It’s about honouring, them to be able to move from a space where they’re at, you know, caring for someone with a mental health problem or with an addiction. It’s getting them over the fear. To do that you have to form a relationship before anything can move.

I enjoy that, to do that, and then I and let them go on. Well not let them, but wave to them as they carry on’ (Gaynor).
Craig

Craig notes the role that counselling played in helping to understand and come to terms with his abuse:

*It’s only through counselling that you probably understand these things and understand why they have been, you know’* (Craig).

Craig works part time and also has shared care of his two children, one with special needs. Craig is involved in play centre and all activities in relation to his children, he feigns difficulty at being the only male to take interest in play centre but there is a distinct delight in his tone.

‘Even going to play centre, 25 females there and I’m the only male. Never thought I would see myself at bloody play centre, working with children and doing courses, and (smiling proudly) learning bloody Maori, the tika-fucka the learning curriculum and all the other crap that goes with it you know. But it is quite enjoyable. Yeah’ (Craig).

Following a difficult court battle Craig now has a co-operative parenting relationship focusing on the welfare of the children: ‘I wasn’t going to let my ex stop me from seeing my kids, so I stood and I fought’ (Craig).

Craig acknowledges all of the help that led to him being happy and settled in his own home with his children including; his counsellor, lawyer, neighbour’s and friends. Craig, in reflecting on the help he was given likes to help people in return. He notes that now he knows that he is as good as any other ‘bloke’:

‘You know, sometimes everybody needs a little bit of help.

I’ve got a conscience, I like to try, I help people all the time and I do what I can for people, you know.

I used to have not very good confidence, you wouldn’t believe it. But (now I know) I’m as good as the next bloke’ (Craig).

Loren

Loren was working for three years part time but then her symptoms recently re-presented and she had to go back into therapy:

‘I’m just sick of it. I’m sick of crashing. I didn’t understand how, I don’t know, I didn’t’
understand. And I’m just going to have to continue sorting it out for the rest of my life because there are just so many triggers.

‘It’s a process; it was safety, my personal safety. And I had to be able to support myself financially before I was safe enough to, yeah’ (Loren).

Summary

The post therapy dialogue encompasses an emotional and cognitive integration within the narrative. This assimilation is indicative of a reduction in the distress related to the trauma and trauma symptoms, resolution of the original trauma and abuse and an embodiment of the gains achieved within the therapeutic experience. Narratives are coherent and integrated in terms of the individuals thinking and emotional process, signalling some resolution to the historic abuse and a new abuse free internal working model operating within the psyche of the participant. The current lives of the participants reflect resolution, relationship and personal growth within the individual, their relationships, families, work and peer groups and community.

What would have happened if you hadn’t gone into therapy?

Raylene:

‘If I didn’t meet my therapist – I would have gone into a psychiatric unit. I would have because I seriously got to a point where, and that was my whole goal in life, not to go. And even though I feared it greatly, but in the end I realised it would be better to go there (psychiatric hospital) than not be around for my children.

Yeah, I often used to think of just being dead, or dying cause I just couldn’t handle the pain, or the torment of my mind’.

Joan:

‘I think the hard part was having someone break through the wall that I put up. I had
a lot of anger, a lot of anger. I think my shoulders were always up around my ears. Just a lot of anger I’d say, yeah, defence.’ Anger was just the norm, it was always there’.

Loren:

‘Without therapy, I would be dead or in jail or someone else might be dead. And I would be a fucking nuisance in society. Yeah a nuisance.

I just thought it was all my fault so I shut down. I used to shoplift and lie. Lie was a good one, yeah, make up elaborate stories. My adopted mum just called me a thief and a liar my whole life and I believed it.

I didn’t give a fuck.

‘If there was no therapy I would have just resorted back to what I know, which is abuse.’

Gaynor:

‘I honestly think that if I hadn’t have had that therapeutic relationship. If I had never found the person to do my therapy with, I can honestly say I’d be dead, I wouldn’t be able to, I wouldn’t have not wanted to carry on. It just would have been so big... I wouldn’t have even have wanted to live with drugs. You know, because that is painful.

I would have just wanted to sign off. Because it’s too hard on my own, and it was, I spent a lot of time trying to discover life on my own, and yeah,... yeah,... and that’s honest. My kids wouldn’t have kept me alive, it wouldn’t have been enough. I would have killed myself’.
CHAPTER SIX

Therapist Findings

The therapists interviewed had a minimum of 10 years working therapeutically with both children and adults on a variety of issues including abuse, trauma and attachment disturbance. Professional backgrounds included, counselling, psychotherapy, social work and psychology.

Therapist’s dialogue incorporated understandings of: trauma and abuse; theoretical perspectives; varying styles and preferences in treatment; professional experience; training; organisational and political difficulties in relation to treatment; difficulties in access to treatment; supervision; self care and meta-theories.

Dialogue was extracted which primarily mirrored themes identified by the client group but also incorporated therapist knowledge, understandings and ways of working. The chapter includes therapist understandings of childhood relational trauma and the effects of trauma, entry into and engagement into therapy, the therapeutic relationship and change as a result of therapy.

Therapist understandings of childhood relational trauma

All therapists commented on their understanding of childhood relational trauma. Responses included their particular individual perspective which was shaped by professional training, background and world view, experience, discipline and professional development.

Therapist 1’s understandings held intrinsic relational elements reflecting their psycho-dynamic field:

‘Trauma is always going to involve some kind of relationship which has shockingly gone wrong, either a relationship with another person or a relationship with a situation. It’s always about something else, trauma’ (Therapist 1).

Therapist 2 firstly outlines the area that she works in related to trauma and the effects of trauma on relationships at an attachment level. The variations in manifestation of the effects of trauma on individuals are also noted:

‘Areas that I work with include sexual abuse, physical injury, attachment traumatisation in which relationships have become disrupted in some way at a child
or adult level and also complex trauma. Complex trauma itself can create attachment disturbance and is self perpetuating’ (Therapist 2).

The link between trauma, attachment disturbance and relationship is noted as problematic for the individual by therapist 2. Also the propensity for complex trauma to create attachment disturbance and the self perpetuating cycle of complex trauma is significant. The variable effects on the individual in relation to trauma and fluctuation over time is also a factor for consideration in working with individuals:

‘Some things that may be traumatic for some individuals may not be for others. So the effects of trauma on the individual over time may be different for different people’ (Therapist 2).

Therapist 3 reflects on attachment patterns of the individual and difficulties in parenting as a result of disturbed attachment patterns. Therapist 3 notes that parenting from a disorganised attachment pattern has the propensity to create a self perpetuating generational cycle which requires consideration in relation to the therapeutic treatment:

‘Some people survive and manage to form healthier attachment patterns. So for whatever reason, you end up in adulthood, trying to raise your children from a disorganised pattern of attachment you are going to have trouble. Absolutely you are’ (Therapist 3).

Therapist 4 notes the varying work situations in which she has encountered individuals presenting with trauma. The correlation between the type of trauma and subsequent attachment problems is noted. A link is drawn between relational trauma and individual presentation to services:

‘The trauma I worked with in relation to children in the mental health system was sometimes about relationships because it was children that had been removed from homes by CYFs because of domestic violence. So there were quite strong attachment problems.

Sometimes it was around sexual abuse by known or unknown perpetrators’

(Therapist 4).
Summary

Therapists understanding of trauma incorporated relational events and other traumatic incidents as emotionally and psychologically problematic for the individual. The problematic effects of trauma are cited as having the potential to create ongoing difficulties at the intra-personal and relational level for the individual. Language corresponding to trauma varied across disciplines and included terms of reference such as: attachment disturbance; trauma; relational trauma and complex trauma. The link between relational events and trauma including the self perpetuating cycles of complex trauma is noted by all therapists as significant in the development of difficulties for the individual.

Effects of trauma across the lifespan

Therapists noted the effects of trauma on the individual across the life span. Therapist 2 noted the parallel between trauma; its effects and the link to underpinning theories in relation to trauma and traumatic acting out. Dialogue has been divided into categories noting the association with theoretical paradigms. Categories include: attachment disturbance; problems with alcohol and drugs; variation in the effects of trauma and difficulties over the lifespan.

Attachment Disturbance

Therapist 2 noted relational and attachment disturbance from childhood as contributing to adult acting-out behaviours. Furthermore an Abuse Replication Dynamic is noted in the ‘playing out’ of the trauma and subsequent relational disturbance over time:

‘Disruptions in attachment can create a traumatic acting out in adulthood which may include problems with alcohol and drugs, police, authority figures. This is simply because those attachment patterns that actually start in early childhood are developed and just continue to play out. They continue to play out over time. In psychology it is referred to as Abuse Replication Dynamic. And basically that is a playing out of past traumas’ (Therapist 2).
Alcohol and Drugs

Therapists discussed the use of alcohol and drugs associated with trauma and that this becomes problematic when clients seek treatment for AOD issues. What may begin as self medication to escape the pain of trauma can lead to a life-time of entrapment for the individual:

‘I notice a lifetime entrapment with a problem as a result of the abuse. Alcohol and Drugs get used around the trauma. ‘With alcohol and drugs they become a replacement relationship; a relationship with the bottle, or pills. It becomes a way of feeling that is absolutely, totally avoidant’ (Therapist 2).

Alcohol and drug use around trauma and AOD treatment can sit in a discordant juxtaposition in relation to treatment. Therapist 2 also notices that avoidance of the individual to address their alcohol and drug issues is mirrored by treatment providers who avoid addressing the underlying issues that facilitated the original addiction pattern.

‘...I think it’s quite funny that in alcohol and drug work the elephant in the room (i.e. alcohol and drugs) gets talked about but that nobody talks about but what is mirrored in the way people use alcohol and drugs. They’re not talking about the other elephant in the room inside themselves, which is the traumatic stuff that has actually started all of this.

It’s also difficult to find the motivation to change an alcohol or drug habit when it’s hiding the trauma’ (Therapist 2).

Variation in the effects of trauma

Therapists discussed variation in the impact of trauma as an important element for the professional to consider in the treatment of trauma:

‘The traumatic effects of abuse are different for different people, what might be traumatic for one person might not be for another. So it is important to consider the variation in effects of trauma on each individual and take that into consideration in treatment’ (Therapist 2).
Difficulties over the lifespan.

Therapist 4 notes the trauma she encountered within her professional field. The long term impact of this was also noted alongside intra-psychic disturbance including fear, lack of trust and submissiveness:

‘I saw some incredible traumas that people experienced in childhood and the long term impact that has had. The impact of trauma includes submissiveness, incredible submissiveness, absolute fear of people, fear of new situations and lack of trust.’

(Therapist 4)

Summary

All therapists discussed relational explanations of trauma that encompass a range of other issues including acting out behaviours and AOD issues which may bring the individual to the attention of police, authority figures and treatment providers. The significant personal effect on the individual over their life time is also an element noted by therapists.

Initial interventions

Therapists had varying experiences of client presentation to services within health, NGO and social service systems they have worked in or completed locums in e.g. mental health, family counselling and disability organisations. Working in organisations has occurred while simultaneously maintaining their therapeutic private practice. For some participants reference is made to previous organisations they have worked for; for others reflection on assessment was in relation to working both within organisations and private practice.

Assessment Process and Issues

Therapist 1 reflected that assessment can be useful but only if it grows out of the developing therapeutic relationship. Consideration is given to the theory meeting the individual in session and not the person ‘fitting’ a theory:

‘I think assessment is useful but I think the idea really needs to grow out of a certain amount of engagement.'
And I don’t mean this business of going to see somebody and they say in one session (eg) the therapist will say, yip, and ‘Oedipus complex’. Well, I don’t find that too useful. You have to be able to work without being constrained by too much theory. Good to have the theory but the session has to meet the theory, not the other way around. Too much of that goes on and I think that’s a little premature’ (Therapist 1).

Therapist 2 also considers the person at the centre of an assessment process and the unfolding process of assessment. Time constraints around assessment and formulation are variable depending on various funders and contracts for treatment:

‘Assessment and formulation is an unfolding process. Although different funders may expect it after so many sessions I complete formalised assessment wether it is required or not’ (Therapist 2).

Assessment may include comprehensive assessment and clinical formulation, psycho-social assessment and attachment assessments. Client participation forms part of the assessment process and is fed back to clients on completion of assessment.

‘Assessment may be a Psychological clinical formulation or ‘mud map’ and include childhood attachment patterns, psychosocial assessment, and comprehensive assessment, psychosocial history, biological and psychological. It is a snap shot of the client over their life-time, what they identify and don’t identify and then it gets fed back to the clients.

Feeding the assessment back to the client is an important part of the process’ (Therapist 2).

For therapist 3 formalised assessment requirements while working in an NGO, at times created conflict in relation to therapeutic delivery and what was best for clients. This, at times developed frustrations working within NGO organisations as therapist 3 felt the focus on accountability for funding undermined what the client actually needed in treatment. Therapist 3 resisted compliance when it was not therapeutic for clients which inevitably created conflict with the organisation:

‘I use assessment but that isn’t formalised. When I worked with an NGO I had to use lots of forms and this was frustrating. Taking referrals and doing assessments and comprehensive assessments but ‘I would work really hard not to, I was always in trouble with administration’ (Therapist 3).
The usefulness of attachment assessment when working psychotherapeutically is noted by therapist 3:

‘How they form their relationship with me is an enormously rich and valid piece of information’ (Therapist 3).

Therapist 4 notes the importance of the link between the client’s identified presenting problem and assessment. Assessment remains an essentially client centric process:

‘I don’t use a formal assessment but go with what is presenting and then consider assessment in relation to the presentation for example; depression and the Beck rating scale.

Questioning around the client is linked to client presentation on the day, it’s a client centric process’ (Therapist 4).

Therapist 4 has developed an assessment tool which includes personal history, mental health history, daily functioning, psycho-social assessment and family history. The therapeutic conversation is a tool to assist in assessing well-being and functioning:

‘I have developed a self-assessment tool for clients which includes depression history and daily functioning. The therapeutic conversation reveals more of the patient’s well-being and history. It also includes their family history, family history and maternal and paternal grandparents and parts of a psycho-social assessment’ (Therapist 4).

For therapist 4 assessment occurs at multiple levels including: systemic; context and intra-personal levels and is an ongoing reflexive process. Assessment is developed which informs the therapist but remains a client centric process connecting the client with their history, their family history and their maternal and paternal history. The presenting problem is considered in the assessment process which is a comprehensive process over time:

‘I suppose that is part of my training, to assess very broadly but in fact it is quite intense because after the session I write it up using bullet points and a geno-gram and build up a picture of the person also considering the parts that I do not know, which I will cover in the next session.

So it’s an ongoing unfolding assessment which holds ‘relationship’ at the centre’ (Therapist 4).
Therapist 4 notes the therapeutic relationship in assessment is given particular care when working with clients who have been sexually abused:

‘It’s particularly important to use relationship in assessment in relation to clients who have been sexually abused as this significantly impacts on relationship. It effects relationships and their development, their future, their parenting, the friends they make, it effects the type of friends they become, it effects relationships with their partner- so there is a whole big world of effects on the individual’ (Therapist 4).

Diagnosis

Therapist 1 notes caution in the use of diagnosis; what is the purpose of it? Will it assist the client? What will it add to the therapeutic relationship? Therapist 1 also notes that caution should be exercised in relation to premature or rushed assessment and diagnosis without a full and embodying connection to the person in treatment:

‘I resist, generally, a diagnosis too soon. You can treat patients without having hard and fast constraining labels. That’s the nature of psychoanalytic work. You’re not treating the label your treating the patient, and they’ll tell you in the end what the problem is, If we are lucky enough’ (Therapist 1).

When therapy is not going well

At times if therapy is not going well this is also noted by the therapist as a growing sense of not relating, for various reasons:

‘First of all I think it’s fair to say that one mostly notices these things in an aggregate. I don’t think you notice them ‘one day’. I think it’s a creeping kind of thing. One of the things I’ve noticed is when I think, mmm, ‘something’s not going too well here;’ It’s when I sense that the patient is trying to please too much. I don’t think the therapy is going well. I think they are doing something that they think you want. That’s one of the marks I’ve noticed. The other is the feeling that, two people in the same room, having a conversation and there is a wall, between them. How you could substantiate that I don’t know but since we are talking about a psychological
art there are a lot of things we know that we can’t concretise. When I get that feeling, ‘who the hell am I talking to? Oh, myself’. And I think, ‘who is the patient talking to, oh, they are talking to themselves’.

Yeah, that session’s not going well’ (Therapist 1).

Therapist 3 notes that at times it can be difficult to engage in relationship with a client which creates an awareness and appreciation for the times that engagement naturally and easily occurs. Forming relationships with children can be an easier process as adults may have complex layers of defence mechanisms and are more difficult to develop relationship with:

‘On a rare occasion when you don’t feel like you can engage you realise how amazing it is that you do again and again.

In terms of forming a relationship with children, they don’t have all of the defence mechanisms that adults have. It’s not tricky.

Adults can get quite tricky, because you have often got quite complex layers of things. And the skill is just to see in amongst that and assess the pattern, along-side that there might be alcohol abuse, there might be crime, there might be gambling, there might be historic trauma’ (Therapist 3).

Summary

Therapists note complexity and difficulties in relation to initial intervention including first contact and assessment. An overall theme of discordance between the help the client is seeking and assessment and funding requirements within agencies which may limit the usefulness of initial interventions is noted by therapists.

Assessment is noted by all therapists as useful if it grows out of the developing relationship between client and therapist, is linked to client presentation, relevant to client need and linked to a therapeutic process.

Assessment varies between professionals and includes: Attachment assessment; psycho-dynamic formulation; psycho-social assessment and comprehensive assessment. Therapists note the engagement and participation of the client as an essential element in the process.
Entry into and engagement in therapy

Therapists perspectives provide an in depth understanding of entry into and engagement in therapy. The understanding encompasses client choice of therapist, entering therapy, engagement, building trust, relationship and difficulties with engagement.

Engagement, Building Trust and developing Relationship

Therapist 1 notes an ‘actual engagement’ in relationship with the client which may not be able to be empirically measured initially. Awareness of the conscious and subconscious of the individual in developing trust and engagement is an element to be considered in the development of empathic relationship:

‘There is a sense of an ‘actual’ engagement, an ‘actual’ relationship; it’s not something that, one I think one can empirically establish but if one is operating and believes that the unconscious is also at work, along with conscious process; one can get to the sense of a kind of empathic relationship.

‘So it’s that immediate sense, or that growing sense rather that one is actually engaged with the other person’ (Therapist 1).

Use of the patient’s language is noted as important for building trust and confidence in the relationship. Building relationship to facilitate the capacity for transference is given particular consideration:

‘When you use the patient’s language I think you begin to gain the trust and the confidence of the patient. Without that it’s difficult to have transference, except for maybe a negative kind. So that’s (using the patients language) very important for establishing an empathic relationship’ (Therapist 1).

For Therapist 1 mindfulness of transferential potential as a tool to mediate trauma is held by the therapist in the engagement process. This is considered by the therapist at both conscious and unconscious levels:

‘I think implicility it needs to be held in mind that the engagement is not only at a conscious level it also happens at an unconscious level. Otherwise you can’t have any transference’ (Therapist 1).
Engagement and development of the therapeutic relationship is given careful consideration from the outset. Specific elements in the engagement process are held by the therapist in fostering relationship within the engagement process. Building trust, use of the patient’s language, therapist awareness of conscious and unconscious processes and development of an empathic relationship combine to provide a growing sense of a relationship in which two people are engaged.

Therapist 2 notes that the conscious choice of the therapist by the client as valuable for development of the therapeutic relationship, engagement in therapy and therapeutic outcomes:

‘Choice (of therapist) is important, the client choosing the therapist in a conscious way. This assists in the engagement and the positive outcomes of the work undertaken’ (Therapist 2).

Particular note is made of the importance of the therapeutic relationship in the absence of which work on the trauma will not be able to occur:

‘Building relationship from the outset is given careful consideration. Relationship is important in the therapeutic process and particularly for doing the deeper work of trauma therapy. We won’t be able to work on the trauma without relationship. I think it’s important that they find somebody that just gets them, that they are heard and understood and reflect it back.

It’s important to be your authentic self; I hark back to Carl Rogers who said that the most important thing is me being authentic.

Being real provides the space for the client to be open’ (Therapist 2).

The depth and length of therapy is given consideration in the engagement process:

‘Working deeper takes longer, the more depth people go to the longer it’s going to take, and also the level of trauma, when its trauma it’s going to take more work’ (Therapist 2).

Therapist 3 notes that children can be easier to engage in therapy than adults; and that can make engagement a less complicated process. In working with adults it takes skill to assess the relational pattern along-side abuse, addiction, crime and trauma:

‘With children you’ve got to be really careful, because the reason they might not be
engaging or wanting to disengage might be something that is not in their control. They have been told not to talk, um or they have been told I’m a silly bitch or that therapy’s crap and a waste of time. You know they have got another, someone else’s script and that’s their vulnerability’ (Therapist 3).

Therapist 4 notes how difficult it is for people who have suffered the effects of previous traumatic relationships to enter therapy.

Client insight into knowing that they need help is noted as a significant step in the process. Approaching a service to ask for help takes a great deal of courage to front up. Building trust between the counsellor and client is of significant value to the therapy and therapeutic outcomes:

‘In relation to trauma and going into therapy – I always think that one of the hardest things in life is to recognise you need help, the next hardest thing is to find out how you get the help and the third is actually to turn up and try and get the help.

Therapeutically building trust between counsellor and client is incredibly valuable’ (Therapist 4).

Summary

Therapists have multiple and varied lenses for viewing the delicate ground of the engagement and the therapeutic relationship. Some highlighted particular aspects in relation to their experience but all reflected aspects of each other’s elements in the dialogue. Individual choice, authenticity, openness and integrity in interaction with the individual all assist in building engagement and relationship. Awareness of conscious and unconscious process and transference potential is held in the cognitive awareness of the therapist.

Therapists note that when the client consciously chooses the therapist it assists in underpinning engagement in therapy, maintenance of the therapeutic relationship and positive therapeutic outcomes. Building relationship is given careful consideration from the outset of the engagement process. The importance of the relationship when doing deeper trauma work is noted.
The therapeutic relationship

Therapist understandings and knowledge of the therapeutic relationship emerged as complex and multi-layered. Their knowledge and understanding encompass micro, macro and mezo levels of the individual at cognitive, emotional, intra-personal, relational and social levels in the context of the individual life and spanning over time over the individual’s life-time. Although the interview unfolded in a weaving pattern; back and forward between ideas, concepts, elements, theories and entities the material is presented here in a linear style. Consideration of a weaving template within the linear presentation is helpful to facilitate understandings of linkages between elements and concepts presented. It also assists in the idea of multiple layers contained within the therapeutic process and location to the next layer of the therapeutic process which occurs simultaneously while the therapist is holding, mirroring and continuing to unfold further elements and concepts within the therapeutic process.

Key aspects of the therapeutic process are identified which simultaneously contain therapeutic treatment tenants along-side aspects of the work undertaken. Elements in the therapeutic process have been identified and extracted as follows: empathic relationship; unfolding therapy; defence/coping mechanisms; attachment and therapy; conscious and unconscious process; relationship and systemic approaches. Although within therapy these dynamics interact with each other in a non-linear pattern the following extraction identifies the operational dynamics contained within the therapist interviews and is presented in a linear form.

(a) Empathic Relationship

Therapists note that their sensibilities, cognitive and emotional awareness are engaged in noticing that both the therapist and client are engaged in relationship, even if it that is confrontational.

Therapist 1 notes palpable observations occur in relation to body movement, voice tone and language and add to the sense of a growing relationship and engagement between two people:

‘It’s a sense of a developing empathic relationship. So it’s a sense of two people being engaged, even if it’s confrontational. It’s the idea of engagement’.

‘The only way you can tell that is experientially; you can see it in the body movement, you hear it in the voice you can hear it in the language –e.g. if it is not going well - the way it trails off – it doesn’t go anywhere’ (Therapist 1).
The ability to ‘sit with’ the client and what they are presenting is noted by as an important component of the therapeutic process. This ‘sitting with’ requires the skill of the therapist to manage their own emotions and cognitions while the client is unpacking ‘their’ emotional and cognitive distress. Particular note is made of the therapist skill in containing themselves and listening without pursuing answers or results. This is vital for the therapy to remain therapeutic and therefore beneficial to the client:

‘It’s a sense of being able to listen without chasing after some kind of result or answer’ (Therapist 1).

Reflections following sessions are helpful in monitoring the progress of the therapy. This is achieved via the therapist reflecting on the session and their role within the session:

*I think the important thing is to keep asking the question. Where are we? What does the patient need in the therapy? Who was I today, for the patient? Was I the benign listening ear or was I the mother, the father, the uncle or the antagonist?* (Therapist 1).

Mindfulness about what actually works for the individual in therapy is a continuous reflexive process for the therapist:

‘What actually works for people?’ (Therapist 1).

The multiple aspects of relationship that are occurring during the therapy session are observed and experienced by the therapist in relation to the client and the session. This appeared to be an ongoing process over every session.

Therapeutic fit

Therapists discussed the importance of initial focus on getting a sense of the right therapeutic ‘fit’. Client choice is described as enhancing the therapy:

*I say to clients initially (prior to therapy beginning) that we would have one session together to see how they felt about it but equally to see if it was the right fit for both of us.*

*I pay attention to what the other person might need in relationship* (Therapist 4).

Listening for the person in treatment.

Therapists discussed the way in which they hold in mind that they are treating a person not
a label. How the therapist sits with these issues and views the therapeutic relationship that is identified as making the difference in therapy:

‘Psychoanalysis makes much of this too; to listen without chasing after some kind of result or answer.

That’s the nature of psychoanalytic work; you’re not treating the label your treating the patient, and they’ll tell you in the end what the problem is.

But it’s the nature of how the therapist see’s the relationship that matters’ (Therapist 1)

Relationship for results

The ongoing significance of the centrality of relationship between the therapist and the client was emphasised by the therapists:

‘Without relationship you are not going to have any therapy, you’re just going to have one person talking in a room. So there has to be a relationship’ (Therapist 1).

Therapists noted results emerge as a result of the relationship between the client and the therapist. Giving advice is portrayed as only working if there is a relationship:

‘It’s all about relationship (therapy) and of course your expert knowledge. But you can’t work without relationship. That’s my opinion. Even if I give people some relaxation techniques or I might give them skill, basically for sleep and things like that but it only works if I’ve got a relationship with them. They will only enact it and try it out and trust if there is a relationship. Otherwise they are making it up. They are having you on’ (Therapist 3).

The developed relationship is described as containing a shared understanding of the purpose of the therapy:

‘I think unless you have formed a relationship and have an understanding together of what you are doing. It doesn’t have a purpose really’ (Therapist 3).

Unconditional Positive Regard

Therapists note suspension of judgement is vital and contains several aspects that assist the
therapy including, listening for the developing relationship and what that will be about and allowing the patient to define the direction:

‘Suspending judgement means being present, listening, for whatever the relationship is going to be about, and allowing the patient to define the direction’ (Therapist 1).

Patients’ language and therapeutic material

That the patient testing of trustworthiness or safety might involve conflictual encounters of some kind was noted. Therapist use of the patient’s language indicating understanding and empathy is described as assisting the building and deepening of the relationship:

‘Almost fundamentally you would say that the patient really wants to be able to fight with the therapist or to please the therapist. But those are the projections of some of their own situations, so if you make it, (within the boundaries that you established) if you make it a session devoted to the patient’s language, you are better off. You, don’t need to hear too much of the therapists language. I think it’s a common, it appears to be a common constraint in counselling’ (Therapist 1).

Language Art

An understanding that therapy involves language as art was considered important. One therapist emphasised the significance of learning, knowing, understanding and using the patient’s language within the therapy:

‘Therapy is certainly an art, a language art. A lot of training in psychoanalysis, psychodynamic psychotherapy is language training. If you think about it. Anyone can get the theory. But how can you have a language to talk to the patient or the patient to have a language to talk to you. It’s absolutely crucial. Some people don’t have it.

And anybody can read a few books and do the theory. But how can you ‘hear’, in the language the patient is saying if you’re not interested in language itself? The art of psychoanalysis is being able to listen to the symbolic references of the language’

(Therapist 1).
Therapists noted the ability to sit with the juxtaposition of the unfolding therapeutic process as an important skill. The therapist sits with any uncertainties and doubts within the therapeutic process without feeling pressured or compelled to find a premature solution:

‘I think it is important in order to discover what’s happening—is to be able to listen without any strenuous chasing after some kind of result or ‘answer’. It’s what Keats said when he talked about ‘negative capability’ (Therapist 1).

The centrality of being present and listening consciously and unconsciously and suspending the judgemental aspects of self (therapist) remain central to definitions of therapy. This allows freedom for the client to use the session effectively.

‘The idea is to be present and to be listening, both consciously and unconsciously without striving after any kind of conclusion or any kind of solution. So it’s like suspending the judgemental part. This allows the patient to be free to allow unconscious process to take them where they want to go’ (Therapist 1).

Modelling the embodied self

Therapist modelling genuine interest and curiosity in the client experience is described as assisting the client to begin developing an embodied interest in self. This is seen as a process that builds over time and cannot be rushed and is intrinsically vital to moving into the deeper trauma work:

‘I just know that if I can sit and be me and just be really interested; and I am, I’m naturally interested in human beings, I’m naturally interested in our sameness and our difference and I think it’s actually that natural interest that actually helps build the relationship, and I know the ‘building’ is absolutely important and it’s not going to build just like that, it develops over time I’m not saying you can’t build it more quickly, you can, but in order to do deep level work it takes time’ (Therapist 2).

Trust and treatment

Therapists noted that it is difficult for clients to share important aspects of their information without a consistent relationship with one person built on mutual trust over time:

‘I once worked with someone who had multiple suicide attempts and so would end up invariably in intensive care then get admitted to the mental health unit for a period of time.’
She told me the staff would say to her ‘you can talk to us’ but again there is no relationship. And I think she was very clear how important a relationship was for her because she said ‘you know they just get off at three o’clock and then they are home and they might be there the next day or they might be off the next day, so she said ‘I’m not telling them.’”

She said – ‘why should I trust them?’ and you know I have great empathy for that view of her’ (Therapist 4).

Re-storying negative self perception

Re-storying the unacceptable or negative perceptions of self is described as a process that occurs over time within the therapy. A client might be weighed down by a sense of not being okay. The therapeutic relationship and curiosity of the therapist in relation to the client assists the beginnings of the client interest and curiosity within themselves leading toward a re-storying of negative self perception triggers:

‘People are usually quite bogged down and they might do some blame and some avoidance and following processing that out they will become curious about themselves. It’s almost like my curiosity is mirrored into them and so they start doing it for themselves’ (Therapist 2).

Disengagement

The therapist continues to hold the idea of engagement throughout therapy particularly at sensitive points within the therapy that might create disengagement. These sensitive markers are managed in advance in conjunction with the client so that the client has a map to assist in managing disabling emotion at vulnerable points in the therapy:

‘A client might disengage when things are not going well due to the trauma stuff. But this is discussed with them in terms of their traumatic response while processing in therapy. This assists in the management of the same’ (Therapist 2).

Shifts in the presenting trauma

The curiosity and interest the therapist has for the client in the therapeutic process is described by one therapist as activating the development of the individual’s interest and curiosity for themselves. This curiosity and developing value in self develops capacity including a growing skill to reduce self harm negative self perceptions:
‘It’s like my curiosity is, mirrored into them and so they are actually start doing it themselves when the therapeutic relationship has been well established. Again, a lot of stuff reflects the relationship of mothers and children I guess; but we actually do this stuff together in therapy. I say to clients; ‘you know what we can do in one hour a week, you really do the main bit of the work in between the sessions and how fair is that?’ (Therapist 2).

Emotional Processing

Therapists describe the way in which all of the therapeutic elements facilitate emotional processing with the session. This can be intense and difficult at times within the session but in time the gains start to appear within the individual and the therapist is able to observe shifts, change and development within the client each week:

‘Yes we do have this relationship that is quite often very intense at that times, and it can have all sorts of emotional stuff in it, but it is the processing of that all through the week, or the fortnight, or however long that’s been negotiated that I believe the real transactional work occurs. It’s the internalisation of the process. And I see shifts every single week’ (Therapist 2).

(c) Defence/coping Mechanisms

Adaptations and defence mechanisms which have been historically developed by the client as a way of surviving in the world are considered and worked with, within the therapy and form part of the therapeutic change process:

‘Defence mechanisms developed as a result of the abuse are worked with in therapy. For example; I might say to my clients: – “we start coping with abuse or trauma as soon as it happens to us and some of it is actually really, really appropriate for that time’ (Therapist 2).

This is also a process that is raised in the client’s consciousness as they are invited to participate in reducing problematic adaptations:

‘I will say to people e.g.; “some of the ways we cope become not so useful later on
and so we need to actually look at the ways that are good and improve them and the ways that are not so good and adjust them so they work more effectively’’ (Therapist 2).

Therapists discussed the way in which reduction of depression and PTSD symptomology are worked with in session. Therapist 2 notes that depression may conceal the PTSD symptoms around the trauma and this is discussed with the client:

‘Depression is often the shell that is concealing the trauma.

It may also mask PTSD (Post Traumatic Stress Disorder) and if you’ve got somebody that’s really, really, shut down I’d say to clients that yep we’re going to work on the depression first because it’s like a hard ‘nut’ shell of your’re trauma stuff, that’s covering your trauma. The good thing about that is that you may not be depressed anymore. The bad thing about it is you’ll have all of these other symptoms like flash backs and memories and dreams and that can feel really awful, but in a way it needs to come out, it needs to come out in a safe way.

So I guide them about what could happen and how to manage it’’ (Therapist 2).

Therapist 2 notes that some counselling trainings prohibit disclosure to the client of possible escalation of symptomology at particular locations within therapy. The therapist notes the unhelpfulness of this approach in relation to adults affected by childhood abuse, trauma and complex trauma:

‘I know in counselling training that just wasn’t something people did. You just didn’t tell clients those sorts of things and I didn’t think this was helpful’ (Therapist 2).

Therapist 2’s use of colour therapy may assist the client in connecting to the parts of themselves that are split off during the abuse or trauma:

‘I use colour therapy for processing early childhood trauma and this assists in locating the client in their body and identification of feelings via colour’ (Therapist 2).

Use of colour therapies can assist in clarifying the intra-personal difficulties that require work in therapy:

‘It’s a very gentle process and sometimes the client might only know that they are not comfortable in their own skin when they arrive’ (Therapist 2).

Therapists noted importance of being aware of and working with the presenting psychopathology in the room e.g. anxiety or social trauma is described as the route to the
coping mechanism; and how to factor this into treatment:

‘You have to go through the psychopathology, their personal stuff to get that sort of coping mechanism. So yeah, people are masking a terrible sense of anxiety or social trauma’ (Therapist 3).

(d) Attachment and Therapy

Trauma and therapy

Therapist 2 notes the role the therapist takes in mediating abuse and trauma. This occurs when the therapist brings their authentic self, along-side holding a secure base for the client from which the client is then able to build self capacities over time:

‘The therapist is the mediator of abuse and trauma and this occurs by using the authentic self and holding a secure base, which assists in building client self capacities over time’ (Therapist 2).

Re-working Disrupted Attachment Patterns

Therapists described the way in which material from the client’s day-to-day life is used to illuminate unhelpful coping strategies, problematic behaviour and relationship difficulties:

‘In relation to attachment disturbance and trauma I think it is really important that, just through the telling of day to day stuff that people do when they come to therapy that they actually start seeing those patterns’ (Therapist 2).

The therapist does not short-cut this process by putting her interpretation on it as this would undermine the work in progress:

‘I might see those patterns early on but it is really important that they (the client) come to see them. And, you know if I were to point it out earlier, it would not be helpful’ (Therapist 2).
Development of Attachment capacity, mentalisation and affect regulation

Therapists identified various therapeutic techniques that are simultaneously held and woven together by the therapist to develop self capacities for the client. This includes: mirroring and reflecting back what the client is saying to validate their experience, naming and identifying emotions for the client in order for the development of their emotional recognition and understanding of the same:

‘Reflecting back and mirroring I explain it to my supervisee’s like this: when we look at babies and they might be cranky or whatever and we’ll reflect to them, ‘oh so you’re feeling really cranky about that is not fair is it?’ And so our expression will reflect back the stuff that they are feeling and that actually gets them to understand their emotions and regulate affect and so forth and put words to it and I guess that’s some of the stuff that we’re doing’.

This assists with attachment and learning self through therapeutic holding’ (Therapist 2).

Disorganised attachment

Working with attachment patterns that have become problematic emerged as a common theme in therapy. This is described by therapists as presenting in disorganised or disordered ways of relating:

‘The attachment comes from the client and of course that’s why they are in therapy because it has gone wrong for them. Because their attachment patterns are in some way disordered or damaged or disorganised’ (Therapist 3).

Adults with problematic attachment patterns may present to therapy in relation to their children and generational issues:

‘I think probably disorganised adults won’t and don’t engage in therapy; that’s exactly what’s going on. Where I meet them is because their children are being presented with generational issues’ (Therapist 3).
Insecure attachment patterns

Working with ambivalent or avoidant attachment is described as creating its own problems. Individuals might not engage in therapy because these categories form part of the spectrum of what might be considered normal:

‘But it’s the worried well, the healthy and ambivalent or avoidant attachment who are in the spectrum of normal, or healthy if you like. But they’re tricky in different ways and they are the ones that bring an enormous amount of information. For example, a guy that came in already having an argument with me, he’s someone that is pretty ambivalent about forming a relationship with me. And he did, it would have been a fantastic teaching session really, because he just presented it beautifully’ (Therapist 3).

Therapists identified that it is very difficult to engage someone with avoidant attachment as they generally do not engage:

‘Individuals who are totally unconscious and avoidant, they are the ones that don’t quite; they are the ones that are genuinely hard to engage in the therapeutic contract. They are not quite giving you what they need to, they are giving you what feels safe, you know’ (Therapist 3).

Repairing Ruptures in the Secure Base

Therapist skill in remaining consciously aware of the material arising in therapy and its relationship to the trauma is delicate work. Re-working negative self beliefs can assist in repairing ruptures in the secure base but is paced in relation to the client’s ability to sit with and emotionally manage the trauma at their intra-psychic level:

‘It is delicate ground working with abuse in therapy including being present and staying conscious (consciously aware) with the abuse can be very difficult. This is because trauma creates a rupture in the development of the secure base. Therefore pacing the therapy in relation to the individual’s ability to sit with it (the trauma) is important. And if that (the client) container is fractured or shallow because it is filled with trauma then it is going to take a while to process it. Hence the length of time in therapy is matched to this pacing’ (Therapist 2).
Conscious and Unconscious Process

Listening for conscious and unconscious process assists in the development of the empathic relationship facilitating access to the material required to be re-worked within therapy. Engagement between the therapist and the client allows client engagement and access to their unconscious within treatment. The therapist simultaneously allows this and holds an awareness of this developing access to the unconscious:

‘If one (the therapist) is operating and believes that the unconscious is also at work, along with conscious process, one can get to the sense of a kind of empathic relationship. ‘This allows the patient to feel free to allow unconscious process to take them where they need to go, Jung called active imagination’ (Therapist 1).

Engagement in a therapeutic relationship facilitates engagement of the unconscious in both the therapist and the client:

‘If one is engaged with the patient then that by definition, things are happening with the unconscious of the patient and the unconscious of the therapist. And they are going to happen whatever you say. And one has to listen for that too and allow that. But that’s an act of faith’ (Therapist 1).

Difficulties with objective approaches

Therapists emphasised the importance of a subjective approach. They specifically cautioned against the search for objectivity because it may prohibit movement in relation to the issues for the client:

‘So the idea of a quest for objectivity, let’s say in psychotherapy, you just won’t get anywhere. You will run into a brick wall every time. That’s why listening to the unconscious, that’s’ why dream work is really important, and art work, really’ (Therapist 1).

Making the unconscious conscious

Therapists discussed the way in which working with the unconscious is a process that continues both within and outside of therapy. One noted the importance of setting the session aside to allow unconscious processes to become engaged in treatment:
‘I believe that what happens between the unconscious of the patient and the therapist or the analyst is going to be taking place when you are away from the session. So if I consciously leave it aside, it allows my unconscious, actually, to deal with it’ (Therapist 1).

In psychoanalysis a fundamental paradigm is allowing the unconscious to be made conscious:

‘To me it’s certainly one of the foundational tenants of psychoanalysis, certainly if you think about it when they talk about psychoanalysis. Absolutely. To talk about things that are unconscious to be made conscious. That’s the keystone’ (Therapist 1).

Deeper work

Therapists identified that some clients are looking for a therapist who will allow them to do a deeper level of work:

‘I think at an unconscious level people know they are going to be doing deep work when they come to see me. But they may not fully realise this at a conscious level’ (Therapist 2).

Transference, Countertransference, Projections & Attachment Activation

All of the therapists discussed the use of transference, countertransference, projections and attachment activation within the therapeutic relationship. Transference is described as forming a vital part of treatment informing the therapist of the precise area of difficulty to be worked with. The transference may be projected onto the therapist at various points in the therapy as the client continues to use their particular defence mechanisms within the therapeutic relationship:

‘The idea of transference is hugely helpful and important. Because that then gets projected onto the therapist and then you begin to see...’oh, so there it is, right...’ And then the way I come to finally think about it is to ask the question. ‘Who was I today for the patient?’

It’s a belief in the way I think psychoanalysis/ therapy works, its resident in me when I’m in the room’ (Therapist 1).

Therapist 2 notices the subconscious emerging in therapeutic ruptures or attachment activation. The therapist might consider a theory to fit the presenting attachment activation
but this is held in the consciousness of the therapist which is reviewed from time to time:

‘In relation to Therapeutic Ruptures, transference and counter transference or attachment activation there is learning from both the client and the therapist. When noticing transferential material I put a theory and a formulation on it which the therapist holds as the secure base and then I will check this out from time to time’ (Therapist 2).

Therapeutic exchange space

The therapeutic relationship was considered to require more than providing a therapeutic space: it requires provision of a therapeutic exchange space between the therapist and the client:

‘It’s more than just providing a space, its providing an ‘exchange’ space. In which there’s an exchange between the patient and the therapist, particularly at an unconscious level. But if you don’t get the report to begin with, it’s not going to go anywhere’ (Therapist 1).

(f) Relationship and Systemic Approaches

Therapists noted that when working with children and families a systemic approach to relationship building is given consideration:

‘It’s the relationship that’s important and building those relationships. While I was working in paediatric social work I discovered that the work is with the whole family and that led me into counselling’ (Therapist 4).

Family therapy

Family therapy sessions are described as adding a further complexity in terms of multiple unconscious process, defence mechanisms and definitions of the problem. This complexity itself can become a barrier to results or a barrier to engagement and individual’s ability to gain a sense of getting their needs meet:
‘Most family therapy sessions don’t go well, that’s why you have got them all in because they are not going very well. But I love it, I love the challenge. It’s always easier to blame someone else, or someone is feeling disenfranchised or not wanting to be there, its rich stuff’ (Therapist 3).

Generational considerations in relation to trauma and family therapy

Therapists noted that it was important to adopt a generational and relational perspective when assessing presenting issues. For example some presentations for treatment might be in relation to a mother seeking treatment for a child but it might the therapy or treatment will be around mum as the primary attachment figure for the child. If for example the mother has unresolved issues they may affect the baby’s routines or development and hence the problem can lead to treatment for the child:

‘Where there is a problem and it’s around mum’s responses to baby the referral generally comes in from somebody like Plunket or the GP. For example the baby has got sleep problems or the baby cries a lot. Or there is a 2year old and the new baby is having trouble sleeping. And it’s interesting because it’s not actually about the baby. In the majority of cases it’s about the mothers own relationship that she has had with her mother or grandmother or parents that is effecting her relationship with the child and not being able to read what the child leads, etc. and so while it comes in and it’s about the child, and the mother and child. The work actually needs to be done with the mum’ (Therapist 4).

Summary

Developing new ways of interacting with self and people at personal, family, social and community levels becomes part of the therapeutic work. Consideration is given to the therapeutic ‘fit’ and relational aspects of systemic approaches. The therapist uses their sensibilities and personhood in building a genuine empathic relationship along-side fundamental counselling tenants e.g. unconditional positive regard, therapeutic frame, non judgmental, listening, empathising and building of trust. Client survival strategies, defence mechanisms and attachment patterns are considered and worked with as treatment material. Conscious and unconscious processes are worked with by the therapist in relation to the client. Re-storying the trauma and re-working disrupted attachment patterns form an essential part of the therapeutic work. This is continually worked with therapeutically
within sessions toward the development of self capacities, emotional containment, reflexive insight and attachment capacity over time. The therapist also is mindful and works with the individual to reduce risk taking behaviours and develop self care strategies.

**Change as a result of therapy.**

Changes in the individual as a result of therapy are observed and monitored by the therapist in multiple ways. Therapists note palpable shifts in the person’s physiological self and improvement in self perception via their body language and shifts in inter-relatedness.

A visible and palpable shift can be observed in the individual as a result of resolution within the therapeutic process including holding themselves with more confidence, a change in their skin colour, body language and interactions with others:

‘I notice a shift in people at a palpable level, they look taller, it’s like a presence, their demeanour skin colour, they hold themselves differently, their body language change’s toward others, they respond to things differently, it’s like a growing up’ (Therapist 2).

Therapist three notices the moments in therapy that people get and see for themselves are positive experiences for the therapy to keep moving with results:

‘There are those wonderful cathartic moments. They are wonderful when people go ‘ah ha’, you know? And get something or they have an insight that’s not been available to them before.

_I had a client who was actually able to verbalise that; the switch from now I understand what it is that I do and what I need to do differently but how do I do that? So she was actually able to verbalise that really, because that’ the next bit about change’ (Therapist 3).

The cathartic moments themselves are not sufficient to facilitate change in behaviour and old patterns. These are moved when the jewel of the cathartic moment is used along-side practicing new ways of understanding and relating outside of therapy:

‘You can understand to an enormous depth what it is that you are doing that’s not working. But you have got to change it because cathartic moments don’t create
change within themselves. But they have to be a precedent to it. They start working that out and visualising and practicing’.

‘but you know 99% of the time it’s about relationships.’ (Therapist 3)

Summary

Therapists note careful attention is paid to relationship as it forms the basis for the therapeutic work to be undertaken and subsequent change process for the client. Therapists work with childhood relational trauma is linked to the presenting issues and relationship disturbance and is held centrally within a relational therapeutic frame.

Elements in engagement are given careful consideration and include a getting along-side and use of the individual’s language not the therapist’s language as this builds trust and confidence in the therapeutic relationship.

Multiple and comprehensive assessments are use to understand the presenting issue and inform the work to be undertaken in therapy. The use of diagnosis is viewed with caution in psychoanalytic work as it may create constraints which become counter-productive to the therapeutic process.

Key elements and themes include: therapeutic relationship; provision of a therapeutic exchange space; working through attachment ruptures and transference issues; moderating trauma and emotion; therapist ability to contain self and client with the presenting issues; therapist reflexivity and development of self capacities toward competent relationships and future focus.

All therapist emphasis the nature and importance of the therapeutic relationship and therapeutic elements and the ability to sit with ‘not knowing’ rather than advice giving which is associated with counselling.
CHAPTER SEVEN

Discussion

*The development of a human being is a complex interaction of genetics, environment and relationships.* (Bowlby, 1969)

In discussing the usefulness of the therapeutic relationship for AACRT consideration is given to; client perspectives, therapist perspectives, literature and current research. The discussion acknowledges all elements contained within the research and the inter-relationship between each other.

Firstly and at an over arching level findings reflect a personal and meta-view of the pre-engagement, engagement, therapeutic relationship and post therapy narrative of the client and the therapist. This individual and meta-view incorporates the operational mechanism in the presenting disturbance of the client and is juxtaposed in relation to the therapist as the embodied secure base.

Client acting out of the CRT creates an entity separate from the therapeutic encounter which has its own particular trajectory crossing legislation and initiating mandated behavioural interventions which may include: mental health; justice; police; AOD; CYFs and NGOs. These mandated interventions often ostensibly lack client consent or choice and so client irritation in relation to this is evident in their narratives. The ability to locate a therapist to begin a therapeutic journey is problematic and usually occurs quite some time following completion of mandated or voluntary interventions.

The therapist holds the potential for the client to develop Earned Secure Attachment (Roisman, Padron et al, 2002) via the therapeutic relationship at a decisive step removed from any previous mandated interventions.

The therapeutic intervention reflects relational, psychodynamic and attachment psychotherapeutic tenants. On analysis it emerged that therapists incorporated attachment psychotherapy tenants as recommended by the NZ Brainwave Trust (2014) in relation to CRT and AACRT being: (a) quality of relationship; (b) sustained moderate levels of arousal; (c) summoning cognition and emotion and (d) co-constructing a new narrative. The work in time over therapy includes: development and maintenance of quality within the therapeutic relationship; use of transference and therapeutic ruptures as a tool in moderating trauma; development of emotions and cognitions free of an abuse filter and co-constructing a new narrative toward future focus.
Effectiveness of initial interventions

For some participants initial interventions occurred as a result of acting out behaviours throughout teenage years and adult hood as a consequential result of the original trauma. For others initial intervention was self motivated entry into counselling.

Initial intervention spanned justice, health and NGO organisations. These agencies included CYFs, Policing, mental health, AOD agencies and NGO interventions and family counselling.

Client narratives contain an irritation and in some cases ongoing anger at agencies and initial interventions which failed to consider the childhood trauma in relation to the adult presentation. Participants powerfully critique inappropriate or inadequate interventions.

For the therapists frustrations in relation to agency required Assessment Processes is a theme, others query the use of assessment and some incorporate assessment into the therapeutic relationship as a tool.

Client experience of initial intervention

Loren had contact with police and justice systems for assaulting police officers, also mental health services following a self harm attempt. Loren attended counselling while living in Wellington but struggled to trust her counsellor. She also attended AOD treatment programmes. Loren continues to hold some bitterness in relation to police as they were unable to assist her:

‘The only people helping me were therapists, the police didn’t help’ (Loren).

Craig also had justice interventions for petty crime and theft, a period of prison incarceration and time in a psychiatric unit following sectioning under the Mental Health Act. Craig reflects his time in a mental health unit as an unhelpful intervention following the loss of his unborn son:

‘you know, they seen my violent, not violent, but outbursts to be something more than what they were and they try to slap a diagnosis on you and want to give you pills and I get quite rebellious towards that’ (Craig).

Raylene’s contact with services was self motivated entry into counselling. Differences in counselling were evident and problematic to Raylene as judgemental treatment added to her distress and self condemnation.

Raylene disagree’s with counselling which is interrogative and combative as it was unhelpful to her:
‘One thing I will say strongly to this day is that I hate counsellors who ask you a question but will never give you an answer. Or that you ask them a question and they will ask you a question back’ (Raylene).

With cumulative negative counselling experiences Raylene found it difficult to find the right counsellor for her and became fearful and anxious of entering counselling or not ever finding the right person to complete her therapy with.

Gaylene’s contacts with agencies were in relation to CYFs intervention with her children she describes these experiences as ‘horrible’. Gaylene reflects that her thoughts and feelings were discounted in the counselling process and the level of control in the sessions meant that she had to comply with the counsellor:

‘It wasn’t helpful, nothing changed. Nothing changed for me. Nothing changed. I would reflect on that when I was getting in my car and I would think, oh, I’m just as fucked up as when I went in’ (Gaylene).

The counsellor also worked with Gaylene’s daughter and told her ‘that she would become a burden on society when she grew up:

‘To me it was abuse all over again, it felt yuk, it made me feel powerless’ (Gaylene).

Joan initiated her own counselling noting that for her it was time she went into counselling and sorted things out. Joan experienced that not all counsellors were the right fit for her and she kept trying counsellors until she found the right one for her.

**Therapist Experience of initial assessment processes**

Therapists had varying reflections on the usefulness of assessment, its use and application.

Therapist 1 notes that assessment is only useful if it grows out of a therapeutic relationship furthermore premature assessment and diagnosis is not helpful to the client. Caution is used in approaching assessment and consideration of who the assessment is ‘actually’ for is important. Therapist 1 notes that in the end treatment is in relation to a person, not a label and that in itself is a journey taken by two people:

‘You’re not treating the label your treating the patient, and they’ll tell you in the end what the problem is, if we are lucky enough’ (Therapist 1).

Therapist 2 considers the person and relationship at the centre of the assessment process but notes the time pressure and other constraints around assessment processes. Therapist 2 manages the pressure of assessment constraints and requirements and considers
assessment similarly to the developing therapeutic relationship i.e. it is an unfolding process:

‘Assessment and formulation is an unfolding process’ (Therapist 2).

Assessment includes comprehensive assessment and clinical formulation, psycho-social assessment and attachment assessments, childhood attachment patterns, psychosocial assessment, psychosocial history, biological and psychological history:

‘it is a snap shot of the client over their life-time, what they identify and don’t identify and then it gets fed back to the clients’ (Therapist 2).

Therapist 2 feeds the assessment back to the client, so they are aware of the content of the assessment.

Therapist 3 notices that formalised assessment sits in conflict with her therapeutic process, this has created professional frustrations at times and difficulties and conflicts with administrators in NGOs. Therapist 3 finds an Attachment Assessment helpful when working psychotherapeutically.

Therapist 4 links assessment to the initial presenting problem for the client using multiple ways of assessing the client including: personal history; mental health history; daily functioning; psycho-social assessment and family history. Assessment is an ongoing process and assessment in relation to sexual abuse is given extra consideration.

Client and therapist difficulties with initial intervention and assessment processes

Client narratives of initial intervention reflect irritation in relation to perceptions of ‘not being heard’ in the intervention. Mandated intervention via policing, justice and CYFs initially created another bewilderment for the individual because abuse in relation to themselves from perpetrators went unnoticed but response to abuse they perpetrated on others was swift, public and contained firm consequences. For some clients there remains a tension between punishment received and not being ‘heard’ in relation to their own abuse.

Some of the narratives also hold irritation in relation to the type of intervention and the sense of it not meeting the individual needs. For others who voluntarily sought counselling, these experiences were mixed and a sense of ‘being judged’ or ‘not being heard’ compounded the abuse experiences. The development of a sense of being ‘no way out’ for the individual added to the ongoing distress.

For the therapists difficulties with initial intervention was primarily identified while working for government or non-government agencies. In these settings assessment of an individual
was required as part of the contractual agreement with funders or as part of the position description. Therapists identify the timing of assessment became more of an ‘accountability for funding’ exercise and was not helpful to the work with the client and often had no relevance or usefulness to the individual receiving treatment. Some therapists note that an over zealousness of requirements in justifying funding made it difficult to initiate an ‘actual’ therapeutic encounter which may have been helpful for the client. The pressure for assessment and diagnosis too soon was also noted as undermining the therapeutic relationship. For others development of a particular skill set in relation to assessment assisted in making it a seamless part of the therapeutic encounter.

Summary

Both the client and therapist group resonate with frustrations in relation to initial intervention and assessment. For the client a sense of not being heard is one of the frustrations contained within the narrative. For the therapist organisational funding requirements have been a hindrance to developing a viable therapeutic relationship.

Operational mechanism of presenting disturbance over time

In consideration of the trauma over time attention is given to elements the client group note in their experience including intra personal and relational effects. The effects include aspects of personhood and personhood in relation to others. The therapists’ transcripts are also given consideration in relation to understandings of effects across client lifespan. Not all therapists discuss the effects and consideration is given to this in the chapter summary.

Client Experience

Client narratives echo a pervasive palpable despair and anguish relating to personal effects over their lifespan. Transformation of personal despair into ‘acting out’ behaviours in society is a common theme within the narratives as the child moves into later teenage years and adulthood. (Minzenberg, Poole, et al, 2006; Brick, 2005; Fonagy, 2003; Green, Hayes et al, 2002; Fonagy, Target, et al, 1997)

The manifestation of acting out behaviours or abuse replication dynamic (Briere & Scott, 2013) in teenage and adult years contained overt and covert behaviours, cognitions, emotions and physiological reactivity. These included: undermining self talk; risk taking behaviours in relation to alcohol and drugs; violent relationships; perpetuating cycles of
violence; negative self image; failures scholastically and work/career; difficulties with intimate relationships; getting along with people and socialisation also suicidal ideation and attempts (Briere & Scott, 2013; Briere & Scott, 2006; Perry, 2006; Brick, 2005; Fonagy, 2005; Fonagy, Target et al, 1997).

Raylene noted the ‘profound effects’ of abuse on herself over her lifetime stating ‘It’s always hard to explain to people the depth and subtleness that abuse affects people’.

Problematic manifestations for Raylene encompassed: a cluster of fears including fear of failing, of peers, relationships and participation in life, and own self potential. Raylene also felt psychological pressure to protect her family from knowing about the abuse. Hiding the abuse and hiding what was ‘real’ from her family and others became a constant problem and a way of being in the world. Feelings of numbness and a sense of being cut off from self and the world persisted throughout her developmental years along-side difficulties with trust, nervousness, PTSDs, lowered concentration and anxiety.

Fear was also a problem for Loren, fear of ongoing abusive attacks from everyone she came into contact with. Loren’s life was defined by a perpetual vigilance and expectation of ‘the next attack’. Loren developed anxiety and PTSDs and used alcohol and drugs to cope with fear, anxiety, hyper-vigilance and emotional pain. Loren’s belief systems in relation to abuse persisted and she viewed the world in terms of attackers and victims. Flashbacks and emotional flooding was a problem creating incapacity to maintain work and attention to daily living activities. Development of suicidal ideation and plan also became a problem for Loren to manage. Difficulties engaging in life and connecting with other people were also ongoing problems. Being involved in continuing violence self-mutilation and assaulting police officers were part of Loren’s life in her late teenage years and early 20’s.

Violent acting out became a problem for Craig from late childhood and throughout his teenage years, also petty crime and drug use, choosing partners who were mentally and verbally abusive. Craig was affected by anxiety, had difficulty relaxing and developed ongoing thyroid problems.

Joan notes her choice of relationships was affected by family violence and she entered abusive relationships. Joan notes hostility and anger in relationships and difficulty in maintaining relationships. Also noted was the need to be in control of any relationship she was in was a problem. Promiscuity became another problem over the life-span which Joan linked to the domestic violence within the family home.

For Gaynor acting out behaviours as a result of her abuse included: alcohol and drug abuse;
anger; violence; lack of trust in relation to all people; emotional pain; and suicidal thoughts and ideation from a young age.

**Intra Personal and Inter Relational effects**

Two distinct categories emerge from the narratives relating to the effects of childhood abuse. These effects related to integrity of personhood and relational ability, are noted by the client group as being directly related to their childhood abuse and subsequent abuse across their lifespan. These effects are identified by the client group as problematic and encompass intra-psychic and inter relational effects.

**Intra Personal Effects**

Intra-psychic effects include physiological reactions, understandings and perceptions of self, others and the world, and abuse effected emotions, perceptions and thinking.

Emotional effects include: Emotional difficulties; difficulties with identifying and understanding feelings; low self esteem; low self worth; fear; mistrust of people; anxiety; PTSD; disassociation; feelings of disconnection from self and others; shame; numbness and anger.

Cognitive effects include: distorted perception of self and others; difficulties with concentration; thinking and problem solving; confusion; persistent self doubt; negative self talk; suicidal ideation and plan and persistent fears of self others and the world.

Physiological effects include: numbness; exaggerated fight, flight and freeze reactions; hyper-vigilance and dissociation.

**Inter Relational Effects**

Inter-relational effects and difficulties for the individuals included: relational dysfunction in interpersonal, family and intimate relationships’, and interactions with others; getting along with people and social interactions; and difficulties with work and school activities and participation in life roles e.g. family, social and community interactions.

Problems encompassing inter relational effects included; choosing abusive relationships; promiscuity; nervousness and anxiousness around peers; alcohol and drug abuse; perpetration of cycles of physical, verbal and psychological abuse; suicidal ideation, attempts and plan; lowered life skills and coping ability and disruptions with work and
educational functioning e.g. Loren: ‘I would sit in my flat and cry’ and Raylene noted that she felt she was ‘dumb and unable to achieve scholastically’.

Difficulty in life role participation included isolation and bullying at school and work environments, missing important milestones e.g. forming a significant relationship and development of self identity.

_Therapists positioning in relation to the effects of trauma_

Therapists held a generalised overview of effects of trauma and traumatic acting out over the life-span including Attachment and relational disturbance; promiscuity; violence; controlling relationships; anger and the alcohol and drug abuse.

One therapist noted that variations in the effects of trauma were considered in treatment and included: developmental contexts of the individual; the age abuse began; developmental years abuse spanned and other pre-disposing and precipitating factors.

Emotional factors noted by another therapist included fear, fear of people and new situations, lack of trust and extreme submissiveness.

_Dissonance between client and therapist narratives_

The client narrative links understanding of childhood abuse and the predisposition for ongoing abuse over their life-time at intra-personal, inter relational and physiological levels (Minzenberg, Poole, et al, 2006; Brick, 2005; Fonagy, 2003; Green, Hayes, et al, 2002; Schore, 2001; Fonagy, Target, et al, 1997; Terr, 1991).

Therapists identified intra personal and relational difficulties relating to CRT (Renn, 2009; Bretherton & Munholland, 2008; Brick, 2005; Schore 2000; Siegel, 1999; Fonagy, Target, et al, 1997). However not all therapists identified life span difficulties as a result of CRT or inter- relational effects at contextual, peer, social and community levels (Briere & Scott, 2013; Briere & Lanktree, 2012; Fonagy, 2003; Terr, 1991).

There are several ways of considering this dissonance; firstly the development of the psychological field itself and the lack of historic consensus in relation to the variable factors of genetics, context and environments contribution to the development of psychopathology (Fonagy 2003; Holms, 2001; Sable, 2008; Briere & Scott, 2008; Hernam, 1992).

Secondly the field of complex trauma is relatively new and (Briere & Scott, 2013; Briere &
Scott, 2006) alongside increasingly complex societal and family systems there does not currently appear to be an effective model to identify this group of people and appropriate treatment pathways. Added to this is the difficulty for the professional in seeing the person affected by childhood abuse in a behaviourally problematic adult.

Thirdly the therapist holds a particular piece of ground which enables a therapeutic and intrinsically healing journey. Therefore the therapists focus is on the complex elements of Relational, Attachment and psychotherapeutic tenants in the treatment of AACRT.

Summary

Findings in this study reflect aspects of narratives between the client and therapist groupings as they do in the previous section. However where the client links ongoing affects of abuse to CRT not all therapists discuss this; furthermore it is actually the literature that links the client and therapist understandings. This raises questions in terms of current knowledge, global understanding and treatment tenants of individuals in New Zealand and effects of CRT over time.

Attachment Theory developed by Bowlby, Ainsworth and Mains identified relational disruptions which informed psychotherapeutic treatment. However there is emergent information from The People’s Report (2014) that treatment in relation to this group of people contemporarily has not been specific to their needs. Current treatment tenants lean heavily towards short-term therapy which assumes a certain ability for cognitive and emotional capability within the clients self capacities. Paradoxically; the research narratives indicate that assuming a particular level of self capacities for individual’s affected by CRT creates a further set of difficulties to be managed by the AACRT.

Childhood relational trauma crosses multiple developmental stages effecting emotion, cognition, perception and physiology in complex interactions. Therefore it cannot be assumed that short-term interventions have the capacity to meet the needs of this group of people.

**Post therapy narrative coherence**

The client narrative coherence post therapy indicates resolution to childhood relational trauma. It is within the client coherent narrative that the junction of the shared therapeutic relationship becomes evident. The therapists’ capacity to work with childhood relational trauma also emerges within this section.
Client narrative

The client narrative contains a distinct clarity and understanding in relation to their abuse history and over-arching effects across the developmental years. The narratives include the type of abuse and elements surrounding it which enabled and continued to perpetuate the difficulties and consequences over the lifespan.

Contexts and developmental time span of abuse history for the participants contain strong links to family, extended family and adopted family and included: placement with extended family; domestic violence in family homes spanning the entire developmental years; family participation in a community group which facilitated access by paedophiles over significant developmental years; and adoption by an abusive family which included a paedophile and spanned the entire developmental years.

The individual experience of abuse fits with researchers’ understandings of what constitutes childhood abuse including psychological, emotional, physical, sexual abuse (Atwool, 2000; Brick, 2005; Briere & Lanktree, 2012; Briere & Scott, 2013; Briere & Scott, 2006; Fonagy, 2003; Holmes, 2001; Minzenberg, Poole, et al, 2006; Perry, 2006; Target, et al, 1997; Terr, 1991). Spiritual abuse was also noted by one of the participants as part of the multiple abuses operating in her childhood and there is some acknowledgement of this in the literature (see for example Altman, 2014).

Research indicates that socialisation via abuse from an early age across the developmental years creates a particular disposition in relation to other abuse experiences at varying points in the individuals’ life; ‘a number of studies demonstrate that victims of interpersonal traumas are at a statistically greater risk of additional interpersonal traumas’ (Briere & Scott, 2013, p17). This phenomenon is also reflected in this study and is identified by the participants themselves who recognise their own vulnerability to further interpersonal trauma as a result of their original abuse. Loren echoes this in her statement: ‘I was, brainwashed, so brainwashed it took me to other abusers.’

Additional interpersonal traumas continued to be accrued over the individual lives and included: becoming a victim of opportunistic paedophiles; bullying at school over the schooling years; violent social relationships; alcohol and drug abuse; violence and interpersonal power and control issues.

Emergent resolution contained within the client abuse narrative.

The adult victims describe their abuse experience at an emotional, almost clinical distance. A lack of distress or emotion is evident in the narratives. This ostensible distance belies the emotional and factual power of the narrative.
On the surface this might signal an emotional discordance or detachment operating which would signal a dissociative problem (Briere & Lanktree, 2012; Briere & Scott 2013). However on further consideration of the dialogue it emerges that this is no longer a reaction of shock or a problematic dissociation in relation to the individual. The post therapy integrated individual is simply explaining, at an emotional distance a powerful and emotionally contained narrative reflection of a difficult and arduous childhood.

Significantly the witness to the narrative (the researcher) can sense that the abuse now has limited power to control or define the individual in their lives currently. There is a palpable sense that the participant’s have resolved AACRT difficulties and ‘moved away’ from being defined by the abuse.

‘Moving away’ from the abuse

This ‘moving away’ from the abuse, or earned secure attachment (Ijzendoorn, 1995; Roisman et al, 2002) can be observed again via the dialogue in which an essential inclusion of all the aspects of the individual is contained within the narrative. This is observed in the mindfulness of the individual within the interaction of the interview. The individual is simultaneously containing their emotional and cognitive self while maintaining engagement with the researcher in the moment of the shared conversation of the interview. The narrative is succinct, coherent, and complete and signals the achievement of earned secure attachment being achieved (Ijzendoorn, 1995; Mains & Goldwyn, 1993; Riessman, 1993; Roisman et al, 2002; Siegel, 2006).

The ability to mindfully contain and reflect on oneself while continuously maintaining relational engagement within the process reflects in part embodied inter-personal well-being (Fonagy, 1999; Fonagy and Target, 1997; Schore, 2000; Schore, 2001; Siegel, 2006; Sonkin, 2005). This relational well-being is evidenced in the emotional and cognitive containment of the individual in action within the context of the research interview. Other aspects of well-being besides continuous co-operative engagement include; voice tone, the ability to remain present in the context of the interview, maintenance of personal autonomy throughout the interview and the present time narrative holding the major content of discourse within the interview.

All of these markers are noted by Attachment, psychological, neurological and psychoanalytic researchers as indicators of the healthy adjusted relationally competent self and signal resolution of the original abuse and trauma. (Bowlby, 1973; Briere & Scott, 2006; Briere & Scott, 2006; Daniel, 2006; Holmes, 2001; Saur, 2003; Schore, 2000)
Therapist understanding of childhood abuse over the lifespan

Therapists’ narratives reflected understandings and professional training of their particular discipline. All therapists reflected relational elements in their dialogue as significant to the instigation, perpetration and ongoing nature of childhood abuse.

Emergent information contained within the therapist narratives

Therapists hold a perspective one step back from the client and although statements are quite simply made and seemingly dissonant from the client experience; analysis of them in fact reveals multiple bodies of knowledge operating in relation to human development, relationships, relational capacity, systemic dynamics, counselling & psychotherapeutic tenants, emotional well-being, life stages, and social interactions. These multiple bodies of knowledge include; interpersonal factors in the development and maintenance of trauma, disruptions in developmental stages, Attachment Disruption, understandings of abuse development and contexts, psycho-pathology of the human relationship which instigates and perpetrates abuse, emotional and cognitive shock for the individual as a result of the abuse, the external factor to the ‘self’ in relation to childhood abuse i.e. an action by another human being and the significance of attachment relationships in familial abuse (Brick, 2005; Daniel, 2006; Fonagy and Target, 1997; Fonagy, 1999; Fonagy, 2003; Holmes, 2001; Minzenberg, Poole, et al, 2006; Perry, 2006; Poole, et al, 2006; Roisman et al, 2002; Siegel, 2006; Saur, 2003; Schore, 2000; Schore, 2001; Sonkin, 2005).

Therapist understanding of childhood abuse encapsulated the emotion for the Adult Affected by Childhood Relational Trauma (AACRT) in the situation which mirrors the horror of the abuse experience for the child.

The therapists reflect from the ground of emotionality in relation to the trauma experienced by the AACRT in a way that remains containing and coherent within their professional frame. Hence the therapist is able to hold and reflect the emotionality contained within the issues in much the same way as they might do within the context of the therapeutic relationship (Bowlby, 1978; Briere & Scott, 2013; Daniel, 2006; Fonagy & Target, 1997; Geller & Greenberg, 2002; Holmes, 2001; Schore, 2000; Siegel, 1999; Sonkin, 2005).

In essence the therapist ‘holds and contains’ the multiple facets and manifestations of the trauma for the AACRT in order to facilitate re-working of the abuse based adaptive internal working models.
‘One-step away’ from the abuse.

For therapists holding the ground ‘one-step away’ from the abuse contains an envelope of therapeutic anticipation in relation to the client. This therapeutic preparedness is a ‘making ready’ for the provision and establishment of the therapeutic relationship. The therapist is the secure base and contains the potential for the collaborative ‘journey out’ of childhood relational trauma.

From the position of ‘one-step-away’ the therapist is able to consider all elements in relation to the individual which are effected as a result of the abuse including; the sensibilities of the individual, cognitive and emotional process, implications for the vulnerable child in relation to adult perpetrators of abuse, disruption to developmental stage/s, damage to the ongoing development of the individual effecting the subsequent developmental stages and cumulative effects of trauma.

The Journey Out

Therapist knowledge of ground held ‘one-step away’ is an important first step in the therapeutic journey should the client choose to engage in therapy. This one-step-away creates an anticipation and a point of stillness (TS Elliot – The Four Quartets, 1945; Roldan, F. Wilson, P. Hinerangi, M. 2001) embodying an attitude of prepared listening out of which not only the client’s unique narrative is able to emerge but also a potential for co-construction of a new narrative and the development of client earned secure attachment.

This preparative approach reflects the essential cooperative nature of the therapeutic relationship which as Siegel (2001) notes:- ‘...collaborative interpersonal interaction can be seen as the key to healthy development’ (Siegel, 2001; p72).

A relationally collaborative approach encapsulates the client and therapists shared understandings and experience of the therapeutic relationship in action and is reflected in the narratives of both therapist and client.

The shared journey

At this juncture it becomes clear that there is an intrinsic link between the therapist and the client in that the therapist is able to reach out into the client’s subjective view and not only empathise and understand it but, hold it, contain it and mindfully articulate it within appropriate boundaries for the client to know, understand, process and move away from.
Siegel (2001) noted that the mind develops at the interface of human relationships and that the fundamental process of integration of the mind, emotional well-being and psychological resilience occurs within securely attached relationships.

It is in the therapist provision of a secure base and containment of the abuse experience on behalf of the client within the therapeutic relationship that enables the client to move in incremental steps away from it. Hence the therapist becomes the mediator for abuse and trauma (Bretherton & Munholland, Briere, 2001; 2008; Daniel, 2006; Fonagy, 1999; Fonagy & Target, 1997; Holmes, 2001; Schore, 2000; Siegel, 1999; Siegel, 2001; Sonkin, 2005).

Summary

The therapists hold the capacity for a therapeutic relationship in which the client can choose to engage. The hallmarks of the therapeutic relationship begin to emerge and reflect a quality relationship including: empathy, care, reflection of client need and ability to sit with uncertainty.

The journey out via the therapeutic relationship

The Journey Out signals the therapeutic relationship in action between the client and the therapist and the process toward mediating CRT and the effects over the clients’ life time.

Within the client group there is a palpable change in the language which is inclusive and reflective of self in relation to the therapist and the relationship. This is in part evidenced in Client Findings p43 in the post therapy coherent narrative and again in this section by; the coherence of the narrative and inclusion of self in interaction with intimate and interpersonal relationships in present time.

The therapists discuss their therapeutic technique in action which encompasses an expansive knowledge and application of human relationships, psychic balance, holding and containing distress, re-working disrupted attachment patterns and re-storying a future focused narrative.
**Client Narrative**

Finding an appropriate therapist to complete a therapeutic journey with was a significant problem for all of the participants. Difficulties were in relation to lack of clarity in treatment pathways and confusion in relation to how to seek treatment.

From the outset of individuals discussing entry into therapy there is a perceptible difference in the dialogue. Client participants palpably note the value in the therapeutic relationship itself as making the difference to their CRT. Throughout the narrative via the use of language, the inclusion and reflection on self including a cognitive and emotional integration it becomes clear that the client is no longer a victim to the effects of CRT but is now in possession of their own personhood.

Other features pertain specifically to the client narrative of the therapeutic encounter which mediated CRT including an over arching sense of resolution in relation to the CRT contained within the narratives (Bowlby, 1978; Fonagy & Target, 1997; Holmes, 2001; Roisman, Padron, et al, 2002; Schore, 2000; Schore, 2001).

A current sense of the participant’s well-being, enjoyment and autonomy in their lives becomes evident in this section. All participants have managed to eliminate violence and abuse from their lives and their children’s and families lives. Participants are now able to resume their life in relation to the particular developmental stage they would have been at had the CRT not occurred.

Another marker of personal resolution to CRT is that the individual no longer views themselves through an abuse lens with exclusion and fragmentation of their personhood. Their narratives are inclusive, complete and encompassing of personhood reflecting a peaceful resolution which is reflected in future focus.

Some clients also reflect on what it would be like if there was no therapy. At that point the narrative becomes a statement, a clear and concise statement of the negative personal consequences to selfhood had there not been a therapeutic opportunity or encounter.

Client self awareness and shared reflection with the interviewer is a particular hallmark of this section as the shared moment also contains the potency of a life being lived. There is a palpable sharing in present time with mindfulness on the future.

Individuals noted the therapeutic relationship as pivotal to change and the sense of being valued and esteemed in the relationship. A sense of a collaborative relationship between the individual and the therapist is evident and is reflected in the individual’s narrative coherence and ability to be fully present in relation to the interview process.
Craig found his therapist via an organisation his daughter was involved in. He notes feeling validated in his therapy in relation to the abuse he had experienced. This made a particular difference to Craig knowing that his therapist had been involved in women’s abuse organisations, being believed by her was particularly important for him. For Craig it was the personal qualities of the counsellor and a previous psychologist that made a difference for him. He felt listened to and not judged, he felt validated as a person:

‘It was the way they made you feel, like a person’ (Craig).

Craig also felt that when people in the field are there because it’s a vocation rather than an occupation that makes a difference to treatment outcomes:

‘It was because they wanted to do it and not because they had to do it’ (Craig).

Following a difficult court battle Craig has shared care of his two children. Craig is actively involved with his children, works part-time, now has his own home and enjoys his neighbours and community. A neighbour assisting in developing Craig’s section delivered gravel during the interview. Craig noted the sense of community and enjoyment in his neighbourhood and his overall enjoyment in his life now.

Gaynor found her therapist via supervision when she was working at a Rape Crises Centre; it was concerns in relation to her daughter’s drug use that led her into counselling.

Trust was an obstacle to be faced in entering therapy as Gaynor did not think she would ever be able to go into counselling again after previous negative experiences. She realised that she had to form a relationship with someone even if it was just one person and that person was her therapist:

‘...even if I developed that relationship only with my therapist. Then that was all I needed to do’ (Gaynor).

For Gaynor beginning to trust her therapist started to:

‘feed a value for myself’ (Gaynor).

which in turn developed her interest in life and opened up opportunities in life. Gaynor notes that her life is now rich and full which is a result of her therapy. The collaborative relational element of therapy is noted:

‘But I had to do it with someone’ (Gaynor).

Gaynor is currently studying a social work degree and working with people with disabilities.
Gaynor maintains a close relationship with one of her daughters and has supported the other over the years through drug addiction. Gaynor enjoys her life, work, study and being a mother and grandmother; she exudes a sense of delight in her life as it is now. She is an active grandmother and sets time aside to develop relationship with her granddaughter:

‘Being a grandmother is magic. It’s about forming a relationship’ (Gaynor).

Gaynor reflects on what her life would be like if there was no therapy:

‘If I had never found the person to do my therapy with, I can honestly say I’d be dead. My kids wouldn’t have kept me alive, it wouldn’t have been enough. I would have killed myself’ (Gaynor).

Raylene had tried several counsellors and did not find a therapeutic ‘fit’ for her, she did not realise that she had the right to choose her own counsellor. Raylene’s fear of going into a psychiatric hospital pushed her to keep trying to get into counselling. Her sense from the beginning of therapy was that the counsellor was a whole person and had the ability and skills to empathise with where Raylene was currently at but simultaneously was able to reflect where she needed to go i.e. Raylene detected the reflexive function operating within the therapist:

‘she had the ability to see the person where they were at and where they need to go’ (Raylene).

Raylene found tools that she got in therapy were helpful but also that her therapist embodied integrity which allowed Raylene to come to her own understandings in relation to herself. Raylene’s adaptation or defence mechanism of telling people what they wanted to hear was by-passed with drawing as this directly accessed Raylene’s emotional self:

‘I remember drawing a picture, that was marvellous for me because my mind was so overworked...’ (Raylene).

Raylene believes she is who she is today as a result of that particular therapist and the ability to share a therapeutic relationship. Raylene feels she survived because of her therapist.

Currently Raylene is in her last year of her nursing degree and she remains optimistic about the future for her and her children.
Raylene reflects that if she did not find her therapist:

‘I would have gone into a psychiatric hospital and even though I feared that greatly, in the end I realised it would be better to go there (psychiatric hospital) than not be around for my children.

I often used to think of being dead, or dying cause I just couldn’t handle the pain, or the torment of my mind’ (Raylene).

Joan knew she had to enter therapy and had tried a few counsellors before she found her therapist. Joan remembers her low self esteem and how hard it was to look her therapist in the eye and continue with the whole process. Joan had a break from therapy and on returning she appreciated the challenge her counsellor provided in what Joan hadn’t changed in her life.

Joan has eliminated alcohol, anger and promiscuity from her life, is actively engaged in parenting her teenage son and has started studying in the social services. Joan reflects she is not the same person that she was prior to her therapy:

‘I think the hard part was having someone break through the wall I put up. I had a lot of anger, it was the norm, it was always there’ (Joan).

Loren entered counselling following another period of being triggered. Loren was able to develop a sense of feeling safe with her therapist and appreciated that her therapist had the qualifications to know what was going on for Loren in terms of understanding her behaviours and where they come from.

Loren is clear about what would have happened if she hadn’t gone into to therapy:

‘I’d be dead or in jail if I didn’t find my therapist, or else somebody else might be dead. I didn’t give a fuck’ (Loren).

Loren has developed some gains in terms of accepting herself and developing a small business but she continues to be triggered by the effects of CRT. She believes she will have to continue sorting the effects of CRT out for the rest of her life:

‘I’m just sick of it and I’m going to have to continue sorting it out for the rest of my life because there are just so many triggers’ (Loren).

She is grateful for sensitive claims funding availability to relieve her symptoms.
Personal and relational well-being on completion of the therapeutic journey is evident in the post therapy narrative of the client. The coherence of the client narrative resonates with the work completed within therapy.

**Therapist Narrative**

This section constellates elements identified by the individual therapists as contributing to genuine therapeutic outcomes for the client. Material extracted is presented as incremental elements within the therapeutic relationship ‘in processes’. Simultaneously, therapeutic techniques contributing to building client self capacities in the development of earned secure attachment were also identified.

To understand the therapists working model, narratives were coded in relation to naturally occurring themes. These themes were then grouped into categories for further analysis. What emerged are categories of treatment that link to understandings of current research tenants as effective in moderating AACRT and elements contributing to the development of the healthy relationally competent self (Holmes, 2001; Mains & Goldwyn, 1993; Schore, 2000; Schore, 2001; Sonkin, 2005).

Analysis reveals the incorporation of relational and attachment paradigms operating within the therapeutic relationship. These operational paradigms consequentially contribute to the development of relational and attachment capability within the psyche of the client.

In considering the therapists’ narratives an empathic understanding of disruption to emotional and personal self organisation as a result of inter-relational abuse and trauma becomes evident. Furthermore there is an intrinsic understanding that therapy over time will moderate destructive internal working models (Briere & Scott, 2006; Fonagy, 1999; Holmes, 2001; Seigel, 1999); provide a secure base for re-working heightened emotional states as a result of CRT (Brainwave Trust, 2014; Schore, 2000; 2001; Sonkin, 2005); develop client self capacities (Bretherton & Munholland, 2008; Briere & Scott, 2012, Briere & Lanktree, 2013 Fonagy, 1999; Green, Hayes et al, 2002; Renn, 2009); and assist in the construction of a new narrative (Fonagy & Target, 1997; Roisman, Padron, et al 2002; Schore, 2000) which is free from abuse and will allow the client to move forward with a sense of satisfaction and purpose in their lives.

Therapists finely tuned sensitivities in relation to the client and the relationship is the pivotal change mechanism. Furthermore using the process of relationship allows the material that needs to be re-worked to arise at timing that is encompassing of earned secure attachment tenants (Roisman, Padron et al, 2002).
All of the aspects in the therapeutic relationship are intimately woven together but are also distinctly separate entities. Therapist awareness of each aspect of therapy while holding the overview of the entire therapeutic process is essential to overall outcomes of therapy.

Therapist narratives in relation to the therapeutic relationship were individually coded by themes and extracted into groups. From there broad themes emerged which included: Empathic Relationship; Unfolding Therapy; Defence/Coping mechanisms; Attachment and Therapy; Conscious and Unconscious Process and Relationship and systemic approaches. All sections are intimately linked to each other and although distinctly separate are essentially connected within the context of therapy in relation to AACRT.

There is an inherent delicacy and sensitivity in the emergent categories alongside a mindful awareness which appears as a gentle weaving back and forth between the client and the therapist. Simultaneously the therapist remains an authentically embodied individual while holding and containing the client and their trauma while using skills, ability, wisdom and empathy to artfully stitch relational and attachment capacity to the client. 

These themes condense down into the categories recommended by the Brain Wave Trust (2014) being Attachment Psychotherapy Foundations including:

<table>
<thead>
<tr>
<th>(a) The quality of the relationship</th>
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</thead>
<tbody>
<tr>
<td>(b) Sustained moderate levels of arousal</td>
</tr>
<tr>
<td>(c) Summoning cognition and emotion</td>
</tr>
<tr>
<td>(d) Co-constructing a new narrative</td>
</tr>
</tbody>
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Table 7.2

It is a particular expertise operating which appears to be more akin to genuine empathic relationality than clinical treatment.

| (a) The quality of the relationship |

**Therapeutic Fit**

Consideration of the ability for the client and therapist to develop a therapeutic relationship or ‘therapeutic fit’ is given consideration from the outset of therapy. The therapist invites the client to consider the therapeutic fit for themselves and this remains an essentially collaborative process.
**Relationship**

The relationship between the therapist and the client is central to longer term treatment and the work to be undertaken in relation to CRT. The relationship is the foundational stone of the therapy. Mediation of CRT is not able to be achieved without therapist’s careful attention to development and maintenance of the therapeutic relationship.

Therapeutic results emerge between the client and the therapist as a result of both parties knowing that there is an engagement in the therapeutic relationship. The relationship contains a shared understanding of the purpose and goals of therapy.

**Therapeutic Exchange Space**

Therapy is not just about providing a space, it is about providing a therapeutic exchange space, and this allows the therapeutic exchange between the therapist and the client to occur at the unconscious level. Developing rapport in the beginning is important for the development of a therapeutic ‘exchange’ space between the client and the therapist. This can only happen if there is relationship and rapport from the beginning.

**The Secure Base**

The therapist holds an embodied awareness of a secure base at a conscious level as the basis for the entire therapeutic relationship.

**Empathic Relationship**

Therapists hold a conscious awareness of developing an empathic relationship to engage the client in the work to be undertaken and to provide a secure base to enable a successful working through of therapist client challenges, ruptures in treatment, transference and counter transference issues.

Therapists particularly note that an ability to ‘sit with’ presenting material is required in this process to keep the ground clear to allow the client to emerge themselves.

The development of the empathic relationship is observed, noted and nurtured by the therapist in action at each session and over the session. It involves engaging all of the aspects of personhood of the therapist in relation to aspects of personhood in relation to
the client. The therapist uses mindfulness to notice their own body language, voice tone and engagement in empathic relationship and the correspondence of this to the client’s developing empathic relationship.

*Results and Relationship*

The relationship that develops between the client and the therapist contains a shared understanding of the purpose of therapy. Therapeutic results emerge from collaborative understandings of relationship.

*Listening*

Therapist ability to listen for the individual in treatment is important. This listening is without any kind of objective idea which is not helpful. Therapist listening without judgement or any kind of chasing after allows the client to go to where they need to in treatment.

*Modelling the embodied self*

For good engagement and effective treatment the therapist consciously embodies an authentic self while engaged with the client.

*Trust and Treatment*

Trust is an important element in all aspects of the therapeutic relationship and is built out of the authentically embodied therapist in relation to the client. Trust in relation to clients with CRT will take time and has to be built at the client’s pace. Individuals who have been abused will naturally not trust and if past interventions have not considered the client in a respectful way then this can also add to difficulties with trust.

Development and maintenance of trust is an important component of the therapeutic relationship. Building and maintaining trust is vital for the work to take place. Trust also enhances capacity for challenges, ruptures and transference issues which will occur within the therapeutic process. Without the development of trust treatment will not be able to take place.
**Non Judgemental**

To be present and listening in therapy requires suspension of any judgements that the counsellor may have. This assists in the emergence of the client and the work to be undertaken. Also listening to the developing relationship and what that will be about and allowing the client to define the direction.

**Unfolding Therapy**

Therapy focuses on listening without chasing after any kind of answer or result. The therapist has sufficient self capacities to sit with uncertainty within the therapeutic relationship in order for what the client needs to unfold.

**Relationship and Systemic approach**

When working with children and families the whole family system is considered in relationship building for treatment.

**Language Art**

Holding and maintaining the delicate balances in therapy in relation to the client requires meta-understanding of language and communication and is closer to art. Theory is readily accessible but in order to access the client the therapist has to be able to speak in the patient’s language.

(a) Sustained moderate levels of arousal

**Trauma and Therapy**

The therapist as a mediator to trauma and therapy brings their authentic self to the relationship and holds a secure base for the client to build self capacities over time.

**Re-working Disrupted Attachment Patterns**

Re-working disrupted Attachment Patterns occurs within the therapeutic relationship when
the client is given the room to discuss their day-to-day experiences. The therapist does not short-cut this process by putting premature interpretations on it or interrupting it. Rather a ‘noticing’ for the client takes place between the therapist and the client; this therapeutic noticing begins development of attachment capacity.

Disengagement

In relation to CRT the therapist is aware of sensitive points in the therapy which may create emotional flooding and lead to disengagement.

The therapist is mindful of this from the outset of therapy and considers the pace and management of strong emotions in consideration of maintaining the therapeutic relationship.

Defence Mechanisms

Individuals develop psychological defence mechanisms in relation to CRT over time. These defence mechanisms, although at times helpful in relation to abuse and trauma e.g. disassociation, become unhelpful and problematic as the individual grows into adulthood.

Defence mechanisms are part of the therapeutic material but may also mask trauma symptoms e.g. PTSD or depression, so skill in managing defence mechanisms is required. It may be at times the individual also links with their GP for extra monitoring of symptoms arising.

Conscious and unconscious process

Engagement in a therapeutic relationship facilitates engagement of the unconscious in both the therapist and the client.

Therapist consideration of process occurs at both conscious and unconscious levels. This occurs by being present and listening at both levels without any kind of ‘chasing after’ a result. This allows access to the level to be re-worked in therapy at a pace that sits naturally and comfortably with the client.

Working therapeutically with the unconscious is a continuing process inside and outside of therapy hence it becomes important for the therapist to consciously set the session aside to allow the unconscious to work with it.
(b) Summoning cognition and emotion

*Repairing Ruptures in the Secure Base*

The rupture in the individual's secure base as a result of trauma is restored over time. The developmental stage in relation to onset of CRT is identified, also attachment relationships prior to onset of CRT and following end of CRT. The therapist holds these markers consciously while maintaining the therapeutic relationship in order to repair rupture created by CRT.

Pacing the therapy in relation to the individual’s ability to cope with it is important at this stage as ruptures in the secure base mean that emotionally the individual is not able to contain themselves either; at all, or at certain points; or beyond the developmental stage when the CRT began.

*Transference*

The therapist watches for transferences within treatment. Transferential material gives the therapist information in relation to points of relational disruption creating difficulties within the client’s inter-personal framework.

*Attachment Activation*

Therapeutic ruptures assist in the ability for transferential material to arise to be worked on in therapy. This is also referred to as Attachment Activation and provides the opportunity to re-work the damage done in the childhood abuse.

*Coping Mechanisms*

Coping mechanisms which have been developed over time by the individual as a result of CRT are re-worked within the therapeutic relationship. Coping mechanisms assist at the time in the face of overwhelming distress by e.g. avoidance or use of AOD to block out emotional pain, or dissociation in the face of further emotional challenges. As the individual realises that they are struggling to integrate in a real way into life; previously useful coping mechanisms become a hindrance to the development of the individual. The individual may present when they come to realise (consciously or unconsciously) that their coping mechanisms are not longer helpful to them and is in fact now hindering them.
Patients Language and Therapeutic Material

The patient project onto the therapist some of the situations related to their CRT experience. In order for the therapist to work with the client, they need to align themselves with the patients language to enable the emergence of therapeutic material within the therapy.

Family Therapy

Family Therapy sessions add a further complexity in terms of multiple unconscious processes sitting in the room. This complexity itself can become a barrier to results or a barrier to engagement in therapy.

It is more likely that within for family group’s individuals may not feel individual needs have been met which makes it inherently difficult to maintain the therapeutic engagement when working therapeutically with the whole family.

Development of attachment Capacity, metallisation and affect regulation

Reflecting and mirroring back the client’s feelings to them is part of the development of mentalisation. This assists in the development of the client coming to clarify and recognise their own feelings. This technique mirrors early parent child attachment relationships.

Mirroring back gradually begins the development of the client’s ability to understand their emotional self which in turn begins the development of attachment capacity and regulation of emotion.

Consideration of attachment patterns

Attachment pattern considerations are helpful in informing the therapist what is occurring within the therapeutic relationship and where they need to go to in the work to be undertaken i.e. they inform the points of damage in relation to CRT.

Individuals with Disorganised attachment patterns might present when their Attachment Patterns have become further disordered or disrupted in some way. The ways of relating that the individual has used over their life-time becomes untenable and self reflection on the need for change is identified by the client.
Ambivalent attachment patterns make it difficult to engage with the client as they might use confrontation as a way of deferring relationship with the therapist.

Individuals with Avoidant attachment may be genuinely difficult to engage as they do not quite say what they need to in the relationship with the therapist.

(c) Co-Constructing a new narrative

Shifts in the presenting trauma

Therapist genuine interest and curiosity in the client and their way of being in the world begins the development of interest in relation to self in the world. This is also an attachment paradigm the therapist is using in the therapeutic relationship which mirrors healthy parent child relationship interactions.

Emotional Processing

The therapeutic relationship contains a wide range of powerful emotionality. It is not only during the session but during the week away from session that the client is continuing emotional processing that is the internalisation of the work completed in therapy. Shifts in the presenting trauma and relational difficulty can occur regularly/weekly at times as the original trauma is processed, reflexive function and affect regulation develop, and new ways of understanding self emerge.

Re-storying negative self perceptions

Re-storying occurs over-time in therapy and is a process whereby the therapist will assist in the development of reflexivity in the client by developing curiosity into the events around the client narrative to develop confirmation or self correction in relation to the other information around the particular narrative.
Summary

While some themes and threads may appear to be repeated between the therapist and discussion chapters it is important to note the subtle but significant differences between themes identified within these two chapters. Firstly the therapist chapter via the methodology of hermeneutic phenomenology emerges the individual therapist data via hermeneutic observation. Secondly, this emergent phenomenon is then clarified in the discussion as concrete concepts in the therapeutic change process.

Although post modern feminist theory assisted in hermeneutic bracketing in the emergence of phenomenological data, discussion remains focused on emerging categories arising within the narratives relating to the original research question of the therapeutic journey and process. Hence specific post modern feminist analysis is not employed in discussion; nevertheless it remains inherent in the emergence and validation of the individual realities (Butler, Cornell & Fraser, 2013; Mazza, 1991).

At the time of the interviews all of the client group is working on redressing the developmental stage which they would have been at had they not been disrupted by CRT Eg. Raylene and Gaynor are studying toward a degree and nearing completion of this, Craig now has a family in his life, Joan is enjoying parenting and looking toward future study and Loren has gained some relief in her symptoms and is planning to look toward working again.

Clients are able to verbalise the precise points that made a difference in the therapeutic encounter/intervention and primarily includes: being ‘heard’; being ‘validated’ as a person; a non-judgemental forum; therapists who care and embody integrity in their work practice. The importance of Relationship resonates; echo’s and reverberates through client narratives as the vital ingredient which made the difference along-side the therapist skill and expertise.

Therapists’ narrative was strong on the first 3 elements of attachment psychotherapy as indicated by The Brain Wave trust. Material in relation to re-storying was scant but this may have been that the interview narrative focused more precisely on the elements that contributed to therapeutic relief of CRT symptomology rather than the completion stage of re-storying. It may also be that re-storying is also a very delicate process in that it emerges from the clients newly defined and easily influenced subjective reality. So it may be that the therapist is mindful of this and is careful not to impose new narratives which have not arisen from and specifically belong to the client.
For the client group it is evident from the client narratives that there was in fact a re-storying and that an alternative narrative of being has grown out of the clients newly developed Earned Secure Attachment. The findings have implications of how we manage interventions toward entry points to other potential opportunities which could assist the client group on a healing journey at an earlier point in their life-span.

Mandated interventions will continue to be required for this group of people for the foreseeable future as the individual requires containment in relation to the acting out behaviours. However any effective work will require validation of where the person is at as an effective starting point and so every intervention could be viewed as a missed opportunity when there is a failure to link the individual to further, ongoing, or appropriate treatment.

Although mandated services continue to be part of necessary interventions a better balance between mandated services and treatment may be more cost effective as mandated interventions cost the country substantial amounts of money annually.

It may be more cost effective to consider a model for how mandated services link with treatment that would be effective for this group of people. If we consider that for adults the way out of childhood relational trauma is akin to a journey that requires to be taken with another human being then maybe referral from mandated services to treatment may be more easily facilitated.

A model is proposed in the concluding chapter to consider how these juxtapositions can be viewed for more streamlined intervention and treatment for the client.
CHAPTER EIGHT

Conclusions and Recommendations

This research project sought understandings of the client experience of the therapeutic relationship. Factors which assisted in moderating the original trauma were of particular interest. The client’s individual subjective experience of the therapeutic relationship was central to this study including post therapy insight and understandings.

The client group individually identified and discussed the relationship between themselves and a particular therapist as being pivotal to change in and mediation of the original trauma. What it was that mediated the trauma and associated life-time inter-personal and relational problems of distress was identified and extracted.

Therapists were also interviewed to gain insights of their understandings about what worked in relation to longer term therapy for adults affected by childhood relational trauma.

Therapists from a variety of disciplines with a minimum of 10 years working therapeutically were interviewed. 10 years was set as a minimum peramateur for therapists to reflect the complexity of accumulated knowledge juxtaposed with the cumulative complexity of trauma over the client’s lifetime (Briere & Scott, 2013).

The multi-disciplinary selection of therapists was to allow consideration of differences or synergies in therapeutic delivery which assisted or undermined ability for mediation of AACRT across disciplines. Emergent themes and threads within the therapist transcript were extracted mirroring client identified themes.

The research revealed post therapy clarity of the client group in relation to the original abuse and corresponding trauma which had subsequently unfolded difficulties over the individual’s life-time. Correspondingly therapeutic intervention was identified as the catalyst which mediated, moderated and allowed the client to resume their lives free of the enduring constraints of CRT.

The depth, knowledge, understanding and clarity of the adult client in relation to their life including: the development of the issues; consequences over their lifetime and interventions which undermined or assisted in relieving the trauma was revealed in the research.

Significantly it emerged that a client seeking a therapeutic alliance in relation to CRT dovetailed precisely with the required therapeutic skill set, knowledge and ability of the therapist group.

It was revealed in the research that the therapists contain, hold and moderate the client
trauma in a way that is conducive to development of Attachment capacity and corresponding mental-wellbeing (Bowlby, 1988; Briere & Scott, 2013; Holmes, 2001; Shaw, 2001).

The research revealed that therapists interviewed all worked with a similar relational approach within the therapeutic frame. The findings revealed that therapeutic intervention encompassed the four parameters that the NZ Brainwave trust identifies being Attachment Psychotherapy as the mediator for AACRT (Brainwave Trust, 2014).

Difficulties in finding a therapist to complete the therapeutic journey were also discussed by the client as being a significant issue in their process.

**Literature review**

Global understandings were sought in relation to this research to allow accessibility to multiple disciplines and so the first point of understanding was the literature review.

The literature review revealed many conflicting points of view in relation to Adults Affected by Childhood Relational Trauma since the beginning of the field. Freud himself sidelined his initial findings of context and relationship in his hysteria (trauma) research due to the particular social and political issues of his time (Herman, 1992).

This conflict in the literature continued with Bowlby who insisted researchers, therapists and clinicians consider context and interactions in relationship when working with trauma. However Bowlby’s work was sidelined for 50 years by the British psychoanalytic community. Bowlby also subsequently lamented that his work was used to advance behavioural psychology rather than be used by clinicians in the field.

In New Zealand there have also been historic divisions between professions and organisations in terms of inclusivity or exclusivity in the way this group of people is understood and treated; e.g. some individuals with similar histories to the clients in this study have been classified as Personality Disorder by the mental health system thus relegating them to a diagnosis that offers no hope and no way out.

However hope on the horizon has been provided by the neuroscientists whose research confirms the damage to individuals as a result of childhood trauma and family violence. Furthermore neuroscience has revealed that the relational approaches of longer term therapy assist in moderating the damage in adults as a result of childhood relational abuse. In essence neuroscience is confirming what therapists and trauma therapists have been saying for decades, that is; interpersonal damage occurs within the context of human
interaction and the mediator to this is a relationally therapeutic alliance with another human being.

The current scientific evidence provided by neuroscience is helpful in validating and allowing therapists to continue to focus on the therapeutic relationship as the mediator for AACRT.

**Childhood trauma**

The adult clients’ narrative contained distinctive post therapy clarity of the genesis of the individual and personal problems.

The descriptions of trauma experienced fitted childhood abuse definitions accessible in general and specialist literature and understood today by many organisations and individuals working within organisations and also by many individuals who are not working professionally in the field.

Although this is a small sample, it emerged that where there is domestic violence operating there is a heightened risk of sexual abuse and where there is one abuse operating in the family home there are cluster abuses. Abuses of one category or another work in a cluster e.g. physical, psychological, emotional, sexual and spiritual abuse appears either within or at the parameters of a family violence context. For example in this study the vulnerability of Joan and Gaynor living within the context of family violence created the ground for opportunistic paedophiles to sexually abuse them.

Considering vulnerability to multiple abuses may be a helpful point for professionals and organisations to consider in relation to family or individual assessment around abuse. It may also be a useful starting point for further research.

**The effects of childhood abuse across the lifespan**

Family violence has multiple and complex layers and the interviews unfolded the difficulties across the lifespan which included incredible isolation and bewilderment in understanding the world and interacting with it for survival.

During childhood defence mechanisms for survival were developed which created significant behavioural problems as young adults and adults. The particular defence mechanisms developed as a result of childhood trauma may have also contributed to child victimisation in other settings e.g. bullying throughout schooling years
Complex conflicting feelings emerged as a result of childhood trauma including: feelings of isolation and there being no way out; difficulties with trust and feelings of being insane which had to be hidden. Intolerable cognitive and emotional difficulties and discord became a precursor to a volcanic like acting out for some which was wrecked on self, individuals and society.

First interventions

Acting out of trauma as young adults and adults created multiple difficulties interpersonally and relationally.

Initial interventions included contact with mandated authorities e.g. police, justice, CYF and mental health systems have been difficult and bewildering for the individual. For some individuals in this period seeking help themselves was also problematic as the intervention sought or mandated failed to identify and treat the underlying problem. This created a compounding effect for the individual. As a result suicide also became an increasing idea for some with a developed plan for others and for some an actual attempt. Suicidal thoughts and ideation incrementally increased as the individual has correspondingly sought and failed to get appropriate assistance. e.g. as Raylene noted judgements in her counselling; ‘added to my self condemnation’.

Although mandated interventions are vital and necessary in society; it becomes evident in this research that what was often lacking within and following the mandated intervention was referral to appropriately identified follow-up treatment and therapy.

A model for this is proposed for professionals, health and social services, both mandated and non-mandated to consider. The model is adapted from Bohm’s (1985) holograph as a way of understanding inter-related unfolding meaning.

The model offers a way of raising awareness and consideration of: context, socialisation and environment along-side developmental stages. Furthermore the model holds as central idea; interactions of all of these elements as contributing to the emotionally well-adjusted individual or the development of mental ill-health.

The model intends to offer a broader and multi-dimensional view of the individual across the life-span including interactions with shorter term or mandated interventions and therapy. The purpose of the model is to consider the complexities for the individual as a result of CRT and provide a map for professionals to consider in moving a client through shorter-term and mandated interventions towards appropriate follow-up and treatment.
The model is designed to be accessible to all professionals as a way of understanding the multiple operational dynamics of AACRT and so assist in understanding the complexity of the issues for the individual and facilitate linkages to treatment.

**The therapeutic journey out**

From the outset of individual discussing entry into therapy there is a perceptible difference in the dialogue. It has been identified that for the client discussing the therapeutic encounter there is a palpable difference in the narrative of the original abuse.

This palpable difference includes: a coherent narrative; emotional distance between the individual and the original abuse and subsequent effects; a new self narrative reflecting the change in the internal working model and the development of earned secure attachment. In essence, resolution of the trauma is evident within the narrative (Holmes, 2001; Roisman, Padron et al, 2002; Schore, 2000).

For the therapist group multiple complex understandings of what works in therapy was identified and extracted. The therapy essentially contained attachment psychotherapy components as recommended by the NZ Brainwave Trust (2014) Including: 1. Quality of relationship. 2. Sustained moderate levels of arousal. 3. Summoning emotion and cognition. 4. Co-constructing a new narrative.

**The model**

*THE HOLOGRAM OF PERSONHOOD*

The proposed model of the Hologram of Personhood is a bio-psychosocial model considering relationships and their impact on how an individual understands and relates to the world. The model acknowledges the complexities of human development as an inter-relationship between genetics’, context and socialisation.

The development of the concepts of the multi-dimensional Hologram of Personhood is designed to be used in a way that allows the professional to consider complexity of any one individual while continuing the completion of the particular role they are required to carry out.

The Hologram of Personhood acknowledges that at any one point health and social service professionals working with a brief intervention or mandated approach will not necessarily have access to all the information in relation to the individual. As indeed the individual does not have all of the information in relation to themselves while they remain entrapped in; and continue to act out of CRT.
Just as the Hologram of Personhood has individual aspects which intrinsically link with the whole so each part of the individual is intrinsically linked to and connected with the whole person. The model acknowledges this by inviting the professionals to consider interrelationships between individual elements of the person which may be separate but yet intrinsically linked with the whole personhood of the individual. The hologram offers a way of raising awareness and consideration of: context, socialisation and environment. It is also held in mind that the whole is constantly changing and revealing itself which corresponds to the individual’s ability to develop insight and integrate with others.

The Hologram of Personhood acknowledges the multi-dimensional complexity of the human being alongside the development of AACRT and the multiple factors influencing the original trauma.

It acknowledges complexity in developmental difficulties as a result of CRT along-side relational, perceptual and reflective difficulties as a result of family violence and childhood relational trauma.

A place for mandated or other interventions as necessary behavioural interventions is followed through. Simultaneously to this the professional working with brief intervention holds awareness of the individual’s requirement to link with a bridge to ongoing support or therapeutic options.

Thus the Hologram of Personhood offers an olive branch of hope toward a consciously linked intervention and post intervention process rather than the accidental occurrence evidenced within this research. It allows the professional a tool for considering aspects which may not be emergent in any one particular presentation but simultaneously allows a bridge for the individual to further treatment or therapy.

The hologram of personhood

Figures 1, 2 & 3 notes the dimensions of the model. Figure 4 presents the model of The hologram of personhood. The 3 dimensions of the hologram (1, 2 & 3) and 4. The Model

1. **Personhood in context over time**: crossing developmental stages over the individual’s lifetime. Including enhancing and diminishing factors effecting personality growth and personhood:
   a. Enhancing factors include nurturing attachment relationships
   b. Diminishing factors include childhood abuse; physical, emotional, psychological, spiritual and domestic violence.

2. **Micro, meso and macro intersections**: of the individual in relationship with self, family, peer group and community. This dimension of the hologram acknowledges the interaction of the individual with various aspects of self family, social, peer and
community effected with an abuse lens i.e. distortion effected cognitions and emotions as a result of CRT.

3. **Brief and mandated interventions**: the effect of interventions on the individual, the presenting issue and the linkage to therapeutic intervention along-side mandated or other interventions. This aspect of the Hologram considers mandated interventions which continue to isolate the individual where therapy sits outside the process as evidenced in this research.

4. **THE HOLOGRAM OF PERSONHOOD**: Signals fluid access and linkages between the individual, brief intervention and therapy. Brief intervention is viewed as a seamless part of the process for the individual. Professionals consider mandated and first interventions as linked to the client journey in a way that facilitates referral to therapy and therefore a treatment pathway out of CRT. Therapy is wrapped around the individual indicating a flow on from mandated process and intervention.
Summary

It has been identified in this study that primary relationships and their effects are significant in the instigation and perpetuation of relational trauma and subsequent effects on the developing individual including the development of emotional distress, psychological dysfunction and consequential social maladaptations.

In this study the changes in the abuse affected trajectory over the developmental years and the personal, social and relational difficulties for the individual are clearly discussed and explained by the client group. The client group is also articulate in relation to any interventions that were not useful or in which they were not ‘heard’.

Examination of the elements contained within the therapeutic relationship reveals the factors which facilitated the change for the individual and as indicated by researchers as pivotal to the development of the healthy well-adjusted self (Bowlby, 1969; Bowlby, 1973; Fonagy, 1999; Holmes, 200; Sonkin, 2005; Schore, 2000).
In the environment of abuse and trauma the child is unable to develop attachment capacity which assists in healthy inter-personal ability and positive mental health, instead developing a highly attuned coping mechanism in relation to the abuse and trauma experienced within the particular environment. This way of relating to the world via an abuse paradigm continues through the developmental years into adulthood distorting cognitive and emotional process in relation to self and others. The moderation of abuse relational patterns and the development of Attachment capacity can occur if the adult is able to find a therapeutic relationship to engage in. The engagement in a therapeutic relationship assists in reducing abuse related interactions and reactions and begins the development of attachment capacity to self and others free of abusive paradigms.

Researchers agree that Attachment bonds lie at the core of mental well-being and include the development and regulation of emotional capacities, the ability to reflect on self and others in relationship and the development of empathy. (Bowlby, 1969; Bowlby, 1973; Fonagy, 1999; Sonkin, 2005; Schore, 2000; Schore, 2001; Renn, 2009; Slade, 2005; Daniel, 2006; Bretherton & Munholland, 2008).

The Family as a micro-culture of childhood abuse

John Bowlby contended that consideration of the family micro-culture was a significant factor in the inheritance of personal well-being or mental ill health. Bowlby’s studies led him to conclude that the family micro-culture may in fact be more important in the inheritance of mental ill health than the medium of genes (Bowlby, 1973). The client group articulates in detail the effects of abuse over their lifespan including childhood, teenage and adult years. John Briere (2012) notes the progression of childhood trauma which starts with neglect, physical and sexual abuse, progresses into schoolyards with bullying and then continues as an adult. The client group coherently describe the problematic reverberations of childhood abuse over the lifespan in keeping with research into the area.

As a society it is difficult to consider the prevalence of childhood relational trauma and the multiple abuses that link to it. But to ignore this problem is to consign individuals to a lifetime of entrapment as a result of childhood trauma. Furthermore as family violence is cyclic it allows an ongoing generational development of entrenched family abuse to develop as the norm in society, as one of the therapists said: ‘What kind of society do we want?’ (Therapist 2).

It is hoped that in completing this research and proposing the model of the Hologram of Personhood that as a society we can begin to face the complex problems that exist within family and relational contexts when a family system is in trouble; thus allowing this group of people to also have a treatment pathway in the way that every other citizen is entitled to.
From government level down the increased focus on protection of children is a good start to this problem. It may be that targeting specific resources to families for childhood well-being may also be a helpful point for the government to consider.

Developing a system whereby mandated services across all areas are able to refer individuals on for treatment or therapy would also assist in moderating the problem as these individuals are children of parents and are parents of children. So to assist the parent to resolve their own trauma issues assists in reducing the likelihood that their child will repeat the same childhood trauma as their parents. Or at the very least reduce the effects and raise awareness of seeking help when the family is in trouble.

If we considered as a society working toward raising an entire generation of children free of violence then we are well on the way to eradicating this very difficult problem from families and society.

And so it becomes obvious that every intervention including mandated services e.g. policing, justice, mental health and CYFs present an opportunity to work with the adult to improve things for the children in their lives.

Mandated interventions will continue to be required for this group of people for the foreseeable future as the individual requires containment in relation to the acting out behaviours. However any effective work will require validation of where the person is at as an effective starting point and so every intervention could be viewed as a missed opportunity when there is a failure to link the individual to further appropriate treatment.

Although mandated services continue to be part of necessary interventions a balance between mandated services and treatment may be a more cost effective approach to the problem. A model for how mandated services link with treatment that would be effective for this group of people.

If we consider that for adults the way out of childhood relational trauma is akin to a journey to be taken with another human being then maybe referral from mandated services to treatment may be more easily facilitated. The savings in terms of health and social dollar by the government would be substantial and would be a helpful point for further research.
Reference List


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Hayes et al, 2002.


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Source: Academic Search Premier.


Thank you for showing interest in this project. The project is part of the requirement for a Master of Social Welfare. This information sheet is intended to answer any questions you may have about participating in the project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

**What is the aim of the project?**

This project aims to explore what you found helpful in therapy from your perspective.

You will be asked to reflect on your experience of the therapeutic relationship to add to knowledge about ‘what works for clients’ to the field of counselling and psychotherapy.

**Who will be invited to participate in this project?**

Participants who have completed therapy in relation to trauma or abuse will be asked to participate in this project.

- Your therapist will approach you with an invitation letter to see if you are interested in participating in this project.

- You are under no obligation to participate and if you prefer not to then that is entirely your choice.

- 10 adults who have completed their therapy will be invited to participate in the project.
What will participants be asked to do?

Should you agree to take part in this project, you will be asked to participate in an interview about what you found helpful in relation to your therapeutic process.

- You will be asked to participate in an interview that will take approximately 1-1.5 hours.
- The interview will be recorded by audiotape and written up.
- The written record will be returned for your to check and you will have the chance to identify any material that you do not want included.
- Your therapist will be available should you wish to discuss anything with them following your interview.
- Your therapist will also be available should you wish to talk over any aspects of the project with them.

Please be aware that you may decide not to take part in the project without any disadvantage to yourself of any kind.

What data or information will be collected and what use will be made of it?

If you choose to participate in the project your information will be covered by the Health Information Privacy Code and the Privacy Act and will be securely stored at all times. The project will be analysing themes in relation to counselling and will not be using specific information. You will have access to your information at any time.

- As mentioned above your interview will be audio taped. The audio tape will be used to:
  1. Identify what you found helpful or unhelpful in therapy.
  2. Ascertain themes that emerge from the interviews.
  3. Analyse themes to inform the field of counselling and psychotherapy.

- Who will have access to the data or information?

  1. The researcher, the researcher’s supervisor at the University of Otago and the professional transcriber for the tape recordings will have access to the information. You will also have access to your information.
2. The information will be securely stored in a locked filing cabinet which only the researcher will have access to.

3. The tape recordings will be destroyed immediately on completion of the project.

4. Personal identifying information will be destroyed at the end of the project.

5. The transcripts will be destroyed after 5 years.

What data or information will be reflected in the completed research?

The data will be reflected on for themes that may emerge as a result of the interviews. It may be that some examples of narratives may be used to demonstrate themes. Your permission and consent will be sought in this case. You will always retain the right to decline this request. Specific names or other identifying information will not be used in the writing up of the project.

The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve your anonymity.

This project involves an open-questioning technique. The general line of questioning includes: What motivated you to enter therapy? What was the problem that you wanted to work on in therapy? Did therapy assist in resolving the problem? What did you find helpful/not helpful about the therapeutic process?

The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. Consequently, although the University of Otago Human Ethics Committee is aware of the general areas to be explored in the interview, the Committee has not been able to review the precise questions to be used.

In the event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and also that you may withdraw from the project at any stage without any disadvantage to yourself of any kind.
Can participants change their mind and withdraw from the project?

You may withdraw from participation in the project at any time and without any disadvantage to yourself of any kind.

What if participants have any questions?

If you have any questions about the project, either now or in the future, please feel free to contact either:

Pamela Wilson or Nicola Atwool

Department of sociology, Gender and Social Work

University of Otago: 03 4795442

Email address: pamela.wilson@xtra.co.nz; Nicola.atwool@otago.ac.nz

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
Appendix 2 – Information Sheet for Professionals

Thank you for showing an interest in this project. The project is part of the requirement for a Master of Social Welfare. The aim of the project is to explore client and professional perspective about what aspects of the therapeutic relationship facilitate change in the presenting issue for adults who have experienced childhood trauma. The project aims to interview professionals and clients working therapeutically about their experience of the therapeutic relationship and what contributes to successful outcomes.

Who do we want to have a conversation with?

I am interested in talking with experienced professionals who work therapeutically with adults in relation to childhood trauma and abuse.

What will participants be asked to do?

Should you agree to take part in this project, you will be asked to participate in an interview about what you found helpful in relation to the therapeutic relationship.

- You will be asked to participate in an interview that will take approximately 1 hour.
- The interview will be recorded by audiotape and written up.
- The written record will be returned for you to check and you will have the chance to identify any material that you do not want included.

What data will be collected and what use will be made of it?

The project will be analysing themes in relation to the therapeutic process and will not be using specific information. You will have access to your information at any time. Your audio taped interview will be used to identify what you as the therapist find helpful in the therapeutic relationship.

The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand).
Can participants change their mind and withdraw from the project?

You may withdraw from participation in the project at any time and without any disadvantage to yourself of any kind.

What if participants have any questions?

If you have any questions about the project, either now or in the future, please feel free to contact either:

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Appendix 3 – Consent Form for Participants

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:

1. My participation in the project is entirely voluntary.

2. I am free to withdraw from the project at any time without any disadvantage.

3. Personal identifying information e.g. audio-tapes, names, date of birth etc., will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for at least five years.

4. This project involves an open-questioning technique. The general line of questioning includes; What motivated you to enter therapy?, What did you find helpful in therapy?, did therapy assist you? The precise nature of the questions which will be asked have not been determined in advance. In the event that the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the project without any disadvantage of any kind.

5. If it becomes uncomfortable for me to reflect on my therapeutic process (during the interview) I will request the interview be stopped and I can reschedule if I choose to continue with the process. That is my choice.

6. I understand that there is no remuneration for this research project and that it is not intended for commercial use.

7. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve my anonymity should I choose to remain anonymous.
I agree to take part in this project;

..............................................................................................................................................
..............................................................................................................................................
(Signature of participant)          (Date)

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.