

**A Grounded Theory study of time-limited therapy  
for complex trauma:  
How NHS psychologists manage the challenge of  
working with developmentally traumatised clients  
within a time-limited therapeutic frame**

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### **Abstract**

Psychological research in the field of childhood trauma indicates that the earlier the age of onset and the more severe the traumatising in terms of intensity, duration and repetition, the more extensively impaired individuals become. In such cases long-term, phase-oriented treatment is recommended. Over the last decade, the NHS has undergone significant changes in the delivery of psychological therapies. There has been a substantial rise in the use of evidence-based practice and time-limited psychological treatment has become a focal point in the delivery of clinical interventions within community mental health services working mainly with complex traumatised individuals. As such, there appears to be a tension between clinical need, resources available, and a requirement to adopt a more results-driven, time-limited therapeutic framework as the primary treatment. This research sought to examine how clinicians contend with the dilemma of working within a time-limited frame with developmentally traumatised clients. Semi-structured interviews were conducted with seven NHS psychologists. Findings suggest that the imbalance between demand and resources generates an imbalance of emotional resources and a tentative model is presented outlining the process of progressive emotional depletion experienced by participants as a direct result of the various and conflicting demands placed on them by the client, the organisation and the clinical task. Key implications arising from this research surround the implementation of Eye Movement Desensitization and Reprocessing (EMDR) for the management of dilemmas on a client, organisational and clinician level. Implications of this for theory and practice are discussed with an emphasis on enhancing knowledge in the field of Counselling Psychology and recommendations for future research are provided.

### **Reflexive Statement (Part 1)**

I have chosen to conduct my research in the area of complex mental health difficulties stemming from extensive developmental trauma and the pathway for recovery from this. I was aware, when I chose this topic, that this is an area that has been increasingly researched and written about by psychologists in recent years; however it is a subject I feel very passionately about both personally and professionally. My personal link with complex trauma stems from my own complex trauma history and the challenges I have experienced as a result of this. I feel that my personal association with this area has provided me with a unique insight and enhanced awareness of the detrimental impact complex trauma can have on a person's life but, equally, the remarkable effects of posttraumatic growth that can occur from greater self-understanding and healing. My personal background has driven my interest and desire to understand the psychological and biological processes that occur when human beings are put under acutely overwhelming, stressful situations from an early age, as well as the manner in which they are then able to recover from their difficulties. My personal endeavour to expand my own understanding of this area as a whole has motivated me to pursue research in this domain so that I may also contribute to others' knowledge of the field. I feel that my doctoral training has provided me with the ideal opportunity with which to do this and I hope to not only contribute to the field from a Counselling Psychology (CoP) perspective, but also to approach this topic from a unique understanding acquired through personal experience.

From a professional perspective, I have experienced first-hand the challenges that lie within working with severely traumatised, complex mental health presentations due

to working within a secondary care team of the National Health Service (NHS). I have experienced challenges in utilising a time-limited, primarily Cognitive Behavioural Therapy (CBT; Beck, 1976) based approach due to the nature of this method focusing on presenting issues rather than addressing past experiences. I have encountered situations where my clients' past traumatic experiences have been brought into the therapy room triggered by discussions of present-day difficulties and have found myself having to adapt my therapeutic approach accordingly. The drive for time-limited, evidence-based practice is pertinent to the current standing of psychological treatment within the NHS. Experience has taught me, however, that applying an integrative therapeutic approach with complex trauma clients within a time-limited framework can assist the therapeutic process and begin to address the difficulties underlying their presenting issues.

Given the challenges I have faced in my experience as a psychological practitioner working with severely traumatised clients within an NHS secondary care service, I have wondered which key methods or processes other practitioners find helpful when working with developmentally traumatised clients within a time-limited framework and how these could help alleviate presenting difficulties linked to their history of childhood trauma. As the time-limited framework is increasingly becoming the standard across NHS Trusts (Clark, 2011) I feel this is a very current and relevant issue psychological practitioners face and therefore feel highly motivated to address this topic.

In my experience as a Trainee Counselling Psychologist within the NHS thus far, I have often felt the conflict between the humanistic philosophy of CoP which adopts



a holistic approach to psychological treatment (Orlans & Van Scoyoc, 2009) and the principal recommended treatment approach which often draws on diagnostic categorisation from a medical model perspective. I have felt the tension of combining a primarily top-down, symptom-based method with a bottom-up approach based on the experiences and context of the individual. I fully recognise that, due to my personal and professional experiences, I hold a somewhat partial view that short-term psychological therapy may not be sufficient to address the extremely complex difficulties that manifest as a result of extensive, early-onset trauma. This is also due to the vast research highlighting the neurobiological impact of childhood trauma, therefore modalities which address the neurobiological deficits from a processing perspective (such as EMDR) may be more efficacious than cognitive-based approaches. Equally, however, I hold the awareness that some psychological treatment is better than none at all and that short-term cognitive treatment has been found to be effective. I have certainly noticed and held the difficulty of bracketing my personal views throughout the writing of this thesis and have endeavoured to present a well-balanced, clinically and theoretically informed piece of research.

## **1. Introduction**

In outlining the function of psychological knowledge within the professional knowledge base of CoP, Orlans and Van Scoyoc (2009) highlight that “psychology offers us perspectives on the physiology of human beings, the intricacies of our memory systems, general cognitive functioning and the physiological effects of stress. This kind of knowledge is crucial, for example, in dealing therapeutically with the experience of trauma.” (p. 41). The authors aptly highlight the importance of the understanding of trauma from a psychological perspective which encompasses every aspect of the traumatised individual. As such, this is a very relevant topic for psychological exploration and contribution to the existing knowledge base.

Psychological research in the field of childhood trauma indicates that the earlier the age of onset, and the more severe the traumatising in terms of intensity, duration and repetition, the more extensively impaired individuals become. These impairments may encompass major risks to future coping, functioning, additional mental health difficulties and health and social costs. In such cases, short-term, trauma-focused CBT has demonstrated effectiveness in relieving trauma symptoms, however studies indicate that a longer-term, phase-oriented approach may be more effective for addressing the complex difficulties that chronically traumatised individuals often encompass. Resource constraints within the NHS require practitioners to adopt an outcome-focused, time-limited therapeutic framework as the primary model for treatment.

The first chapter of this thesis will present the most relevant empirical and theoretical literature in relation to complex trauma, including available treatment for this, and will deliberate the dilemma psychological practitioners face in working with developmentally traumatised clients within a time-limited therapeutic frame. Additionally, the research aims of the study will be outlined.

### **1.1 Diagnostic categorisation of trauma**

The development of complex, trauma-related difficulties has become an increasingly deliberated topic within the clinical field, both empirically and theoretically. A traumatic experience has been defined as “an inescapably stressful event that overwhelms people’s existing coping mechanisms” (Van der Kolk & Fisler, 1995, p. 506) and the experience of a traumatic event can lead to the development of posttraumatic stress disorder (PTSD). The trigger to PTSD is defined as exposure to actual or threatened death, serious injury or sexual violation and a diagnosis of PTSD encompasses four key behavioural components: re-experiencing of the traumatic event; avoidance of distressing memories, thoughts, feelings or external reminders of the event; negative cognitions and mood; and heightened arousal such as sleep disturbance, hypervigilance and aggressive or self-destructive behaviour (APA, 2013).

Interestingly, PTSD appears to have undergone a significant shift recently within its diagnostic categorisation, rendering this a very current and relevant area of debate. The American Psychiatric Association’s (APA) fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013) has reclassified PTSD under the category “trauma- and stressor-related disorders” whereas, previously,

PTSD was classified under the category of “anxiety disorders” (APA, 1994). The rationale for this has been stated to be due to the recognition that PTSD causes substantial variability in clinical expressions of distress, therefore this can no longer be addressed as an anxiety disorder (APA, 2013). Furthermore, criteria for a diagnosis of PTSD have been reviewed with the most noteworthy changes resulting in the addition of three symptoms – overly negative thoughts and assumptions about oneself or the world, negative affect and reckless or destructive behaviour; the division of the avoidance and numbing criterion into two separate categories meaning that a PTSD diagnosis includes at least one avoidance symptom; and, finally, the removal of the criterion indicating that the individual’s response encompasses “intense fear, hopelessness or horror” due to research indicating that this criterion did not improve diagnostic accuracy (Friedman, Resick, Bryant & Brewin, 2011). Changes in the diagnostic criteria have minimal impact on prevalence (Friedman, 2015); however, this move in nomenclature demonstrates the precariousness of diagnostic criteria and also marks an important shift within clinical thinking around trauma-related disorders. Further, it serves to highlight that psychiatric manuals are beginning to reflect a more sophisticated understanding of trauma and its aetiology. It is anticipated that this will positively impact empirical and theoretical efforts to enhance understanding of the relationship between trauma and disorders stemming from PTSD (Dorahy & Van der Hart, 2014).

It is important to note that the changes to the PTSD diagnosis have been employed within the APA’s diagnostic manual, however the NHS formally employs the World Health Organisation’s (WHO) International Classification of Diseases (ICD-10; WHO, 1992) for diagnostic categorisation. Nonetheless, it is recognised that the

DSM fundamentally influences the way mental health is thought about and treated in the United Kingdom (UK; NHS, 2013). It has been argued that the DSM has enhanced understanding of conditions such as attention deficit and hyperactivity disorder (ADHD) and borderline personality disorder (BPD) within the UK (NHS, 2013). Consequently, as the WHO prepare the ICD-11 for release in 2018, it is likely that the DSM-5 will influence the mental health section of this.

The term complex PTSD (CPTSD) was first proposed as a diagnosis by Herman (1992) in response to the inadequacy of the PTSD diagnosis in encompassing the complexity of difficulties presenting among individuals exposed to prolonged, recurrent trauma starting from an early age. This proposed new category included symptom sets that encompassed alterations in consciousness, affect regulation, self-perception, perpetrator perception, meaning systems and relationships. This proposal of CPTSD was closely linked with Disorders of Extreme Stress Not otherwise Specified (DESNOS) and this was tested within the PTSD field trial for the DSM-IV (APA, 1994). Results of the field trial indicated that, although there was insufficient evidence to consider DESNOS as a standalone diagnosis, the majority of individuals meeting criteria for DESNOS also met criteria for PTSD. Consequently, DESNOS symptoms were included as associated features of PTSD (Resick et al., 2012). The DSM-5 (APA, 2013) does not currently encompass a CPTSD diagnosis, therefore this remains problematic for individuals presenting with difficulties relating to complex trauma. Encouragingly, however, the evidence in support of the diagnosis has been reviewed (Cloitre et al., 2013) and the revision to include a complex trauma diagnosis within the upcoming ICD-11 has been confirmed (First, 2017).

As outlined, clear diagnostic construct for CPTSD remains to be established. However, from a CoP perspective, it should be highlighted that any diagnostic construct objectively derived could not encapsulate the impact of the complex and diverse difficulties associated with extensive and recurrent interpersonal childhood trauma to a person's life.

## **1.2 Medicalisation of mental health and psychological treatment within the NHS**

Treatment options and accessibility within the Community Mental Health Teams (CMHT's) of the NHS base themselves heavily upon diagnosis within which the National Institute for Health and Care Excellence (NICE) provide treatment guidelines for. The concept of diagnosis within mental health is viewed as fundamentally flawed by many within the psychological field, however. As Boyle (2007) highlights, a diagnosis within mental health suggests that psychological problems will follow a predictable pattern that will automatically fit within a pre-existing framework, much in the same way as a physical illness would. The difficulty with this notion, however, is that people's behaviour, emotions and symptomatology do not always easily fit into 'categories' and attempts to place individuals into pre-existing frameworks can be problematic and even precarious due to the risk of increased pathologising through actions such as dual diagnosis. This difficulty is particularly pertinent to complex trauma given the complexity and variability in presentations within these. Nevertheless, diagnoses are favourable in that they enable mental health professionals to communicate using a common diagnostic language and are the route to accessing appropriate treatment within medical contexts such as the NHS. This has key implications for counselling psychologists working within NHS settings given that the discipline of CoP has

adopted a questioning stance towards what has been described as a medical model of distress (Woolfe, Dryden & Strawbridge, 2003). Thus, it is of key importance that counselling psychologists maintain an awareness of the challenges of working within a medical framework and apply the pluralistic, integrative way of working advocated within the philosophy of the division (Cooper & McCleod, 2011).

Over the last decade, the NHS has undergone significant changes in the delivery of psychological therapies. There has been a substantial rise in the use of evidence-based practice as recommended by NICE and time-limited psychological treatment has become a focal point in the delivery of clinical interventions within the CMHT's of the NHS. As a result of this, a principal psychological treatment recommended by NICE is Cognitive Behavioural Therapy (CBT). Although time-limited CBT was predominantly the key treatment within primary care mental health services, the clinical and cost-effectiveness of evidence-based, time-limited therapy means that is also now the primary form of psychological therapy offered within secondary care services of the NHS (Clark, 2011). Cost-effectiveness has become a key point within the delivery of psychological interventions due to increasing constraints in resources for mental health services within the NHS (ESRC, 2013). The Department of Health (DH) has set out an agenda for increasing funding for mental health services over the next five years (DH, 2016), however this remains a real issue in the day-to-day delivery of psychological therapies.

### **1.3 Time-limited therapy for complex trauma**

As highlighted, time-limited therapy has become the principal framework implemented across NHS Trusts nationwide and practitioners working within

secondary care services are increasingly required to work within this frame (Clark, 2011). This has great implications for the treatment of complex trauma given that sufferers will often experience particularly severe, enduring and complex mental health presentations resulting from extensive developmental trauma and that this may have to be addressed in order to resolve presenting issues. What, then, happens when this is not possible due to the brief nature of time-limited therapy? How do clinicians manage the demanding task of treating individuals comprising complex difficulties within very limited timescales, combined with the increasing pressure for results? These are some of the questions that this research will endeavour to address.

#### **1.4 Childhood complex trauma**

Across the last three decades, clinicians and researchers became increasingly aware of forms of trauma that were much more complex and pervasive than those triggered by a single event. The term “complex trauma” was adopted by the field of traumatic stress when referring to developmentally adverse traumatic events, experienced recurrently and cumulatively, over an extended period of time and with early-life onset (Van Der Kolk, 2005). Courtois (2008) highlights that enhanced understanding of complex trauma stems from the increase in awareness of childhood abuse. In the late 1970’s the prevalence of childhood sexual abuse, incest and domestic violence became increasingly apparent among women and girls (Herman, 1992) as well as men (Gartner, 2000). Childhood abuse involving physical, emotional or educational neglect or maltreatment beginning in early childhood and occurring over an extended period of time, often within the child’s primary caregiving system, has since continued to gain attention. Van Der Kolk (2005) highlights that the experience of perpetual trauma significantly disrupts a child’s development due to the fact that



children are physically and psychologically immature and trapped in an environment in which they are subjected to conditioning through adverse occurrences – often within the caregiving system intended to protect and assure their safety. These chronic, developmentally adverse and aversive interpersonal experiences are viewed as forming the basis of complex trauma (Herman, 1992).

Research findings on developmental processes such as attachment, emotional understanding, social cognition and theory of mind (ToM) have contributed to a key theory linking developmental psychology and psychopathology – an elaborated developmental model of mentalisation proposed by Fonagy and Target (1996). Mentalisation is highlighted to be “a form of mostly preconscious imaginative mental activity, namely, perceiving and interpreting human behaviour in terms of intentional mental states (e.g., needs, desires, feelings, beliefs, goals, and reasons)” (Fonagy & Target, 2006, p. 287). Within this theory, the authors propose that a child develops a sense of self through the experience of being treated as a psychological being with its own mind by a caregiver and identity is therefore formed through these interactions that reflect the child’s mind (Ensink et al., 2014). As was observed by Fonagy and Target (2006), great difficulties arise in the capability to imagine the minds of others or mentalise in respect to others due to not having experienced being treated empathically as someone with a mind. As a result of this, great vulnerabilities are said to develop in regards to social relationships due to a fundamental disruption or maltreatment pattern in attachment relationships that play a central role in the development of social-cognitive capabilities and emotional regulation. Failures of mentalisation have been linked with a wide range of disorders including psychosis (Brent, 2009), BPD (Fonagy & Luyten, 2009) and major depressive disorder

(Fischer-Kern et al., 2013) as well as having been associated with increased violence (Pfafflin & Adshead, 2003).

### **1.5 Health and social costs of complex trauma**

Chronic, interpersonal trauma experienced from an early age has also been said to interfere with neurobiological development and disrupt the ability to integrate affective, sensory and cognitive information into a unified whole (Ford, 2005). The consequences of suffering extensive developmental trauma may also have major implications for the life trajectory of suffering individuals given that these often undergo lifelong difficulties such as addiction problems, psychiatric disorders, chronic physical health problems and legal, vocational and family difficulties. Moreover, their experience can increase vulnerability and risk for exposure to additional trauma (Cook et al., 2005). As Van der Kolk (2005) highlights, “developmental trauma sets the stage for unfocused responses to subsequent stress leading to dramatic increases in the use of medical, correctional, social and mental health services” (p. 3). Particular links have been found with chronic PTSD and offending behaviour (Ardino, 2011; Foy, Furrow & McManus, 2011; Weeks & Widom, 1998) as well as substance misuse (Jacobsen, Southwick & Kosten, 2001). Moreover, physical abuse and neglect are linked with high rates of arrests for violent offences (Allwood & Widom, 2014) and it is highlighted that the vast majority of the entire US prison population consists of individuals with childhood histories of extensive complex trauma, abuse and neglect (Van der Kolk, 2005). This has great implications for psychologists working with this client group as they have a bearing on what it means to provide therapy and, particularly, to do so within a time-limited framework.

### **1.6 Neurobiological impact of trauma and implications for treatment**

Due to the overwhelming emotional and sensorimotor processes often invoked with the experience of a traumatic event, traumatic memories are consequently viewed as fragmented sensory recollections of these events. Van der Kolk and Fisler (1995) highlight that these are then “retrieved in the form of dissociated mental imprints of sensory and affective elements of the traumatic experience – visual, olfactory, affective, auditory, kinaesthetic experiences” (p.505). These dissociative processes, stemming from the extreme affective responses to traumatic events, have been proposed to form their basis within the individual’s inability to process and, therefore, integrate traumatic memories at the time of occurrence. Consequently, the information is said to become static within the time of the disturbing event and this is then attributed to be the cause of the individual behavioural and emotional maladaptive responses as they are reacting in ways consistent with the traumatic event experienced (Shapiro, 2001). This has major implications for treatment and it has been highlighted of key importance that practitioners take the neurobiological deficits commonly experienced by these individuals into careful consideration when implementing psychological treatment (Van der Hart et al., 2006).

### **1.7 Challenges within the treatment of complex trauma**

A person with a complex trauma history may remain in a psychobiological state of alarm and threat-response even when that person is no longer at risk of danger (Ford & Courtois, 2013). Ford (2009) provides a sophisticated explanation for this in his review outlining the impact of early-onset, recurrent trauma on neurobiological processes. This is elegantly approached from the manner in which brain systems

regulate emotion, process information and develop healthy attachments and interpersonal relationships. This biological model is thought to be useful for the enhanced understanding of the neurological impact of extensive trauma (Resick et al., 2012) and it can thus aid in providing effective trauma treatment. As previously highlighted, it has been suggested that an individual's failure to biologically process information – such as repeated incidents of trauma – into their memory systems impedes experiences from being categorised and integrated with other experiences and, consequently, overwhelming events or memories may persist unprocessed at the very core of presenting difficulties (Van der Kolk & Ducey, 1989). This has major implications for treatment for clinicians working within the treatment of complex trauma given that hyperarousal and intrusive reliving can interpose on the client's ability to separate current reality from past trauma. As such, careful consideration should be given to techniques and strategies implemented and a formulation for risk management and managing abreactions throughout the therapeutic process is maintained.

## **2. Literature Review**

### **2.1 Evidence for Effective Therapies for Complex Trauma**

The lack of diagnostic clarity for complex PTSD presents challenges when comparing and evaluating effective treatment for complex trauma. Nevertheless, comparable evidence can be found within studies for the treatment of chronic PTSD and DESNOS. Within this, Foa et al. (2008) aptly highlight that “relatively little is known about the successful treatment of patients with these trauma histories [however] there is a growing clinical consensus, with a degree of empirical support, that some patients with these histories require multimodal interventions, applied consistently over a longer period of time” (p. 2).

#### **2.1.1 Brief CBT for complex trauma**

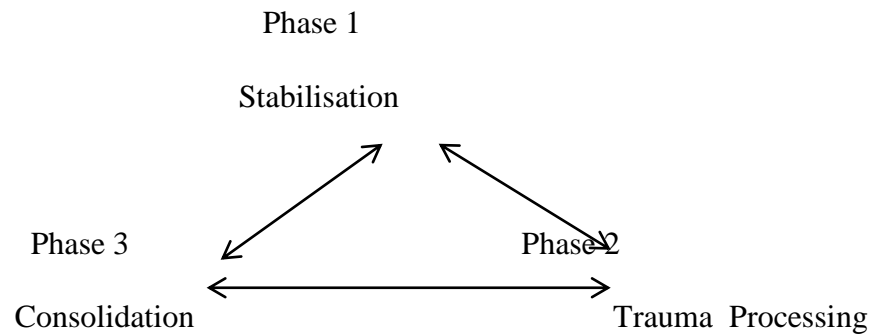
Short-term CBT interventions (6-12 sessions) have proven efficacious in the treatment of PTSD symptoms among rape victims, primarily involving cognitive processing therapy (CPT) and exposure therapy (Foa et al., 1991; Foa et al., 1999; Resick & Schnicke, 1992, 1993). The applicability of these therapeutic approaches in the treatment of complex trauma has been questioned, however, as research findings from randomised controlled trials (RCT's) of manualised CBT protocols may not be generalisable to NHS populations which may be more extensively impaired and experience higher levels of comorbidity with other disorders (Korn, 2009). Nevertheless, RCTs have shown CBT to be effective in relieving symptomatology of complex trauma. For example, Feeny, Zoellner and Foa (2002) randomly assigned 72 female victims of sexual assault and non-sexual assault to one of four treatment conditions: prolonged exposure, stress inoculation training, combined treatment, and wait list control. Treatment consisted of nine bi-weekly individual sessions. 17% of

participants met full (10%) or partial (7%) criteria for BPD pre-treatment. The authors found significant treatment benefits for participants with BPD however found poorer end-state functioning in comparison with the non-BPD group. This indicates that although CBT approaches can be reliably efficacious in relieving PTSD symptoms, they may not be so effective in community populations or where there is a 'complex-trauma' clinical picture.

Resick, Nishith and Griffin (2003) found CBT to be effective in the treatment of female rape victims with extensive complex trauma histories. The authors randomly assigned 121 participants to one of three conditions: cognitive processing therapy, prolonged exposure or a delayed-treatment-waiting-list condition. Findings indicated significant improvements of depression, PTSD and CPTSD symptoms and these were maintained for at least 9 months post-treatment. The authors concluded that CBT is an effective treatment for individuals with complex trauma histories, however it should be noted that there were no differences between treatment groups post-treatment once the pre-treatment scores were covaried. Moreover, while the studies presented demonstrate effectiveness of CBT interventions for individuals with complex trauma, it should be noted that neither of these studies included a diagnostic formulation of CPTSD or DESNOS within their inclusion criteria therefore this should be considered in view of CBT effectiveness for the treatment of complex trauma. The authors' conclusions are thus rather unclear and are of limited utility in informing NHS treatment.

### **2.1.2 Long term, phase-oriented treatment for complex trauma**

Longer-term sequential approaches have also been found effective in treating complex trauma. Phase-oriented treatment may be becoming a more widely advocated approach for treatment of individuals with complex trauma histories and has become the standard of care for the treatment of severe dissociative disorders (Chu et al., 2011). In the ‘ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults’ published by the International Society for Traumatic Stress Studies (ISTSS), Cloitre and colleagues (2012) appointed a Complex Trauma Task Force (CTTF) made up of key experts in the research and treatment of complex PTSD with its primary aim to “compile clinical and empirical knowledge about these survivors and to make recommendations regarding the study of the effects of complex trauma and its treatment” (Green, 2000, p. 2). Within these guidelines, the authors highlight the results of a consensus survey conducted among 50 clinicians specialising in treatment of PTSD and CPTSD/DESNOS (Cloitre et al., 2011). Results demonstrated that 84% of these recommended a phase-oriented approach as a first-line treatment approach for complex PTSD. Survey results also indicated that this should be implemented using a person-centred approach with the range of interventions focused around prominent symptoms. The phases of treatment and the interactional relationship of these can be seen in *Figure 1* below:



*Figure 1.* The three interactional stages of phase-oriented treatment for complex trauma adapted from Cloitre et al. (2012)

The phases of treatment outlined above as follows: Phase 1 (stabilisation) focuses on ensuring the individual's safety with a view to reduce symptoms and increase competencies within all aspects of the individual's life i.e. social, emotional, psychological. Phase 2 (processing) moves into the trauma processing aspect of treatment where unresolved traumatic memories are addressed and reappraised in order to integrate them into an adaptive manifestation of the self, relationships and the world. Finally, phase 3 (consolidation) seeks to consolidate the gains of treatment so that the individual is able to better engage with all aspects of community life with increased social, emotional and relational competency. As highlighted in *Figure 1*, treatment within the phases is not linear but instead a fluid process involving the activation of coping strategies, re-evaluation of core trauma-based themes and beliefs and challenging these (Courtois, 1999) within the relative safety of the therapeutic alliance.



Clinical research comparing phase-oriented treatment with other treatments is currently underdeveloped. One study by Cloitre et al. (2010) investigating phase-based treatment for women with extensive backgrounds of childhood abuse compares the implementation of a preliminary phase of skills training in affect and interpersonal regulation (STAIR) with two control conditions: supportive counselling followed by exposure (Support/Exposure) and skills training followed by supportive counselling (STAIR/Support). Results demonstrated increased benefits within a phase-oriented skills-to-exposure approach than those excluding either exposure or skills training at 6 months follow-up. Although these findings are encouraging, they should be interpreted with caution as previous studies investigating the combination of stress management skills training and exposure did not establish the combination to be superior to either standalone treatment (Foa et al., 2008). It should be highlighted that the studies do differ in the composition of the skills-based phase, however, and a reason for the opposing results could be due to differences in the type of skills training implemented within each i.e. dialectical behaviour therapy-type skills may be more effective in targeting the difficulties of this population than general stress management and relaxation techniques implemented in previous studies (Cloitre et al., 2010).

Empirical support for a sequential approach to the treatment of complex trauma has been demonstrated within nine RCT's examining enhanced or phase-based treatment models. Within these, varying emphases on the different phases of treatment are advocated (Cloitre et al., 2002; Cloitre et al., 2010; Steil et al., 2011; Chard, 2005) with some not considering 'trauma processing' as an essential stage of treatment but rather a focus on stabilisation (Dorrepal et al., 2010) or affect management (Bradley

& Follingstad, 2003; Ford, Steinberg, & Zhang, 2011; Zlotnick et al., 1997). Trauma processing has been outlined as a key stage by Cloitre et al. (2012) and taking into consideration the neurobiological impact of unprocessed traumatic memories as previously highlighted, there appears to be strong evidence for trauma processing in the treatment of complex trauma. Further research is needed comparing phase-based treatment with other treatments to inform future treatment for complex trauma.

### **2.1.3 Eye Movement Desensitization and Reprocessing (EMDR) for complex trauma**

Phase-oriented treatment within EMDR therapy has been standardised within the protocol for EMDR clinicians (Van der Hart et al., 2013). Originally developed by Shapiro (1989) for the treatment of PTSD, EMDR is a scientist-practitioner based approach which grounds itself in theory (Shapiro, 2001) and combines this with individually formulated treatment plans based on case formulations informed by the needs of the person (Korn, 2009).

A clinical strength of EMDR is considered to be the overall low dropout rates in comparison with CBT type treatment such as exposure therapy (Korn, 2009). Research has demonstrated dropout rates of 10% or below for individuals undergoing EMDR treatment (Wilson, Becker & Tinker, 1995; Rothbaum, 1997; Ironson et al., 2002) in comparison with 41% of CBT participants (McDonagh et al., 2005). An explanation for this has been suggested by Korn (2009) that EMDR may be better tolerated due to the emphasis placed on the individual in guiding their treatment in contrast with the therapist-guided approach of CBT. Furthermore, phase-based treatment is gradually titrated in comparison with the exposure/reliving

element of CBT approaches as it focuses more on the self-regulation of the individual (Rothbaum & Schwartz, 2002).

In evaluating the effectiveness of EMDR for adult survivors of chronic abuse meeting criteria for CPTSD/DESNOS, Korn and Leeds (2002) highlight the importance of dedicating an adequate length of time to the stabilisation phase outlined within the EMDR protocol (Shapiro, 1995) for increasing psychological resources. The authors conclude that pacing within this phase is crucial for increasing skills within self-efficacy and mastery when working with individuals whose experience bases itself on an enduring sense of powerlessness, defeat and loss, as this will assist in decreasing affective distress when faced with trauma-related triggers and processing (Korn & Leeds, 2002).

Despite there being few studies comparing a phase-based approach with other treatments, the former method may be able to help improve the overall complex trauma presentation of a client, rather than solely addressing their PTSD symptoms. As Van der Kolk and colleagues (2007) highlight, “for most individuals with childhood-onset trauma...eight weeks of therapy was not enough to resolve longstanding trauma imprints and adaptations” (p. 8). The phase-oriented approach encompasses adequate time for trauma processing together with the opportunity for addressing issues of dysregulation, dissociation and interpersonal relationships (Korn, 2009). This promotes clinical effectiveness within each of these aspects and thus allows for improvement in overall quality of life. This has great implications for treatment within a time-limited frame, however, as this approach may not fit into the specified timescales for the provision of psychological therapies by NHS secondary

care mental health services and, consequently, may not be achievable within the time-frame.

## **2.2 NICE guidelines and psychological treatment in the NHS**

NICE evaluates the clinical and cost-effectiveness of treatments and interventions which then lead to the development of treatment guidelines. It is highlighted that: “NICE produces national guidance on the promotion of good health and the prevention and treatment of ill health. The guidance is evidence based and issued to ensure delivery of high quality treatment within NHS organisations. All health and social care professionals are expected to comply with NICE guidance...Clinical guidelines are to be taken into account when planning and delivering treatment and care. NICE plays a key role in contributing to the quality and productivity of the NHS” (NICE, 2006, p. 4).

Currently, overall resources for mental health treatment within the NHS are constricted. The DH has recognised the impact of resource constraints and a proposal to increase funding for mental health treatment was outlined in March 2015. An independent Mental Health Taskforce brought together health and care leaders, people who use services and experts in the field to create a ‘Five Year Forward View for Mental Health for the NHS in England’ (DH, 2015). Within this, greater funding for mental health services overall has been assured in a document entitled ‘The Mental Health Taskforce Strategy’ (NHS England, 2016) and outlines financial goals for the treatment of mental health problems highlighting “Our ambition is to deliver rapid improvements in outcomes by 2020//21 through ensuring that 1 million more people with mental health problems are accessing high quality care. In the context of

a challenging Spending Review, we have identified the need to invest an additional £1 billion in 2020/21, which will generate significant savings” (NHS England, 2016, p. 11). Improving access to psychological therapies for people with severe and enduring mental health difficulties has been highlighted as an objective.

At its current standing, the primary treatment recommended by NICE and the most widely accessible within the NHS for sufferers of PTSD and, thus, complex trauma is CBT (Clark, 2011). Notwithstanding the solid evidence-base outlined for the use of time-limited CBT previously, it appears as though there is growing evidence for treatment of complex trauma using a longer-term and ideally phase-based relational approach, which may well incorporate CBT, but within a trauma-focused therapeutic framework. As such, there appears to be a tension between that which clinical research appears to be suggesting and both NICE compliance/NHS service pressures on clinicians to deliver brief interventions due to resource constraints.

### **2.3 Evidence for the effectiveness of time-limited therapy**

Research into the effectiveness of time-limited therapy in a CMHT setting is currently underdeveloped. A study by Carter (2005) highlights the pressure that CMHT’s are under to deliver time-limited therapy for complex clinical presentations and examines the effects of time-limited therapy for severe presentations of anxiety and depression. Results demonstrate clinical effectiveness in reducing psychological distress following six sessions of therapy and the author concludes that this outcome justifies the use of time-limited therapy within a CMHT (Carter, 2005).

The increasing demand for the application of time-limited, evidence-based psychological treatment has led to the development of specific approaches to address varying psychological difficulties. For example, psychodynamic therapeutic approaches such as Dynamic Interpersonal Therapy (DIT) and Interpersonal Psychotherapy (IPT) have been designed to address difficulties with interpersonal function and mood states within a time-limited framework and preliminary research has demonstrated effectiveness in these approaches. Lemma, Fonagy and Target (2011) piloted 16 sessions of DIT for depression in a primary care context and found 70% of patients reported significant symptom reduction to below clinical levels. DIT research remains limited, however, and the authors outline this outcome as a basis for a larger scale RCT to increase research in the application of DIT for depression (Lemma et al., 2011).

Preliminary research of the application of a modified version of IPT for BPD has demonstrated effectiveness. In an open pilot study, Markowitz and colleagues (2006) reported significant improvement in 5 out of 8 participants with a clinical diagnosis of BPD. Treatment involved a two-stage process consisting of an initial acute phase of 18 sessions in 16 weeks followed by 16 weekly sessions as a continuation phase. Although this study yielded results of improvement in functioning, it is highlighted that this period of treatment is unlikely to return comprehensive functioning in these individuals and follow-up sessions would need to be implemented (Bateman, 2012). This is highly relevant when considering effective time-limited treatments for complex trauma given that BPD has been linked with childhood trauma and has been argued to be one of the “toughest and most insoluble problems for the average clinician” (Linehan, 1993, p. vi). BPD is characterised by problems with attachment,

affect management, rapid mood fluctuations, impulsivity and interpersonal dysfunction between self and others. Thus, it is argued that time-limited treatments such as IPT are tailored to address the key components of the difficulties surrounding the self in relation to others. It is suggested that the longer-term the approach, the most notable change this will effect (Bateman, 2012).

Cloitre et al. (2012) highlight that clinical trials for phase-oriented treatment of individuals with complex trauma presentations have found substantial benefits from 4 to 5 months of treatment, however the ISTSS guidelines have advocated a longer course of treatment than those implemented within clinical trials. The authors emphasise that “while there is no consensus on ideal treatment duration, the majority of experts considered 6 months a reasonable length of time for Phase 1, and 3 to 6 months for Phase 2, producing a combined treatment duration of 9 to 12 months for the first two phases.” (p. 10). As phase 3 occurs when overall difficulties and functioning have been consistently improving, this is recommended to be a 6-12 month period to allow for full consolidation of the therapeutic process. Importantly, the authors highlight that this is merely a recommendation for minimum timeframes for this treatment approach and strongly emphasise that treatment should be planned around individual needs (Cloitre et al., 2012).

#### **2.4 Potential clinicians’ dilemma and research implications**

Resource constraints have caused psychological treatment within the NHS to become considerably restricted and outcome-focused, time-limited therapy is now the most widely implemented approach within secondary care services primarily encompassing highly complex, traumatised populations. The individuals that often

present within these services may suffer severe impairments as a result of extensive, unresolved childhood trauma that may have impacted upon their ability to cope and self-regulate in times of difficulty and made them particularly vulnerable to boundary violations. Additionally, knowledge surrounding the neurobiological impact of developmental trauma has advanced considerably in the last two decades with the advancement of neuroimaging. This has great implications for treatment given that practitioners would need to take into consideration the neurobiological deficits commonly experienced by these individuals when treatment planning (Van der Hart et al., 2006).

As indicated by the clinical and empirical literature presented, the key recommendation for the treatment of complex trauma indicates that this should be a longer term, phase-oriented approach given the difficulties with self-identity, self-regulation and relational deficits that chronically traumatised individuals often present (Courtois, 2008). The brief nature of time-limited therapy does not allow for the lengthy psychological treatment approach advocated, therefore, there is a seemingly important divergence between, the substantial clinical need of complex traumatised individuals, on the one hand, and the service-level constraints and time-limited treatment approaches typically offered, on the other.

The aim of this research will be to examine how clinicians contend with this dilemma. Specifically, what methods they employ in their therapeutic interventions within the confines of a time-limited therapeutic frame when the majority of individuals who seek psychological treatment have suffered extensive, recurring trauma from an early age.



The research questions are therefore as follows:

- How do practitioners think about and work with the high need/short timeframe dilemma and which models, constructs or principles do they draw upon in doing so?
- What are the possible implications for practice, training and service developments arising from this work and its challenges?

The above objectives are not to be seen independent of each other, but rather as all linked to issues surrounding the dilemma counselling psychologists and other psychological practitioners face of service pressure to deliver time-limited psychological interventions with a complex population encompassing substantial clinical need.

## **2.5 Counselling psychology relevance**

As outlined in the introduction, Orlans and Van Scoyoc (2009) highlight the importance of understanding “memory systems, general cognitive functioning and the physiological effects of stress” (p. 41) when working therapeutically with individuals who have experienced trauma. The theoretical literature presented in this review has directly explored each of these areas and, on this basis, recommended treatments which address these aspects of functioning in people who have suffered extensive developmental trauma have been reviewed. In doing so, however, it has become apparent that the literature available on this topic primarily involves RCTs. These studies advocate differing treatment approaches for developmentally traumatised clients and, essentially, adopt a positivistic, empirical approach to

complex trauma. Cooper and McCleod (2010) crucially highlight that “research evidence can never provide certainties about how people change” (p. 121) but rather identify possibilities for pathways for change. Therefore, there appears to be a substantial gap in the literature for the exploration of the subjective experience of those working therapeutically with developmentally traumatised individuals and examining the methods which, in their clinical experience, relieve the difficulties their clients encompass which are associated with their histories of childhood trauma. Therefore, this is a key area in which CoP can make a contribution.

Additionally, Strawbridge and Woolfe (2010) highlight three key areas which distinguish the discipline of CoP: a growing awareness of the role of the therapeutic or helping relationships; a questioning stance towards the medical model of professional-client relationship and a move towards a more humanistic base; and an interest in promoting wellbeing rather than focusing solely on sickness and pathology (p. 4). I feel this study would encompass an exploration of each of these areas given that it explores the subjective experience of the clinician in the therapeutic process with their clients and looking specifically at those methods which they feel promote wellbeing in their clients. Further, this study could add value for counselling psychologists grappling with the tension of working within time-limited, results-driven therapeutic frameworks while trying to maintain the humanistic philosophy the division firmly grounds itself within.

The resource constraints within the NHS affect not only psychologists but all who are employed within NHS organisations, however this study will be looking specifically at the dilemma psychologists face in working with extremely complex

individuals within a brief time period. As previously highlighted, complex trauma has an impact on all aspects of an individual's life, for example, health, social care, other mental health difficulties. Therefore, it should be highlighted that brief psychological treatment is better than no treatment at all for these often rather debilitated people. As a consequence of the current standing of psychological treatment within the NHS, it therefore seems all the more important to explore the methods of clinicians working within these frameworks with developmentally traumatised people. In contrast to the clinical studies highlighted within this review, the present study would focus on maintaining the essential values highlighted by Cooper (2009) of an appreciation of the client as unique; understanding of the client as a social and relationally embedded being and, crucially, a focus on facilitating growth and actualisation of potential.

Finally, this study could help to inform practice within CoP. Counselling psychologists are increasingly finding employment within NHS settings, therefore this type of research could help highlight how psychologists make sense of working within time-limited therapeutic frameworks with complex traumatised clients, how they manage it, how they work within this framework with clients, and also how things could potentially (and realistically) be improved within a context of service cuts and constraints. This is a key area in which this type of research is needed and CoP could make a real contribution to inform practice.

## **2.6 Conclusion**

In summary, research indicates that the earlier the age of onset and the more severe the traumatisation in terms of intensity, duration and repetition the more extensively

impaired individuals become with major risks to future coping, functioning, additional mental health difficulties, health and social costs (Van der Hart et al., 2013). In such cases long-term, phase-oriented treatment is recommended. However, due to resource constraints within the NHS, there is likely to be a tension between clinical need, resources available, and a requirement to adopt a more results-driven, time-limited therapeutic framework as a primary treatment. Consequently, my research aims to enhance our knowledge of how clinicians work within a time-limited frame with extensively developmentally traumatised clients in services with increasingly limited resources and aims to inform practice for counselling psychologists and other practitioners working with complex trauma within a time-limited therapeutic frame.

### **3. Method**

The following chapter will provide a rationale for the chosen qualitative approach and outline the methodology used to conduct this study. The reasons for selecting the chosen qualitative methodology will be discussed along with the influence of the researcher's own research paradigm. The procedure for conducting the study will be outlined in detail including data collection, ethical considerations and the analytical process undertaken. Finally, the management of the researcher's subjectivity throughout the research process will be considered.

#### **3.1 Selecting methodology**

Research within the field of complex trauma has advanced significantly over the last two decades and this largely comes as a result of an enhanced awareness of the neurobiological impact of extensive, recurrent trauma experienced from an early age combined with substantial advances within the field of neuroimaging (Van der Hart et al., 2006). Research within this field is still relatively limited, however, and studies exploring treatment of complex trauma are typically done so from a positivistic stance with the evaluation of RCTs and a focus on symptomatology. Qualitative investigations of this topic and, within this, the process of applying a time-limited framework with highly complex presentations are scarce. As a result, this creates a substantial need for qualitative research in this area.

Although this study may have been amenable to several qualitative methods, Grounded Theory as outlined by Strauss and Corbin (1990) was selected. An Interpretative Phenomenological Analysis (IPA; Smith 1996) methodology was

considered as this would have been useful for exploring the subjective experiences of clinicians working with complex trauma within a time-limited framework and this would have added value to qualitative research in this area. IPA, however, involves exploring experience alone whereas the study's aim was to develop an explanatory theory or model that took into account participants' experience but also key processes which could potentially assist clinicians in future with their management of time-limited interventions with developmentally traumatised clients. As a result, it was felt that implementing a ground theory methodology would be the most appropriate method of analysis for the aims of the research. Given that this was a small-scale study as part of a doctoral research project, an abbreviated version of grounded theory (Willig, 2001) was used.

### **3.2 Research within a critical realist paradigm**

The nature of knowledge can be understood in a variety of different ways and has implications for how research is conducted and the stories it tells (Mason, 2002). The study's research paradigm combines the researcher's ontological realism which assumes that there is a real world independent of theories, perceptions and constructions as well as epistemological constructivism which outlines that understanding of the world is fundamentally a construction from each person's perspective and that this comes as a result of their experiences. Therefore, the study is underpinned by a critical realist perspective.

Critical realism is a relatively new philosophical perspective that offers a radical alternative to the established paradigms of positivism and interpretivism (Houston, 2001). Realists maintain that progress is possible because the intransitive dimension of reality (enduring structures and processes) provides a point of reference, against

which theories can be tested (Bhaskar, 1978). However, from a critical realist perspective, our perceptions are shaped by our theoretical resources and investigative interests, therefore it is impossible to fully capture this reality. Constructivist approaches are concerned with generating new meanings inductively through research rather than starting with a theory; therefore research is typically conducted by exploring participants' views about the area of interest (Creswell, Hanson, Clark & Morales, 2007). Although Strauss and Corbin's (1991) version of grounded theory can be viewed as an approach in which the investigator's role is to discover the truth that lies within the object of investigation, with reality existing independently of any consciousness (Crotty, 1998; Charmaz, 2006), the constructivist epistemology underpinning this study concerned itself with understanding human experience from the perspectives of the participants. Consequently, this research assumed that data would be constructed from the multiple realities of the participants while recognising researcher subjectivity and the interaction between researcher and participants. Therefore, rather than aiming to achieve the discovery of a fixed truth, this research aimed to construct a theory through the shared experience of the participants and the researcher's process of meaning-making in the analysis in accordance with the constructivist epistemology of the researcher.

### **3.3 Procedure**

#### **3.3.1 Participants**

Participants were recruited from two NHS Trusts in England. Consistent with the abbreviated version of grounded theory (Willig, 2001), seven participants in total were recruited. The criteria for participation were that participants be qualified

counselling or clinical psychologists with experience of working with developmentally traumatised clients within a time-limited therapeutic frame in the NHS. Five female psychologists and two male psychologists were recruited and although trauma therapy training was not a requirement, six out of seven participants were trained in EMDR (Shapiro, 2001). See Table for a summary of participant demographics.

*Table 1. Summary of participant demographics*

Age	Gender	EMDR trained	Number of years qualified	Number of years worked within the NHS
36	Female	Yes	8	11
37	Male	Yes	5	8
32	Female	Yes	4	7
36	Male	Yes	6	13
59	Female	Yes	16	16
35	Female	Yes	4	7
34	Female	No	8	11

### **3.3.2 Recruitment**

A meeting was arranged with the managers for the psychological therapies team in order to discuss the study and obtain a list of potential participants. Potential participants were then approached directly via email invitations (Appendix A) sent out by the researcher outlining the aims and objectives of the research. The study's information sheet (Appendix B) was attached outlining the background information of the study, inclusion and exclusion criteria and the specifics of participation.



### **3.3.3 Data collection and management**

Prior to commencing the interviews, participants were fully briefed verbally on the aims of the research and how the information provided would be used and stored. A consent form was provided for participants to complete (Appendix C) and full debriefing took place following the interviews both verbally and using a debriefing form (Appendix D) which also contained the contact details of the researcher and the researcher's supervisor. A distress protocol was prepared in advance (Appendix E) should participants display any signs of distress during or following the interviews.

A semi-structured interview with open-ended questions was initially compiled to generally explore participant's work with complex trauma clients within a time-limited therapeutic frame. A pilot interview was conducted in order to trial and refine the initial interview schedule and the initial interview schedule is provided (Appendix F). A first stage of interviews was conducted involving three participants. As the interviews progressed, the interview questions were refined and adapted based on participant responses and the themes emerging from these. A revised interview schedule was used for the second stage of interviews (Appendix G) and the remaining four participants. Interviews were conducted face to face within participants' places of work and were audio recorded using a digital recording device. Interviews lasted between 45-75 minutes and were transcribed in full by the researcher. Recordings and transcripts were immediately anonymised and stored on an encrypted laptop accessed solely by the researcher. The audio recordings were destroyed following submission of the research.

### **3.4 Ethical approval and considerations**

Ethical approval was initially sought and granted from London Metropolitan University's Ethics Committee (Appendix H). Following this, NHS ethical approval was sought for the two Trusts involved. Approval was granted by the Health Research Authority (HRA) (Appendix I) and local approval had to be sought for the other Trusts. Ethical considerations were maintained throughout the study with issues around design and conceptualisation considered at the beginning of the research process, issues around data collection and analysis considered throughout and considerations of issues relating to reporting methods towards the end. Particular attention was paid in protecting participants' rights and interests by ensuring secure data management as highlighted above as well as appropriate analysis and interpretation of data in line with the BPS code of ethics (2009).

### **3.5 Analysis**

#### **3.5.1 Coding**

Grounded theory analysis involves constant comparison of the data throughout the process. The procedure followed closely resembled Strauss and Corbin's (1991) approach to grounded theory analysis. During the first stage of analysis, units of data are identified through a process of open coding involving examining the data line-by-line or in phrases to produce detailed codes. Labels were given to codes identified in the initial stage and these were referenced with participant and line numbers.

Once the first three interviews had been examined and open coding undertaken, the constant comparative method (Glaser & Strauss, 1967) was used to identify

similarities and differences between codes. Within this method, particular attention is paid to interpersonal processes occurring within the data, the conditions in which these processes develop, the context in which they occur, the context in which they change or covary, and, finally, the consequences of these processes on the individual (Strauss & Corbin, 1991). This is then applied to identify interrelationships within the data forming the next stage of axial coding of the analytic procedure. Similar codes were combined and assigned a higher order category label which encapsulated the meaning of all the codes. This process was undertaken iteratively in order to identify the core themes of the data that would construct the theoretical model.

### **3.5.2 Constructing the model**

The links and relationships between the subcategories identified within the axial coding stage of analysis were thoroughly examined in order to represent these within a diagrammatic model that would visually explain the interactive processes occurring in the data. For this to occur, full immersion in the data was necessary with subcategories and higher order categories held in constant comparison to develop and enhance awareness of the emerging themes. This aspect of the analysis was somewhat challenging due to the substantial amount of interactive processes occurring between the organisation, the client and the psychologist that were emerging from the data. An end-point was reached when it was considered that the model could accurately represent the majority of the data collected. Theoretical saturation was not an aim of the analytical procedure.

### **3.5.3 Validity**

In order to enhance validity, continual cross-referencing was undertaken between the coding process and the raw data to ensure relevance and fit (Glaser & Strauss, 1967).

Furthermore, to ensure participants' voices were reflected, codes were constructed using participants' own language where possible. Codes were converted into an audit trail and an audit was undertaken by the researcher's supervisor (Appendix L) to ensure the analysis was sufficiently grounded in the data (Willig, 2001) and enhance overall validity.

#### **3.5.4 Memo writing**

Memo writing forms a central part of the analytical procedure within grounded theory (Strauss & Corbin, 1991). During the research process, memos were documented from the beginning of analysis from the first interview and throughout to maintain awareness of the researcher's thoughts, beliefs and interpretations of the data. This was invaluable to enhancing awareness of interrelationships and deeper psychological processes emerging from the data and formed a significant part in the formation of the subcategories and higher order categories. Through the continual process of memo writing, it was possible to examine similarities and differences within the data and move beyond a mere description of the data to a more inductive approach which facilitated the construction of the final theory representing the data.

#### **3.6 The researcher**

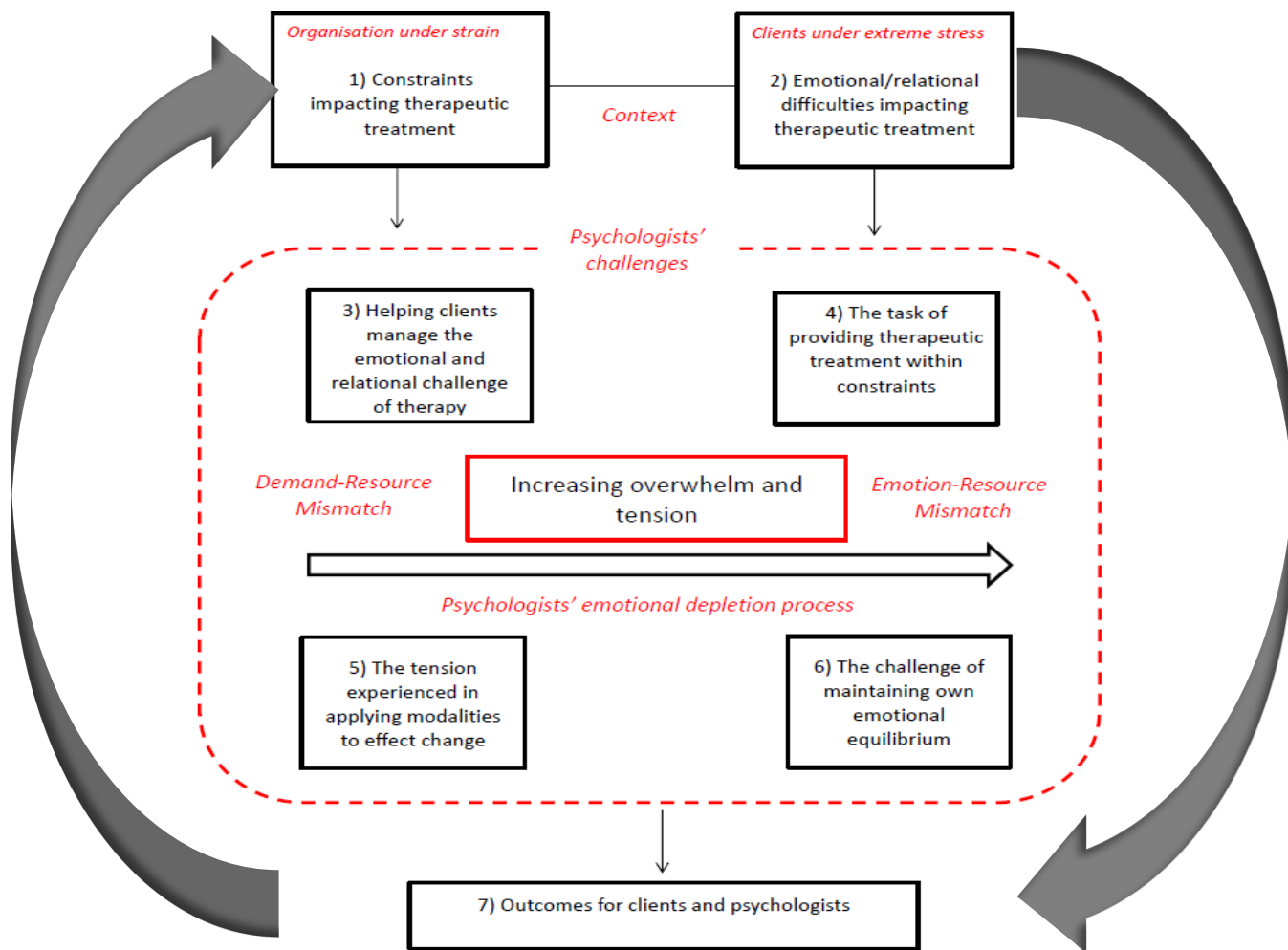
The study was undertaken by a female trainee counselling psychologist with experience of working in an NHS setting with complex trauma clients within a time-limited therapeutic frame. Due to the subjectivity of qualitative research owing to the researcher's interpretation of the data during the analytical process, the influence of subjective experience was maintained in awareness throughout the study and the notion that it would not be possible to bracket this entirely was held. This was

managed by maintaining self-awareness of the impact of personal beliefs and biases when coding the interview data and documenting these throughout the memo writing process. Reflexivity played a crucial role throughout the duration of the research and reflections on the personal and professional links between the researcher and the subject area have been highlighted within the reflexive statements at the beginning and end of the research which encompass segments of the memo writing process undertaken throughout.

#### **4. Analysis**

The following chapter will provide an overview of the theoretical model developed through analysis of the research data. A table outlining the main categories and subcategories comprising the model will be provided and each of these components will be discussed in narrative form using quotations from participant interviews to highlight their role in comprising the overall model. Finally, the chapter will conclude with a discussion of the emergence of the core category constructed from the research data.

#### 4.1 The Research Model



*Figure 2. A grounded theory model representing the interactional process of increasing emotional depletion experienced by NHS psychologists providing time-limited therapy to complex trauma clients*

The core dimension of the model highlights the overwhelm participants experience in providing therapeutic treatment to complex trauma clients due to the substantial, cumulative imbalance of demand and resources available within their NHS contexts. The interactional process for participants working within an overwhelmed organisation with overwhelmed and, at times, overwhelming clients generates a process of increasing emotional overwhelm which then leads to depletion.

## 4.2 Overview of the analysis

The following section will provide an overview of the components displayed within the research model. The subcategories comprising these are summarised below within *Table 2*.

The following research questions were explored through the analysis:

- How do practitioners think about and work with the high need/short timeframe dilemma and which models, constructs or principles do they draw upon in doing so?
- What are the possible implications for practice, training and service developments arising from this work and its challenges?

Central to the research model, a progressive process of emotional depletion was described by participants working with complex traumatised clients within a time-limited therapeutic frame. This process appeared to emerge as a result of the mismatch between demand and resources within participants' NHS contexts, leading to a mismatch of emotional resources as participants highlighted contending with the various conflicting demands and challenges placed on them by their clients, the organisation and the clinical task they faced within this context.

Psychologists interviewed expressed having to contend with an organisation which is under a considerable amount of strain (component 1) and the constraints resulting from working within the NHS context. Within this context, clients are presenting with symptoms of extreme stress due to their traumatic histories. As a result of their difficult experiences, clients typically encompass extensive emotional and relational



difficulties which can impact on the therapeutic process (component 2). Participants seemed to highlight their challenges experienced within four key areas of their roles. Firstly, the intricacies of carefully helping clients manage their emotional and relational difficulties in order to help them manage the therapeutic process so that they may assist them with addressing these (component 3). Added to the challenge of working with highly complex presentations, the task of generating outcomes within time-limited constraints caused further feelings of pressure (component 4). The organisation's recommendations for applying specified treatment modalities for complex trauma clients conflicted with some participants' experiences of what they found more effective in practice, and this seemed to create tension for them when delivering treatment with clients (component 5). Finally, due to the challenges highlighted within the previous three components, participants highlighted their own challenges in maintaining emotional equilibrium and the methods they employ to help them do so (component 6). Outcomes for clients, but also for participants themselves, were reflected upon (component 7). EMDR was highlighted as the most effective modality for enhancing recovery amongst complex trauma clients within a time-limited frame. Participants additionally highlighted their experience of emotional overwhelm as a result of the various challenges and dilemmas they faced daily in their roles. The imbalance of demand and resources generated an imbalance of emotional resources and an interactional process of progressive overwhelm was highlighted to occur.

### **4.3 Outline of the model**

The following section will present a summary table of each category and subcategory with a detailed analysis of these following this. Participant quotations will be presented to elaborate the analysis in the context of the data.

*Table 2. Summary of components, subcategories and contributing participants*

COMPONENT	SUBCATEGORY	PARTICIPANT
1. Organisational constraints impacting therapeutic treatment	1.1 The funding deficit for mental health services puts vast pressure on resources	ABCDEFGF
	1.2 Diagnostic labels can create challenges for complex trauma treatment	BCDEFG
2. Client emotional and relational difficulties impacting the therapeutic process	2.1 A fundamental distrust of relationships	ABCDEFGF
	2.2 Emotional dysregulation and the strife of tolerating distress	ABCDEFGF
	2.3 Striving to avoid the overwhelm of traumatic experiences	ABCDEF
3. Helping clients manage the emotional and relational challenges of therapy	3.1 Building trust and developing safety in the therapeutic relationship	ABCDEFGF
	3.2 Fostering the ability to tolerate distress	ACDEFG
	3.3 Reframing symptoms through formulation, psychoeducation and validation	ACDEFG
4. The task of providing therapeutic treatment within constraints	4.1 Restricted vs. focused treatment: the dialectic of the time-limited therapeutic frame	ABCDEFGF
	4.2 The pressure to produce outcomes within short timeframes	BCDEFG
	4.3 The challenge of formulating difficulties and identifying treatment goals	ABDEFG
	4.4 Managing risk and prioritising client safety	ABCDEF
5. The tension experienced in applying modalities to effect change	5.1 The requirement for an integrative therapeutic approach	ABCDEFGF
	5.2 The deficits of a CBT approach in complex trauma cases	BCDEFG
	5.3 The adaptability and suitability of EMDR for time-limited treatment	ABCDEF
	5.4 Comparing trauma therapies: preference for EMDR over TF-CBT	ABCDEF
6. The challenge of maintaining own emotional equilibrium	6.1 Recognising and accepting the limitations of treatment	ABCDEFGF
	6.2 Maintaining awareness of the	BCDEF

	psychological risks of trauma work	
	6.3 The importance of self-care	ACDEFG
	6.4 Making use of team support	BCDEG
7. Outcomes for clients and psychologists	7.1 The importance of trauma processing for enhancing client recovery	ABCDEFG
	7.2 EMDR accelerates the rate of recovery	ABCDEF
	7.3 The emotional overwhelm experienced by psychologists due to increasing demands	ABCDFG

### **Component 1: Organisational constraints impacting therapeutic treatment**

<b>COMPONENT</b>	<b>SUBCATEGORY</b>	<b>PARTICIPANT</b>
1. Organisational constraints impacting therapeutic treatment	1.1 The funding deficit for mental health services puts vast pressure on resources	ABCDEFG
	1.2 Diagnostic labels can create challenges for complex trauma treatment	BCDEFG

This component of the model highlights the contextual challenges participants described as a result of organisational constraints and the impact these have on therapeutic treatment for clients. The national funding deficit for mental health services overall was emphasised by all participants and this was highlighted as a primary problem they encountered within each of their NHS Trusts. Furthermore, cuts to state services outside of the NHS were deemed an additional contributing factor for the rising demand for mental health services. The overall decrease in state support was considered to have an impact on individuals' mental wellbeing therefore creating additional pressure on NHS mental health resources.

In addition to this, participants highlighted the challenges of a lack of diagnostic categorisation for complex trauma. The variability in presentations resulting from recurrent trauma, coupled with the absence of a complex trauma diagnosis, seemed to make determining therapeutic treatment difficult as there was no set treatment pathway or guideline for this. This component is representative of the overall contextual challenges participants experience from the organisation and the impact of these on therapeutic treatment.

***Subcategory 1.1: The funding deficit for mental health services puts vast pressure on resources***

Participants collectively expressed the view that their services are under-resourced overall. The reduction in overall state funding was felt to impact individuals' mental wellbeing, placing increased demand on NHS resources. Additionally, the differences in funding between physical and mental health services were emphasised by some participants with mental health services considered a lower priority than physical health. Further, there was a strong sense of emotional impact from the resource deficit coming from the organisation.

*“...if we said 10,000 people that needed chemo got one lot of chemotherapy, or two lots if they're lucky for the next month or two, there'd be a national outcry – we've got that for psychology, if not less, it's about 1 to maybe 100,000 if not less in terms of numbers” (Participant D)*

Additionally, the funding deficit was expressed to not only have a direct impact on resources available for therapeutic treatment, but also on mental health teams across

NHS Trusts. Specifically within psychological therapies teams, there were some areas where single psychologists covered large county areas. Some of the participants interviewed, for example, highlighted that they were the only psychologist employed for the quadrant of their respective Trust and, moreover, were working part-time hours, adding to the sense of deep constraint.

*“...and do you know who is the PTSD clinic now? It is myself. It’s only me practicing (laughs). It is ridiculous (laughs)...just me, nobody else in my quadrant, just me” (Participant C)*

The impact of these highly under-resourced teams resulted in some participants having to focus solely on offering assessments and consultations due to the inability to meet the demand as the sole psychological practitioner for their area.

*“At the moment I’m so overwhelmed here I’ve had to adopt a system where I’m offering assessments and consultations and can’t even offer therapy because we don’t have the resources” (Participant D)*

The substantial funding deficit within the organisation was seen as a primary challenge impacting therapeutic treatment for clients presenting with complex trauma. Due to the limited resources available participants highlighted that this can result in the inability to offer therapy to clients within their Trust due to the requirement to address large client waiting lists for assessment.

***Subcategory 1.2: Diagnostic labels can create challenges for complex trauma treatment***

A further contextual difficulty was that of contextualising the extreme stress and dysfunction clients presented with, in particular due to the lack of a complex trauma diagnosis within the diagnostic manuals DSM-5 and ICD-10. This seemed to create an additional challenge to the resource difficulties, for those clients able to access treatment, of determining a treatment pathway for extremely distressed clients presenting with symptoms of recurrent and complex trauma.

*“I think it’s difficult not having a diagnosis for complex trauma as there is a lot of variability in presentations, um, and this can be a challenge for treatment as I feel the diagnosis interferes with the types of therapies available to people” (Participant A)*

Diagnostic labels often applied in the presentation of complex trauma symptoms were thought to be misleading for what may lie at the core of an individual’s difficulties.

*“I think sometimes these patients come with Bipolar II diagnoses, which is not wrong, Bipolar II does describe what is happening, but it can be misleading as Bipolar does tend to get lumped in with the psychotic end of things whereas the damage, if you like, the dysfunction, is rooted in an attachment trauma” (Participant E)*

Participants felt compelled or under pressure to offer diagnostically-driven therapies for Bipolar and other diagnostic labels when the core issue was more often considered to be that of complex trauma. Indeed, most participants felt that a complex trauma diagnosis may not only be a more accurate representation of a client's difficulties, but also help to delineate a treatment pathway with access to psychological therapies.

In summary, this component of the model highlights the impact of the contextual challenges participants described experiencing in their roles. The lack of funding within their NHS contexts created a pressurised environment for therapeutic treatment and the additional difficulty of diagnostic categorisation further enhanced the challenges faced at an organisational level.

### **Component 2: Client emotional and relational difficulties impacting therapeutic treatment**

<b>COMPONENT</b>	<b>SUBCATEGORY</b>	<b>PARTICIPANT</b>
2. Client emotional and relational difficulties impacting therapeutic treatment	2.1 A fundamental distrust of relationships	ABCDEFGF
	2.2 Emotional dysregulation and the strife of tolerating distress	ABCDEFGF
	2.3 Striving to avoid the overwhelm of traumatic experiences	ABCDEF

This aspect of the model describes how clients with histories of recurrent, interpersonal trauma present in ways that strongly impact therapeutic processes. Participants described the very substantial amount of relational trauma many clients have experienced, and their traumatic histories engender a fundamental distrust of

relationships (creating extensive interpersonal difficulties). Additionally, clients typically presented with difficulties in managing and tolerating emotions, therefore developing coping mechanisms such as self-harm or dissociation. Further to their avoidance of emotions, clients often were felt to display high levels of avoidance of discussing their traumatic experiences in psychological therapy. These difficulties with relationships, in combination, impact and disrupt the therapeutic process. Participants highlighted the challenges of managing all dynamics within short timeframes permitted and resourced for their psychological intervention.

***Subcategory 2.1: A fundamental distrust of relationships***

Participants described the relational aspect of therapy as one the greatest of challenges for trauma clients and highlighted that an inability to tolerate the relational aspect of therapy could impact on engagement. Issues with trust stemming from extensive relational trauma were considered to be at the foundation of clients' relational difficulties and the challenge of applying psychological interventions with clients who experience relationships as threatening was highlighted.

*“Adaptive behaviours such as tolerating being vulnerable and asking for help where, with somebody, where it’s rooted in a survival experience, it’s very difficult, and that’s why the therapeutic relationship is so important because if a person is phobic of relationships they can’t use that natural human calming experience of somebody being there with you to help you through this” (Participant E)*



Some participants additionally highlighted that the focus on outcomes within the short timeframes of their NHS contexts could interfere with addressing clients' relational issues in therapy.

*“The relational aspect...really needed the focus and the work. I think that would have been more helpful for us, to understand the ways of seeking help or getting needs met that might be causing a lot of problems to be maintained, but because that's not what the work was set up as from the beginning you couldn't really do that” (Participant G)*

In participant G's NHS service, there was a strict requirement to provide a maximum of 20 sessions of CBT with the vast majority of clients presenting with extensive histories of developmental trauma. This was highlighted as a major challenge and will be discussed further (see subcategory 4.2).

### ***Subcategory 2.2: Emotional dysregulation and the strife of tolerating distress***

A further challenge for clients with complex trauma histories was highlighted to be the difficulties they often experience in managing their emotions. Participants discussed that clients typically are unable to regulate their emotions effectively and tolerating distress becomes too overwhelming, therefore they often try to suppress or avoid their emotions and can do so by way of self-harming or dissociating from these. This was considered to be a difficulty potentially stemming from the absence of emotional regulation within clients in their developmental years.

*“Emotions are really hard and really difficult to tolerate and to know how to manage that distress in a more helpful way. There wasn’t anybody able to regulate their early emotion, um, and so, you know, that pattern of responding has continued” (Participant F)*

The potential for severe emotional dysregulation to cause clients to dissociate during the therapeutic process due to their limited capacity to cope with emotional overwhelm was discussed. Participants highlighted that any psychological interventions applied with clients in a dissociated state would likely be ineffective, therefore the priority would be to ground clients safely back in their present prior to continuing with any further interventions.

### ***Subcategory 2.3: Striving to avoid the overwhelm of traumatic experiences***

There may be some overlap with this subcategory and subcategory 2.2 as they both partly describe how clients avoid overwhelming emotions. The key difference, however, relates to the conflict clients often experienced when they came for therapy. The strong desire to resolve their traumatic symptoms, faced with the overpowering urge to avoid emotional overwhelm in disclosing traumatic events, meant clients felt highly ambivalent about therapy. Some participants mentioned how clients even became suspicious of the psychologist’s intentions for enquiring about their trauma (as if they have malign intentions). This was particularly evident in CBT therapy (see component 5).

*“in the initial sessions we work so much on this defence, on the avoidance, and they say “I don’t want to talk about this” and “this is horrendous” and “why do you*

*want to torture me again?” and “why do you want me to reveal the trauma?” and “I can’t understand the reason, give me the rationale” (Participant C)*

As participant C highlights, clients may perceive the psychologist as another perpetrator when asked to discuss their traumatic events. This relates to subcategory 2.1 as this is also an example of the substantial levels of distrust severely traumatised clients can express. The strong desire to avoid discussing traumatic events posed considerable challenges for time-limited trauma therapy.

### **Component 3: Helping clients manage the emotional and relational challenges of therapy**

<b>COMPONENT</b>	<b>SUBCATEGORY</b>	<b>PARTICIPANT</b>
3. Helping clients manage the emotional and relational challenges of therapy	3.1 Building trust and developing safety in the therapeutic relationship	ABCDEFG
	3.2 Fostering the ability to tolerate distress	ACDEFG
	3.3 Contextualising difficulties through formulation and validation	ACDEFG

Participants felt that helping clients to manage emotional and relational challenges (highlighted in component 2) was a key challenge within the resource and time constraints. The impact of this on participants’ own emotional resources was also highlighted (see component 6). This component of the model, however, focuses on participants’ methods to help their clients manage the challenge of just being in therapy. Methods of developing safety and trust were highlighted to be crucial with clients who have endured a lifetime of unsafety and interpersonal distrust.

Additionally, helping clients tolerate distress, not least to manage their emotions during therapy, was considered central, as was helping clients to make sense of their experiences (psychoeducation) given that they often found their symptoms deeply confusing, adding to the distress.

***Subcategory 3.1: Building trust and developing safety in the therapeutic relationship***

Maintaining acute awareness of the trust issues that clients typically exhibit assisted clinicians in managing these, as well as maintaining awareness of their own impact on a client's sense of emotional safety in therapy.

*“Typically, people with developmental trauma histories come with an overactive amygdala and hypervigilant reactions, they may be either consciously or unconsciously studying your every move in sessions to determine whether they render you safe or not, so to come across as threatening in any way is not going to be very helpful” (Participant F)*

Certain qualities were highlighted as particularly important when building a therapeutic relationship with clients. Transparency, honesty and consistency were considered to be fundamental for helping clients to feel contained within sessions. The application of specific interventions to help clients feel empowered and in control within sessions were discussed. Some felt it important not to pressurise clients to disclose their traumas if they were displaying high levels of avoidance and distress until they felt comfortable to do so.

*“Using metaphors which then empowers them, gives them the sense of control that they can talk about it when they’re ready I think...paradoxically, by not putting pressure on people, people are more likely to open up and talk about those things”*  
(Participant A)

Finally, conveying empathy for their clients’ traumatic experiences and sense of equality within the therapy room, helped to build trust and safety.

### ***Subcategory 3.2: Fostering the ability to tolerate distress***

As described in subcategory 2.1, clients with developmental trauma histories struggle to tolerate and regulate emotions. Developing distress tolerance skills with clients was considered a key part of therapy and participants said they primarily draw from the stabilisation phase of EMDR and DBT for this.

*“A lot of the stuff I do is initially basic trauma management stuff protocol, so I would do things like grounding and imaginary container, imaginary safe place, very much in line with EMDR so trying to do the opposite of what their emotions are telling them to do”* (Participant D)

The primary goal in helping clients to regulate their emotions and building their capacity for tolerating distress was felt to not only relieve their overall emotional dysregulation, but also as preparation for tolerating the trauma-processing aspect of therapy (should this be implemented as part of their treatment plan). One participant said that in helping clients to regulate their emotions more effectively, they are essentially taking the role that a caregiver would to a young child. The aim of this

was to provide a form of limited reparenting with the objective of fostering an internalised parent within clients so that they may eventually be able care for themselves better.

*“I guess my fundamental thoughts are ‘I’m trying to teach you to be a good parent to yourself’ so teaching self-regulation is really important” (Participant E)*

Skills such as mindfulness, relaxation and grounding drawn from approaches such as DBT and the stabilisation phase of EMDR were considered the most effective methods to develop clients’ capacity for tolerating their distress.

### ***Subcategory 3.3: Reframing symptoms through formulation, psychoeducation and validation***

All participants highlighted the importance of helping clients to make sense of their experiences as a crucial aspect of the therapeutic process, particularly when clients typically exhibit severe symptoms associated with hypo and hyperarousal of the autonomic nervous system.

*“Sometimes just helping someone understand their own reactions was the most helpful aspect of the therapy, so psychoeducation around what was happening in terms of fragmented memories and how trauma affects the brain and recognising that hypervigilance and those sorts of things are ways of coping and dealing with the trauma” (Participant F)*

The tendency for clients to feel highly confused and distressed by both their symptoms and the experiences which may have caused them was highlighted. The role of psychoeducation to normalise, accept and validate clients' experiences, helping them to develop an understanding of their symptoms and traumas, was considered fundamental. Participants felt that framing clients' coping skills as survival strategies and validating these (rather than pathologising or criticising them) was particularly effective for developing coping and understanding.

*“Why wouldn't you start self-harming at 12 when you've had a domestic violent family, mum and dad really couldn't look after you, you know, things are so overwhelming that either you dissociate and self-harm as a way to manage”*  
(Participant D)

Formulation and validation was deemed to have a powerful impact on a client's beliefs about themselves and considered to be the most important aspect of therapy for some clients.

*“We spent so much time formulating, but for him this was the most important piece of work because he understood, for the first time in his life, what is going on in his brain because he felt, like, that he is just crazy”* (Participant C)

#### **Component 4: The task of providing therapeutic treatment within constraints**

<b>COMPONENT 4</b>	<b>SUBCATEGORY</b>	<b>PARTICIPANT</b>
4. The task of providing therapeutic treatment	4.1 Restricted vs. focused treatment: the dialectic of the	ABCDEFGH

within constraints	time-limited therapeutic frame	
	4.2 The pressure to produce outcomes within a short timeframe	BCDEFG
	4.3 The challenge of formulating difficulties and identifying treatment goals	ABDEFG
	4.4 Managing risk and prioritising client safety	ABCDEF

This component of the model relates to another of the key challenges that participants described; namely, a “demand-resource” mismatch (see model diagram). The advantages and disadvantages of a time-limited framework were highlighted and participants reflected on the utility of undertaking highly focused therapeutic work, however expressed feeling overall restricted by the time-limited framework. The organisational focus on outcomes within the NHS was described as generating high amounts of pressure (leading to depletion of energy and morale) given the time constraints, particularly when working with the substantial complexity of clients who have been recurrently traumatised. This complexity was highlighted to have an impact on the formulation and identification of treatment goals as participants discussed that the full extent of this may not reveal itself until treatment is well underway and goals may have to be adapted accordingly. The prioritisation of client safety through risk management was discussed as a key aspect of the therapeutic process as therapeutic treatment can be difficult for clients to tolerate.

***Subcategory 4.1: Restricted vs. focused treatment: the dialectic of the time-limited therapeutic frame***

Participants reflected on the advantages and disadvantages of working within a time-limited framework. On one hand, they discussed that working within a time-limited



model generates the requirement for highly focused, recovery oriented therapeutic treatment which encourages collaborative working between the therapeutic dyad. Alternatively, the framework was considered to be restrictive and, at times, unreasonable for clients.

*“There are pros and cons. The pros is that, uh, if you imagine that the client and therapist is like a team, so can team up and set some very specific goals and can work on them, and that this means that in each single session we work very hard together and this is a positive...the con is that if the client wants to raise something different, something that really bothers him, we don’t have the time, so we’ll need to stay very focused on our agenda and this can be very oppressive” (Participant C)*

This clearly represents a conflict with the need to hold an open space as discussed in component 3.1. Participants also highlighted that working towards an ending with clients can be therapeutic and therefore beneficial.

*“I think the idea of there being an end point, I think, is actually quite therapeutic with people because things end, you know, things end, whether it means that somebody is moving to a different job, whether it ultimately means the death of someone, you know what I mean, there is, sort of, an end and to help people to work towards an end, and manage that well, I think is, sort of, very, sort of, therapeutic” (Participant A)*

Most participants were supportive of a time-limited therapeutic approach within the NHS overall, however all felt that the current time-limits when working with highly

complex clients were not suitable and felt that a more flexible approach to the number of sessions offered with these clients would be more beneficial.

***Subcategory 4.2: The pressure to produce outcomes within a short timeframe***

The focus on outcomes within the NHS was considered an additional pressure when managing the other challenges of a time-limited framework with highly complex clients. The impact of this on the therapeutic was highlighted, and often seemed to be owned and internalised by the clinicians.

*“I can feel, as a therapist, pressure to, um, to get results if that makes sense, you know what I mean, pressure for there to be, sort of, any change or any gains in therapy because of the limited amount of time and I think in terms of how I, sort of, approach my work, um, it means that every session is very important because you know you haven’t got that many, so there’s a real pressure on me to get this right”*  
(Participant A)

Additionally, participants discussed the perceived expectation from the organisation to proceed with the trauma processing aspect of therapeutic work without taking into consideration the ability of clients to manage the strain or the pace of this.

*“We have to be seen to be doing...so it’s almost like ‘come on, you’ve got to try and get this trauma stuff done because it’s clear that the patient is ready’ when that’s not always the case”* (Participant B)

The focus on outcomes leaves clinicians feeling not only pressurised, but resentful of the organisation, at times, as they feel that the primary concerns of the organisation surround outcomes data rather than recovery of clients. Some participants expressed strong feelings around this and these will be elaborated within category 7 which highlights the emotional impact of participants' roles as psychological therapists within the NHS. This feeds into the depletion process mentioned earlier.

***Subcategory 4.3: The challenge of formulating difficulties and identifying treatment goals***

The challenge of identifying treatment goals was part of the complexity of working with recurrently traumatised clients. As discussed within subcategory 3.4, formulating these with the client was considered a key part of the therapeutic process. However, given the time constraints clinicians were working within, there was often not enough time available for extensive formulation, therefore collaborative prioritisation of goals becomes essential.

Participants felt that, due to the complexities of severely traumatised clients, difficulties arose around treatment goals. The core traumas which may be causing the most suffering to clients may not reveal themselves immediately and may only emerge once therapy is underway.

*“The client I just mentioned [...] was a very straight forward assessment, maybe 3 or 4 sessions, then the anticipation was that we would start working on the recent trauma, but then she disclosed about these [physical characteristics] that were actually far more distressing to her and we had to prioritise that” (Participant E)*

Trauma therapy is unpredictable due to the deep-rooted issues clients may be unaware of and which can surface during the therapeutic process. This, within a time-limited frame, while prioritising treatment goals and having to adapt these during treatment in order to relieve other areas of unexpected and major distress (to enhance client recovery), contributes to the multiple tensions the therapist has to manage.

***Subcategory 4.4: Managing risk and prioritising client safety***

The issue of client risk can arise due to the unpredictability of issues that emerge in therapy. Participants highlighted that there is no capacity within the time-limited framework to work with clients that are, or become, actively suicidal due to the potential impact of therapy on their risk levels.

*“The contract is that somebody cannot be suicidal or currently self-harming because we don’t have the capacity to hold them in therapy” (Participant B)*

Participants highlighted that clients becoming suicidal during the therapeutic process is typically an indicator of their ability to cope with therapy at that time. Often, therapy will be terminated if a client becomes suicidal during the therapeutic process as it would be deemed too unsafe for them to continue. Said action, of course, is not an easy one for a therapist to take.

*“it’s about making sure that clients are safe, and sometimes therapy can open a lot up, and if we’re opening things up and the person isn’t able to manage that*

*exploration then we'll ask them to come back when it's safer for them to do so"*  
(Participant F)

On the other hand, a participant recalled his experience of working within a crisis team undertaking EMDR with clients, and had quite a different view of treating clients in acute crisis.

*"I did do trauma-focused work with people who were in acute crisis, I did do that, so people who were very suicidal under the crisis team, but the way I managed that I was seeing them twice weekly or three times weekly intensively for some really focused work and I'd be focusing on the trauma that's triggering the crisis, because if you treat the trauma that's triggering the crisis then the crisis abates and that's what we found"* (Participant D)

It is interesting to note participant D's experience in which he found that treating the trauma activating clients' states of crises would have the effect of abating their crisis. Evidently, the approach used was a far more intensive one. Nevertheless, this is thought-provoking when considering what may be the most effective in relieving the psychological suffering of clients in a state of crisis.

#### **Component 5: The tension experienced in applying modalities to effect change**

COMPONENT	SUBCATEGORY	PARTICIPANT
5. The tension experienced in applying modalities to effect change	5.1 The requirement for an integrative therapeutic approach	ABCDEFGF
	5.2 The shortfall of applying a CBT approach for complex	BCDEFG

	trauma	
	5.3 The adaptability and suitability of EMDR for time-limited treatment	ABCDEF
	5.4 Comparing trauma therapies: preference for EMDR over TF-CBT	ABCDEF

A further part of the “demand-resource mismatch” is the issue of therapeutic modality, which may contribute to therapists’ “depletion”. Participants highlighted that applying other therapeutic modalities when working with complex trauma clients can conflict with the organisation’s recommendations. They described difficulties with the CBT-focused approach, despite this being the principal recommended modality within their NHS Trusts. Psychologists trained in EMDR spoke of the effectiveness of this modality for chronically traumatised clients and considered it a superior approach when compared to a solely CBT or TF-CBT approach. Cognitive interventions were deemed effective when integrated into a pluralistic therapeutic approach individually formulated for each client. Unlike TF-CBT, the non-verbal processing aspect of EMDR could protect therapists from secondary or vicarious traumatisation. The support for EMDR from all psychologists interviewed (including those not trained in this modality) stands out as a prominent outcome from the research analysis as it indicates that a therapeutic modality creates an “outcome” for therapists themselves in managing their own “demand-resource mismatch” in their role and clinical contacts.

***Subcategory 5.1: The requirement for an integrative therapeutic approach***

All participants were trained in multiple therapeutic modalities and discussed the importance of adopting an integrative therapeutic approach with complex trauma clients.

*“I do find the broadly cognitive behavioural modalities useful for the formulation and early interventions, obviously DBT is developed with that in mind, it’s all about stabilisation, um, so drawing on quite a lot of those interventions is important for people to learn those skills really but the formulation is fundamentally attachment related” (Participant E)*

Participants highlighted that regardless of modalities applied, holding attachment issues in mind with clients was particularly important for those presenting with developmental trauma due to the relational trauma they will have experienced as a result of this. The relational aspect of therapy was emphasised by all participants and was viewed as a crucial issue to attend to within the therapeutic process. It was highlighted that some modalities are not very relational and particular reference was made to CBT within this.

*“I don’t feel CBT is relational at all and with clients who have been relationally traumatised it’s so important because you’re trying to build that trust and develop a basis for the therapeutic relationship” (Participant F)*

All participants seemed to find a need for an integrative therapeutic approach which is relationally based. The limitations of adopting one sole therapeutic modality, such

as CBT, with complex trauma clients was problematic for the clinicians (see subcategory 5.2).

***Subcategory 5.2: The deficits of a CBT approach in complex trauma cases***

All participants noted the conflict created by recommendations from their Trusts to prioritise a CBT approach with “complex trauma” clients. The useful elements of CBT were recognised as equipping people with adaptive coping skills, for example, but incorporated within a wider, integrative therapeutic approach (see subcategory 5.1). They felt a purely CBT-focused approach inappropriate for the complexity of the client presentations. Difficulties experienced in using a primarily cognitive approach in a 20 session time-limit were articulated by all participants.

*“Predominantly we were asked as a department that we prioritise CBT as an approach [but] sticking purely to CBT was just not going to work at all, I found it, um, really surface level and not appropriate for what I was facing in the clinical room” (Participant G)*

This clearly puts the clinician in a stressful dilemma, clinically and personally. All participants suggested that, in practice, CBT for clients who have been chronically traumatised does not address the root cause of a client’s difficulties due to this being present-focused and primarily directed at symptom management. Participants acknowledged that, although this can be helpful, the underlying issues that are likely causing the symptoms will remain unresolved. This was considered to potentially impact clients’ vulnerability to re-presenting at later dates with further issues



stemming from unresolved trauma. Moreover, it was expressed that cognitive therapies can be dismissive of clients' traumatic histories.

*"I mean most therapies are geared up to be a sticking plaster, all of DBT, CBT, yeah we get there's people around with horrendous histories but we don't care about that, we focus on the here and now and perhaps they're going to change" (Participant F)*

All psychologists advocated for the focus to be on modalities that would address the root causes of clients' issues for the purposes of enhancing recovery.

*"if we think of the trauma tree they'll stick very much with the leaves, nice and fluffy leaves with a bit of CBT, that's nice, but the leaves grow back, that's not going to change it – let's get to the trunk, let's get to the roots, then we might actually make some changes" (Participant D)*

Participants clearly expressed that, from their experience, a purely CBT-focused approach is unable to resolve the core issues generating the distressing trauma symptoms clients with extensive traumatic histories experience. It was highlighted that these symptoms would likely therefore continue to resurface causing clients to relapse and return to the service as a result.

### ***Subcategory 5.3: The adaptability and suitability of EMDR for time-limited treatment***

The six participants trained in EMDR discussed the adaptability of this modality for time-limited treatment due to the focused approach within each phase of

stabilisation, trauma processing and consolidation. All considered the stabilisation phase to be particularly key when working with severely traumatised clients for the purposes of increasing their resources to manage trauma symptoms and, crucially, to build their tolerance for the trauma-processing aspect of therapy. The flexibility of the phases within EMDR was highlighted and the ability to adapt the length of these for each client was illustrated. For example, it was discussed that a client presenting with high levels of dissociation may need a longer period to increase their ability to tolerate distress, therefore the EMDR stabilisation phase could be adapted for this purpose.

Additionally, the effectiveness of EMDR within short amounts of time was highlighted: *“particularly with EMDR, you can do a lot with 12 sessions, you can do a hell of a lot” (Participant D)*. This was considered to be due to the “focused processing” element of EMDR which all practitioners deemed to be fast and efficient. It was highlighted that EMDR focuses on targeted, non-verbal processing rather than developing dialogue between client and psychologist therefore this makes it particularly efficient within time-constraints.

*“In EMDR it’s solely, if you’ve got 90 minutes or 50 minutes to do EMDR with somebody the processing itself is consumed by most of the session, so I find that time-efficient rather than me asking them questions about their life experiences because some of that time is taken up by me” (Participant B)*

This clearly highlights what a premium there is on time in these clinicians’ sessions and EMDR helped more than CBT with that clinical challenge, as well as creating

less vicarious stress/traumatisation for the clinician. The effectiveness of the “adaptive information processing” element of EMDR was also discussed to be particularly beneficial by five of the six EMDR trained participants when working within time-limited constraints for quicker recovery (see subcategory 5.4).

***Subcategory 5.4: Comparing trauma therapies: preference for EMDR over TF-CBT***

This subcategory relates somewhat to subcategory 4.3 in their advocating an EMDR approach, however participants elaborated particular differences between TF-CBT and EMDR to explain their support for an EMDR approach. The five EMDR trained participants had experience of applying both modalities with trauma clients and reflected on the key aspects that led them to prefer the application of EMDR.

*“in my view, CBT, I think it takes a lot longer and I think it can actually be a lot more overwhelming. EMDR in my opinion is a lot quicker, a lot less overwhelming, a lot more focused and 8 or 9 times out of 10 managed to sort out trauma within an hour, I’m lucky if I can do that within probably 6-8 sessions of CBT for one trauma memory... I could spend 60 sessions doing Socratic questioning and getting them to get somewhere in their own mind which I could spend 10 minutes in EMDR”*  
(Participant D)

The reliving aspect of TF-CBT was considered unnecessarily lengthy and overwhelming for clients due to the impact of having to relive traumatic events repeatedly until these have been processed: *I feel it [TF-CBT] can achieve what*

*EMDR does but it will take a lot longer and it's a lot harsher, the exposure and reliving within CBT affects people quite negatively" (Participant E)*

Participants explained the distinctiveness of EMDR which utilises bilateral stimulation to focus on "processing" the traumatic event and implementing "adaptive information" to support change on a neurobiological level. This process was considered far quicker and more efficient than the "repeated reliving" required within TF-CBT which they felt overwhelmed clients and was thus a lot more difficult to manage clinically in a brief therapy frame. The acceleration of trauma processing was not only considered beneficial for clients, but also an advantage when working within short time constraints as more can be achieved within a shorter space of time. Given that all participants were working within outcome-focused, time-limited frameworks, this was considered a key advantage and added to the support for an EMDR approach over TF-CBT.

*"for me is, the beauty of EMDR is, how you can actually get results really quite fast it's not about millions of questions or Socratic dialogue, straight in there, right, very simple basic questions as per the standard protocol, you get cracking with the process, you're starting to get some traction with it really fast, you reprocess that memory, done" (Participant D)*

An additional factor was the non-verbal processing aspect of EMDR. This was a buffer to vicarious traumatisation, as the details of the traumatic event are not required: *"Also, with EMDR, you're, sort of, protected a bit from vicarious*

*traumatisation as you don't need the details of abuse during the trauma processing stage" (Participant A)*

The strengths of EMDR in resolving client trauma when compared to TF-CBT were clearly emphasised by all participants. Given that NICE guidelines (2017) recommend a TF-CBT approach for PTSD clients, this component describes a key tension for clinicians working with complex trauma clients created by “modality demands” from their NHS organisations. This may be a hidden, but significantly depleting part of practitioners’ experience of their time-limited therapy dilemmas in complex trauma cases.

#### **Component 6: Psychologists’ challenge of maintaining emotional equilibrium**

<b>COMPONENT</b>	<b>SUBCATEGORY</b>	<b>PARTICIPANT</b>
6. The challenge of maintaining own emotional equilibrium	6.1 Recognising and accepting the limitations for treatment	ABCDEFGF
	6.2 Maintaining awareness of the psychological risks of trauma work	BCDEF
	6.3 The importance of self-care	ACDEFG
	6.4 Making use of team support	BCDEG

The last of the four key areas of the substantial imbalance of demand and resources from the organisation highlights clinicians’ emotional-resource pressures. Specifically, it was emphasised that maintaining their emotional equilibrium became increasingly difficult and participants reflected on the ways in which they tried to maintain their own emotional resources and wellbeing in their time-limited complex trauma practice.

***Subcategory 6.1: Recognising and accepting the limitations of treatment***

A key issue was the importance of managing their own expectations when working with complex trauma clients in time-limited therapy. This helped them to maintain a pragmatic view when facing the complexities of their clients.

*“I guess it’s important for me to manage my own expectations in terms of how much I’m able to help people, some of these clients have had such complex traumas, grief, relationship breakdowns and difficulties that I can’t do it justice in the sessions that we’ve got” (Participant B)*

Finally, participants accepted that severe developmental traumas, such as those that have occurred within the earliest months of life, were unlikely to be resolved in the timeframe available. This was highlighted as important for not only managing their own expectations, but also those of their clients.

*“In order to manage something as profound as that early disturbance which would have no words, no clear memories attached to it, it’s not very likely we’re going to do that within 20 sessions” (Participant E)*

***Subcategory 6.2: Maintaining awareness of the psychological risks of trauma work***

The importance of maintaining awareness of the risks of working with severely traumatised clients was discussed. Participants reflected on the impact that this can have on their emotional wellbeing.

*“I guess, just in terms of the type of work that we do in working with really, horrendously traumatised people is that you have to be really careful on how it affects you, there are times when I have caught myself thinking outside of work about a particular session and whether what I did or said was right” (Participant A)*

Vicarious traumatisation was discussed as a risk factor when regularly working with traumatised clients. Participants described feeling overwhelmed by their clients’ narratives at times and finding themselves becoming numb, desensitised, withdrawing or ruminating about sessions. Countertransferential feelings of overwhelm from their clients were also expressed to occur and ways in which to manage this were articulated.

*“But, you know, vicarious traumatisation is the first thing and the second is, the second can be, sometimes I catch myself withdrawing because, you know, it is too much to take, and then I realise that it is not wise for me to have two child soldiers in a row, like a 2 o’clock appointment and a 3 o’clock appointment, because it is too much, so I start taking some measures, again to protect myself” (Participant C)*

Maintaining awareness of their own feelings of emotional overwhelm in their work with severely traumatised clients helped participants to develop methods for self-preservation to protect themselves against the psychological risks. These are explored further within the subsequent subcategories.

### ***Subcategory 6.3: The importance of self-care***

As previously highlighted, participants discussed that ensuring not to schedule two highly complex clients one after the other was one of their methods for safeguarding their emotional wellbeing. In addition to this, one participant highlighted that engaging with her own therapy outside of her NHS role would help to preserve to this: *“I am in therapy, uh, not for my caseload, I mean, I started therapy when I was a trainee and I carry on and this is another way to protect myself” (Participant C)*

Additionally, participants reflected that taking care of their physical health was important and discussed the benefits of maintaining a healthy diet with regular exercise as this promotes overall wellbeing. Finally, one participant expressed the importance of separating themselves from their psychological role during their leisure time.

*“I suppose I protect myself through my own bit of dissociation really...I don’t touch anything to do with psychology outside of work, outside of work I don’t watch anything psychological on TV, no way, I want nothing to do with it, no, I’m a psychologist, sod off, I’m not having any of that” (Participant D)*

The ability to detach from their NHS roles was highlighted by all participants to be important. All discussed engaging in social activities that were entirely unrelated to their work for the purposes of disengaging from the emotional strain that can result from undertaking psychological work with severely traumatised clients.

#### ***Subcategory 6.4: Making use of team support***



Within their roles, psychologists highlighted that the support of a multidisciplinary team when working with highly complex clients was essential. Participants emphasised the importance of robust clinical supervision, as well as peer supervision, for relieving some of the emotional pressures of working with trauma.

*“you just have to make sure you have really good supervision and also talking to colleagues sometimes really helps, um, in a way kind of like, um, peer supervision, so that can really help too...but that’s also where care coordinators and doctors come in I guess as well” (Participant A)*

Additionally, participants highlighted the benefits of receiving support from team members when reflecting on complex clients and sharing risk.

*“I do feel the team are very supportive of one another and as a whole we work well together. We have a fantastic team of psychiatrists who we work closely with and consult to one another quite a bit about patients. Also, you’re sharing the risk with the team and that’s important, I mean, I wouldn’t do this kind of work privately because it’s just too risky, whereas in the NHS that risk is shared and everyone is supportive of that” (Participant E)*

Collaborative team working was considered paramount by all participants for feeling supported in their work, as was reciprocating that support to their colleagues with particularly complex clients on their caseloads. Finally, a multidisciplinary team approach was advocated for drawing from the full range of skills from each

discipline within the team, thus providing comprehensive and effective care to clients.

### **Component 7: Outcomes for the client and the psychologist**

<b>COMPONENT</b>	<b>SUBCATEGORY</b>	<b>PARTICIPANT</b>
7. Outcomes for the client and the therapist	7.1 The importance of trauma processing for enhancing client recovery	ABCDEFGF
	7.2 EMDR accelerates the rate of recovery	ABCDEF
	7.3 The emotional overwhelm experienced by psychologists due to increasing demands	ABCDFG

This final component of the model reconciles the key outcomes of participants' practice with complex trauma clients within a time-limited therapeutic frame. Furthermore, this aspect of the model highlights the impact of the NHS role on psychologists interviewed and the interpersonal processes that are occurring between them and the organisation. Two key themes emerged from the analysis of participants' reflections on client recovery outcomes and recommendations for enhancing these. The final subcategory synthesises the outcomes for participants managing the challenges of the "demand-resource" imbalance within the NHS and the effects of this resulting in an imbalance of emotional resources.

The emergence of the core category within the research model stems from this subcategory due to this accentuating the emotional impact of the NHS role on the

psychologists interviewed and the purported “depletion process” that seemed to exist related to this.

***Subcategory 7.1: The importance of trauma processing for enhancing client recovery***

When considering the most effective methods for enhancing rapid recovery amongst clients with complex trauma histories, the crucial role of “trauma processing” was highlighted. This was advocated by all participants (including those not trained in EMDR or DBT).

*“I think you need to do all the grounding, the stabilisation, the making sense, the formulation and the distress tolerance work and then moving on to exploring and unpacking the trauma” (Participant G).*

Participants reflected that stabilisation work can be effective for relieving the symptoms of trauma and helping clients to develop adaptive ways with which to manage these, however the inadequacy of sole stabilisation work for long-term recovery was articulated.

*“I don’t necessarily think it’s enough, I think it’s putting a sticking plaster upon things, will a sticking plaster hold for a bit? Probably yeah, maybe it’ll help them a bit, but all the same stuff is still there and if we don’t address that the person is going to relapse, they’re going to re-present, they’re gonna come back” (Participant D)*

Much support for the “trauma processing” element of therapy for traumatised clients was evident. Participants expressed that “processing” enhances client recovery outcomes due to this addressing the core issues generating the symptoms and difficulties they experience. As such, this was felt to supersede standalone CBT, and even the “reliving” processing of TF-CBT.

***Subcategory 7.2: EMDR accelerates the rate of recovery***

Participants reflected on the efficiency of trauma processing using EMDR as part of an integrative approach. The key strength of EMDR was elaborated.

*“The thing with EMDR which is useful to remember is there is nothing, as far as we know, that EMDR does other than speed up, um, adaptive processing, what the therapist does is kind of facilitate access to the adaptive parts and bilateral stimulation oils the wheels of that really” (Participant F)*

The bilateral stimulation of EMDR processing encourages the acceleration of neurological change through the implementation of missing adaptive information. This allows for the speeding up of trauma processing, thus encouraging faster resolution of traumatic memories and enabling quicker recovery for clients: *“think about the idea of the amygdala being on hypercharge mode because of all this trauma, once that updates and it clocks there’s no longer a threat, anxiety drops” (Participant D)*

Finally, it was highlighted that not only does EMDR processing benefit clients, but also assists practitioners in identifying the adaptive information that may be required to make the changes that will help clients the most.

*“the other thing that all of the theory around EMDR is concerned with is helping the therapist work out what adaptive information might be missing and be able to facilitate recognition of that adaptive information, so, like I say, that maybe people can be helpful and calming as opposed to a source of threat, so that’s what the therapist can kind of, um, facilitate” (Participant E)*

This is another unique component of EMDR and additionally supports the advancement of trauma processing for clients in employing this modality.

***Subcategory 7.3: The emotional overwhelm experienced by psychologists due to increasing demands***

The final key finding from the analysis underlies the research model as participants highlighted the emotional impact of working with complex trauma clients within the time and resource constraints in their NHS organisations. The emotional overwhelm that most participants described experiencing as a result of the multiple and conflicting demands placed on them was apparent. Feelings of anger and helplessness due to not being able to influence the resource dilemma in any way were also articulated.

*“I can feel quite angry at times...angry and powerless because often that decision is kind of, like, put on my shoulders, [...] including other sort of therapists and other*

*workers within the team, um, whereas those people who make the decisions in terms of commissioning the services and the budgets for services and things don't have to essentially make this dilemma all the time and yet sort of I do and equally I don't feel I have any sort of power to, to influence that"*(Participant A)

Some participants' anger manifested in their sense of disconnection with the NHS and this appeared to stem from a perceived misalignment of values between them and the organisation, particularly the experience of demands and expectations on clinicians rather than a focus on clients.

*"What's really important to the NHS? Have you done your mandatory training. Do they give a shit about what you're doing with clients in the room? No. Do they give a shit about outcomes? No. Do they care about your mandatory training? Yes. That galls me because it's like there's a complete loss of a focus on the patient "it's all about the patient" – fucking bollocks. It's all about numbers and crunching and it's about keeping the data up to date, that's all they care about, they do not care about the patient, and that's me being really harsh but it's true – as a service they do not care"*(Participant D)

Participants highlighted the personal impact of regularly contending with the demand-resource imbalance within their NHS roles. Regular experiences of physical fatigue, anxiety, despondency and low mood were highlighted. Finally, participants discussed experiencing helplessness and hopelessness due to the increasing demands placed on them and the unlikelihood of this subsiding in future.

#### **4.4 The emergent core component of the research model**

This analysis of the data suggests that the interactional process of “demand-resource” mismatch generates an emotional resource mismatch in which participants experience increasing emotional overwhelm as a direct result of the various conflicting demands placed on them by the client, the organisation and the clinical task (and team). Consequently, the core dimension of the research model suggests that a process of progressive emotional depletion may occur. For psychologists working with severely traumatised clients, this risks paralleling the clients’ own depletion, so may have a negative impact on them personally, professionally and organisationally. Furthermore, this creates additional strain when undertaking emotionally challenging work such as that involved when working with complex trauma clients.

The model also highlights how practitioners are undertaking “emotional work” not only for the client, but also on behalf of the organisation by absorbing the various demands as well as the extensive resource constraints in the client, in the organisation’s provision and in the practitioners themselves. This analysis has highlighted that the task of time-limited therapy for complex trauma not only has “outcomes” for clients, but also considers the “outcomes” for practitioners themselves in relation to the difficulties and dilemmas they described facing daily in their roles. Indeed, one participant summarised the outcome of this as: *“I am burning out day by day” (Participant C).*

## **5. Discussion**

The following chapter will relate the model to existing literature and consider the contribution of this research to NHS psychologists' time-limited interventions for complex trauma with particular reference to the field of counselling psychology. The validity and limitations of the research will be considered and recommendations for future research will be provided.

### **5.1 The overwhelm of imbalances experienced by practitioners**

#### **5.1.1 The demand-resource imbalance**

The findings of this study point to the emotional overwhelm that participants regularly experienced in their roles as a result of a multi-layered demand-resource imbalance. This was in part attributed to the substantial funding deficit for mental health services within the NHS which caused growing mismatch between the demand upon psychological therapists and the resources they have available (practical and emotional). The pressure on NHS resources results in the implementation of time-limited frameworks for all clients, including those presenting with complex trauma histories, due to focus on the cost-effectiveness of these (ESRC, 2013). On average, participants highlighted working within a 20-40 session time-limit within their NHS contexts.

The time-limited treatment framework was felt to be useful for highly focused, recovery-oriented work with clients, and participants felt this often yielded



improvements in symptoms. This is supported in the literature as time-limited interventions have demonstrated a positive impact on symptom relief amongst recurrently traumatised individuals (Resick et al., 2003). Participants in this study, however, deemed the number of sessions offered within the time-limited framework rigid and overly restrictive given the substantial complexity of the difficulties severely traumatised clients present. It was highlighted that work with complex trauma clients is often unpredictable, therefore longer-term work with these clients is advocated for generating improved recovery outcomes and this finding is supported in the literature (Carter, 2005; Chu et al., 2011; Cloitre et al., 2011).

Additionally, the pressure experienced to produce recovery outcomes within the short timeframes available was highlighted by all participants and this was discussed to manifest in an expectation from the organisation to undertake trauma work seemingly, at times, regardless of clients' readiness to do so. The inefficiency of applying psychological interventions with severely dysregulated clients was highlighted, as were the risks of undertaking trauma work with clients without ensuring they are able to tolerate this. This is supported in the literature which has demonstrated that clients with complex trauma histories typically have substantial neurobiological deficits which linked to severe emotional and behavioural responses (van der Hart et al., 2006). Consequently, the safety implications of this should be considered when implementing psychological treatment.

### **5.1.2 An “emotional” demand-resource imbalance**

Due to contending with the above substantial imbalances of demand and resources at an organisational level, psychologists interviewed discussed experiencing a

significant “emotional” demand-resource imbalance, resulting in an increasing challenge to maintain their own sense of emotional equilibrium. Consequently, the research model highlights a process of emotional depletion occurring and this appeared to manifest in a complex interpersonal process of helplessness, hopelessness and burnout due to the unmanageable task participants highlighted contending with regularly.

It is interesting to note that these emotional states appear to parallel the experiences that traumatised clients often present with. The emotional depletion participants described experiencing was felt to not only have a personal impact on them, but also to enhance the challenges of working with severely traumatised clients. The emotional depletion experienced by the NHS psychologists interviewed as a result of the demand-resource imbalance places them in more vulnerable emotional states when dealing with highly emotionally challenging work. Consequently, this is an additional risk factor for both burnout and vicarious traumatisation (McCann & Pearlman, 1990).

Burnout has been defined as “a state of physical, emotional and mental exhaustion caused by long-term involvement in emotionally demanding situations” (Pines & Aronson, 1989, p.9). Pines and Maslach (1978) found high levels of burnout amongst healthcare professionals and with the major factors associated including low morale, absenteeism, high job turnover and other indices of job stress. Specific figures on the health and social costs associated with NHS staff burnout have yet to be explored, however a study conducted by Evans et al. (2006) on burnout among mental health social workers in England and Wales found high levels of stress and

exhaustion amongst participants, with 47% showing symptoms of significant distress. Furthermore, figures from the NHS staff survey (2015) show that satisfaction with place of work, pay and staffing levels have fallen since 2013 with only 41% of respondents agreeing that they felt valued and would recommend the NHS as a place to work (Wilkinson, 2015). This study has highlighted the emotional exhaustion experienced by participants due to excessive demands on energy and resources. Findings suggest that with increasing demands placed on NHS staff, there may also be a requirement for an increased focus on staff health and wellbeing.

The emotional impact of working with traumatised clients has been well documented (Collins & Long, 2003) and vicarious traumatisation has been provided as a theoretical framework to understand the complex and distressing effects of trauma work on therapists (Pearlman & Saakvitne, 1995). In this study, participants described experiencing treatment-related feelings of overwhelm, rumination about sessions, anxiety, sleeplessness and relational dread as a result of their work with complex traumatised individuals and these effects have also been documented in the literature (McCann & Pearlman, 1990; Schauben & Frazier, 1995; Cieslak, Shoji, Douglas et al., 2014). Given the emotional strain participants highlighted working within due to the resource issues within their NHS contexts, this study highlights the importance for psychologists (and their managers and organisations) to maintain enhanced awareness of the risk of vicarious traumatisation in order to try and moderate this, particularly when working with extreme cases of complex trauma such as victims of conflict and torture.

Finally, psychologists interviewed highlighted the amount of pressure experienced when working in isolation in highly under-resourced teams. Within some of the NHS contexts, participants were the sole psychologist within the county area providing trauma treatment. This caused them to feel highly exposed and pressurised as well as regularly overwhelmed due to the significant demand for psychological therapy overall. Additionally, participants highlighted experiencing regular ethical dilemmas when feeling pressured to balance clients with resources and having to implement systems in which assessments and consultations are prioritised over therapeutic work. The pressure of having to make daily decisions surrounding the resources available for the demand of clients in need of psychological help, together with the seemingly unacknowledged emotional challenge of the overall role and task they face, resulted in them feeling hopeless, angry and resentful towards the NHS, specifically towards commissioners of services. Some participants noted feeling a sense of complete disconnection from the organisation, at times, and this was expressed to be as a result of the perceived misalignment of values between them. Yet this, too, could serve to create a further source of isolation, stress, absence of availability of support needed and have further practitioner “depletion”. Such a positive feedback loop, if ignored, could be highly corrosive both for the organisation and its practitioners and impact the client population.

### **5.1.3 Organisational disidentification**

The sense of disconnection participants described experiencing from the NHS appeared to develop as a result of two key factors. Firstly, the helplessness experienced to influence budgetary decisions on resources when faced with the responsibility of having to manage these daily within their Trusts. Additionally,

participants highlighted experiencing a sense of disregard for staff and client wellbeing from the organisation. It was highlighted that the organisation's principal concerns seem to surround obtaining outcomes data and ensuring staff compliance with mandatory training while the complex nature of psychologists as, essentially, humans with a human task is wholly diminished. As a result, it appears that a process of disidentification with the organisation can develop.

Substantial theory and research have examined the identification of individuals' self-concept with particular social groups or organisations (Tajfel 1982, Turner 1987, Abrams & Hogg 1990, Kramer 1993). Organisational identification has been argued to have important implications at the individual, group, and organisational levels as this has been found to be positively associated with performance and negatively associated with turnover (Mael & Ashforth, 1995; Pratt, 1998; van Knippenberg, 2000;). Additionally, Ashford (2001) asserts that organisational identification helps individuals develop a sense of meaning, belonging and control in their roles and is therefore typically viewed as a desirable attachment from individuals to their employing organisations (Kreiner & Ashforth, 2004). Disidentification has been explored as an aspect of organisational identification (Dukerich et al., 1998; Ashforth, 2001) and is described as a process that occurs when individuals no longer define their own principles and values as corresponding with that of their organisation. Participants in this study expressed the view that the current short-term therapeutic framework offered for complex trauma within the NHS is primarily done so for the purpose of managing an overstretched organisation, rather than as a treatment which is clinically appropriate for this client group. Participants highlighted the conflict experienced of this with their own principles surrounding

therapeutic work. Additionally, the sense of disregard for demands placed on staff and the perceived lack of patient focus appeared to further reinforce a misalliance of values between participants and their organisation. Consequently, findings in the present study indicate a process of disidentification occurring amongst psychologists interviewed. Moreover, practitioners seemed to feel their hands were even being tied in their complex predicament by the perceived pressure to adhere to a CBT model from their organisation.

## **5.2 The application of modalities in a strained context**

### **5.2.1 NICE recommendations of a CBT approach**

Each participant's Trust recommended CBT as the primary modality to be applied within their psychological therapy teams. This was attributed to the RCT evidence supporting it as the most effective modality for generating outcomes within time-limited treatment (Clark, 2011). However, research findings from RCT's of manualised CBT protocols may not be generalisable to NHS populations which may be more extensively impaired and experience higher levels of comorbidity with other disorders (Korn, 2009), therefore their applicability in this context should be carefully considered. Nevertheless, CBT approaches have demonstrated efficacious in relieving PTSD symptoms (Foa, 2002) and this study does support the implementation of CBT interventions for complex trauma clients, although this should be in the context of a wider, integrative therapeutic approach when working with recurrently traumatised individuals. Participants highlighted that they found applying an exclusively CBT-based approach with complex trauma clients clinically inadequate due to the limitations of this focusing primarily on symptoms rather than the underlying trauma generating the symptoms. Indeed, this supports the

requirement for carefully considering the applicability of RCT data within “real world” settings such as secondary care CMHT’s.

Findings from this study highlight the preference for the application of EMDR for complex trauma and this is supported in some of the literature (Korn, 2009; Rothbaum & Schwartz, 2002). EMDR was considered most effective for its flexibility and adaptability of the stages of trauma therapy based on individual client needs. This supports the recommendations of Korn and Leeds (2002), van der Kolk et al. (2007) and Korn (2009) who all advocate EMDR for complex trauma due to this being an approach which can be gradually titrated, therefore may be better tolerated as the emphasis is placed on the individual in guiding their treatment (in contrast with the therapist-guided approach of CBT).

### **5.2.2 Trauma-focused CBT vs. EMDR**

Participants in this study highlighted the challenges of the lack of a specific treatment pathway for complex trauma due to the absence of a complex trauma diagnosis. Treatment guidelines for adults exhibiting PTSD symptoms for longer than three months post-trauma recommend the implementation of TF-CBT as a first-line approach (NICE, 2017). This research explored the differences between applying a TF-CBT and an EMDR approach and findings demonstrate increased support for employing EMDR. Two key factors were highlighted when considering both approaches. Firstly, the view that TF-CBT is a far more abrasive and overwhelming approach for clients was emphasised. This is due to the trauma processing aspect involving clients having to repeatedly relive their traumatic events. The preference for employing EMDR was highlighted to be due to the primary focus

of this modality on the accelerated processing of traumatic events through neurobiological change using the adaptive information processing model. This finding supports the theory underpinning the effectiveness of EMDR (Shapiro, 2001). Furthermore, the lengthy reliving aspect of the trauma processing stage within TF-CBT was highlighted to take much longer than EMDR to produce outcomes. In implementing EMDR, practitioners are able to assist clients with processing traumatic events quickly, thereby generating improved outcomes in shorter amounts of time. These findings support the existing literature comparing EMDR with TF-CBT (Wilson, Becker & Tinker, 1995; Korn, 2009; Rothbaum, 1997; Ironson et al., 2002). As such, this research advocates the implementation of EMDR within time-limited frameworks in real-world contexts (these are not always reflected in NICE RCT evidence reviews) such as NHS secondary care psychological therapy services.

### **5.3 The auxiliary strengths of an EMDR approach**

#### **5.3.1 A buffer for vicarious traumatisation**

Psychologists in this study highlighted their awareness of their vulnerability to vicarious traumatisation when working with complex traumatised clients. An interesting finding which has emerged from this research, however, is the notion that EMDR can serve as a protective factor against vicarious traumatisation. This is due to the non-verbal aspect of the trauma processing element which does not require clients to describe their traumatic events in detail, but rather visualise the memory whilst bilateral stimulation is provided and processing is undertaken. As a result, practitioners are moderately safeguarded from full exposure to the detailed narratives of traumatic memories, thus mitigating vicarious trauma. This finding suggests that



in employing EMDR, the modality itself can act as a buffer for vicarious traumatisation.

### **5.3.2 The possibility of vicarious resolution**

As previously highlighted, findings from this study emphasise the preference for the application of EMDR due to practitioners experiencing enhanced success in the resolution of client trauma relatively quickly and efficiently. Central to this study's theoretical model is the emotional overwhelm experienced as a result of organisational demand-resource and emotional demand-resource imbalances. The parallels of overwhelm between the organisation, the client and the psychologist indicated in this study are evident and denote the likelihood of a complex, intersubjective process occurring between these three domains. The intersubjectivity between client and therapist during the therapeutic process has been explored in the literature. Natterson (1991) argues that the concept of countertransference is too limited in understanding that any powerful emotional experience of the therapist is simply reactive, as this ignores the complexity of the interaction between client and therapist within the therapeutic process. Additionally, in examining the neurobiological effects of the therapeutic process, Schore and Schore (2008) emphasise the implicit right-brain-to-right-brain interactions that lie at the core of the therapeutic process. Furthermore, Rasmussen and Bliss (2014) recently examined the neurobiological alterations in therapists treating trauma. Alterations within mirror neurons, the autonomic nervous system, the sympathetic and parasympathetic systems, the amygdala, the hypothalamus-pituitary-adrenal axis, memory, and the left and right hemispheres during the therapeutic process were considered (Rasmussen & Bliss, 2014). On reflection of this evidence and the complex

interactional processes seen in this study between the organisation, the client and the therapist, the possibility is presented that psychologists may, in fact, be experiencing a sense of vicarious resolution of their own overwhelm through the application of EMDR with clients. By focusing on resolving client trauma in a fast, efficient way through accelerated alterations within their neurobiology, there is the potential that clinicians may actually be experiencing a sense of mirrored resolution of their own emotional overwhelm ensuing from the organisation and the many challenges of their complex trauma work. As such, it could be postulated that the relief clinicians experience in effectively, rapidly and less painfully resolving their clients' overwhelm through the application of EMDR, may also allude to an implicit process occurring in which they experience a catharsis of their own through their clients' healing. The "client" they are serving in their overwhelming, overstretched and burning out predicament may be threefold: themselves, their organisation and the client in the room. The implications of this seem to have been unexplored to date in the organisational and clinical literature on trauma (and other) treatment in complex cases.

## **5.4 Implications**

### **5.4.1 Implications for NHS organisations**

A key issue that has been raised throughout this research relates to the perceived extreme strain on NHS resources. Participants expressed their view that the resource issue is highly unlikely to change, therefore perhaps the question should focus on how best to make use of the limited resources available (in the organisation, in the client and in the psychologist). The model presents ways of understanding dilemmas related to the use of the resources available within NHS Trusts. One proposal by

those trained in EMDR was that this modality is more effective for resolving client trauma than adopting a purely CBT or TF-CBT approach with complex trauma clients. Although the primary recommendation is to employ a TF-CBT approach for PTSD clients (NICE, 2017), EMDR is increasingly gaining strength as a modality due to increasing research in this area. This study supports the primary use of EMDR as recommended by experienced psychologists currently applying this in practice with clients encompassing complex trauma histories. It should be acknowledged, however, that this research has found that the lack of a complex trauma diagnosis presents an additional difficulty for treatment as there is currently no set treatment pathway for this, however. Nevertheless, evidence in support of a complex PTSD diagnosis has been reviewed (Cloitre et al., 2013) and the revision to include the diagnosis within the upcoming ICD-11, due for release in 2018, has been confirmed (First, 2017). In summary, one of the recommendations arising from this study is that EMDR is the preferred modality for treatment of complex trauma as this could help relieve some of the pressure on resources due to the focus of EMDR on accelerating recovery. Consequently, its efficacy within fewer sessions compared to other modalities such as CBT or TF-CBT should be taken into consideration.

A further implication arising from this study relates to staff wellbeing within not only psychological therapies teams, but wider mental health services across NHS Trusts. The strain on resources is causing substantial duress on teams resulting in these being significantly under-resourced as the demand for mental health services continues to rise (Evans et al., 2006; Wilkinson, 2015). As previously highlighted, psychologists working with complex trauma are already exposed to risks such as vicarious traumatisation and burnout (McCann & Pearlman, 1990; Schauben &

Frazier, 1995; Cieslak, Shoji, Douglas et al., 2014), therefore this presents an additional challenge. The research analysis has highlighted that the emotional strain resulting from resource pressures and the management of large caseloads of highly complex clients creates an additional vulnerability to such risks. This should be taken into consideration by both practitioners working in the field of trauma and NHS Trusts offering psychological therapies for complex trauma. The outcomes of this study have highlighted that ensuring clinicians are well supported within their individual teams through peer support and regular clinical supervision could assist in moderating the risks that are associated with trauma work. Furthermore, the additional finding from the research analysis surrounding EMDR highlights the protective aspect of this modality due to the potential of this as an additional buffer for vicarious traumatisation. This further adds to the previous recommendation in support of employing EMDR with complex trauma clients.

Finally, this research has highlighted the importance of several factors in the management of the emotional and practical challenges of working with complex trauma within the NHS. Participants highlighted the importance of self-care through social support and robust supervision for maintaining a sense of emotional equilibrium. This finding is supported in the literature as social support and supervision have been found to be key factors in buffering emotional burnout when working within the trauma field (Schauben & Frazier, 1995; Salston & Figley, 2003). The support of colleagues and supervisors within the work environment assists with key aspects such as sharing client risk and relieving emotional pressure through the collaborative reflection of complex clients. Outside of the work environment, support from friends and family members was considered of crucial

importance in addition to engaging in social activities entirely unrelated to the “psychologist” role.

In summary, the professional implications of this study place EMDR at the nexus of a multi-layered solution: firstly, as a rapid and effective modality for client recovery; secondly, as a mitigator for secondary/vicarious trauma for the psychologist; and, finally, efficacy at an emotional level (as well as a pragmatic level) as it helps psychologists manage the “total demand” of their work, and the potential for providing vicarious resolution of their own overwhelm through client healing. This is proposed as a valuable “outcome” that (to the date of this research) does not appear to have been measured within standard RCT’s, effectiveness studies or audits.

#### **5.4.2 Implications for future research**

This research has highlighted the challenges of the NHS psychologists interviewed when working with severely traumatised clients within a time-limited frame. The psychologist’s experience is evident, however there appears to be a noticeable absence of the client’s voice and perspective within the present study’s outcomes and an area for future research could be to investigate this aspect further. The experience of clients who have sought treatment for complex trauma within the NHS, their challenges and the methods that assisted them with managing these could help to inform future practice in this area and also give clients a voice to outline their own experience through their narrative.

Additionally, the experience of organisational disidentification highlighted in the present study could create a further avenue for future research. Within this study,

psychologists highlighted the emotional impact of their felt misalliance of values with the organisation. Future research would not necessarily have to be limited to psychologists, but could explore the area of identification and disidentification with the NHS across a variety of staff disciplines. The impact of this on individuals' sense of meaning, belonging and control within their roles, and perhaps the effects of this on performance, could yield interesting outcomes for practice and add to the existing literature on organisational behaviour within the NHS.

Furthermore, this study has demonstrated support for the effectiveness of EMDR and postulated the potential for vicarious resolution with the application of an EMDR approach. Given the increasing prevalence of research demonstrating the effectiveness of EMDR, a specific avenue for neuropsychological research could be to investigate the effects of the EMDR therapeutic process on clinicians' neurobiology. The evidence and theory underlying EMDR bases itself on the very notion that this accelerates resolution on a psychobiological level, therefore it would be interesting to explore whether this has the same effects on therapists practicing this modality. The outcomes of such a study could potentially offer unique contributions to the existing neuropsychological literature surrounding EMDR.

Finally, based on the findings of this study, it seems that a sole focus on "client outcomes" for evaluating a therapeutic modality may need to be reviewed and a study evaluating the "total effectiveness" in addition to "outcomes" could prove beneficial. This study has highlighted the requirement for research in this area which would not only increase organisations' understanding of clinicians' burdens, but also help organisations respond more effectively to them and build alliances/morale among the workforce. Additionally, this would allow NICE recommendations to

include “total effectiveness” outcomes rather than the somewhat limited view of “client outcomes”. At present, “client outcomes” exist solely as a frame for evaluating therapeutic modalities that, in fact, are tools that resolve not only client dilemmas, but organisational and clinician ones. Recognition of this is equally important and long overdue, therefore it is the recommendation of this study that future research examine the “total effectiveness” of modalities, perhaps examining emotional burden as an outcome with a focus on total clinical/organisational workload and burdensome/burden-relieving properties. Such a study would not only provide a greater holistic view of modalities, but also enhance understanding of “total effectiveness” outcomes for a system (such as the NHS).

#### **5.4.3 Implications for counselling psychology**

The findings of this study help to highlight how NHS psychologists think about and manage the time-limited therapeutic framework with recurrently traumatised clients and the challenges they experience when doing so. Given that counselling psychologists are now increasingly finding work within NHS contexts, this research will be of particular relevance to enhance awareness of the challenges that can be experienced. Research in the area of complex trauma from the discipline of CoP is limited, therefore this study hopes to add to the literature as well as inform practice in the field. As this study has found, the application of an individually formulated, integrative approach for severely traumatised clients within constrained contexts is advocated for enhancing wellbeing amongst the complexities of individual presentations. This finding is in line with the values of counselling psychology which advocate for a pluralistic approach within therapeutic work and focuses on wellbeing rather than sickness or pathology (Strawbridge & Woolfe, 2010).

Additionally, this research has highlighted that the lack of a treatment pathway for recurrently traumatised clients that do not meet the criteria for other set diagnoses presents challenges for clients seeking therapeutic treatment as well as for clinicians providing this. Although CoP has adopted a questioning stance towards the medical model (Cooper & McCleod, 2010), counselling psychologists working within the NHS will recognise the conflict that can arise when working within a positivistic context given their humanistic backgrounds. From a CoP perspective, a complex trauma diagnosis could not fully encapsulate the impact of recurrent trauma on an individual. However, as this research has highlighted, diagnostic categorisation can assist in outlining a treatment pathway for these individuals and help them obtain access to treatment. Therefore, although the tension between CoP values and working within a medical context may arise, it is of key importance that counselling psychologists working in the NHS maintain awareness of the practical difficulties that can present in the absence of treatment pathways and diagnoses. Nevertheless, it is encouraged that counselling psychologists maintain their essential values when working with complex trauma clients by appreciating each client as unique and focusing on facilitating growth and actualising potential, regardless of the contexts they work amongst.

### **5.5 Research validity and limitations**

This study has adopted a critical realist approach with a constructivist epistemological stance which emphasises that there is not a direct relationship between reality and our understanding of it but rather that reality is constructed by the perspective of the individual (Willig, 2011). This variability in the relationship between reality and the understanding of it therefore indicates that the findings



presented in this study are merely one interpretation of the data. The inherent intersubjectivity between participants' accounts of their experiences and the researcher's task to extract and develop meaning from these is acknowledged and the results are recognised to be the outcome of the interrelationship between multiple realities.

Additionally, this study was as a small-scale research project with a small number of NHS psychologists interviewed. Therefore, although the theory offered is representative of the data in this study, it is not asserted to be generalisable to all psychologists working with complex trauma across all NHS contexts. Furthermore, due to the practicalities associated with a small-scale study, it was not the aim of this research to reach theoretical saturation. Therefore, the model is based on theoretical sufficiency which, ultimately, has an impact on the theory generated from the analysis. A larger participant sample could have allowed for the aim of theoretical saturation where the gathering of new data would not have yielded further insights to the analysis and could therefore have enhanced the robustness of the model. Thus, the findings presented are considered tentative and recommendations made are done so with caution. Nevertheless, the possibility is maintained that the study's findings may be representative of occurrences within the field of NHS psychologists employing time-limited interventions with complex trauma clients and is therefore amenable to wider application of the model's theory.

## 6. Conclusion

This research sought to explore the dilemma psychologists working within the NHS face of service pressure to deliver time-limited psychological interventions with complex traumatised individuals encompassing substantial clinical need. The various and conflicting demands experienced within the NHS role due to resource constraints and working with clients presenting with extensive emotional and relational issues were highlighted, and an interactional process of “demand-resource” mismatch generated an emotional resource mismatch leading to progressive emotional overwhelm. A tentative theoretical model highlighting the emotional depletion that can result from the overwhelm of imbalances that practitioners experienced was presented.

This study has additionally presented the notion that the implementation of EMDR may provide a multifaceted solution for NHS psychologists. EMDR has been emphasised as the preferred modality to implement with complex trauma clients due to its capacity for enhancing recovery for clients within shorter periods of time. Additionally, the potential for EMDR to mitigate vicarious trauma for clinicians working with severely traumatised clients has been highlighted. Finally, EMDR has been suggested an effective tool that may help NHS psychologists with managing the overall emotional demands of their role.

The key implications arising from this study suggest further exploration around evaluating the “total effectiveness” of modalities as opposed to a sole focus on “client outcomes” which are currently the primary measures applied to determine a modality’s “effectiveness”. Such a move away from solely examining client outcomes to a more holistic evaluation of overall modality effectiveness could explore the ability for modalities to address not only client dilemmas, but also clinician and organisational ones and could provide valuable research data for the effectiveness of modalities within a complete system. Although recommendations made from this research are tentative, it is the hope of this study to help inform practice in the area of time-limited therapy for complex trauma by highlighting the real issues that are experienced by psychologists currently working in this field.

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### **Reflexive Statement (Part 2)**

Willig (2012) suggests that a researcher should be prepared to be changed by their research. Reflecting back on the process of undertaking this thesis, I feel I have undergone a rather significant developmental journey both personally and professionally which I feel has, indeed, changed me. Upon review of the thesis, I noted that this journey is also reflected within the literature that I included. The evidence I highlighted within the literature review at the start primarily focused on client outcomes, and although these studies are referred to within the discussion, I have added literature surrounding the emotional wellbeing of clinicians. I feel that this is demonstrative of the research journey of this study, which started with a focus on client outcomes, but then progressed in line with the findings arising from the data which indicate much more about the emotional process and wellbeing of NHS psychologists working with complex trauma clients. Indeed, I began my study with the title of “Time-limited therapy for complex trauma: how do clinicians work with developmentally traumatised clients within a time-limited therapeutic frame? A Grounded Theory study” as indicated within the participant documents provided in the appendices, however found that the research journey highlighting the emotional process and wellbeing of participants arising from the data was better represented by the title of “how do clinicians manage the challenge of working with developmentally traumatised clients within a time-limited therapeutic frame?”. I therefore amended the title of my study to reflect this.

Additionally, having kept a reflexive journal throughout enabled me to note my thoughts and feelings during the research process and looking back upon this proved

useful in helping me to reflect on my journey. I realise that I held quite strong views at the start of the research process about the unsuitability of time-limited therapy for complex trauma, and found myself feeling angry at times during the initial stages of compiling my literature review and research proposal. Although I maintained an awareness of these feelings, I found it difficult, at times, to bracket my views entirely. This undoubtedly shaped my research in the initial stages and, with the help of supervision, this was identified as something for me to try and manage throughout the process in order to present a well-balanced piece of research.

Moving into the data collection phase of the research brought excitement and enthusiasm. I found myself identifying with much of what my participants talked about during their interviews and I recall being aware of maintaining my “researcher” identity rather than moving into my “professional” identity which I did find challenging at times as the frustrations of, and motivations to work in, the field of complex trauma resonated with me. I do feel that there is a possibility that participants’ awareness of my role as a trainee counselling psychologist working with complex trauma clients in an NHS setting may have had an influence (and perhaps may have allowed them to open up more about their wellbeing) given the parallels of our clinical work. I certainly noticed the tension of bracketing my own views throughout the data collection and analysis phases of the research. One way in which I tried to ensure I was staying “true” to the data, however, was by using participants’ own terminology as much as possible during the analysis phase.

I found undertaking the analysis using a grounded theory methodology one of the most difficult aspects of the process. My unfamiliarity with this method, along with the overwhelming amounts of data collected, meant that I had to return to this

several times to try and make sense of the core constructs that were emerging from the analysis. Here, I noted an interesting parallel with my research in my own process, as I was trying to work within my own time-limit for submitting my thesis and ended up experiencing my own imbalance of demands as a result. This led to me feeling quite overwhelmed and emotionally depleted at points during this stage. However, once I was able to restore some balance of my personal and professional demands, I found I was able to restore myself emotionally and this assisted me in being able to step back and identify that which was emerging from the analysis.

The research journey has been a challenging one at times, however I feel it has been a fantastic process which has helped influence and modify the views I held quite strongly at the start. realise that my personal experience of complex trauma, as well as my frustrations with using a time-limited approach in my practice, were the main drivers behind my initial strong views. After this process, however, my view is that some psychological help is better than none at all and that clients highly value having their experiences heard and validated no matter what framework we are working within. I find that this is more consistent with the values of Counselling Psychology which highlight the importance of developing a strong, collaborative therapeutic alliance with clients (Orlans & van Scoyoc, 2001) and feel that this, in itself, can be an important part of the healing process – particularly for clients who have been extensively relationally traumatised.

I feel that after having undertaken this study I can now approach the topic of time-limited therapy for complex trauma from a wider perspective and this will be a key

benefit to take forward in my professional career. I feel excited about pursuing EMDR training following the findings from my research which highlight the benefits of applying this modality on multiple levels, and am enthusiastic to work within the area of complex trauma to try and help clients suffering from the many difficulties that come from having experienced developmental trauma.

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## **Appendices**

### **Appendix A: Invitation to Participate Email**

Dear

I am undertaking a study into psychologists working within a time-limited therapeutic framework with clients suffering complex trauma.

Please see attached an information sheet and research summary outlining all the aims of the study and what participation would involve.

My study is being supervised by Dr Philip Hayton (Clinical Psychologist/Senior Lecturer) and has been approved by the School of Psychology Ethics Committee as well as the NHS Ethics Committee (197473).

If you would like to participate or require any further information please reply to this email.

Many thanks.

Best wishes,

Katrina Aguilera

## **Appendix B: Participant Information Sheet**

### **London Metropolitan University Professional Doctorate in Counselling Psychology**

#### **Participant Information Sheet**

**Time-limited therapy for complex trauma: how do clinicians work with developmentally traumatised clients within a time-limited therapeutic frame? A Grounded Theory study.**

#### **BACKGROUND**

My name is Kat Aguilera. I am a Trainee Counselling Psychologist studying with London Metropolitan University and as part of my Professional Doctorate in Counselling Psychology I am conducting research in the field of complex developmental trauma. The aim of my research is to examine how clinicians working within an NHS context grapple with the dilemma of service pressure to deliver time-limited psychological interventions with a complex population encompassing substantial clinical need. Specific objectives are to examine how they make sense of the dilemma of working with high need clients encompassing substantial difficulties due to an extensive history of childhood trauma within the confines of a time-limited therapeutic frame, and the models or constructs they draw from in their therapeutic interventions.

My study is being supervised by Dr Philip Hayton (Clinical Psychologist/Senior Lecturer) and has been approved by the School of Psychology Ethics Committee as well as the Health Research Authority (IRAS ID 197473).

#### **WHAT WILL HAPPEN**

In this study, you will be asked to participate in a semi-structured interview at your workplace, lasting approximately 45 minutes, and which will be audio recorded. Prior to the interview, you will be asked to sign an informed consent form indicating your willing participation. During the interview you will be asked questions surrounding your thinking about, and work with, clients presenting with difficulties as a result of complex trauma. You have the right to omit or refuse to answer any question asked without penalty. Following the interview you will be fully debriefed with the assistance of a debrief form reiterating the aims and objectives of the study and your participation within this. You will also be provided the opportunity to discuss your interview experience with the researcher should you wish to do so. You will be offered contact details for the researcher and the researcher's supervisor should you have any questions or wish to discuss anything further following your participation. Finally, you will be offered the opportunity to contact the researcher should you wish to view the study's analysis or results.

#### **TIME COMMITMENT**

The interview is expected to take approximately 1 hour.

### **PARTICIPANTS' RIGHTS**

You have the right to stop being a part of the research study at any time up to 4 weeks following participation without explanation.

You have the right to ask that any data you have supplied to that point be withdrawn and destroyed.

You have the right to omit or refuse to answer or respond to any question that is asked of you without penalty.

You have the right to leave the interview at any point.

You have the right to have your questions about the procedures answered (unless answering these questions would interfere with the study's outcome). If you have any questions as a result of reading this information sheet, please ask the researcher before the study begins.

### **BENEFITS AND RISKS**

It is hoped that participation of experienced clinicians in this field could highlight key processes which will potentially assist other practitioners with their implementation of time-limited interventions with developmentally traumatised clients.

There is a possibility that interviews may bring up distressing psychological issues for you around employing time-limited therapeutic frameworks with complex traumatised clients, however, this is unlikely. Participants have the right to leave the interviews any point and should do so by verbally announcing their wish to leave.

Participants will be given a full debriefing after the interview and will also be able to speak to the researcher individually regarding any issues resulting from the interview. They will also be given contact details of the principal supervisor should they wish to discuss any issues afterwards. Details of online resources will additionally be provided within participant debrief forms should participants wish to access further support.

### **CONFIDENTIALITY/ANONYMITY**

Your participation in this study is voluntary and you will remain fully anonymous should you wish to participate. The interviews will take part in a closed room at the NHS Trust. Any information discussed will remain confidential and any personal identifying information will be anonymised in transcription. Transcripts containing personal identifiable information will be protected at all times. This means that participant names will not be stored on any database and they will be assigned a unique numeric code instead. Any information discussed within the interviews will remain confidential and will not be shared with work colleagues within the Trust or with anyone else.

You will be assigned a unique numerical data code when you take part in the interview. If you wish to withdraw, you will be able to contact the researcher's supervisor and quote this code to have your data removed up to 4 weeks following your participation in the research.

**WHAT WILL HAPPEN TO DATA COLLECTED WITHIN THIS STUDY?**

The data will be stored securely in line with the Data Protection Act (1998). Access will be restricted to researchers involved by password protecting the data files.

You will be offered the opportunity to review the findings once these have been written up approximately 6 months after the interview has taken place. The study will also be submitted to a journal for publication. Data will be stored until no longer needed for publication purposes following this.

**FOR FURTHER INFORMATION**

Dr Philip Hayton will be glad to answer your questions about this study at any time. You may contact him at [P.Hayton@londonmet.ac.uk](mailto:P.Hayton@londonmet.ac.uk)

If you want to find out about the final results of this study, you should contact me via email on [katrina.aguilera@hotmail.co.uk](mailto:katrina.aguilera@hotmail.co.uk)

**If you would like further information or would like to discuss any details personally, please get in touch with me by phone or by email:**

**Kat Aguilera**

**Tel: 07919911501**

**E-mail: [katrina.aguilera@hotmail.co.uk](mailto:katrina.aguilera@hotmail.co.uk)**

Supervisor: Dr Philip Hayton (Clinical Psychologist/Senior Lecturer)

E-mail: [P.Hayton@londonmet.ac.uk](mailto:P.Hayton@londonmet.ac.uk)

Thank you very much for your participation

## Appendix C: Participant Consent Form

### London Metropolitan University Professional Doctorate in Counselling Psychology

#### Informed Consent Form

**Time-limited therapy for complex trauma: how do clinicians work with developmentally traumatised clients within a time-limited therapeutic frame? A Grounded Theory study.**

I, the undersigned [*please give your name below, in BLOCK CAPITALS*] hereby freely agree to take part in the above named study

.....  
.....

	Initials
I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, and any plans for follow-up studies that might involve further approaches to participants.	
I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.	
I have been assured that I may withdraw from the study at any time up to 4 weeks following participation without disadvantage or having to give a reason.	
I have been assured that I may omit or refuse to answer or respond to any question that is asked of me without penalty.	
I understand that short quotes (less than 70 words) from an interview may be included anonymously in the final thesis to illustrate key concepts and that there is a possibility that, as a result, confidentiality may be very slightly affected.	
I have been assured that I may leave the interview at any point and without penalty.	
I have been informed that my interview will be audio-recorded.	

I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.	
I have been told that I may be contacted again in future in connection with this study.	
I confirm that I have received the Research Summary for this study.	
Original copy of the participant information sheet and completed informed consent form is to be given to the participant, in addition to the original copy that is filed in the investigator file	

Signature of participant.....

Date.....

Signature of investigator.....

Date.....

Name of investigator

.....  
 .....

## **Appendix D: Participant Debrief Form**

**London Metropolitan University**

**Professional Doctorate in Counselling Psychology**

### **Participant Debrief Form**

**Time-limited therapy for complex trauma: how do clinicians work with developmentally traumatised clients within a time-limited therapeutic frame? A Grounded Theory study.**

The aim of my research is to explore how clinicians think about their work with clients suffering difficulties resulting from extensive childhood trauma and what processes or models they draw from to do so within a time-limited therapeutic framework.

The aim of this interview was to explore your practices when employing a time-limited therapeutic approach in the treatment of difficulties of clients with an extensive history of developmental trauma.

Do you have any further questions?

Do you wish to be informed as to the outcome of the study?

**Thank you for participating in this study.**

You may contact me in future on:

Kat Aguilera: [katrina.aguilera@hotmail.co.uk](mailto:katrina.aguilera@hotmail.co.uk)

Tel: 07919911501

Supervisor:

Dr Philip Hayton: [P.Hayton@londonmet.ac.uk](mailto:P.Hayton@londonmet.ac.uk)

**Should you feel you need further support following issues raised as a result of participating in this study please see below for a list of resources you may seek further support from should you wish to:**

‘Sane Line’ ([www.sane.org.uk/what\\_we\\_do/support/helpline](http://www.sane.org.uk/what_we_do/support/helpline))

‘Mind’ ([www.mind.org.uk](http://www.mind.org.uk))

‘7 Cups of Tea’, free listening service ([www.7cupsoftea.com](http://www.7cupsoftea.com))

This study has been approved by London Metropolitan University's School of Psychology Ethics Committee as well as the Health Research Authority (IRAS ID 197473).



## **Appendix E: Distress Protocol**

### **London Metropolitan University**

#### **Professional Doctorate in Counselling Psychology**

##### **Distress Protocol**

### **Protocol to follow if participants become distressed during participation:**

This protocol has been devised to deal with the possibility that some participants may become distressed and/or agitated during their involvement in this research. There follows below a three step protocol detailing signs of distress that the researchers will look out for, as well as action to take at each stage. It is not expected that extreme distress will occur, nor that the relevant action will become necessary. However it is included in the protocol, in case of emergencies where professionals cannot be reached in time.

#### **Mild distress:**

##### **Signs to look out for:**

- 1) Voice becomes choked with emotion/ difficulty speaking
- 2) Participant becomes distracted/ restless

##### **Action to take:**

- 1) Ask participant if they are happy to continue
- 2) Offer them time to pause and compose themselves
- 3) Remind them they can stop at any time they wish if they become too distressed

#### **Severe distress:**

##### **Signs to look out for:**

- 1) Crying, inability to talk coherently
- 2) Panic attack- e.g. hyperventilation, shaking, fear of impending heart attack
- 3) Intrusive thoughts of the traumatic event- e.g. flashbacks

##### **Action to take:**

- 1) The researcher will intervene to terminate the interview/experiment.
- 2) The debrief will begin immediately
- 3) The participant can be advised to focus on and regulate breathing/ reduce agitation
- 4) The researcher will reassure that their experiences are normal reactions to particular events that are being raised.
- 5) If any unresolved issues arise during the interview, accept and validate their distress. Researcher can discuss the support mechanisms provided within the debrief in the first instance. Remind participants that the research (unless

specifically otherwise) is not designed as a therapeutic intervention. Suggest researcher discusses with Supervisor and health professionals.

- 6) Details of counselling/therapeutic services available will be offered to participants

### **Extreme distress:**

#### **Signs to look out for:**

- 1) Severe agitation and possible verbal or physical aggression
- 2) In very extreme cases- possible psychotic breakdown where the participant relives the traumatic incident and begins to lose touch with reality

#### **Action to take:**

- 1) Maintain safety of participant and researcher. Call for assistance from a member of the Security team if on University premises. Call for assistance from Security staff if off premises.
- 2) If the researcher has concerns for the participant's or others' safety, he will inform them that he has a duty to inform any existing contacts they have with mental health services, such as a Community Psychiatric Nurse (CPN) or their GP.
- 3) If the researcher believes that either the participant or someone else is in immediate danger, then he will suggest that they present themselves to the local A&E Department and ask for the on-call psychiatric liaison team. And/or the Police?
- 4) If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain someone and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency)

**Appendix F: Interview Schedule (Phase 1)****London Metropolitan University  
Professional Doctorate in Counselling Psychology****Interview Schedule**

1. How long have you worked within the NHS?

\*How long have you been qualified?

2. How many clients do you currently have on your caseload?

3. How many of these are you working in a time-limited capacity with?

\* How many sessions of therapy are typically offered?

\* How long are therapy sessions usually?

4. How many of these clients would you say have experienced recurrent childhood trauma?

\* Are you able to extend the length of therapy with more complex presentation clients?

5. What key difficulties do you notice when working with clients with complex trauma?

\* i.e. difficulties with self-identity/self-regulation/relational deficits?

\* How do you help clients manage these\* throughout the therapeutic process?

6. Given the time constraints, how do you overcome trust difficulties with people who have experienced extensive relational trauma?

7. What key methods/approaches do you find helpful in building trust within the therapeutic relationship with these clients?

8. How do you manage any potential negative effects of short-term therapy with these complex need clients?

\* what do you consider when thinking about preserving your clients' safety during and after the therapeutic process?

9. How do you feel about undertaking trauma work within a time-limited framework?

10. Do you undertake private work?

\* If yes, how do you feel this works differs from your NHS practice?

11. How have austerity measures/lack of funding impacted your NHS practice?

\* how do you feel about this?

\* what does it mean for you as a clinician working within an NHS context?

12. In your view, what are the advantages of time-limited therapy?

\* What are the disadvantages of time-limited therapy?

13. Alternatively, what do you think are the advantages of non-time-limited therapy?

\* What are the disadvantages of time-limited therapy?

Thank you, that was my last question. Many thanks for your time and cooperation, you have been very helpful. If you have any questions or would like to hear about the outcome of this study, please feel free to contact me via the details on your information sheet.

**Appendix G: Interview Schedule (Phase 2)**

**London Metropolitan University**  
**Professional Doctorate in Counselling Psychology**  
**Interview Schedule**

1. How long have you worked within the NHS?  
  
\*How long have you been qualified?
2. How many clients do you currently have on your caseload?
3. How many of these are you working in a time-limited capacity with?  
  
\* How many sessions of therapy are typically offered?  
\* How long are the sessions typically?
4. How many of these clients would you say have experienced recurrent childhood trauma?  
  
\* Are you able to extend the length of therapy with these types of clients?
5. What key difficulties do you notice clients present with when they have experienced this kind of history?  
  
\* i.e. difficulties with self-identity/self-regulation/relational deficits?  
\* How do you help clients manage these throughout the therapeutic process?
6. There has been a lot of research terming presentations involving this kind of history 'complex trauma' could you tell me what 'complex' means to you?  
  
\* what areas of your work do you notice involve complexity?  
\* with clients? Within MDT? Within organisation? Nationally?
7. As a clinician working in the NHS, what areas of your work do you feel involve trust?  
  
\* how important do you feel it is to have trust in these areas?  
\* why?  
\* what do you feel happens when there is a lack of trust in any of these aspects?
8. What part do you feel hope plays in your role?

- \* in which aspects do you notice that hope is particularly important?
- \* why is hope important in these areas?

9. How important do you feel containment is in your work?

- \* how contained do you feel overall in your role?
- \* how do you feel this impacts on your clients?
- \* how do you feel this impacts you personally?
- \* how do you feel containment (or lack of it) impacts the interaction of you/your team/the organisation?

10. How do you feel pressure impacts on your everyday work?

- \* what other areas do you notice are impacted by pressure?

11. In what ways do you feel risk is encompassed in your work?

- \* clients?
- \* personally?
- \* any other areas?

12. How do you feel about undertaking trauma work within a time-limited framework?

13. Do you undertake private work?

- \* if yes, what similarities/differences do you notice with your NHS role?

Thank you, that was my last question. Many thanks for your time and cooperation, you have been very helpful. If you have any questions or would like to hear about the outcome of this study, please feel free to contact me via the details on your information sheet.

**Appendix H: University Confirmation of Ethical Approval****London Metropolitan University,  
School of Psychology,  
Research Ethics Review Panel**

I can confirm that the following project has received ethical approval by one anonymous Reviewer, the Head of School of Psychology and the Dean of the FLSC to proceed with the following research study (Professional doctorate):

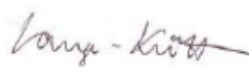
**Title:** Time-limited therapy for complex trauma: how do clinicians contend with the dilemma of working with extensively developmentally traumatised clients within a time-limited therapeutic frame? A Grounded Theory study.

**Student:** Ms Katrina Aguilera

**Supervisor:** Dr. Philip Hayton

Ethical clearance to proceed has been granted providing that the study follows the most recent Ethical guidelines to dated used by the School of Psychology and British Psychological Society, and follows the above proposal in detail.

The researcher and her supervisor are responsible for conducting the research and should inform the Ethics panel if there are any substantive changes to the project that could affect its ethical dimensions, and re-submit the proposal if it is deemed necessary.

Signed: 

Date: 11 April 2016

Prof Dr Chris Lange-Küttner  
(Chair - School of Psychology Research Ethics Review Panel)

Email [c.langekuettner@londonmet.ac.uk](mailto:c.langekuettner@londonmet.ac.uk)

## Appendix I: Health Research Authority Letter of Ethical Approval



**Health Research Authority**

Miss Katrina Aguilera  
 Trainee Counselling Psychologist  
 Hertfordshire Partnership University NHS Foundation Trust  
 Saffron Ground  
 Ditchmore Lane  
 Stevenage  
 SG1 3LJ

Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net)

10 August 2016

Dear Miss Aguilera

### Letter of HRA Approval

<b>Study title:</b>	Time-Limited Therapy for Complex Trauma: How do clinicians work with developmentally traumatised clients within a time-limited therapeutic frame? A Grounded Theory study.
<b>IRAS project ID:</b>	197473
<b>REC reference:</b>	16/NW/0454
<b>Sponsor</b>	London Metropolitan University

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

#### Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

*Appendix B* provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. Please read *Appendix B* carefully, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.



**Appendix J: Full Interview Transcript (Participant D)****How long have you worked in the NHS?**

Probably since 2004 that was when I was working as an assistant psychologist, that was the first assistant psychologist post that I had well NHS

**And how long since you've qualified have you been working in the NHS?**

Uh, 5 years, no is it 6? Good grief 6 years now, qualified in 2011 so yeah it would be 6 years in September.

**How many clients do you currently have on your caseload here?**

Um, I currently have 5 clients therapy wise and I kind of do anywhere in between 3-4 assessments each week and I only work part-time and on top of that I've got a range of other things to do, rewind time a couple of months back I probably would've had more like 10 clients

**How many of those clients are you working in a time-limited capacity with?**

All of them

**How many sessions are offered typically?**

The maximum we can offer here in the CMHT is 24 sessions but we never really offer that, um, I tend to try and keep to 12 sessions if I can cause it's just me and I'm part-time, in the CMHT for XXXX that's it there's no other psychology resource so I tend to try and keep sessions quite low where I can and keep very focused, um, so, it would be between 12 probably at the most sometimes it can go to 16-18 but generally speaking it's 6-12

**You're the only psychologist for the CMHT?**

In XXXX, yeah, and I'm part-time

**How long are sessions typically?**

An hour

**How many of those clients would you say have experienced recurrent childhood trauma?**

Um, pretty much all of them, without a doubt. In my view, people don't come to us if they had happy wonderful childhoods so inevitably they are going to have some historical form of trauma, depends how significant the trauma is, that's the key questions, and how much it disturbs them now

**And what kind of key difficulties do you see when clients have experienced extensive complex trauma?**

If you're looking at extensive complex trauma you're looking at attachment based trauma so therefore you're looking at problems in relationships with other people, probably problems coping with their emotions, probably lacking a sense of identity, typically would attract labels of borderline personality disorder, and also would have developed ways to cope by dissociating and things like that, um the trauma they experienced as kids though the problem is that then it trips more into the psychotic-y

end of things where they hear voices and things like that so it's usually as a reaction to all of that stuff, so I see people typically diagnosed with this stuff, so

**How are you able to help them manage these difficulties as they come up during the therapeutic process?**

I mean, there's always a frequent rule, I think the label is a block if I'm honest, BPD because of course the evidence base is not within much individual work it's just with DBT group, um, which certainly I think now which is good but that will already be an automatic block before you can think about any individual work however I worked with quite a few people who have had the label and actually still been able to get some good results. I mean how would I help people manage this stuff, then I guess, I'm thinking of one lady, I'm working with one case at the moment who's got complex trauma history with lots of history of sexual abuse, um, some more recent stuff about rape that occurred and a lot of the stuff I do is initially basic trauma management stuff so I would do things like grounding and imaginary container, imaginary safe place very much in line with EMDR protocol and then in addition to that some DBT skills around distress tolerance and emotional regulation to make sure she can cope with some intense emotions without self-harming and if she's stable enough then I would go for some more trauma based work so try to reprocess early sort of trauma memories using EMDR, I wouldn't use CBT for that because, in my view, CBT I think, it takes a lot longer and I think it can actually be a lot more overwhelming, EMDR in my opinion is a lot quicker, a lot less overwhelming, a lot more focused and 8 or 9 times out of 10 managed to sort out trauma within an hour, I'm lucky if I can do that within probably 6-8 sessions of CBT for one trauma memory

**You mentioned self-harming, when those come up how are you able to manage the safety of the client?**

I wouldn't do EMDR with someone who's actively self-harming, um, saying that I did do trauma-focused work with people who were in acute crisis, I did do that, so people who were very suicidal under the crisis team but the way I managed that I was seeing them twice weekly or 3 times weekly intensively for some really focused work and I'd be focusing on the trauma that's triggering the crisis because if you treat the trauma that's triggering the crisis then the crisis abates and that's what we found and actually we've got a study coming out soon which shows that that's been very effective, um, even if people are self-harming the question is give them alternative skills to try and reduce the self-harming but why are they self-harming. Then if you take a strict trauma lens on it you can say what's the trauma fuelling that? you know, what is it that it's about? A childhood experience of sexual abuse and now they're being invalidated by their partner, is it about a recent traumatic event where the person was raped and they're just completely overwhelmed by their emotions or is it that they've been in a domestic violent relationship and they don't know what else to do, they can't cope with their emotions so they self-harm, it's about trying to formulate the self-harm and figure out what's going to be helpful, I mean ultimately DBT skills are the thing you'd want to weave in there to try and give people alternatives so self-harming harm minimisation, holding ice cubes, using TIP skills, breathing down, STOP skills just trying to stop them from acting on their emotion that time and try to give them alternative emotional regulation skills so trying to do the opposite of what their emotions are telling them to do so

**Do you find you're able to contain that within the therapeutic relationship?**

If people self-harm, yeah, I mean I don't have routinely clients on my books, I'm trying to think recently, nobody who's actively cutting all the time and things like, I don't tend to have so many clients like that but then it's also because of the barrier of the label, um, people with PD, if they said that is their only diagnosis then I may not say that individual therapy is going to be the best thing anyway due to the NICE guidelines and evidence base but again that's a barrier. I feel the diagnosis interferes with the types of therapies available to people, very much so, 100% DBT is the only thing you can offer somebody with borderline, that's basically what the NICE guidelines say really, you might be able to get away with a bit of schema but the NHS system there's no way they're going to offering 6 months' worth of schema therapy really, these days, CAT maybe, um, but, you know I had a bit of experience in CAT, I'm not CAT trained, I still use ideas of it in my work and formulate with it and I use some of the interventions as an integrative psychologist and practitioner, but yeah, I think that people with borderline, it does create a serious block there

**Do you find the fact that there isn't a formal diagnosis for complex trauma is a bit of a barrier at all?**

Yeah. I think it's massive because borderline is a very pejorative term, and also clients who enlist care, teams often stigmatise them in the sense that it's "personality" so there's something intrinsically wrong with them, that's the problem, rather than actually being a bit more compassionate and saying well actually they've actually been horrifically traumatised, they actually haven't had a decent attachment figure or good parenting they've just had horrendous stuff that's happened to them so actually what else are they going to do, what else can we expect, um, we as a service work with that and manage that, um, that's the problem with attachment to services we can become surrogate parents really and actually in some ways we can also be abusive surrogate parents, we can easily repeat the same pattern which is a real problem I think

**How do you manage the relational difficulties within a time-limited frame?**

It's time-limited work so I mean, it depends upon, how good your therapeutic alliance is with somebody, again I tend to think about these things on a continuum, so you have people that think they are going to be abandoned every 5 seconds and disengage from things, those people won't be suitable for therapy, you can't do any work with somebody who's going to be like that, I'd probably see people more on the mild to moderate end of the spectrum who can sit down and engage and who will come to appointments, um, and the thing is with things like trauma focused work, what's interesting is that people generally don't come back because they do notice the difference and change within them, and often people with this kind of complex trauma history typically branded with personality disorders in my experience and I use EMDR with these people, it's actually been one of the one things that they want the most, you know one client recently who's got borderline and she found it profoundly life-changing, she was like "my gosh, I feel so much better, things are so much more positive now" I wonder if she might have been idealising me a bit but on another level it was the therapy itself that did that not me which is very interesting so I think you know, the way I work here is, you know, I kind of think what's the traumas, how can we deal with that quickly in an EMDR way and then prioritise say 2 or 3 traumas to treat within a 6 to 8 session timeframe and be very focused and try to get those things sorted because in my experience if we crack those that can help

the here and now experience in a positive way, maybe at times things might get ruptured and it's when people might disengage and then here we have to be pretty stringent if people disengage because there just isn't any time or resources so you know someone cancels then ok that's fine we offer another appointment, if they cancel again we have to start asking questions and if they cancel a third time it's like ok look then we might send an opt-in if they DNA once then we kind of here's a measure put in place if the DNA without good reason we discharge because we need people to turn up and actively engage with the service because otherwise it's just wasted time and we can't afford that, so yeah, it's hard

### **Why do you think EMDR works so well for some people?**

Because it targets a particular memory, the beauty of it is it's done in the room so you're focusing on a very clear trauma memory, you're hitting the jugular, is how I would say it, of why "why am I like this?" it almost validates the sense of well because you were sexually abused as a kid it makes sense why you have trust issues with guys and why you've ended up in some more harmful relationships, so, let's target this early trauma experience of the sexual abuse, let's target these memories which are still plaguing you a lot, because again if you look at the research 50% of people meet the criteria for PTSD who've got borderline even though that's never even considered by psychiatry which is my frustration, it's just borderline and that's it, um, and I think what EMDR is it tackles the problem directly and if you're hitting that and you're really validating that experience, you're going in there, you're reprocessing that, and it gets quick results fast, people see a change and I think that's where people kind of think my god this can actually really work and all the stuff there and services for want of a better word pussyfoot around trauma, because they do, including a lot of other psychologists are terrified of it, if we can go straight in there and sort that out quickly that can really make a big difference and I think that's one of the powerful things about EMDR it does that, it does it really well, and it's not about millions of questions or Socratic dialogue, straight in there right, very simple basic questions as per the standard protocol you get cracking, you're starting to get some traction with it really fast, you reprocess that memory, done, what's the next what's the next what's the next what's the next, and you can see some really great recovery and I think that's for me why EMDR works and it's also quite containing, I'll say that, people are terrified that dealing with trauma is going to destabilise, particularly clients with borderline and self-harming, I'd say the polar opposite, that's what I learned in crisis, you treat the trauma you stop the crisis, you reduce the suicidality, you reduce the self-harming, you go in and you deal with that it's not going to destabilise somebody it's actually going to make them much better, it's probably one of the best things you can do

### **Why do you feel some psychologists are terrified of trauma?**

Well my supervisor even today, we were talking about a case which is complex, there's been complaints and we're trying to deal with that and she was saying well in my view this person needs to be stabilised with the self-harming a bit, and be in a place where you can do some EMDR with that person and I'm thinking more stabilisation, that for me is pussyfooting around because you could say right so this person is now whacked in for some more stabilisation so ok I'm giving her some DBT skills or something, whilst there's the need for some of that, ok, but is this person acutely suicidal and even if they are actually you can still do some trauma work in my opinion and I am a bit radical with that and I respect that I'm probably a

positive risk taker whereas most psychologists are vastly averse to this, because what they would say is that you do not do anything with somebody that's in suicidal crisis – my previous supervisor was the same when I worked in crisis, don't do anything, offer them some basic ideas about some distress tolerance, that's it, don't go in deeper, whereas I will go deep all the time, what happened to you, what brought you here, why are you feeling this awful, what's happened in your life to bring you to me, if you start asking those questions the trauma's there, um, and I think the fear is just about people becoming destabilised the fear is that it'll make clients worse and the fear is that they can become more suicidal cause they can't contain the emotions of the experience with EMDR you can manage that extremely well in the room – CBT I think there's a lot more vulnerability to that, because you really have to go let's through this again, and again, and again, where with EMDR it's like it doesn't really talk that much, it's like ok has anything changed? Yes/no? Yeah, a little bit? Ok go, has it changed a bit more? Yeah ok, no, ok let's go again, what do you notice now, a bit more 0-10 scale about a 7 ok – it's light speed it is so much more effective in my opinion if I'm really honest CBT you go through the same things thousands and thousands of times for one situation and it's just, I get that I know it's got the primacy relevance space right now but I do think it's going to change once EMDR gets there but I just think that psychologists are terrified of it, I think as well they're scared of getting traumatised themselves by hearing these stories and a lot of psychologists won't go there with trauma, they'll stick very much with the symptom and if we think of the trauma tree they'll stick very much with the leaves, nice and fluffy leaves with a bit of CBT, that's nice, but the leaves grow back, that's not going to change it, let's get to the trunk, let's get to the roots then we might actually makes some changes here and some research that we just did here showed that CBT and EMDR combined had better outcomes than CBT alone comparing practitioners and things like that so there is an evidence base there growing, it's a very tiny study but I do think there will be something there in the future

### **What other methods or approaches do you find helpful in your work?**

I think attachment theory is pretty important, I don't often think about attachment style but I will think about it in terms of who's been around this person, you might think about compassion focused CBT a bit, think a bit about, people are ashamed of their experiences are highly prone to self-blame which a lot of people who go through complex trauma are because basically they've been invalidated, humiliated and told it's all their fault for many years so actually compassion focused CBT can be really helpful and then looking at positive attachment figures and compassion imagery can be handy, psychodynamic ideas I do hold in the back of mind particularly if there's transference or something happening in the room because all those patterns can come out in one way or another and it's a question of how do you contain that and keep going in a positive way, I mean one advantage of EMDR is because in some ways it's even more prescriptive than CBT, it's very manualised, very set protocol and really boxes that in and very focused on that so there isn't much scope for transference issues to come out in the room or things like that, just kind of bam bam bam, it's not so much a relational process of EMDR, it's a bit because in the therapeutic alliance you need that but it's very much this person going on their own journey and you're just helping guide them along whereas with CBT it is very much relational, is very much in asking questions, guiding, and likewise the psychodynamic as well so very much a different approach to it

**What qualities do you find help in the therapeutic relationship?**

In terms of what I would be like I suppose just being very validating and very acknowledging and making sense of why them a bit, why you can experience these things and why that's quite normal and why you can learn these ways to cope because what else could you do, why wouldn't you start self-harming at 12 when you've had a domestic violent family, mum and dad really couldn't look after you, you know things are so overwhelming that either you dissociate and self-harm as a way to manage, fair enough why wouldn't you do that so it's about validating some of the skills that they've used to survive and I think that's helpful rather than pathologising or attacking, it's important to validate those things and think how can we make things better now, so I think that's pretty crucial. I also think it's about being boundaried and keeping clear about this is what I can offer, this is what we can do, that's kind of it. I mean I've had quite a few cases where I've been rejected, abandoned, you know, gone from being idealised to denigrated pretty quickly, you know, and sometimes I say to clients so I will say there's a chance you might idealise me, you might denigrate me and afterwards how are we going to manage that? You know if it's someone with borderline I'd expect that so I'll put that on the table really early on and say like what are we going to do with that if it comes up, how are we going to manage it because it's important that we continue working together, but again it depends on where on the continuum they are, at the severe end it's going to be really interfering with therapy, mild-moderate end then it doesn't interfere too much and I can still get some reasonable results with people

**How do you feel about undertaking trauma work within a time-limited frame?**

I think on one hand its quite daunting but equally I find it interesting and exciting as well because I think, particularly with EMDR you can do a lot with 12 sessions, you can do a hell of a lot, um, one case I've just done recently which I'm trying to write up, well two examples, one chap came in, basically first time he came to psychology, in his fifties, said I was sexually abused my uncle, I didn't need to know anything else – that's it, fine, “got an image of that?” “yeah” (clicks fingers), great, let's follow some EMDR, did some stabilisation, that was session 1, did some stabilisation in session 2, we focused on the trauma memory which is the composite memory so again if it's the same event repeated, you treat the memory you treat them all, like a domino effect, brilliant, same event repeated, we cracked that in one session, follow up he was absolutely fine, done, dealt with my god it's better, after 50 years of having this horrible stuff, that's the power of EMDR and that's how quick it can be and that's complex trauma, he had sexual abuse by his uncle for 5 years as a kid, but the same thing repeatedly and we just targeted one, we targeted that, bam, he's a lot better he made great recovery on all the outcome measures, he was down the conservative club having beers with his mates, he's fine and that for me is the beauty of trauma work and how you can actually get results really quite fast if you get the right thing, it feels a bit like in the garden weeding, you just need to get the right root sometimes, it feels like that, sometimes you get the wrong root but if you get the right one and pull that out then all of a sudden the brain just resets itself, it chills out if you think about the idea of the amygdala being on hypercharge mode because of all this trauma, once that updates and it clocks there's no longer a threat, anxiety drops, there might be a bit of mystery afterwards, cause sometimes people do feel a bit depressed at the loss of their life after trauma, it happened to a guy I did some work with after the 7/7 bombings, he was a city trader retrained as a carpenter came into crisis, we reprocessed the 7/7 bombing trauma been through 4 sections,

really quickly he got really depressed afterwards because he lost several years of his life because he lost several years of his life cause he was so traumatised but now he's come back, so for me in some ways it's quite exhilarating to try and get in there quite fast and to get some good results and it can be quite quick. Now that goes completely against the grain in the evidence base and everyone says no, woah, complex trauma no this going to take years and there's no resources for that, so what are these people supposed to do? Nothing, is what the answer is, they're left. And then what happens, well, then we see the people revolving door admissions, then we see the fortunes that are spent on beds and crisis assessments, A&E, that's where we've got serious problems whereas if we get in this early I think we could save a fortune and people would get much better outcomes

### **How would you approach things if you weren't EMDR trained?**

I still think about the trauma mindset and the CBT that I did was quite trauma-focused so I'd still consider that and I'd still want to be thinking about dealing with, you know, perhaps one or two key traumatic events, within a CBT framework again if you did the same where you target a particular memory, the worst one, most composite one I expect is going to take a little while, another trauma case with child sexual abuse, again was abused by his uncle and we did reliving and again it took about a good 10 sessions worth of reliving work but he did well, he still had a good recovery, it just took a while longer, but again that didn't take years, that took 10 sessions and that's trauma-focused CBT so, I think it's daunting most people would say don't do it, um, cause again of destabilisation but it's almost like a bear with like a nail in its paw, you can put plasters on it but until you remove the nail nothing's going to get better and that's sometimes why I attribute to this work ??? What the hell's the nail, why are you in this much pain? Pull the nail out and hey, presto, we're going to get some healing, but I suppose I'm quite radical

### **What kind of challenges do you come across when working within a TL frame with more extensive complex trauma?**

It's prioritisation, it's about what's the most important thing, what's the most damaging bits, and I guess you formulate that with the client collaboratively so we typically do a timeline or trauma lapse and what's the worst bits and what's going to be the first worst or what's the most recent and what's the most ones you want to work on for you and you just got to be realistic and say I've got, say, 10 say sessions we could possibly crack at the most 4 or 5 traumas here if we're very lucky what would be the top 5, what would be the top 10 traumas you want to focus on, what's the most dominant, that's how I would do it, it's always prioritised, focused and collaborative with the client and then I suppose the other challenge is follow-up cause again you can't follow up people for 3-6 months afterwards easily certainly not within the CMHT setting here, I mean I might offer follow-ups with people 3 or 6 months down the line but I don't have the capacity to do it that much, so you kind of have what you have, you just blitz what you can do with that person, but also you know the team's gonna follow up that person up here so the risk is still contained, but my experience with people I've finished working with, none of them have been in suicidal crisis, a few people killed themselves who I saw in crisis but they were only people I assessed, all the people I did work with got better, got out for crisis didn't come back to crisis, so, yeah

**If you weren't working within a time-limited framework, would that make any difference to the work you would do?**

Yeah I think I think it would give me more flexibility and obviously you could do a lot more within that and it would give me more confidence cause I think that's one of the key things, confidence, cause if you know you've got 20 say sessions then you can go to some of these places and even in the CBT frame where you could go there you could have some confidence to say I've got a bit of time here whereas if you've only got 10 you say, I don't know, that's where you get the trauma aversion, the pussyfooting around as they say, oh no that's not enough time to go there and do anything with this you know EMDR wise 10 sessions is a long time, 20 sessions, wow we could do a lot of this, but you know, I might work a lot more ruthlessly here because I have to cause it's just me so I don't give myself the luxury of 20 sessions with clients, I don't do that, I give myself the luxury of up to 12 max usually or 16 at the absolute maximum but people usually have 6 or even 4 sessions and seeing how that works

**It sounds like you feel that that might be enough for people that are able to undertake that processing straight away?**

Yes, exactly that, so I think – is it enough? That's a good question, I think it still makes a positive difference is that going to heal everything? No, but would it make a fairly significant difference fairly quickly? I'd say a good 7 out of 10 times it would, you could get some pretty good results pretty quickly, again within an EMDR frame with a CBT frame it would take a lot longer. With dissociation stuff, it's a difficult one because what's the cure for that? What's the solution for that? I haven't really worked that out yet, I mean apart from grounding and trying to do things in a very contained way, you need more time to work on that, I remember one chap I worked with, he couldn't tolerate processing for more than 3 seconds, we managed to expand that a little bit more to maybe 5 but he just had to do really brief steps and that was it because if we'd go any further he'd dissociate and he'd be out for the next half hour, he'd be gone. So, for those kinds of clients they need more time, and in a time-limited way, that's a chap I worked with in crisis actually and I did see him in the end for about 10-12 sessions which in a crisis framework is a hell of a long time, we got somewhere, we managed to crack some of the memories, not entirely but some of it, if he had another 10 sessions we could've done more probably

**Is the trauma processing the key? Some clinicians have said that stabilisation work is enough.**

For me, I'm very pro treating trauma and I think that for me it's what's going to make the biggest difference. I agree that I think it's dependent on what's going to be helpful for that person at the time, I'm aware of my own biases and some people say stabilisation is enough, I don't necessarily think it's enough, I think it's putting a sticking plaster upon things, will a sticking plaster hold for a bit, probably yeah maybe it'll help them a bit but all the same stuff is still there if we don't address that the person is going to relapse, they're going to re-present, they're gonna come back, something else is gonna change. I mean most therapies are geared up to be a sticking plaster, all of DBT, CBT, yeah we get there's people around with horrendous histories but we don't care about that, we focus on the here and now and perhaps they're going to change, and don't get me wrong there's real strengths to that and there's diamond need for that but for me if we're not treating the underlying stuff. What difference are we really making, that's harsh, very harsh given the evidence



based groups of participants you feed them carrots for a week maybe they might feel better, in the real world clients who've been through really shit lives not just students in a Harvard university – you know, what's going to make the difference here?

**In terms of recovery, do you ever see any iatrogenic effects from short-term therapy?**

Sometimes with clients or a client yes, um, if you had an unlimited amount of sessions they might want you more and get more upset because the trouble is, you generally wouldn't want to see someone with borderline only 6 sessions for example but if you did you have to be managing the ending before you've started, um, and it's all about the ending and you have to contain that in a bit of a psychodynamic way so that would be very unhelpful, um, you know, if you've got 12 sessions and it depends again if they're more on that mild to moderate end of that spectrum, then you can probably work and get in there and do some constructive work but the times when things have been more difficult is when people wanted more of me, one client managed to get 27 sessions worth of therapy out of me and she wanted another 24 sessions out of me and she was very upset when I said sorry, no, and that's when we had to contain that down and that was probably a downside. I mean how do people do afterwards is always the million dollar question. Some people disengage from trauma work but only sometimes, not all the time. I'd certainly never had feedback saying oh my god they're so much worse after you've seen them, what are you doing to the clients, you've put them into crisis, what kind of psychologist are you, you're so dangerous, you know, I've never had that even from supervisors who literally are at the polar opposite of what I'm wanting to do, would be completely the opposite, very risk averse, um, even then, there's no reason for them to say you're a very dangerous, maverick psychologist

**How do you feel the current financial environment has an effect on psychological treatment?**

Dramatically, for example I'm part-time for the whole of XXXX, it's pathetic, if we said the same for cancer and we said 10000 people that needed chemo, got one lot of chemotherapy or two lots if they're lucky for the next month or two there'd be a national outcry – we've got that for psychology, if not less, it's about 1 to maybe 1000000 if not less in terms of numbers so we can't actually do it because we don't have the resources to do it and that's the reason why we've had to out more stringent things in, we've got waitlist controls, at the moment I'm so overwhelmed here I've had to adopt a system where I'm offering assessments and consultations and can't even offer therapy because we don't have the resources and it's horrible because you want to do things and help people but you have to turn around and say no to a lot of people and that's because there isn't the money, it's hard to get recruitment in here, only one psychologist for the whole of the area is pathetic, it's absolutely pathetic and again this is the centre of our service at the minute, it is pathetic in comparison to physical health, everyone bangs on about how it should be important and the rest of it but there's no money to back it up. The other impact financially with the tory government is that things are going to get worse and the impact of poverty and debt and all that stuff will affect people's mental health profoundly and can also lead to people coming in, people being homeless, people not being able to get council houses, all that social impact has a huge impact on people's mental health. And NICE is evidence based driven but the argument why is CBT the flavour of the month because it's funded by the drugs companies, they want to fund more short-

term therapies because they are less effective over time, there's all that kind of argument and I think there's a fair argument in that it's easier to get and also publications, it's easier to get a CBT publication out there. In EMDR to get any formal legitimacy you have to really fight but it does have more legitimacy now, people have started to buy into it a bit more now, but it's still just regarded as exposure that's why CBT so much more happens in that, the amount of links that people make is astonishing – I could spend 60 sessions doing Socratic questioning and getting them to get somewhere in their own mind which I could spend 10 minutes in EMDR, it's ludicrous, but again where's the research funding – to get research funding for EMDR is really difficult, CBT can get easily but even then it's still pathetic in comparison to cancer and those kinds of things. We are very dramatically underfunded, probably the equivalent where we are in psychology, we are 1000 years behind medical science, give us another two years and who knows where we'll be

### **How does your role impact you personally?**

It's hard – might just be because I had a rough supervision today, well not rough, I don't know, was it rough? Maybe it is, I don't know. Basically, when you're just overwhelmed it's depressing and it's frustrating, a lot of psychologists are depressed in their roles, I'm part-time private practice is a breeze in comparison to this, it's just you and the client and you can spend as long as you need, and also you haven't got, I've got a waitlist of 6/7/8 months and I'm powerless to do anything about that because I don't have the means or the resources, well I'm not powerless I can shut away and stop people getting access to psychology but then I know I'm creating a vast unmet need and it's on my shoulders, you've got supervision, and it's hard because you want to help people but you can't and then you've got to do indirect work and there's no evidence based there's no RCT that backs the evidence for that. I guess, despairing, not quite there yet but depressed yes, stressed yes, then you have psychiatrists and care coordinators really twisting your arm to take on inappropriate referrals and also forcefully throwing people at you which you know aren't going to benefit, or too complex for waitlist and that's hard when you feel like what you're saying is falling on deaf ears

### **How are you able to manage these challenges and keep yourself contained?**

I suppose I protect myself through my own bit of dissociation really and I suppose when you deal with trauma work you get desensitised to it and, it's like I work with the fire brigade quite a lot and once they've seen one dead body they've seen loads of dead bodies, that doesn't faze them, seeing blood or guts doesn't faze them, same thing with me, I hear a story about sexual abuse it doesn't faze me too much, and also the beauty of EMDR is that you don't need to know the details, you're so saved from any vicarious traumatisation, yep, sexual abuse by my uncle, that's fine, don't need to know anything else, that's fine by me, let's go for it. and if we're protected by that model but also protected in the sense for me I was imagining I was watching a horror movie or TV so I can use my skills in dissociating to help me, again things which I like doing, films, things that kind of switch off, I don't touch anything to do with psychology outside of work, outside of work I don't watch anything psychological on tv, no way, I want nothing to do with it not, I'm a psychologist sod off, I'm not having any of that, trying to get a bit more of health kick since the new year, lost a bit of weight, exercise that kind of stuff helps and I suppose that's the main thing, I don't tend to dwell on things outside too much unless there's

something a bit more serious like a complaint's been made against me that then eats me a bit but then I try to short circuit it and try to apply a little bit of what we preach in terms of what can I do about this and try and do something with the worry rather than sitting there with it, I try to do something constructive like set and action plan what am I going to do and that's one way which I contain things I guess but it's tough, I feel much worse in my NHS job than I do in my private work, I feel a lot worse

**What do you feel are some of the differences between private work and NHS work?**

NHS work is a lot more overwhelming, lots of people thrown at you and you have to think a lot more really stringently about suitability criteria and you have limited sessions and you have to manage a service none of the bureaucratic crap, in one way the NHS keeps you protected but in another what's really important to the NHS? Have you done your mandatory training, do they give a shit about what you're doing with clients in the room? No. Do they give a shit about outcomes? No. Do they care about your mandatory training? Yes. That galls me because it's like there's a complete loss of a focus on the patient "it's all about the patient" – fucking bollocks. It's all about numbers and crunching and it's about keeping the data up to that's all they care about, they do not care about the patient and that's me being really harsh but it's true, as a service they do not care, the beauty of private work it is all about the client, it's a lot more liberating and you've got more flexibility in what you can do, you can be purely integrative you go where the clients goes, do what the client needs

**Appendix K: Data Analysis Sample**

Lines	Raw Data	Open Code	Sub Category	Higher Order Category
A235-236	I think it's difficult, um, not having a diagnosis for complex trauma as there is a lot of variability in presentations, um, and this can be tricky for treatment	No diagnosis for complex trauma can make things difficult for determining treatment due to variability in presentations	Diagnostic labels can create challenges for complex trauma treatment  e.g. no complex trauma diagnosis therefore clients are often given other diagnoses such as BPD, DID and Bipolar which may describe what's happening but may actually stem from attachment trauma so treatment for this will be limited (BPD = DBT, Bipolar = CBTp), also there can be limited compassion for BPD diagnosis in teams	Organisational and contextual factors impacting therapeutic treatment
C415-416	We don't really take borderline clients for individual therapy as they would normally get recommended for DBT	Therapist's service does not typically accept clients with BPD as the recommendation for treatment would be DBT		
D31-32	typically would attract labels of borderline personality disorder	Complex trauma typically attract the label of BPD		
D41-42	I have worked with quite a few people who have had the label and actually still been able to get some good results	Has worked with people with a BPD diagnosis and they have been able to get good results		
D77-78	but then it's also because of the barrier of the label, um, people with PD, if they said that is their only diagnosis then I may not say that individual therapy is going to be the best thing	Label of PD is a barrier as if this is the only diagnosis individual therapy may not be suitable		

D79	due to the NICE guidelines and evidence base but again that's a barrier	NICE guidelines and evidence base can be a barrier for treatment for PD diagnosis		
D129-131	again if you look at the research 50% of people meet the criteria for PTSD who've got borderline even though that's never even considered by psychiatry which is my frustration, it's just borderline and that's it	Feeling frustrated with reductionist approach of diagnosis as research suggests that 50% of people diagnosed with BPD meet criteria for PTSD		
D89-91	borderline is a very pejorative term and also clients who enlist care, teams often stigmatise them in the sense that it's "personality" so there's something intrinsically wrong with them	Feels that borderline is very pejorative and can lead clinical teams to stigmatise clients in the sense that "it's personality" suggesting that there is something intrinsically wrong with them		
D91-92	that's the problem, rather than actually being a bit more compassionate and saying well actually they've actually been horrifically traumatised	Feels that the BPD diagnosis can be a barrier to teams viewing clients more compassionately and just being severely traumatised		
D92-94	they actually haven't had a decent attachment figure or good parenting they've just had horrendous stuff that's happened to them so actually what else are they	Thinking about what individuals with a BPD diagnosis have suffered may help understanding of ways in which they behave		

	going to do, what else can we expect?			
E60-62	and I think sometimes these patients come with Bipolar II diagnoses, which is not wrong, Bipolar II does describe what is happening, but it can be misleading as Bipolar does tend to get lumped in with the psychotic end of things	Diagnoses can be misleading i.e. diagnosis of bipolar II can describe what is happening to a client however this tends to get grouped within psychosis which can be misleading		
E62-63	whereas the damage, if you like, the dysfunction is rooted in an attachment trauma here	Diagnosis can be misleading as damage/dysfunction can stem from attachment trauma		
E65-67	it's so interesting that relationship between people who end up people who end up looking more like Bipolar II and people who end up looking more like BPD	Considering the relationship between people who edge towards Bipolar presentation and those who move more towards BPD when both stem from attachment trauma		
E241-242	I agree that the BPD side of things is important but it's the people that get diagnosed with Bipolar II	Agrees that borderline diagnosis is important but feels that people diagnosed with Bipolar II need to be looked at		
F133-134	I think it would have been incredibly helpful to have a complex trauma diagnosis and there are I	Therapist feels it would have been incredibly helpful to have a complex trauma diagnosis for lots of reasons		

	think lots of reasons for that			
F134-136	the referrals were coming to me via the team members because generally they were quite um kind of frazzled and um, burnt out with working with particular clients and their presentations	Feels the referrals she was receiving from team members were generally due to them feeling frazzled and burnt out as a result of working with particular client presentations		
F136-138	I think if it would have been viewed as complex trauma, and different language was used, I suspect team members would have been more empathic and compassionate in understanding why someone was presenting the way that they were	Feels that team members may be more empathic and compassionate towards understanding why clients may be presenting as they were if the language of complex trauma was used in reference their presentations		
G38-39	often things were viewed as "it's behavioural" was the phrase that was banded round by the team a fair bit	Team members often viewed client difficulties as "behavioural" and would often use that phrase		
G39-40	"it's all behavioural" or "it's PD" in quite a pejorative, negative, blaming way	Team members would often use phrases such as "it's all behavioural" or "it's PD" in a negative, pejorative and blaming way		
G40-42	I think sometimes they referred people to psychology because they	Feels that sometimes clients were referred to psychology out of frustration and care coordinators not knowing what to do rather than viewing their presentation		

	<p>didn't know what else to do out of frustration rather than viewing well there's a treatable difficulty here</p>	<p>as a treatable difficulty</p>		
G42-43	<p>if a complex trauma diagnosis had been given, um, then people would have had a greater level of understanding and seen the usefulness of psychology to treat the trauma</p>	<p>Feels that if a complex trauma diagnosis had been provided rather than personality disorder care coordinators may have had a greater level of understanding and seen the usefulness of psychology to treat the trauma</p>		
G44-46	<p>individually in my therapy, um, I think I mean really you're trying to formulate and conceptualise from a trauma background anyway but you can get blinkered when diagnoses of BPD are there as a label</p>	<p>Therapist tried to conceptualise and formulate from a trauma background but feels blinkering can occur when there is a BPD diagnosis as a label</p>		
G46-47	<p>and treat what you're seeing, the problematic difficulties or behaviours or ways of coping that are seen as problematic rather than address the trauma</p>	<p>Can focus on treating the difficulties/behaviours/ways of coping that are seen as problematic rather than addressing the trauma when dealing with BPD label</p>		
E242-243	<p>at least BPD has a treatment pathway whereas Bipolar II will only have CBT for psychosis so, um, so it's quite limiting for</p>	<p>Feels that people diagnosed with Bipolar II are very limited in terms of treatment as they will only have CBT for psychosis as a treatment pathway</p>		



	people			
E232	Diagnosis for complex trauma is zooming up the agenda	Diagnosis for complex trauma is zooming up the agenda		
E232-233	I think the good thing with that is it'll shift the emphasis I hope from DID	Hopeful that complex trauma diagnosis will shift the emphasis away from Dissociative Identity Disorder		
E233-235	because as soon as you start talking at the moment about complex PTSD and dissociation people just start thinking about DID which is important but that's not the vast bulk of the patients that are coming through the doors	Feels that in talking about complex PTSD and dissociation people assume DID however this is not what the vast majority of clients present with		
D79-80	I feel the diagnosis interferes with the types of therapies available to people, very much so, 100%	Strongly feels that diagnosis interferes with the types of therapy available to people		
D38-41	I mean, I think the label is a block if I'm honest, Borderline Personality Disorder because of course the evidence base is not within much individual work it's just with DBT group, um, which certainly I think now which is good but that will already be an	Feels the label of BPD is an automatic block to individual therapy as the evidence base recommends group intervention as treatment i.e. DBT		

	automatic block before you can think about any individual work			
D80-81	DBT is the only thing you can offer somebody with borderline, that's basically what the NICE guidelines say really	The only available treatment for BPD is DBT according to NICE guidelines		
D81-83	you might be able to get away with a bit of schema but the NHS system there's no way they're going to offering 6 months' worth of schema therapy really, these days	Feels schema therapy could be suitable for BPD although does not feel the current NHS system would offer six months of schema therapy		
D85-86	but yeah, I think that people with borderline, it does create a serious block there	Fees there is a serious block to treatment for people with BPD		
E238-239	the important thing there is it would reduce the number of false schizophrenia diagnoses	Properly assessing for DID would reduce the number of false schizophrenia diagnoses		
E239-240	and the wasted medication and trying to treat people through medication than through therapy i.e. clozapine clinic every week, monitoring people every week	Proper assessment for DID would reduce wasted medication for trying to treat people with schizophrenia diagnoses through medication e.g. clozapine and weekly monitoring for this		
E241-242	I agree that the BPD side of things is important but it's	Agrees that borderline diagnosis is important but feels that people diagnosed with Bipolar II need to be looked at		

	the people that get diagnosed with Bipolar II			
E242-243	at least BPD has a treatment pathway whereas Bipolar II will only have CBT for psychosis so, um, so it's quite limiting for people	Feels that people diagnosed with Bipolar II are very limited in terms of treatment as they will only have CBT for psychosis as a treatment pathway		
F33-34	I think it would have been incredibly helpful to have a complex trauma diagnosis and there are I think lots of reasons for that	Therapist feels it would have been incredibly helpful to have a complex trauma diagnosis for lots of reasons		
F34-36	the referrals were coming to me via the team members because generally they were quite um kind of frazzled and um, burnt out with working with particular clients and their presentations	Feels the referrals she was receiving from team members were generally due to them feeling frazzled and burnt out as a result of working with particular client presentations		
F36-38	I think if it would have been viewed as complex trauma, and different language was used, I suspect team members would have been more empathic and compassionate in understanding why someone was presenting the way that they were	Feels that team members may be more empathic and compassionate towards understanding why clients may be presenting as they were if the language of complex trauma was used in reference their presentations		

G21-23	Yes, with a number of cases, for some people the presenting diagnosis was PTSD but then actually when I was seeing the individual and doing my assessment and thinking about treatment plan it was clear that there were other underlying personality difficulties as well	Would see people with a particular diagnosis i.e. PTSD however when assessing and formulating treatment plan it would become clear that there were also underlying personality difficulties		
G23-24	and that may not have been diagnosed or wasn't the reason for referral	Additional difficulties identified during treatment may not have been diagnosed or been the reason for referral		
G24-25	and, the idea behind the service was that you were to try and work with the accompanying Axis I difficulties even under a diagnoses of BPD	The idea behind the service was that therapist was to work with the accompanying Axis I difficulties regardless of diagnosis		
G50-51	so if there'd been a complex trauma diagnosis maybe that would have helped us argue for longer term therapies and helped me formulate differently possibly	Feels that if there was a complex trauma diagnosis that would help to argue for longer term therapies		
G51-52	I'm not sure, it may have had an impact on the treatment plan	Having a complex trauma diagnosis may have had an impact on the treatment plan		

G52-53	rather than being so CBT focused which was the expectation that maybe could have drawn from different models and maybe been more compassion focused	If there had been a complex trauma diagnosis this may have had an impact on being able to draw from more models and be more compassion focused rather than so CBT focused		
A219-221	with certain places 20 sessions would be the maximum and for me that's sort of not long enough especially with people with sort of complex trauma	20 sessions is not enough for clients with a complex trauma history	Restriction vs. focused treatment: balancing the dialectic of time-limited therapy  open-ended therapy would provide greater flexibility due to feeling less pressure, less restricted, more autonomous, being able to work with clients as long as necessary and help clients through life events but there also needs to be a cut off at some point. Additionally, limits capacity for proactively engaging clients, assessing, formulating, reflecting and building rapport, however T/L therapy provides structured treatment and prevents therapy becoming amorphous	The technical challenge of therapeutic treatment
A97-98	it seems to be the changes you get from sessions 40-60 seem to be sort of very sort of minimal	Minimal changes between 40-60 therapy sessions		
B12	Yes, because the kind of clients that I'm seeing would normally, 20 sessions isn't sufficient enough	20 sessions is not enough for clients with a complex trauma history		
B170-171	I would ideally like a time-limited structure but not to the limit that we're at currently	Favours time-limited framework but 20 session time-limit not enough		
B12	Yes, because the kind of clients that I'm seeing would normally, 20 sessions isn't sufficient enough	20 sessions is not enough for clients with a complex trauma history		
B170-171	I would ideally like a time-limited structure but not to the limit that we're at currently	Favours time-limited framework but 20 session time-limit not enough		
G13	It was 20, and that was fairly strict	Session limit was 20 and that was fairly strict		
G13-14	you could, in negotiation with my supervisor,	Therapist could amend the session limit slightly in negotiation with her supervisor		

	amend that slightly but generally it was 20 sessions regardless of the presentation	but generally it would be 20 sessions regardless of presentation		
B210-211	yeah the autonomy, I don't think it would change my practice as much but I think it would make me feel more comfortable to not feel so restricted	Having more autonomy wouldn't change her practice but would make her feel more comfortable therefore less restricted		
B56-57	I've worked in a capacity where I didn't have to, and it was actually in the same service, that I didn't have to say stop at 20 that I could spend a couple of years working with somebody	Previously able to spend two years working with a client, not restricted to 20 sessions		
C239	there are a lot of pros, more flexibility	Positive aspect of open-ended therapy is having more flexibility		
C17-18	In NHS we try to offer up to 24, uh, but when I work with child soldiers uh, I was quite fussy about it and I said that we need to please offer a year of treatment	Current session time-limit not enough for more complex clients		
C181-182	Years. I don't mean like 5 years, I mean like I have a client that I treat for the last two and a half years and we are in the process of wrapping up	Would typically work with complex trauma clients for as long as necessary, usually years		
D27-280	Yeah I think I think it would give me more flexibility and obviously you could do a lot	Would have more flexibility to do more with clients if working within an open-ended framework		

	more within that			
D280-281	it would give me more confidence cause I think that's one of the key things, confidence, cause if you know you've got 20 say sessions then you can go to some of these places	Would feel more confident within an open-ended approach as he would know he would have enough sessions to go to deeper places		
B206-207	I think if I was to do this work privately for example, the autonomy would make me feel much more relaxed	Would feel more relaxed within open-ended therapy as this would provide more autonomy		
B57-58	so whenever a life event would occur, you'd manage that life event and then you would carry on on the track you were intending to, but that flexibility now isn't there	Was previously able to help clients manage life events when therapy was more open-ended but no flexibility to do that within time-limited model		
C239	more time to formulate	Open-ended therapy allows more time for thorough formulation		
C239	more time to reflect	Open-ended therapy allows more time to reflect on clients		
C167-168	like with the other client I have two years, I did a very extended assessment	Open-ended therapy allows opportunity for detailed assessment		
C199-200	in private practice you have time to reflect and take it easy	Feels she has more time to reflect with clients in private work		
C192-193	In private work you can be more like, uh, curious, when I say curious, more extensive I suppose, you can spend a lot of time investigating family dynamics, contextual factors this kind of stuff,	Feels she is able to conduct more thorough investigation of client's life in private work which she is not able to in NHS work		

	in NHS you don't have the time to do that		
C168-169	You can formulate more extensively I suppose	Able to formulate more extensively in private practice	
C195-196	in private practice you have the capacity to make more links, to cultivate a better insight of things, in NHS it doesn't feel the same unfortunately	Feels there is more capacity to develop insight with clients in her private work which she doesn't feel able to do in NHS role	
A190-A191	I also think it means that there is more time to build rapport and relationship with people	Therapist feels that open-ended therapy benefits the therapeutic relationship as there's more time to build rapport	
A191-193	and more time to engage with people as well so it's not a case of, um, if somebody misses a session, doesn't get in contact, discharge - whereas there might be somewhat more of a proactive approach because you have more time	Therapist feels that an open-ended approach would allow more time for proactively engaging clients rather than having to discharge someone for missing a contact	
A193-196	so it's a case of kind of like you know what I mean going out there and trying to actively engage people to gain in the long term is going to be far more beneficial instead of somebody keep coming in and out of services and or being discharged and not coming back in to the services until it's crisis	Therapist feels that trying to actively engage clients for long-term gain is more rather than having people coming in and out of services or returning when in crisis	
C239-241	you can use more than one modality you can use EMDR you can	Would be able to use a multimodal approach with clients if therapy was open-ended	



	do some DBT with a client and then you can work more like psychodynamically as well such as like doing a lot of links with the past and things		
B95-96	Ordinarily, if there wasn't that time-limited factor in it, I would probably go with what the client brings	Would work with what the client brings if there wasn't a time-limit to sessions	
C158-160	the client cannot delay or divert or deviate off topics and stuff like that	No time for clients to raise issues outside of specific goals in time-limited therapy	
B109-113	I find that I'm using less therapeutic models because I don't have the time to use more, so ordinarily I would use CBT, EMDR, I would use compassion focused therapy, PCP personal construct psychology, but now I feel like I've got to pick and choose which I'm going to use and stick with it because I don't have the time to cross over with other therapies	Feels she does not have time to apply multiple therapeutic approaches within time-limited model	
B112-113	um, and I think that's unfortunate cause I think often clients benefit from multimodal therapies	Feels it is unfortunate she does not have time to apply multiple approaches as clients benefit from this	
B108-109	given the time constraints I find that I'm using less therapeutic	Finds she is using less therapeutic models due to the time constraints	

	models because I don't have the time to use more		
C193-195	in NHS you don't have the time to do that, you do that in the assessment and the formulation phase and then you leave it behind, so	Feels she doesn't have time for thorough exploration of a client's history beyond assessment and formulation in NHS work	
A130-132	also it depends on what I think you're targeting as well, so um, yeah which again can limit I think depending on how many sessions you have	Time-limited model can restrict the therapeutic work undertaken with clients	
C167-173	I did a very extended assessment only the assessment and formulation took like 10 sessions, uh we do like together like CBT formulation and like schema and then I with him Malan triangles from psychodynamic formulation, we spent so much time formulating but for him this was the most important piece of work because he understood for the first time in his life what is going on in his brain because he felt like that he is just crazy. Sometimes we don't have this time and I feel we need to brush over and I don't like that	Therapist feels she has to brush over assessment and formulation which she dislikes as this is sometimes the most important aspect of therapy for clients	
B43-48	so somebody I've been working with, we've done	Therapist spent 20 sessions stabilising her client however complex trauma symptoms have	

	over 20 sessions just stabilisation because she is just really really struggling and it's clear that the complex trauma is the thing that's making her struggle, the memories of it, but then her finances are in such a dire state at the moment that the symptoms have transferred onto that and so we're not in a position to carry on and do trauma work so I've spent 20 sessions or so trying to get her to this stage but then it's gone, it's just gone from what the things have gone on in her life	transferred to areas of clients life and they are unable to complete trauma work		
C238	There are a lot of positives	Open-ended therapy has a lot of positives		
C241-241	There are more positives than negatives to this	Open-ended therapy has more positives than negatives		
C173-174	I cannot see many advantages to this	Cannot see many advantages to time-limited therapy for complex trauma		
C155	There are positives and negatives	Time-limited therapy has advantages and disadvantages		
A202-203	I don't support open-ended therapy, no	Does not support open-ended therapy		
A219	I do support it, yes	Supports time-limited framework		
B170-171	I support time-limited therapy but not the limit we're working to currently	Supports time-limited model but not current session time-limit		
A224-226	I do support it but with a longer timeframe	Supports time-limited model but with longer time-limit		
A223	Yes I do support it but I think there should be more flexibility	Supports time-limited approach but feels this should be more flexible		
A216	eventually they'll	Offering extra sessions does not		

	get better and I don't think sometimes they can do	necessarily mean clients will get better	
A207-210	I think the potential for people thinking that um oh well you know people just need more of it and oh therapy can solve all these sort of problems whereas I don't think it can	Not all problems are resolved by offering more therapy	
A215-216	because it's oh well just keep seeing and eventually they'll get better	Open-ended therapy runs the risk of other professionals thinking clients just need more therapy	
A210-212	I think the potential for people thinking that um oh well you know people just need more of it and oh therapy can solve all these sort of problems whereas I don't think it can and the idea is someone's has had 40 50 sessions and then offer them another 20, no, I think it's got to that point where, for whatever reason therapy has achieved all it can achieve	Open-ended therapy risks other professionals thinking people just need more therapy when offering additional may not help	

## Appendix L: Supervisor Audit on Data Analysis

Lines	Raw Data	Open Code	Sub Category	Higher Order Category
A235-236	I think it's difficult, um, not having a diagnosis for complex trauma as there is a lot of variability in presentations, um, and this can be tricky for treatment	No diagnosis for complex trauma can make things difficult for determining treatment due to variability in presentations	Guidelines for treatment and the barriers these can present e.g. no complex trauma diagnosis therefore clients are often given other diagnoses such as BPD, DID and Bipolar which may describe what's happening but may actually stem from attachment trauma so treatment for this will be limited (BPD = DBT, Bipolar = CBTp), also there can be limited compassion for BPD diagnosis in teams	Organisational and contextual influence <i>higher order category seems to have this granularity in the sub-category</i>
C415-416	We don't really take borderline clients for individual therapy as they would normally get recommended for DBT	Therapist's service does not typically accept clients with BPD as the recommendation for treatment would be DBT		
D31-32	typically would attract labels of borderline personality disorder	Complex trauma typically attract the label of BPD		
D41-42	I have worked with quite a few people who have had the label and actually still been able to get some good results	Has worked with people with a BPD diagnosis and they have been able to get good results		
D77-78	but then it's also because of the barrier of the label, um, people with PD, if they said that is their only diagnosis then I may not say that individual therapy is going to be the best thing	Label of PD is a barrier as if this is the only diagnosis individual therapy may not be suitable		<i>sub-category into - diagnostic - treatment - could be split</i>
D79	due to the NICE guidelines and evidence base but again that's a barrier	NICE guidelines and evidence base can be a barrier for treatment for PD diagnosis		
D79-80	I feel the diagnosis interferes with the types of therapies available to people, very much so, 100%	Strongly feels that diagnosis interferes with the types of therapy available to people		
D38-41	I mean, I think the label is a block if I'm honest, Borderline Personality Disorder because of course the evidence base is not within much individual work it's just with DBT group, um, which certainly I think now which is good but that will already be an automatic block before you can think about any individual work	Feels the label of BPD is an automatic block to individual therapy as the evidence base recommends group intervention as treatment i.e. DBT		
D80-81	DBT is the only thing you can offer somebody with borderline, that's basically what the NICE guidelines say really	The only available treatment for BPD is DBT according to NICE guidelines		

D8586	but yeah, I think that people with borderline, it does create a serious block there	Feels there is a serious block to treatment for people with BPD	
D89	Yeah. I think it's massive because	Feels that having no formal diagnosis for complex trauma is a massive barrier	
D129-131	again if you look at the research 50% of people meet the criteria for PTSD who've got borderline even though that's never even considered by psychiatry which is my frustration, it's just borderline and that's it	Feeling frustrated with reductionist approach of diagnosis as research suggests that 50% of people diagnosed with BPD meet criteria for PTSD	
D81-83	you might be able to get away with a bit of schema but the NHS system there's no way they're going to offering 6 months' worth of schema therapy really, these days	Feels schema therapy could be suitable for BPD although does not feel the current NHS system would offer six months of schema therapy	
D89-91	borderline is a very pejorative term and also clients who enlist care, teams often stigmatise them in the sense that it's "personality" so there's something intrinsically wrong with them	Feels that borderline is very pejorative and can lead clinical teams to stigmatise clients in the sense that "it's personality" suggesting that there is something intrinsically wrong with them	
D91-92	that's the problem, rather than actually being a bit more compassionate and saying well actually they've actually been horrifically traumatised	Feels that the BPD diagnosis can be a barrier to teams viewing clients more compassionately and just being severely traumatised	
D92-94	they actually haven't had a decent attachment figure or good parenting they've just had horrendous stuff that's happened to them so actually what else are they going to do, what else can we expect?	Thinking about what individuals with a BPD diagnosis have suffered may help understanding of ways in which they behave	
E60-62	and I think sometimes these patients come with Bipolar II diagnoses, which is not wrong, Bipolar II does describe what is happening, but it can be misleading as Bipolar does tend to get lumped in with the psychotic end of things	Diagnoses can be misleading i.e. diagnosis of bipolar II can describe what is happening to a client however this tends to get grouped within psychosis which can be misleading	
E62-63	whereas the damage, if you like,	Diagnosis can be misleading as	

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	the dysfunction is rooted in an attachment trauma here	damage/dysfunction can stem from attachment trauma	
E65-67	it's so interesting that relationship between people who end up people who end up looking more like Bipolar II and people who end up looking more like BPD	Considering the relationship between people who edge towards Bipolar presentation and those who move more towards BPD when both stem from attachment trauma	
E241-242	I agree that the BPD side of things is important but it's the people that get diagnosed with Bipolar II	Agrees that borderline diagnosis is important but feels that people diagnosed with Bipolar II need to be looked at	
E242-243	at least BPD has a treatment pathway whereas Bipolar II will only have CBT for psychosis so, um, so it's quite limiting for people	Feels that people diagnosed with Bipolar II are very limited in terms of treatment as they will only have CBT for psychosis as a treatment pathway	
E232	Diagnosis for complex trauma is zooming up the agenda	Diagnosis for complex trauma is zooming up the agenda	
E232-233	I think the good thing with that is it'll shift the emphasis I hope from DID	Hopeful that complex trauma diagnosis will shift the emphasis away from Dissociative Identity Disorder	
E233-235	because as soon as you start talking at the moment about complex PTSD and dissociation people just start thinking about DID which is important but that's not the vast bulk of the patients that are coming through the doors	Feels that in talking about complex PTSD and dissociation people assume DID however this is not what the vast majority of clients present with	
E238-239	the important thing there is it would reduce the number of false schizophrenia diagnoses	Properly assessing for DID would reduce the number of false schizophrenia diagnoses	
E239-240	and the wasted medication and trying to treat people through medication than through therapy i.e. clozapine clinic every week, monitoring people every week	Proper assessment for DID would reduce wasted medication for trying to treat people with schizophrenia diagnoses through medication e.g. clozapine and weekly monitoring for this	
E241-242	I agree that the BPD side of things is important but it's the people that get diagnosed with Bipolar II	Agrees that borderline diagnosis is important but feels that people diagnosed with Bipolar II need to be looked at	
E242-243	at least BPD has a treatment pathway whereas Bipolar II will only have CBT for psychosis so, um, so it's quite limiting for people	Feels that people diagnosed with Bipolar II are very limited in terms of treatment as they will only have CBT for psychosis as a treatment pathway	
A103	for me anywhere between 40 and	40-60 therapy session limit is enough	Balancing the dialectic of the Contextual and

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	60 seems to be enough I think	time-limited therapeutic frame as open-ended therapy would provide greater flexibility due to restricted, more autonomous, being able to work with clients as long as necessary and help clients through life events but there also needs to be a cut off at some point. Additionally, duration affects capacity for proactively engaging clients, assessing, formulating, reflecting and building rapport, however T/L therapy creates boundaries and prevents therapy becoming amorphous	organisational influence
A102-103	I think 40 is a sort arbitrary mark but you've got to make a point somewhere	40 is an arbitrary time-limit but feels therapy needs an end point	
A103-104	40 is fine for me	Happy working within 40 session limit	
A99	40 sessions seems enough	40 sessions is enough for complex trauma clients	
A221-224	I mean, if I was redesigning a service, I would offer 40 sessions of therapy	Would offer 40 sessions if designing a service	
A95-97	seems to be a lot of kind of evidence that if someone's not made sort any real sort of progress after 40 sessions that offering another 40 probably isn't going to help	Evidence suggests that clients who do not make much progress in 40 sessions will not make much progress beyond this	
A219-221	with certain places 20 sessions would be the maximum and for me that's sort of not long enough especially with people with sort of complex trauma	20 sessions is not enough for clients with a complex trauma history	
A97-98	it seems to be the changes you get from sessions 40-60 seem to be sort of very sort of minimal	Minimal changes between 40-60 therapy sessions	
B210-211	yeah the autonomy, I don't think it would change my practice as much but I think it would make me feel more comfortable to not feel so restricted	Having more autonomy wouldn't change her practice but would make her feel more comfortable therefore less restricted	Again, this looks over-inclusive to me so I'd split this & offer help waves. I'd be interested in the way to do it
B12	Yes, because the kind of clients that I'm seeing would normally, 20 sessions isn't sufficient enough	20 sessions is not enough for clients with a complex trauma history	
B170-171	I would ideally like a time-limited structure but not to the limit that we're at currently	Favours time-limited framework but 20 session time-limit not enough	
B57-58	so whenever a life event would occur, you'd manage that life event and then you would carry on on the track you were intending to, but that flexibility now isn't there	Was previously able to help clients manage life events when therapy was more open-ended but no flexibility to do that within time-limited model	
B56-57	I've worked in a capacity where I	Previously able to spend two years working	



	didn't have to, and it was actually in the same service, that I didn't have to say stop at 20 that I could spend a couple of years working with somebody so then that pressure that's eased off	with a client and felt that this eased pressure	
B12	Yes, because the kind of clients that I'm seeing would normally, 20 sessions isn't sufficient enough	20 sessions is not enough for clients with a complex trauma history	
B170-171	I would ideally like a time-limited structure but not to the limit that we're at currently	Favours time-limited framework but 20 session time-limit not enough	
B206-207	I think if I was to do this work privately for example, the autonomy would make me feel much more relaxed	Would feel more relaxed within open-ended therapy as this would provide more autonomy	
C239	there are a lot of pros, more flexibility	Positive aspect of open-ended therapy is having more flexibility	
C17-18	In NHS we try to offer up to 24, uh, but when I work with child soldiers uh, I was quite fussy about it and I said that we need to please offer a year of treatment	Current session time-limit not enough for more complex clients	
C181-182	Years. I don't mean like 5 years, I mean like I have a client that I treat for the last two and a half years and we are in the process of wrapping up	Would typically work with complex trauma clients for as long as necessary, usually years	
D27-280	Yeah I think I think it would give me more flexibility and obviously you could do a lot more within that	Would have more flexibility to do more with clients if working within an open-ended framework	
D280-281	it would give me more confidence cause I think that's one of the key things, confidence, cause if you know you've got 20 say sessions then you can go to some of these places	Would feel more confident within an open-ended approach as he would know he would have enough sessions to go to deeper places	
C239	more time to formulate	Open-ended therapy allows more time for thorough formulation	
C239	more time to reflect	Open-ended therapy allows more time to reflect on clients	
C167-	like with the other client I have two	Open-ended therapy allows opportunity for	

168	years, I did a very extended assessment	detailed assessment
C199-200	in private practice you have time to reflect and take it easy	Feels she has more time to reflect with clients in private work
C192-193	In private work you can be more like, uh, curious, when I say curious, more extensive I suppose, you can spend a lot of time investigating family dynamics, contextual factors this kind of stuff, in NHS you don't have the time to do that	Feels she is able to conduct more thorough investigation of client's life in private work which she is not able to in NHS work
C168-169	You can formulate more extensively I suppose	Able to formulate more extensively in private practice
C195-196	in private practice you have the capacity to make more links, to cultivate a better insight of things, in NHS it doesn't feel the same unfortunately	Feels there is more capacity to develop insight with clients in her private work which she doesn't feel able to do in NHS role
A190-A191	I also think it means that there is more time to build rapport and relationship with people	Therapist feels that open-ended therapy benefits the therapeutic relationship as there's more time to build rapport
A191-193	and more time to engage with people as well so it's not a case of, um, if somebody misses a session, doesn't get in contact, discharge - whereas there might be somewhat more of a proactive approach because you have more time	Therapist feels that an open-ended approach would allow more time for proactively engaging clients rather than having to discharge someone for missing a contact
A193-196	so it's a case of kind of like you know what I mean going out there and trying to actively engage people to gain in the long term is going to be far more beneficial instead of somebody keep coming in and out of services and or being discharged and not coming back in to the services until it's crisis	Therapist feels that trying to actively engage clients for long-term gain is more rather than having people coming in and out of services or returning when in crisis
B157-159	but part of me actually thinks that the client benefits from having those time constraints as well is	Clients benefit from the boundary of time constraint in time-limited therapy

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	making having those boundaries		
B172	but I also think time limits are needed to create to ensure boundaries	Time-limits create and ensure boundaries	
B171-172	so I think time-limited has a place to avoid dependency	Feels time-limits are useful as they prevent dependency	
A206-207	to help people to work towards an end and manage that well I think is sort of very sort of therapeutic, um, with people	Helping people manage endings has therapeutic value	
A204-206	things end, whether it means that somebody is moving to a different job whether it ultimately means the death of someone you know what I mean there is sort of an end	Endings are important as they happen in life	
A203-204	because I think the idea of there being an end point I think is actually quite therapeutic with people because things end, you know	Endings in therapy have therapeutic value	
C235-236	um therapy can turn up to like counselling and just provide a and can be like a chit-chat so this is like a negative thing	Open-ended therapy can be negative due to risk of this becoming like counselling	
C234-235	because when you have OE therapy the client cannot stay focused and can deviate a lot and digress to other things	Open-ended therapy can become unfocused due to client deviating	
C242-243	therapy can be a little bit loose without structure and can end up like a friendship if you do like 3 or 4 years	Open-ended therapy can turn into a friendship between therapist and client due to this being unstructured	
B97	because some therapies going on for years and d years if there wasn't a limit to it	Without the time-limited structure, therapy could go on for years	
C174	the only one is to stay focused	Therapist feels the only positive to time-limited therapy is focused treatment	
B161-163	kind of say well how far have we come and it give us an opportunity to review to say ok well in the 20 sessions has anything really	Reviews in time-limited therapy provide opportunity to help to track progress of therapy with client	

	changed or has anything really helped				
A10-11	typically start with 10 and then we might have a review and then might do another 5 or another 10 or however many depending on our review	Time-limited model beneficial for reviewing the therapeutic process			
B163	if so then has it helped you enough that we can end here or do you think that you still need more so it kind of puts the ownership on them and having the time limit does help with having the constant reviewing	Holding regular reviews with clients to track the progress of therapy is beneficial as it places ownership of the therapy on the client			
B96	but it's almost saying you do need an agenda which is not necessarily a bad thing	Feels time-limited therapy provides an agenda which is positive as therapy could go on for years if there wasn't a limit			
A112-113	which in a way is a positive thing I think because it sort of kind of like focus your mind because it's needing to get moving with things	Feels he has to be focused and get moving with things within time-limited therapy			
A152	um yeah and in terms of kind of therapy we provide as well it has to be very focused	Therapist has to provide very focused therapy when it is time-limited			
C156-157	The pros is that uh if you imagine that the client and therapist is like a team so can team up and set some very specific goals and can work on them and that this means that in each single session we work very hard together and this is a positive	Therapist feels that a positive of time-limited therapy is that it creates collaborative working in which therapist and client work hard together in each session to achieve set goals			
A112	it means that every session is very important because you know you haven't got that many which in a way is a positive thing	Feels that every session is important because there aren't many			
C160-161	so we'll need to stay very focused on our agenda and this can be very oppressive as well, like "I don't want to listen about that we need to talk about the trauma"	Therapist feels that focusing on an agenda can be oppressive as she is not able to listen to clients' other issues due to having to focus on the trauma			
C158-160	the client cannot delay or divert or deviate off topics and stuff like that	No time for clients to raise issues outside of specific goals in time-limited therapy			
			Balancing the dialectic of the time-limited therapeutic frame as T/L therapy can restrict the therapeutic process i.e. clients can find the agenda oppressive, not enough time to apply multiple		Contextual and organisational influence

*Handwritten notes:*

Contextual and organisational influence

Balancing the dialectic of the time-limited therapeutic frame as T/L therapy can restrict the therapeutic process i.e. clients can find the agenda oppressive, not enough time to apply multiple

Therapist feels that focusing on an agenda can be oppressive as she is not able to listen to clients' other issues due to having to focus on the trauma

No time for clients to raise issues outside of specific goals in time-limited therapy

### Appendix M: Excerpt from Memos

- Long term gains for clients: more time would allow for management of life events (B57-58) and actively engaging people in therapy at the initial stages (A195-196)
- Autonomy would make clinician more relaxed (B206-207) – what would they do differently? What effect does not having this autonomy have on current practice?
- Restriction....do clinicians feel safe in this restriction? What would it be like to work for years with someone with CT?
- Time-limit restriction puts pressure on clinician (B56-57) to do what? Achieve results? Outcomes?
- Proactive engagement at the beginning could have a longer term benefit of engagement/disengagement from services and ‘revolving door’ clients
- B156-157: what does “feel better” mean? What makes therapy “successful”?
- B207: let the client “be” rather than “do” – can we do this? Is this the point of therapy? What if we didn’t have results or outcome targets?
- C155-156: the idea of therapist and client being a “team” – is this the aim of all therapeutic dyads? Do clinicians feel this is what should happen? Team, partner, collaborative, us against the world, teaming up against the system?
- B171-172: time-limited therapy avoids dependency, is there a sense of safety/comfort in time limit? Is there a fear of dependency underlying or is it more about healthy boundaries?
- C156-157: “work very hard together” – does that mean that if therapy was open ended they wouldn’t work hard together? What is the point of therapy here?? What is the “work”?
- B161-163: how do you measure progress?? How do you know what’s “helped” or “changed”? Is this objective or subjective? Is this the client? The therapist? The outcome measures? What will determine whether the person warrants more sessions? How does the person know if something has “helped enough”?
- Interesting contradiction: reviewing T/L therapy gives control to client but clinician in control of how much clients will get and determining what they need through reviews
- Interesting that one clinician feels that “moving therapy along” is positive but one feels she wouldn’t feel pressured to do this and this would be positive
- C214-215: clinician feels she is responsible for healing wounded clients. Grandiose?? Does she have the power to heal?

- Domino effect of lack of funding – from wider state services, down to the clinicians, to the individual client themselves
- C212-213: is the blame misplaced here? Easier to blame the Trust than the 3 clinicians who left their clients wounded? Or is this the limit of taking advantage of the “good nature” of people in caring professions?
- C42-44: clinician battling “against” the idea she can’t cure her clients – is she really battling against the idea of her own limitations??
- C85-86: clients become angry, perceive clinicians as perpetrators, can dissociate into time where they were being tortured – how safe do clinicians feel in this work? Risk to clinicians.
- C88-89: Clinician feels it’s very hard to dismantle defences in CPTSD clients. Should we be “dismantling” defences in complex trauma clients when they have developed for very good reasons? Shouldn’t it be about navigating more than dismantling? Stripping clients down – mistrust – vulnerability – abuse.
- B168-170: What defines a “more complex” client? Amount of traumas? Severity? How is this discovered or measured?
- A210-212: why is 40 the magic number? why would everything have “been achieved” in this time? What is there to be achieved? Who is this number benefitting, the client or the therapist??
- A110: what does “get results” mean??
- B87-88: one or two cases where EMDR has not worked due to client “not connecting” – does clinician take any responsibility? What showed that client wasn’t connecting with it??
- Clinician feels angry and powerless about ethical dilemma he finds himself in – powerless from people above? The way clients often feel? Parallel process.
- C260-261: what is the purpose of trauma therapy? Is it solely to resolve the trauma? What about the relationship – isn’t that first and foremost?
- C262-263: what if the issue is feeling safe with you? They don’t know you and you’re asking them to go back to some of their darkest, most traumatic places but at least you can “get on” with the therapy.
- C265: clients are “rendered” ready - synonyms: adjudicated, judged, decreed, declared. Interesting choice of words.
- C266: less time consuming for clinicians – nowhere has there been a focus on the client.
- B60-63: clinician again ignoring the key stabilisation work and feeling that she would have wasted her time if she is unable to extend sessions for core processing work. Isn’t the stabilisation the most important for building trust/relationship??

- Parallel process – time-limit of sessions/time-limit of research!

Restriction: not only of resources but therapists feel restricted in their practice and professional development as well as their ability to help clients.

Emotions experienced by the therapists in their role: anger, frustration, despair, hopelessness, despondency, mistrust, fear, lack of containment. How do these affect their practice/impact their clients?

Safety: therapists lack safety in their work, both by the physical/emotional impact of working with complex trauma but also working within an organisation that seems to only care about efficiency and outcomes. Does time-limited therapy offer them safety and containment though? All of them have expressed the positives of a structure and value of an ending.

Therapeutic models/constructs: all of them have talked about the advantages of applying a multi-theoretical approach with complex trauma work. All of them support EMDR thoroughly. Some say this can fit into T/L approach, some say it can't and work will have been "wasted" if processing is not undertaken. Quite outcome focused which can't be helped I suppose.

Conflict: this needs more unpacking. What is the actual conflict? One describes an ethical dilemma of client vs resources but what if therapy was open-ended? What would be different? Is the conflict one of values as it seems to be at the moment? Psychologists trained to focus on process then work in a context that is purely focused on content?