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RELATIONSHIP-BASED SOCIAL WORK

A 'THIRDSPACE' IN RESPONDING TO TRAUMA

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Summary

This practitioner research study explores people's lived experience of trauma leading to their engagement with the social work service of a hospital emergency department. It further explores the elements of responsive social work in this context and presents a conceptual framework for trauma-informed social work practice.

Trauma has traditionally been understood within an individualised, psychologised idiom. The 'psychiatrisation' of trauma as a single disorder - Post Traumatic Stress Disorder is reductionist in its neglect of the psychosocial and socio-cultural factors that shape trauma narratives. This research suggests that much of the lived experience of trauma is intersubjective in nature and falls outside the parameters of the narrow PTSD diagnostic category.

This research was undertaken within a constructivist-interpretive paradigm with service users, social workers and non-social work emergency department professionals. In total 26 people participated in the research. Semi-structured interviewing and a mini focus group were selected as the approaches to data gathering and the data was analysed using a constructivist grounded theory approach.

The findings indicate that trauma encompasses profound existential feelings including loss, distress, disconnection and disjuncture, a changed sense of self and changed life circumstances, giving rise to experiences of liminality. Trajectories of responding to trauma in private and public emerged from the data. Meaning attributed by research participants to their experiences is shown to arise from and to be modified through inter-personal relationships. For many, trauma becomes their dominant lived experience which is felt, defined, interpreted and incorporated in interaction in the (now changed) everyday world.

Social work in this context was experienced as a relationship-based process which creates a space whereby the significance of trauma is recognised and ways to respond are [re]viewed and made practicable. The findings suggest that despite negative preconceptions of social work held by many research participants prior to attending the service, social work had successfully established itself at the interface of medical and psychosocial realms creating an autonomous 'thirdspace' encompassing spatio-temporal (dedicated time and protected space), relational (collaborative and relationship-based), dialogical (the service is delivered through talking, listening and

interactive discussion), ethical (the social work approach is based on humanistic ethics and principles of social justice) and phenomenological (focusing on lived experiences and meaning making) dimensions.

In working together through the social work process, a safe, contained, 'thirdspace' is co-constructed by social workers, service users and other hospital emergency department professionals who refer to the service. Through dialogue, meaning making and building on people's strengths, social work intervention was found to have contributed to people's capacity to re-position themselves in relation to the trauma, resulting in reduced levels of distress. This allowed a re-connection with themselves, with other people and other aspects of their lives, countering the sense of disconnection which is a common feature of trauma.

The research highlights the significance of psychosocial and socio-cultural dimensions of trauma and illustrates the value of social work intervention in acute healthcare settings where people present in the aftermath of traumatic experiences and events. The relationship-based social work process delineated through this research has informed a conceptual framework for trauma-informed social work practice, which is presented in this thesis.

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Chapter 1 Introduction

"I am I plus my circumstance...."

Ortega y Gasset

Prologue – In Search of Ways to Respond

It's a frosty morning in February and I'm passing through the busy 'majors area' of the Emergency Department of the Dublin hospital where I work as a social worker. The floor space is crowded with people on trolleys, accompanied by concerned family and friends, anxiously awaiting updates from staff. I know this scene is the subject of discussion at a hospital bed management meeting underway upstairs and it will probably feature on 'talk radio' as the day goes on. It's 2003 and we're still dealing with the "bed crisis" that has dominated Irish health care for over a decade since cuts to the health budget in the late 1980s resulted in extensive hospital bed closures leaving Ireland with a significantly poorer ratio of hospital beds per thousand population than is the European average (Tussing and Wren 2005, 2006; Burke 2009). I'm on my way to the Liaison Nurse's office to discuss today's referrals to the social work service. In the office, the liaison nurse goes through a list of overnight admissions and subsequent referrals, prioritising James a thirty five year old man who had tried to end his life the previous night and his partner Helen who had found him and is, according to staff 'traumatised'. The suicide attempt was, staff understood, the result of James's debts coming to light, with initiation of legal action by a major creditor of his business. Helen had been unaware of the extent of James's financial difficulties until then. James has also been referred for assessment to the liaison psychiatry team. As I went to find James and Helen I questioned what, if anything, I could say or do, would have meaning as a response to what I imagined might be their feelings of fear, shock, failure, hurt, guilt, anger and betrayal. I thought about approaches and conceptual frameworks – crisis intervention, indicators of trauma reactions, debriefing and suicide risk assessment - all technical-rational approaches which in themselves didn't seem sufficient to the needs I anticipated I would meet. What seemed to make most sense as I walked into a side room off the Emergency Department main floor where they waited, was to introduce myself, acknowledge that it had been an awful night for them and then listen really well and try to understand their worlds. I would now think of this approach as underpinned by Social Constructionism (Witkin 2007, 2012; Gergen 2009) and also as a beginning process in work aligned to Relationship Based Social Work (Howe 1998; Sudbery 2002; Trevitchick 2003; Ruch 2005; Wilson, Ruch, Lymbery and Cooper

2008; Ruch, Turney and Ward 2010). A strength of Relationship Based Social Work is its capacity for containment of difficult and frightening thoughts and feelings and thus its potential in creating safety, but the term Relationship Based Social Work was just emerging at the time and I was not familiar with it. My intervention on the day was person-centred, focusing on what was most urgent and significant for both people, what were their immediate needs, how they were both feeling and how their needs could best be met in the short and medium term. A key aim was to build an alliance with them and to give them back some control, the loss of which is a common feature of trauma (Dunn 2001). I was mindful that their emotional distress was personal to each of them but was also arising from and affecting their relationship, extending to their individual and shared assumptions, beliefs and hopes and was linked to the broader circumstances of their lives. Potential ways forward needed to address all of these dimensions.

Rationale for Practice-Based Research

Social work in Ireland is located within statutory health, child protection, criminal justice and housing systems, in non-governmental organisations and within an emerging private health and social care sector. In practice, it takes many forms from procedurised, case-management style practice at one end of the spectrum to relationship-based practice at the other. Social work generates debate in Ireland and internationally as to its efficacy in responding to human difficulties and distress. It has been subject to major child protection inquiries and reviews the most recent of which (Gibbons et al 2010; Munro 2011) stress the importance of meaningful engagement with primary clients as a corrective to overly procedurised, defensive, distanced 'case management' type practice. There have been calls in the social work literature too, to re-engage in direct work (Parton 2008; Featherstone et al 2011) and to embrace forms of relational (Broardhurst and Mason 2012) and relationship-based practice (Lefevre, 2008; Ruch et al., 2010).

In addition to questions of efficacy, social work's once particular orientation to individual rights and to a social perspective within inter-disciplinary contexts has been adopted across disciplines with concepts such as 'person-centred planning' and 'the social model of care' now integrated in service delivery. Thirdly the relationship between social work, counselling and psychotherapy has long been a source of tension. On the one hand social work, informed by a political analysis of societal inequality and social

exclusion understands the often detrimental impact of institutionalised capitalism, patriarchy, racism and ageism in people's lives. Social work academic debate has been justifiably critical of counselling's individualisation of distress (Specht 1990; Specht and Courtney 1995; Ferguson 2001; Fook 2002). On the other hand in practice some social workers pursue additional counselling and psychotherapeutic training, feeling de-skilled in responding to emotional distress. Perhaps this is due to a disciplinary orientation to problem-solving and effecting social change (I.F.S.W. 2014) which is not always possible (at least not directly) or even sought in some areas of practice, particularly in health-related settings where people are ill, injured or bereaved. Morell discussed social work's

> *'...uneasy polarization between political explanations and personal solutions'*
>
> (Morell, 1996:307).

These polarised positions need to be integrated theoretically and practically if social work is to continue to make a meaningful contribution in working with psychosocial issues. It has been argued that there is a lack of research on the detail of *'what social workers and other professionals actually do'* (Ferguson 2011: 4). I believe research at practice level can articulate and contribute to the development of defining features of social work by deepening understanding of what social workers do and why it may be useful that they do it. This rationale informed this study which is located within the social work service of a Dublin hospital emergency department where I worked at the time. Moreover mindful of the criticism that all too often

> *'the (social) investigator stood with his or her back to the heart of medicine and studied the "social phenomena" surrounding it'*
>
> (Berg and Casper 1995: 397)

I wanted to undertake research in collaboration with non-social work colleagues, to hear their perspectives on the needs of people who have experienced trauma and to understand how social work practice becomes extensive with emergency department care. I hoped the research could make a contribution to developing inter-disciplinary practice.

As already discussed this is a practitioner research study. As such it has potential to capture 'practice wisdom' and allow for theory building and skills development based on practice experience. It is also potentially problematic due to the inherent risk of bias and other issues related to 'insider status'. Practitioner research is under developed in social work and therefore warrants further research. Early applications of practitioner research in the discipline arose within the empirical practice tradition (Kazi 1997; Thyer

1998). It was also adopted by those who took a pragmatic approach to research methodology (Fuller 1996; Cheetham 1998). Critical appraisal of the fit between social work practice and qualitative research (Lang 1994; Padgett 1998, 2008; Grinnell 2008) provides a significant contribution to the literature and indicates potential for research based on qualitative methodologies in diverse practice settings. In recent years academic-practitioner alliances have formed to build and support practitioner research capacity (McCrystal 2000; Waldman 2005; Fouche and Light 2011; Shaw and Lunt 2011; Beddoe and Harington 2012).

Context of the Research

The research site is a large acute teaching hospital in Dublin, with capacity in excess of 800 beds. It provides acute care to a catchment area of approximately 290,000 in population, together with a regional and national service in areas of specialism. The Emergency Department provides services to more than of 45,000 patients each year, primarily from the local catchment area. This adult Emergency Department service is provided 24 hours a day, 365 days per year.

The social work service provides a daily 'on call' assessment, crisis intervention and referral service to people who are in the Emergency Department and a more flexible follow-up social work service as required. At the time the fieldwork for this study was undertaken (2001-2003) there were two social work posts dedicated to the Emergency Department, staffed by one full time and two part-time social workers.

For some people who attend the Emergency Department, their illness or injury constitutes a crisis and generates traumatic stress due to its seriousness or the meaning it has in the context of their lives. In the course of their medical treatment people often tell frontline staff about difficult or dangerous situations in their lives. These conversations may give rise to referrals for social work follow-up. This study aims to explore the factors which may contribute to a useful social work response to the intensity and complexity of the situations (including self-harm, traumatic bereavements, domestic violence and the impact of accidents or assaults) with which people seek help in the hospital.

Reflexivity

Reflexivity has been defined as

> *"an effort to reflect on how the researcher is located in a particular social, political, cultural and linguistic context"*
>
> (Alvesson cited in McMylor 2005:142)

Reflexivity involves awareness on the part of the researcher of his/her positioning as a participant in the research and how this may affect the research process and outcomes. In addition to consciousness of one's own assumptions and values, reflexivity also requires examination of

> *"the conceptual frameworks within which we work–the assumed and/or chosen ones of our discipline, culture, and historical moment"*
>
> (Harding 1996: 159)

In qualitative research the voice of the research participant is often filtered by the researcher through processes of sampling, data collection, data analysis and representation in the final research text. Reflexivity can highlight how assumptions and values of the researcher, often emanating from their social location, may subconsciously shape both data gathering processes and interpretation of the findings (McNair et al 2008). It is therefore critically important to demonstrate reflexivity in the research process by explicating the 'positioning' of the researcher in relation to the research and taking the necessary steps to address potential bias. The research represented in this dissertation arises from my practice as a social worker at an acute general hospital emergency department and the practice of colleagues. I brought a multi-layered identity to the research process. My biography is that of an Irish, middle class, white woman originally from a rural farming community and living in a city for many years. Only one of the research participants was from outside Ireland and a majority were from an urban background. Most were in employment or self-employed, one was retired, one a full-time mother and one was a student (see appendices 6, 7, and 8). My life history particularly the illness and death of my father when I was a teenager heightened my sensitivity to the trauma experienced directly and indirectly by the research participants.

My own reflective process throughout data collection and analyses and conversations with social work colleagues and with my supervisor, ensured I used my own experience as one of many sources of insight in undertaking this research. As a social worker with

a strong commitment to social work values, embarking on practitioner research in my own organisation, I was very connected to the phenomena I sought to research. The research was carried out with social workers, people who used the social work service, and with a range of professionals who referred to the service seeking a resource for others. Many of the research participants were known to me as colleagues and as service users. My 'insider status' brought a focus to the need for rigour in data collection and interpretation. This informed the choice of semi-structured interviewing and a mini focus group utilising schedules of open questions, as the means of data collection. The aim was to give emphasis to the meaning-making processes of the research participants and guard against insider assumptions and premature interpretations on my part. Being mindful of and responsive to changes in verbal and non-verbal communication on the part of interviewees and of my own reactions as various topics and experiences were explored was important. This allowed me to attend to issues and interpretations of significance for research participants and to avoid over-focusing on my own questions. Reflexivity also heightened my sensitivity to the impact of my biography in relating to interviewees and the potential influences of similarities and differences in gender, class, age and professional status. Differences were acknowledged as they emerged in research conversations for example in conversations with male service users on men's perceptions of help seeking behaviours and in a discussion with a younger service user on the impact of peer pressure.

However my 'insider status' as a service provider also generated a sense of reciprocity as we (interviewer and service user or Emergency Department professional interviewee) committed to a shared purpose of building knowledge of trauma and understanding the elements of a meaningful social work response, in a context in which we were all stakeholders. This reciprocity and common purpose helped us move beyond the actual and perceived differences between us. Reflexivity and reciprocity allowed for conscious sharing of control during the interviews and agreement to apportion time to explore issues of most significance to the interviewees. This approach improved the quality of engagement and trust and enabled negotiated interpretations and development of shared meaning as the interview process evolved.

The findings were analysed within an interpretative paradigm using a structured constructivist grounded theory approach. Interpretations were checked as part of the data collection process and a number of research participants gave feedback on final interpretations when data analysis was complete. Additional rigour was achieved through use of NVivo which tracked the data analysis process. Triangulation of sources

achieved through engaging perspectives and assumptions from outside social work was a critically important counterpoint to my insider social work practitioner researcher position. As Hibbert et al argue

> *"There is a need for reflexive practice that allows the richness of our conversations to be enhanced through the interplay of multiple perspectives and assumptions. This involves engagement between groups that work from different worldviews yet have something relevant to say to the same field of research. By juxtaposing differences, we begin to articulate and question assumptions underlying our knowledge community and paradigm and explore new possibilities."*
>
> (Hibbert et al 2014: 284)

The inter-subjective nature of this work is fully acknowledged in this dissertation. I use the personal pronoun throughout the text so the reader is alert to the reflexive nature of this dissertation, my 'insider status' in the research setting and my standpoint as a social work practitioner researcher. The relevance of reflexivity, my 'insider status' and the connectedness of my personal and professional 'locations' in carrying out the research are further discussed in Chapter 4 Methodology and Chapter 8 Discussion and Conclusions. The dissertation ends with an Epilogue in which I revisit my search for ways to respond to trauma and reflect on key learning achieved from undertaking this research.

Research Questions

The aims of this study are to reach a deeper understanding of the lived experience of trauma and to gain insight as to the elements of a responsive social work service from the perspectives of people who use, refer to and provide a social work service in this context. The primary research questions are:

> *What is the nature of the lived experience of trauma?*
>
> *What are the elements of responsive social work practice in this context?*

More specifically the aims of the research are:

1. To understand the lived impact and subjective meanings of traumatic experiences and to be attuned to both trauma and resilience in people's ways of being and coping in adversity.

2. To gather a range of perspectives on the elements that coalesce as social work, in the context of trauma. I wanted to uncover the details of practice by getting 'behind the scenes' views of what happens in social work sessions and tracking how processes (for example meaning-making or change) emerge, rather than produce a more 'objective', descriptive or evaluative study. I wanted to understand social work as it is viewed by people who have used social work services as a resource for themselves or to which they refer others. In addition I wanted to explore social workers' perceptions of what they do and why it is they do it, in a given way.
3. To contribute to the development of social work in response to trauma in a healthcare context by articulating social work as it is practiced and on the basis of the findings and the relevant literature to develop a conceptual framework to underpin practice.
4. To consider the implications of the findings for trauma-related social work practice, practitioner research and inter-disciplinary practice.

Structure of the Dissertation

This dissertation is organised as follows:

Chapter 2 provides a review of trauma literature much of which is written in psychiatric and psychological idioms. Following a historical overview of developments in understanding of trauma, the construct Post Traumatic Stress Disorder (PTSD) is discussed and critically analysed. It is argued that social and cultural perspectives are under-represented in the psychologised domain of PTSD and the need to theoretically integrate a socio-cultural, critical consciousness in understanding and responding to trauma is discussed. The potential of philosophical, feminist and critical social work perspectives to contribute to a socio-cultural and political understanding of trauma is explored.

Chapter 3 locates this practitioner social work study in the context of a wider social work literature. The literature is reviewed to identify practice approaches which best address the multi-faceted dimensions of human experience that are engaged in the context of trauma. A case is made for the efficacy of Relationship-Based Practice underpinned by reflexivity and informed by theories of Social Construction in order to address personal, inter-personal, socio-cultural and structural causes of distress.

Chapter 4 is concerned with the development and implementation of a research design to address the primary research questions. The selection of an appropriate paradigm in which to pursue this study is outlined. Then the discussion moves to the methodology and methods employed, centring on Constructivist Grounded Theory. The position of the practitioner researcher and the issue of insider status are addressed and ethical issues pertaining to the study are discussed.

Chapters 5-7 report on and analyse the research findings. The findings of this study are presented in three chapters to reflect the dimensions of experiencing trauma, living through trauma in the everyday world and engaging in social work in the context of a hospital emergency department.

Chapter 5 'Experiencing Trauma – Entering a Liminal Space' reports on the individual, lived experiences of trauma recounted by the participants of this study and the socio-cultural forces that shaped their experience. Findings are presented in relation to three key themes (i) changed situation (ii) changed experience of self; and (iii) feelings of trauma and loss. A range of sub-themes arising from the data analysis are discussed. At a further level of abstraction a meta-theme of liminality is proposed.

Chapter 6 'Living Through Trauma in the Everyday World' explores the reflexive experience of living through trauma, the ensuing search for meaning, oscillation between coping and not coping and re-evaluation of priorities, social practices and 'ways of being in the world' (Heidegger 1962; Bracken 2002). The findings reported in this chapter show the research participants to be actively engaged in attributing meaning to and coping with their experiences. At times this takes them to the extremities of their resources (Kelly 2008) and beyond which is often the point when they access professional support. In recognition of the personal agency of people affected by trauma a social constructionist approach which draws on Blumer's (1969) three basic principles (as discussed by Brown) is applied in interpreting the data

> *(1) People act on the basis of meaning that things have for them*
>
> *(2) Meanings derive from social interaction*
>
> *(3) Meanings are modified by their interpretations in practice*
>
> (Brown 1995: 46)

The individual initially displaced in a state of liminality (Chapter 5) is thus relocated as central to change and transition. The socio-cultural context in turn is shown to shape the discourse of trauma and may be both enabling and constraining in relation to the

psychosocial processes of incorporation of the trauma experience and re-orientation in the social world.

Chapter 7 'Co-constructing Social Work - Creating a 'Thirdspace' in Responding to Trauma' explores the praxis of providing social work as part of an inter-disciplinary approach. The negotiated, situated relationships, expectations and conversations that underpin social work in this context are discussed, as are the underlying socio-cultural contexts that shape trauma narratives. The dialectic process of meaning-making between service users, non-social work emergency department staff and social workers whereby social work is constructed and delivered in this setting is explored. Experiences of social work and non-social work emergency department staff are introduced in this chapter. The perspectives of the three groups of research participants coalesced in viewing social work as offering a 'thirdspace' between the emergency department and life outside, within which people can explore the meaning and impact of their trauma experiences. The nature and dimensions of this 'thirdspace' are delineated.

Chapter 8 contains a summary of the literature and the research findings. The discussion then moves on to a reconsideration of the research findings in light of the literature and argues for the integration of a socio-cultural perspective in understanding and responding to trauma. Drawing on the metaphor of the 'thirdspace' a conceptual framework for trauma-informed and relationship-based social work is proposed. Conclusions and observations arising from the study are outlined. The implications of the findings of this research for social work and for inter-disciplinary practice are considered. The potential of practice-based research in this context is reviewed. The chapter ends with an epilogue in which I reflect on key learning from the research process.

Conclusion

This introductory chapter discusses my motivation and rationale in undertaking research on a social work response to trauma. The location of the research in the emergency department of a large acute hospital is described and the case for practice-based research is outlined. The research questions are clarified and further aims of the research in relation to social work practice, interdisciplinary work and practice-based research are established. The significance of reflexivity in practitioner research is discussed. The chapter ends with an overview of the structure of the dissertation.

Chapter 2 Theorising Trauma

> *"....griefs, at the moment when they change into ideas lose some of their power to injure our heart...."*
>
> (Proust, In Search of Lost Time 3: 944)

An Introduction to the Literature Review

While Proust is persuasive on the benefit of growing in our understanding of life's traumas, some qualitative researchers such as classical grounded theorists, whose work has informed this study as discussed in chapter 4, are cautious about use of extant literature until analysis of data is established due to risk of forcing data into pre-established categories (Lempert 2006). However I concur with Lempert's own position

> *"In order to participate in the current theoretical conversation, I need to understand it.....A literature review provides me with the current parameters of the conversation that I hope to enter. Utilizing comparisons from the literature alerts me to gaps in theorizing , as well as the ways my data tells a different , or more nuanced story....It does not however define my research."*
>
> (Lempert 2006:254)

While the impetus for this research emerged from practice experience, analysis of published historical, theoretical and empirical work in the fields of trauma and social work helped to clarify the research questions, informed the design of the study, helped to contextualise the findings and provided a platform for further conceptualisation and theorisation of trauma-informed social work. The structure of the literature review reflects the two central concerns of this dissertation namely understanding the lived experience of trauma and exploring the potential contribution of social work in this context. This chapter 'Theorising Trauma' examines the ways in which trauma has been conceptualised and documented in professional and popular discourses. I will argue that while a need to understand trauma transcends time and place, interpretation and representation of traumatic experiences vary according to historical and cultural specificity. Drawing on postmodern criticism which aims to deconstruct and thereby highlight the contingency of claims to 'truth' (Spivak 1990; Weedon 1997; Gergen 2009), Post Traumatic Stress Disorder (PTSD), the diagnostic construct used in psychiatry since 1980 to categorise trauma reactions, is deconstructed by locating it historically and culturally. My aim is to uncover the intrinsic assumptions underpinning PTSD and to examine its applications and implications in practice. I will argue that

PTSD discourse in its focus on physiological and psychological manifestations of trauma experience, embodies and decontextualizes trauma, neglecting its dynamic social, cultural, existential, political and historical dimensions. This has resulted in a reified PTSD construct that provides, at best a partial representation of the immensity of trauma experience and is but one of many ways trauma may be understood. Other discourses in the traditions of phenomenology, postmodern cultural theory, feminism and critical social work are considered which open a plurality of ways of seeing, experiencing and representing trauma. I will argue that practice-based research and new practice approaches are needed to integrate the insights of an expanded, trauma discourse in responding to the needs of people affected by trauma. Although praxis is integral to some socio-cultural discourses such as feminism (Stanley 2013) other scholars for example Bracken in the phenomenological tradition presents his work as 'a clearing' which allows us to view 'the embeddedness' and all-pervasive nature of dominant discourses in our lives. Bracken intentionally stops short of offering a therapeutic approach based on his critique

> *"Philosophy cannot tell us what to do clinically, but by challenging assumptions and accepted ways of thinking about ourselves and our distress it can encourage a deepened sensibility with regard to suffering and with this an opening up of new therapeutic possibilities"*
>
> (Bracken 2002:14)

In the next chapter 'Theorising Trauma-Informed Social Work', this social work practitioner research study is located in the context of an historical overview and analysis of social work with a view to exploring the existing and potential contribution of social work in responding to trauma. As a discipline built on the range of knowledge bases of the social sciences, I will argue that social work is focused at interfaces of the individual and their social context, their inner and outer worlds and between different realms of human experience for example past and present. At these junctures competing needs and polarised perspectives can give rise to, maintain or exacerbate feelings and experiences of trauma. However these are locations where dialogue is also possible. Engaging in and facilitating dialogue towards expanded understanding, shared meaning and possibility, is integral to social work in this context.

In the final section of the second literature review chapter, the critical analysis of prevailing conceptualisations of trauma already outlined is considered in relation to a selected social work literature in order to theorise 'trauma-informed social work'. It is argued that 'trauma-informed social work' brings a focus to the situated experience of

those directly affected and promotes participation and partnership in change processes. This allows for a more balanced approach to distress and strengths (Marlowe & Adamson 2011) and to *'the traumatised self'* and *'the coping self'* (Smith 2010:112). Following Herman (1998), in addition to the centrality of empowerment a relational imperative is emphasised. Herman encapsulates the essential components of trauma intervention as follows

> *"The essential features of psychological trauma are disempowerment and disconnection from others. The recovery process therefore is based upon empowerment of the survivor and restoration of relationships. The recovery process may be conceptualized in three stages: establishing safety, retelling the story of the traumatic event, and reconnecting with others."*
>
> (Herman 1998:98)

I will argue that trauma-informed practice can be best achieved within a social work frame incorporating what may initially appear to be antithetical approaches of relationship-based practice with its origins in the psychosocial tradition (Ruch et al 2010; Wilson et al 2008) and theories of social construction (Butt and Parton 2005; Witkin 2012) with its attention to context and its potential in co-constructing narratives of strength and hope. Emphasising both relational and contextual dimensions underlines the dynamic integral to social work, which requires the focus of practice to move between the lived experience of individuals and cultural and structural relevancies of their lives. Locating trauma-informed social work practice at this interface allows for the emergence of a 'thirdspace' (Bhabha 1990, 1994, 2003, 2009; Irving and Young 2004; Winnicott 1971) as a relationship-based, transitional resource for people affected by trauma.

Literature Search Strategy

A literature review involves a systematic identification and analysis of relevant information and is underpinned by a search strategy. Developing a search strategy involves the identification of key words and concepts that define and set the parameters of the research topic and guide the identification of information sources from which to retrieve relevant literature. In this study the key concepts relevant to the research topic were social work and trauma. After identifying key concepts an intersection set of literature was identified that discusses both 1) social work and 2) trauma. Books, articles and other publications that fell within this intersection set

constituted the core literature relevant to the topic. The first source consulted was the university online library catalogue which was searched using the key search terms and indicating how they are related using Boolean logic which simply entails using words such as 'and', 'or' and 'not'. The Boolean operator indicating adjacency of words was also useful in searching for the term "social work" allowing for the elimination of references to 'social' and to 'work'.

Initial searches yielded a limited core literature and the search terms were extended using synonyms, words with similar semantic meaning and more generalised terms for example Trauma or Post Traumatic Stress Disorder or 'P.T.S.D' and "Social Work" or "mental health professionals" or "mental health workers" or counselling or psychotherapy or "psychosocial interventions". The facility to group search terms for example ("social work" OR "psychosocial interventions") and (trauma OR "PTSD") was also used. A keyword search strategy was adopted rather than the use of controlled vocabulary terms. Keyword searching was selected due to variance in controlled vocabulary terminology, an absence of thesauri in some of the databases searched and the number of databases to be searched due to the interdisciplinary nature of the topic.

My final keyword search strategy included the following terms:

("post-traumatic stress disorder" OR "posttraumatic stress disorder" OR "post traumatic stress disorder" OR PTSD OR trauma OR "trauma exposed adult" OR "trauma exposed adults" OR "trauma work" OR "trauma intervention" OR "trauma interventions" OR traumatology OR traumatologies OR "road trauma") AND ("social work" OR "social worker" OR "social workers" OR "mental health professional" OR "mental health professionals" OR "mental health worker" OR "mental health workers" OR ((intervention OR interventions) AND (counselling OR psychotherapy OR psychosocial)) OR counsellor OR counsellors OR counselor OR counselors OR psychotherapist OR psychotherapists OR psychiatrist OR psychiatrists

A broad range of databases were identified for inclusion in the literature search. A limiter with respect to publications in the English language only was applied. The following bibliographic and abstracting sources for human and social sciences were searched: ASSIA: Applied Social Sciences Index and Abstracts; Social Science Citation Index; Sociological Abstracts and SSRRN: Social Science Research Resources Network. As traumatology is an interdisciplinary field a range of academic databases outside of the social sciences were used including the Cochrane Library,

CINAHL: Cumulative Index to Nursing and Allied Health, PsycINFO and PubMed. Databases such as Academic Search Premier and search engines such as Google Scholar were used to access wider academic literature on trauma from disciplines within arts and cultural studies. Articles were downloaded, accessed in electronic format and printed as required.

When articles of interest were identified, certain journals emerged as particularly relevant for example the British Journal of Social Work, British Medical Journal, Journal of Social Work Practice, Journal of Trauma Practice, Journal of Anxiety Disorders, Journal of Traumatic Stress, Social Work, Health and Social Work, Social Work in Health Care, Qualitative Social Work, Qualitative Research in Social Work, Psychiatry and Critical Psychology Review. Searches of back issues of these journals were conducted. As books and articles were reviewed and considered important other work by the author(s) was retrieved and their key sources were explored. Subsequent citations of their work by other authors were also accessed.

Database searching was complemented by the identification of key policy-based publications and treatment protocols which were accessed using websites of Irish government departments and national and international bodies for example the Irish Health Service Executive, the American Psychiatric Association and the World Health Organisation.

Literature was reviewed for relevance and a database of relevant literature was compiled. This formed the working bibliography for writing the literature review which sought to review, critically analyse, integrate and synthesise the large volume of published work on trauma and situate this study with respect to the contribution it can make to the body of work reviewed. However qualitative literature reviews are characterized by *'an absence of conceptual finitude'* (Padgett 2008:47) and it was important to remain open to new theoretical perspectives as the study progressed.

Theorising Trauma.

Social work is one of a number of disciplines contributing to a now extensive trauma literature, however much of the work is still produced in the scientific-rational idiom of psychiatry, based on positivist research. Sue and Sue (2003) suggest that reliance of Western science on what is verifiable has resulted in failure to

"recognize our spiritual being and to take a holistic outlook on life"

(Sue and Sue, 2003:198).

There is a risk of a psychiatrised approach, centring on an individual diagnosis and often pharmacologically-based treatment taking precedence over collective and culturally meaningful ways of understanding and responding to trauma for example through congregation of family and friends, a sense of community solidarity, cultural practices and religious beliefs and traditions. Benzodiazepines the 'family' of drugs used to treat anxiety and sleeping difficulties, symptoms commonly associated with trauma, are widely prescribed in Ireland with approximately one in ten people in the General Medical Scheme (which provides for free health care on a means-tested basis) being prescribed benzodiazepines, often on an ongoing basis (Department of Health and Children 2002:15-16). Similar patterns have been found elsewhere in Europe (Department of Health and Children 2002:20-23). This is a cause of concern, in view of the attendant risk of tolerance, dependency and withdrawal effects if used for in excess of as short a time span as four weeks (Department of Health and Children 2002; College of Psychiatry of Ireland 2012). It has been recommended, drawing on Davidson 2004, that benzodiazepines should be used *'with care'* in post-traumatic stress disorder and only

> *'as adjuncts during initial treatment while waiting for definitive therapy with longer term medications and psychotherapy to take effect'*
>
> (College of Psychiatry of Ireland 2012:3).

Further to this benzodiazepines are said to have

> *'no benefit on the course of bereavement and may inhibit psychological adjustment'*
>
> (College of Psychiatry of Ireland 2012:3).

Outside the medical sphere, tragedy and suffering are well established themes in literature, theatre, music and the visual arts, where we find feelings, insecurities and conflicts akin to our own, evoked and explored in words, images and sounds (de Botton 2001). Our lives are revealed to us through the interpretation of others, thereby increasing our understanding, of what we ourselves are going through, and reducing our feelings of isolation. Human suffering has long been a subject of philosophical inquiry too. Schopenhauer suggested insight into the universality of suffering enables a person to

> *"...look less at his own individual lot than the lot of mankind as a whole, and accordingly will conduct himself.....more as a knower than a suffer."*
>
> (Schopenhauer 1966:206)

Further to this, if we believe that knowledge and power are intrinsically linked (Foucault 1980; Penna and O'Brien 1996), then access to knowledge is empowering. Feeling powerless is a common feature of trauma and empowerment is therefore integral to an effective professional response (Herman 1992; Bussey and Bula Wise 2007). This raises questions not only of how trauma may be best understood but how access to this knowledge may be facilitated for people experiencing trauma. These questions are important if we are to go beyond categorisation and prescription of generic solutions and really engage with people in the uniqueness and complexity of their situations and in their individual and collective searches for meaning.

Issues in Defining Trauma

The etymology of the word 'trauma' is from the Greek word to 'wound.' According to Spiers & Harrington (2001: 213) the term was used in relation to soldiers, injured through piercing of their armour. The idea of 'being overwhelmed' is retained in our understanding of trauma today

> *"traumatic events are extraordinary, not because they occur rarely but rather because they overwhelm the ordinary human adaptations to life....the common denominator of psychological trauma is a feeling of intense fear, helplessness, loss of control and threatened annihilation"*
>
> (Herman 1992:32)
>
> *"Experiences of fear go to the heart of people's identity; they lose skills and are faced with options of fight or flight."*
>
> (Smith 2010:116)

Developing the concept of 'shattered assumptions' in the aftermath of trauma, Janoff-Bulman explained that traumatic experiences can shatter the background assumptions of the individual with regard to him/herself and to the order and meaningfulness of life/the world. This causes people to move from feeling safe in the world to feeling vulnerable. The person's former conceptual system may no longer be adequate to give meaning to current experience (Janoff-Bulman 1992)

> *"....one's guiding 'paradigms'—one's fundamental assumptions—are seriously challenged and an intense psychological crisis is induced. . . . The assault on fundamental assumptions is massive...Core assumptions are shattered by traumatic experience..."*
>
> (Janoff-Bulman, 1992:51-2)

The term trauma carries multiple meanings in contemporary popular and professional discourses, for example it may be used to signify a stressor 'her anxiety relates to childhood trauma' or refer to physical effects of a stressor 'the scan revealed severe abdominal trauma' or emotional effects 'he is still traumatised from the attack last year' or to denote a more generalised condition 'trauma is a feature of modern, urban life' and sometimes the term trauma is conflated with the narrower psychiatric diagnosis of Post-Traumatic Stress Disorder (P.T.S.D.). Despite this diversity of meaning, a shared understanding of the term is often assumed as Marlowe and Adamson suggest

> *"It is almost as if this term is taken as an a priori understood concept that escapes the need for definition, and that the locus of inquiry begins only after trauma - whether the focus is upon therapeutic approaches, associated sequelae or documenting people's testimony."*
>
> (Marlowe & Adamson 2011: 623)

This raises a question regarding the differentiation of traumatic and non-traumatic events. The Canadian Council on Social Work Education's definition of a traumatic event asserts that it is the effects of an event rather than any essential characteristics of the event itself that cause it to be traumatic

> *"An event becomes traumatic when its adverse effect produces feelings of helplessness and lack of control, and thoughts that one's survival may possibly be in danger."*
>
> ([Canadian] Council on Social Work Education 2012: 1)

Lieberman and Van Horn locate stress and trauma on a continuum and view an event as traumatic according to the intensity of the fear and threat it produces

> *"Stress becomes trauma when the intensity of frightening events becomes unmanageable to the point of threatening physical and psychological integrity"*
>
> (Lieberman & Van Horn, 2008: 15)

A further question pertains to when a traumatic experience becomes a trauma

diagnosis? Sociologists illustrate the far-reaching consequences of the act of diagnosis in setting the parameters of normality and abnormality and authorising doctors to categorise people and prescribe treatment to people on behalf of society. This categorisation or labelling is often the legal basis for provision of health services, welfare benefits, sick leave certification, compensation claims, and legal redress (Zola 1972; Brown 1990, 1995; Conrad 1992) With regard to the trauma-based diagnosis Post Traumatic Stress Disorder (PTSD) (DSM 5 2013) Davis argues

> *"by virtue of its status as a 'disorder', PTSD implies the particular professional groups competent to 'treat' it, and the types of treatment thought appropriate. Behavioural and cognitive treatments underestimate normative and power issues implicit within the pathologization of trauma. Intervention is not just about treatment, it is also about prevention and mitigation".*
>
> (Davis 1999:771)

Bracken discusses the unusual 'buy in' by the general population to the mental health category PTSD and argues that this is culturally significant in scale

> *"Although the discourse on trauma has been developed by professionals, it has been taken up wholeheartedly by the general public in Western societies.....while there are few psychiatric conditions which people 'like' to have, the diagnosis of PTSD is proving to be popular (JAMA, 1995).....the concern with psychological trauma is not simply a clinical issue, it would appear that it is also a cultural event."*
>
> (Bracken 2001: 736)

The relationship between the phenomenon of wider Western cultural interest in trauma and the exigencies of postmodernity is a theme in Bracken's work

> *'the notion of trauma has come to serve as a cultural trope that expresses many of the concems and fears of our time"*
>
> (Bracken 2002:3)

I would argue that while caution is needed regarding the ubiquitous use of the term trauma there is a case to be made to resist efforts to ultimately define or fix its meaning. Instead there is value in retaining its 'openness' as a word which has currency in everyday language and can be used as people themselves believe best defines and conveys their experiences. Burstow (2003) suggests the term as is, has merit in its potential to evoke empathy and in its cross-cultural relevance

"Trauma is a sensitizing metaphor that conveys a sense of the overwhelming nature of the experiences.....Moreover, despite the ethnocentric nature of dominant trauma discourse, a metaphor based on physical wounds speaks to people across cultures, as evidenced in the Aboriginal concept of "soul wound," as articulated in Duran and Duran (1998). As such, it has at least a type and a degree of cross-cultural validity and can facilitate cross-cultural praxis".

(Burstow 2003:1301-1302)

Classification of Trauma as a Mental Health Disorder

Specified reactions to trauma were classified as a mental health disorder with the inclusion in 1980, of Post-Traumatic Stress Disorder (PTSD) in the authoritative *Diagnostic and Statistical Manual of Mental Disorders* (DSM) produced by the American Psychiatric Association. First published by the American Psychiatric Association in 1952, the DSM seeks to provide standardised criteria for the classification of mental disorders. It is utilised internationally by doctors, other clinicians, the pharmaceutical industry, drug regulation bodies, legal practitioners, policy makers, insurance companies and researchers. Revisions since its first publication in 1952 have incrementally added to the total number and complexity of disorders although also removing entries no longer considered mental health disorders for example homosexuality in 1973, following representations by gay lobbyists from within and outside the APA. The current version, published in 2013, is the DSM-5 (fifth edition).

The DSM classification system exemplifies a technical rational approach that has endured in many disciplines including medicine and psychiatry and has been traced by Berman (1981) to the Cartesian (Descartes 1591-1650) scientific paradigm. Pre-dating this, the Greek philosophers saw reason as a means to gain mastery of human instincts and desires. However the DSM should not be viewed as an objective, scientific conceptual resource but rather a powerful knowledge system that shapes how human experience is perceived, interpreted, managed and controlled. In a chapter entitled 'Seeing Through Language' Davidson asserts that the theories we come to accept tell us what we are seeing (Davidson 1997: 23). Similarly a social constructionist perspective suggests that

> *"...what we take to be the world importantly depends on how we approach it, and how we approach it depends on the social relationships of which we are a part."*
>
> (Gergen 2009:2).

The establishment of the DSM in 1952 and its extensive regulatory powers can be understood in the light of Foucault's belief that increasing complexity in modern society brings new forms of social regulation, characterised by concepts of normalisation, discipline and surveillance (Foucault 1979). Of relevance too is Parton's argument that the body of work produced by the human sciences on the nature of human beings, and how their behaviour may be classified, predicted and perfected has formed the basis of modern systems of regulation (Parton 1996:7). Before examining the PTSD construct as specified in the DSM in more detail, I will locate it in the context of other historically and culturally embedded interpretations of trauma.

Mapping Trauma Over Time

Scholars have specified and analysed accounts of trauma from some of the earliest written texts for example Homer's Iliad (Shay 1991) and the Hebrew Bible (Haughn and Gonsiorek 2009). Pre-dating the development of psychology and psychiatry by more than two centuries Shakespeare writing in 1594, portrays classic trauma symptoms in *Henry 1V* through Lady Percy's concern for her husband's fretful sleep, depression, detachment, loss of appetite and sexual desire, nightmares and flashbacks to the battlefield (Spiers and Harrington 2001). In the next century the London diarist Samuel Pepys writing in the aftermath of the Great Fire in 1666 described dreams of the fire and falling down of houses. Six months later he reported being unable to sleep without terrors of fire (Newman 2002)

In a study seeking to test the construct validity of PTSD diagnostic criteria, Haughn and Gonsiorek (2009) examined the extent to which descriptions of trauma from the Book of Job, one of the books of the Hebrew Bible (dating from between the 6th and 4th century BCE) matched DSM-IV-TR (1994) diagnostic criteria for post-traumatic stress disorder (PTSD). In brief, Job, heretofore a wealthy and religious man had great trauma inflicted on him. In the course of one day he incurred death of his children, his servants and livestock and subsequently was afflicted with a terrible skin disease. The Book of Job written as a didactic poem chronicles his reactions, his discussions with

friends on the nature and origins of suffering, his eventual lament that God allows the righteous to suffer and finally God's response. The Haughn and Gonsiorek (2009) study found a high correlation between Job's reactions and the key symptoms of PTSD (re-experiencing, avoidance and heightened arousal persisting for in excess of one month and causing clinically significant distress or impairment in social, occupational or other important areas of functioning) as delineated in the DSM-IV-TR (1994).

The following selected extracts illustrate their findings

The negative impact on Job's life, lasting over a period of months was documented
Job (7:3), *"So I have been allotted months of futility."*
Job (19:13–19), *"He alienated my kin from me; my acquaintances disown me. My relatives are gone; My friends have forgotten me. My dependents and my maidservants regard me as a stranger; I am an outsider to them. I summon my servant but he does not respond; I must myself entreat him. My odour is repulsive to my wife; I am loathsome to my children. Even youngsters disdain me. When I rise, they speak against me. All my bosom friends detest; Those I love have turned against me.'*
The following extracts exemplify re-experiencing
Job (7:13–14), *"When I think, 'My bed will comfort me, My couch will share my sorrow,' then you terrify me . . . with visions.'"*
Job (7:14), *"you frighten me with dreams."*
Job (21:6), *"When I think of it I am terrified; My body is seized with shuddering."*
Job (7:3, 4), *" . . . nights of misery have been apportioned to me. When I lie down, I think, When shall I arise? Night drags on."*
Evidence of avoidance is found in
Job (9:27–28), *"If I say, 'I will forget my complaint; Abandon my sorrow and be*

diverted, 'I remain in dread of all my suffering."
Heightened arousal is evidenced in
Job (18:4) *"You who tear yourself to pieces in anger . . . ."*

Table 1: Extracts from the Book of Job (Haughn and Gonsiorek 2009: 837-839)

Job's interpretation of his plight typifies the tendency in eras preceding scientific knowledge to attribute events from natural disasters, to crop failure to premature death variously to the gods, the will of an all-powerful God, the work of Satan or to the spirit world (Ellenberger 1970 cited in Figley 2002:18). It is suggested that the Book of Job may be reflective of Israel's trauma following the Babylonian exile, and may have been written to address a collective suffering (West (1981) cited by Haughn and Gonsiorek 2009:836)

In the context of modernity's scientific objectivity and politico-economic rationality (Parton 1996) there has been a tendency to view crises and catastrophe as exceptions or 'fields of disruption' in an otherwise ordered existence (Meiner and Veel 2012:3). Psychological distress was often accounted for in terms of physical injury in this period, for example subsequent to the development of the railways in the 19th century, distress occurring in the aftermath of railway accidents was attributed to damage to the nervous system from shaking, giving rise to the term "railway spine" (Newman 2002). Until recently, a modernist worldview underpinned approaches to crisis and trauma in disciplines including psychiatry (Caplan 1961; Caplan and Felix 1964; DSM III, American Psychiatric Association1980) and social work (Rapoport 1962; Parad 1965; Payne 1997; Roberts 2005) whereby a crisis was seen as an upset in otherwise stable functioning and the goal of intervention was to restore pre-crisis equilibrium, thereby developing problem solving skills for the future, should a further crisis arise. In contemporary society, which has been conceptualised as postmodern (Lemert 1992; Parton and Marshall 1998; Torfing 1999; Bracken 2001) the scale and significance of media-borne crises and catastrophes (Winkel Holm 2012) at global, regional and societal levels including environmental disasters, wars, genocide, international terrorism and globalised financial recession together with trauma experienced and witnessed by individuals in families and communities worldwide, suggest the pre-modern appraisal by Voltaire (1694-1778), outlined by Meiner and Veel (2012) may be a better fit

'In his novel Candide, Voltaire does not consider catastrophe as eruptive, exceptional or order-unsettling events, on the contrary both he and Candide realize that the world seems to be constituted by an endless series of catastrophes, forming the norm or the rule of the world and not the exception to an otherwise positive and good world'

Meiner and Veel (2012:5)

A number of authors have charted the historical antecedents of the contemporary professional trauma discourse Post Traumatic Stress Disorder (PTSD) (Bracken 2001; Davis 1999; Herman 1992; Young 1995; van der Kolk et al 1996; Spiers and Harrington 2001; Figley 2002; Newman 2002). These accounts demonstrate the extent to which interpretations of trauma are embedded in the economic and political developments and social mores in particular societies at particular times. Herman (1992;1997) outlines three periods of significant advancement in the development of the trauma knowledge culminating in the classification of PTSD in the DSM III 1980.

The first was the work of a group of European doctors in the late 19th century that lead to the establishment and later retraction of a link between symptoms of hysteria in adult women and histories of childhood trauma. In the 1880s Charcot, a French neurologist working at the famous Parisian institution Salpetrière, a long established asylum for people who were poor, in prostitution and those with mental illness, was interested to find a scientific explanation for the symptoms of hysteria exhibited by patients during altered states of consciousness. Prior to then such symptoms were regarded with suspicion and superstition. According to Herman, Charcot was influenced by the republican, anticlerical political movement of late nineteenth century France and wanted to modernise the hospital and systems of care (Herman 1997). Charcot proposed the reason for 'dissociation', a term proposed by Janet, one of a number of doctors who came to work with him, was psychological in nature as it could be reproduced and alleviated using hypnosis (Herman 1997). He suggested dissociation was induced by an unbearable experiences and he called the condition 'choc nerveux' or nervous shock. Charcot's work strongly influenced Freud who with a colleague Joseph Breuer produced a *Study on Hysteria* in 1893. Their evidence suggested that trauma was a precursor to the symptoms of hysteria including dissociation. They also observed that symptoms of hysteria could be alleviated when traumatic memories that had been suppressed were recovered and spoken of. For Freud and his colleague, Breuer, this technique was known as 'abreaction' or 'catharsis' (Herman1992:12). Bertha Pappenheim, one of Breuer's patients called it the 'talking cure' (Herman 1992:19). This process was a precursor of psychotherapy. In retelling of experiences

Breuer found the women tended to move from recent traumas to earlier events (Herman 1992). In 1896 Freud published *The Aetiology of Hysteria* a collection of eighteen case studies of women patients. He discovered all of the women had experienced childhood sexual abuse.

> *"I therefore put forward the thesis that at the bottom of every case of hysteria there are one or more occurrences of premature sexual experience, occurrences which belong to the earliest years of childhood, but which can be reproduced through the work of psychoanalysis in spite of the intervening decades."*
>
> (Freud 1955 Vol. 3:203, cited in Spiers and Harrington 2001:216)

Freud's thesis met with hostility in the politically and socially conservative climate of the late 19th century Vienna. In the face of strong opposition Freud retracted his theory saying he had to recognise these 'scenes of seduction' had not taken place but rather were fantasies of the women concerned (Freud 1925 Vol. 20:34, cited in Spiers and Harrington 2002:216). Freud went on to develop what proved to be a more acceptable theory of repressed infantile sexuality and the Oedipus complex. The link between trauma and reactions such as dissociation now gave way to intrapsychic explanations thus setting back developments in understanding and effectively responding to trauma and contributing to a hidden history of trauma (Herman 1992).

Trauma was also a cause of concern during the two World Wars, particularly as affected soldiers were lost to battle. In the context of World War 1, Meyers proposed 'shell shock' (his term for physical injury to the cortex of the brain incurred from flying shrapnel) as a basis for psychological trauma. This failed to explain why soldiers who had not sustained physical injury were also traumatised, including those from officer rank. Traumatised men contravened images of 'the ideal soldier' and were considered morally weak, cowards and deserters. They were treated very harshly sometimes even condemned to death. Others were seen as ill and in need of treatment (Herman 1992; Newman 2002). By 1916, 40 per cent of casualties from some zones were suffering from 'shellshock' (Stone, 1985). This triggered a crisis for the military, for medicine and for masculinity (Bracken 2001). Medicine proposed hereditary genetic factors as the cause of mental disorder (Pilgrim and Rogers 1993:100). However some psychiatrists took a more enlightened approach. WHR Rivers who worked in an institution at Craiglockhart in Edinburgh treated war veterans including the war poet Siegfried Sassoon by building supportive relationships with them and encouraging expression of emotions through writing and talking about their experiences.

In World War II mental disorder accounted for 31 per cent of medical discharges from the British Army (Newman 2002). However by now there seemed to be a greater acknowledgement that exposure to combat in itself would cause strain to any soldier and therefore that psychiatric casualties are as inevitable as gunshot and shrapnel wounds in warfare (Appel and Beebe1946 cited in Spiers and Harrington 2001). The emphasis changed to efforts to rehabilitate soldiers close to the site of combat, so they could return to combat as quickly as possible. The American psychiatrist and psychoanalyst Abram Kardiner in *The Traumatic Neuroses of War* (1941) argued that in addition to recovery of memories and catharsis a cognitive shift was needed, leading to a conscious integration of the experience (Spiers and Harrington 2001).

Finally in the 1970s two major social movements proved catalysts for widespread public recognition of the effects of trauma - the Anti-Vietnam War Movement and the Women's Movement. The return of soldiers from Vietnam highlighted the devastating impact of war. Veterans protested to publicise the link between exposure to conflict and post trauma stress and to demand compensation and care. Their condition shocked an unsuspecting world witnessing the demonstrations on television, a medium which was by then widely available. The American Administration was forced to respond by providing support services and funding research which established the causal link between exposure to the atrocities of war and subsequent adverse psychological and physiological reactions which led to the inclusion of PTSD in the DSM 111 in 1980 (Spiers and Harrington 2001).

During the period of second wave feminism (1960s-1980s) the Women's Movement through public campaigns and personal testimonies of women who themselves had experienced abuse and rape put violence against women and children on the political agenda and promoted awareness that trauma may be caused by stressors other than war, including those occurring in family homes, thus overcoming social processes of silencing and denial (Herman 1992). During this time many women's services including rape crisis centres and women's refuges were developed to assist those most affected (Herman, 1992; Fraser 2003). It was established that

> *".....the psychological syndrome seen in survivors of rape, domestic battery and incest was essentially the same as the syndrome seen in the survivors of war"*
>
> (Herman 1992:31)

This recognition was significant in establishing trauma as something distinct from any one particular stressor or causal factor. Classification of PTSD was further refined in

the 1994 DSM 1V to take account of the experiences of people living in situations of enduring stress including domestic violence and situations of ongoing political conflict.

For some authors PTSD was the latest in a series of medical terms used to describe the same condition of extreme distress caused by the horrors of war, the implications of which they suggest are forgotten and 'rediscovered' with each new insurgence.

> *".....PTSD has been known under various names throughout military history, including 'irritable heart of the soldiers', 'combat neuroses', 'war neuroses' and 'shell shock'..... It is safe to say that in times of war, PTSD, as we now call it, is rediscovered by the medical world, and time after time we are dismayed by its dimensions".*
>
> Gersons and Carlier (1992:743-746)

However Bracken argues that it is mistaken to present PTSD as a discovery of psychiatry that can account for historical depictions of distress, particularly distress that is war-related, which most commonly has been reported in somatic terms

> *"While historically there is considerable evidence of physical and psychological reactions to terrifying events in the medical and non-medical literature, most of these reports point to symptom complexes which are not co-terminus with the defined symptoms of PTSD....the symptoms of intrusion and avoidance, which are at the heart of the DSM concept of PTSD, actually figure quite infrequently. Somatic symptoms appear much more often. On this account, it would appear wrong to conclude that PTSD (as currently defined) has always existed".*
>
> (Bracken 2001:735)

Those influential in the developing field of traumatology in the United States (Horowitz 1976, 1986, 1997; Burgess 1988; Danieli 1985, 1998; Herman 1992, 1997; Figley 2002) saw the inclusion of PTSD in the DSM III as the long awaited official recognition of a widely occurring, psychological trauma syndrome, relevant to and drawing on experience and knowledge from, diverse fields of practice and research including war, sexual assault and sexual abuse. The first non-governmental training conference on PTSD held in Ohio in 1982 extended applicability of the PTSD construct from war related trauma to rape, domestic violence, accidents and disasters (Figley 2002:20). The now international Society for Traumatic Stress Studies was established in the USA in 1985 (Figley 2002).

The 1980s onwards saw practical applications of trauma theory and research in responding to people affected by natural disasters, major emergencies and acts of terrorism including the Zeebrugge ferry disaster 1987 (Hodgkinson 1995; Austin and Godleski 1999), Hillsborough football stadium disaster in 1989 (Shapiro and Kunkler 1990; Newburn 1991,1993), the Omagh bombing 1998 (Turnbull and Gibson 2001), September 11 attacks 2001 (Galea et al 2002; Bonanno et al 2006) Hurricane Katrina 2005 (Gard and Ruzek 2006, Weems et al 2007), Victoria bushfires 2009 (Forbes et al 2010), the Haiti earthquake 2010 (Schafer et al 2010, Raphael and Ma 2011) and the Sandy Hook Elementary School Shooting 2012 (Malekoff 2013).

Extensions were made into related fields such as bereavement analysing various aspects of the interface of trauma and grief (Lindemann 1944; Raphael & Maddison 1976; Pynoos and Nader 1988; Hobfoll 1991; Green 1993; Brewin et al 1996; Figley et al 1997; Horowitz 1997; Raphael and Martinek 1997). Studies have also examined the occurrence of PTSD symptoms among bereaved people, finding that PTSD-related reactions are most likely when the death of a loved one results from violent as opposed to natural causes (Zisook et al.,1998; Bonanno & Kaltman1999; Kaltman and Bonanno 2003; Barry et al 2002). This may be due in part to additional situational stressors for instance police investigations, court hearings and media intrusion faced by people bereaved in traumatic circumstances.

Legal imperatives brought a focus to occupational health and wellbeing and the impact of vicarious traumatisation on workers in armies, police forces, emergency and rescue services and health services. Interventions such as Critical Incident Stress Debriefing (Mitchell 1983; Dyregrov 1997, 1998, 2003) and Critical Incident Stress Management (Everly and Mitchell 1999) were developed to prevent and address adverse psychosocial reactions following exposure to trauma in occupational contexts. The efficacy of debriefing has been contested (McFarlane 1988; Wessely et al 1988; Kenardy 2000; Kenardy et al 1996; Mayou et al 2000). The validity of these studies has also been criticised (Everly et al 2000) who argue that debriefing is safe and effective when used as intended to support frontline responders as part of a wider crisis management programme.

The National Institute for Clinical Excellence in Health Care in the U.K. a body that makes evidence-based recommendations to the NHS and broader service user and provider groups on treating and caring for people with specific conditions proposes trauma-focused Cognitive Behavioural Therapy, Rapid Eye Movement Technique and specified drug therapies to treat the symptoms associated with PTSD (National Institute

for Clinical Excellence 2005). As Walsh argues these approaches are individualist and pathology-based, centring on symptoms associated with PTSD (Walsh 2007). The neglect of socio-cultural and contextual dimensions of trauma inherent in a focus on PTSD symptomology is of concern (Davis 1999; Neimeyer 2000; Bracken 2002; Walsh 2007).

Notwithstanding the progress that has been made in understanding trauma, Spiers and Harrington (2001) identify a backlash evident in the trivialisation of trauma experiences as manifestations of victim culture. Criticism has in part focused on the suggested indiscriminate use of PTSD diagnosis in civil litigation and associated growth of a trauma industry. Post-traumatic stress disorder is the only psychiatric disorder for which compensation can be paid. In some instances, it is suggested this may promote and prolong manifestation of psychiatric symptoms (Ehlers et al 1998). This gives rise to concern about the integrity of much research data on PTSD since many research participants self-reporting PTSD symptoms had also been claiming compensation (Rosen and Taylor, 2007). On the other hand prevailing scepticism may lead to people affected by trauma being disbelieved or stigmatised.

A backlash is also evident in victim blaming in situations of rape (Koss 2000; Abrams et al 2003; Grubb and Harrower 2008) and perceiving women as implicated in or tolerating domestic abuse (Bryant and Spencer 2003; Henning et al 2003). Compassion fatigue (Figley 1995; Cohen 2001) is also a common when we feel beset by images and narratives of suffering that seem beyond our capacity to ameliorate. Herman (1992,1997) suggests the field of psychological trauma is characterized by periods of active inquiry and periods of abandonment due she claims not to lack of interest but to the controversies generated as the study of trauma confronts us with our vulnerabilities to natural disaster and to the capacity for human evil (Herman 1997:7).

In mapping the ebb and flow of developments in how trauma has been interpreted and addressed historically, it is clear that responses are as much a product of the prevailing culture and socio-political order as they are an indication of linear scientific advancement.

The PTSD Construct

With its inclusion in the DSM III, trauma was institutionalised within the canon of psychiatry and defined as follows

"Trauma is caused by a stressful occurrence that is outside the range of usual human experience, and that would be markedly distressing to almost anyone"

(American Psychiatric Association, DSM III, 1980).

This definition marked a paradigm shift in psychiatry from a focus on people's histories and genetics as the location of causal factors for trauma to the recognition that a traumatic experience in adulthood is sufficient in itself to produce significant adverse emotional, cognitive and behavioural reactions. The inclusion of PTSD in the DSM was in part prompted by public demand and the campaigning of social movements for veterans' rights in the wake of the Vietnam War (Spiers and Harrington 2001) and women's rights in a climate of growing recognition of sexual and domestic violence (Herman 1992,1997). It has undoubtedly brought benefits such as official acknowledgement and legitimisation of often hidden, stigmatised suffering, greater public understanding of adverse effects of trauma, development of and access to support services and medical treatment and in some instances legal redress and financial compensation. However it can be argued that the delineation of PTSD is highly technical-rational in nature and thereby reductionist in its categorisation of the immensity of human experience in the context of trauma. The 'psychiatrisation' of trauma reactions through labelling human suffering as a disorder has attracted comprehensive critical analysis from within psychiatry (Summerfield 2001; Bracken 2002) and (Davis 1999; Marlowe & Adamson 2011) from a social work perspective. However in making a case for the usefulness and validity of post-traumatic stress disorder as a psychiatric category, Mezey and Robbins argue that the diagnosis has redefined the symptoms of PTSD as a normal response to an abnormal event rather than a pathological condition thereby helping to deflect blame from the affected person and diminish his or her sense of guilt, shame, and failure (Mezey and Robbins 2001). The concept of 'normalisation' of trauma responses became an integral part of post trauma interventions (Dyregrov 1998, 2003; Mitchell 1983, 1988; Mitchell and Everly 1996, 2000).

The PTSD definition distinguishes specific stressors namely 'traumatic events' from other stressful experiences and makes causal links with a specific constellation of responses, the PTSD syndrome (Breslau 2012). PTSD has thus been classified as a psychiatric disorder understood to result from the experience or witnessing of traumatic or life-threatening events for example violent crime, abuse, military service, terrorist attacks, natural disasters, serious accidents or violent personal assaults (Iribarren et al 2005). The development of trauma studies within the disciplines of psychiatry and psychology has resulted in a professional focus on the physical and psychological

impact of trauma. PTSD was included in the tenth revision of the World Health Organization International Classification System of Diseases (ICD-10) in 1992. It is characterised in the ICD-10, the DSM III, 1980 and subsequently (DSM IV, 1994 and DSM 5, 2013) by an intrusion/avoidance complex whereby distressing memories of the traumatic event(s) are repeatedly re-experienced and conscious attempts are made to avoid this reoccurring, together with more generalised numbing of responsiveness. People re-live aspects of trauma through unsettling thoughts and images, nightmares and sometimes flashbacks. This leads to avoidance of people, places and activities that trigger painful memories. In addition people experience a heightened startle response, become watchful and hyper-vigilant, have difficulty sleeping and/or become angry and irritable. This third cluster of reactions is linked to the 'fight or flight' mechanism associated with functioning of the limbic system which is also known as the 'old mammalian brain'. The DSM 5 (2013) has added a fourth cluster of reactions 'negative alterations in cognitions and mood'. PTSD was defined as follows in the DSM-IV-TR, 1994

> *Posttraumatic Stress Disorder (PTSD) is a anxiety disorder that develops following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threats to one's physical integrity; or witnessing an event that involves death, injury, or threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm or threat of death or injury experienced.*
>
> (American Psychiatric Association, DSM-IV-TR, 1994)

However in the DSM 5, 2013, PTSD has been removed from the class of anxiety disorders and together with Acute Stress Disorder has been grouped in a new class of 'trauma and stressor-related disorders'. All of the conditions included in this new classification (which also includes Adjustment Disorder and Reactive Attachment Disorder pertaining to children) require exposure to an external stressor(s) as a diagnostic criterion. When compared to DSM-IV, the diagnostic criteria for DSM-5 are similar but more specific with regard to what constitutes a traumatic event. Sexual assault is specified, for example, as is recurring exposure, which could apply to emergency service providers. Diagnostic criteria for Acute Stress Disorder and PTSD no longer require a subjective fear-based response at the time of the adverse event as this was seen not to have diagnostic relevance and could exclude categories of people from meeting diagnostic criteria for example emergency responders who may find their training to be a protective factor at the time of the incident but may experience a

trauma reaction subsequently. DSM-5 replaces the three clusters of trauma reactions listed in DSM-IV with four clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. Essentially the DSM-IV criterion "avoidance and numbing" was separated into two criteria: avoidance and negative alterations in cognitions and mood. This change was influenced by factor analytic studies for example (Solomon et al 1989; Foa et al 1995) which highlighted the distinctions between 'effortful avoidance' and numbing (restricted range of affect; detachment or estrangement from others) and found numbing to be an identifying feature for PTSD in achieving a differential diagnosis (Foa and Rothbaun 2001).Three new symptoms were also specified within the symptom clusters. Persistent and distorted blame of self or others and persistent negative emotional state were added to the 'negative alterations in cognition and mood' category and reckless or destructive behaviour was added to the category 'alterations in arousal and reactivity'.

Two subtypes were added. The 'with dissociative symptoms' subtype applies to individuals who meet the criteria for PTSD and experience additional depersonalisation (feeling detached from one's own mind or body) and derealisation (experiences in which the world seems unreal, dreamlike or distorted) symptoms. A 'preschool subtype' with separate diagnostic criteria for children aged six years or younger was added. Adult thresholds and diagnostic criteria are applicable to children over six years of age.

According to Seeley diagnosis is a process of interpretation of physical and behavioural signs according to pre-determined symptoms and diagnostic categories

> *"To make sense of such signs requires first converting them into known symptoms and then matching these symptoms to the diagnostic category that best contains and explains them. Just as medical doctors examine patients' bodies for symptoms of physical diseases, mental health professionals examine patients' mental states and behaviours for symptoms of psychiatric disorders."*
>
> (Seeley 2005:18)

The diagnostic criteria for PTSD, set out in the DSM 5 can be understood therefore as a matrix for the categorisation of experiences, feelings and behaviours as symptoms, the allocation of symptoms to specified categories according to preordained criteria and the subsequent classification of groupings of symptom categories as an established mental health disorder. Brown warns that categorisation or assignment of a condition to a nosological location

"...involves the often reified definitions of disease into which professionals and others fit their observations"

(Brown 1995:39)

The DSM-5 categorisation system with respect to PTSD is as follows

Criterion A: stressor
The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: ***(1 required)***
• *Direct exposure.*
• *Witnessing, in person.*
• *Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.*
• *Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.*
Criterion B: intrusion symptoms
The traumatic event is persistently re-experienced in the following way(s): ***(1 required)***
• *Recurrent, involuntary, and intrusive memories. Note: Children older than 6 may express this symptom in repetitive play.*
• *Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).*
• *Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may re-enact the event in play.*

• *Intense or prolonged distress after exposure to traumatic reminders.*
• *Marked physiologic reactivity after exposure to trauma-related stimuli.*
Criterion C: avoidance
Persistent effortful avoidance of distressing trauma-related stimuli after the event: ***(1 required)***
1. *Trauma-related thoughts or feelings.*
2. *Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).*
Criterion D: negative alterations in cognitions and mood
Negative alterations in cognitions and mood that began or worsened after the traumatic event: ***(2 required)***
• *Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol or drugs).*
• *Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous.").*
• *Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.*
• *Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt or shame).*
• *Markedly diminished interest in (pre-traumatic) significant activities.*
• *Feeling alienated from others (e.g., detachment or estrangement).*
• *Constricted affect: persistent inability to experience positive emotions.*

Criterion E: alterations in arousal and reactivity
Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: ***(2 required)***
• *Irritable or aggressive behaviour.*
• *Self-destructive or reckless behaviour.*
• *Hypervigilance.*
• *Exaggerated startle response.*
• *Problems in concentration.*
• *Sleep disturbance.*
Criterion F: duration
Persistence of symptoms (in Criteria B, C, D and E) for more than one month.
Criterion G: functional significance
Significant symptom-related distress or functional impairment (e.g., social, occupational).
Criterion H: attribution
Disturbance is not due to medication, substance use, or other illness.
Specify if: With dissociative symptoms.
In addition to meeting criteria for diagnosis, an individual experiences high levels of

either of the following in reaction to trauma-related stimuli:
• ***Depersonalization**: experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).*
• ***Derealization**: experience of unreality, distance, or distortion (e.g., "things are not real").*
Specify if: With delayed expression.
Full diagnosis is not met until at least 6 months after the trauma(s), although onset of symptoms may occur immediately.

Table 2: Criteria for Diagnosis of PTSD (American Psychiatric Association. (2013) Diagnostic and statistical manual of mental disorders, (5th ed.). Washington, DC: Author).

Achieving a categorical diagnosis of PTSD is therefore a technical process reliant on adherence to a standardised process as set out above and on the capacity of mental health professionals to make sense of diversity of human experience from childhood abuse, to evacuation from home in the event of a bushfire, to a violent street attack within this structure. It is important to note too, that although at any given point in time rigorous adherence to current diagnostic criteria is required, as Seeley argues such criteria frequently change

> *".....the diagnostic categories mental health professionals employ, and the conceptions of mental instability on which they are based, have proven highly susceptible to change.....every mental disorder has a history and...notions of mental illness undergo continual revision".*
>
> (Seeley 2005:18)

PTSD has been subject to a series of such changes to diagnostic criteria, this has been termed 'criterion creep' (Rosen 2004) and has implications for the stability of the construct and for diagnosis and prevalence. As Rosen et al (2008) point out there is also a risk of pathologisation of normal emotions

"This expansion of the PTSD model, a phenomenon referred to as 'criterion creep', highlights a critical shortcoming of traumatology: the cross-cultural medicalisation of normal human emotions....Labelling situation-based emotions and upsetting thoughts as 'symptoms' is akin to saying that someone's cough in a smoky tavern is a symptom of respiratory disease. Such illogical leaps increasingly inform our cultural narratives when we discuss human reactions to stressful events, possibly giving rise to iatrogenic misapprehensions and contributing to chronicity".

(Rosen et al 2008:3)

Summerfield cautions

"The psychiatric sciences have sought to convert human misery and pain into technical problems that can be understood in standardised ways and are amenable to technical interventions by experts. But human pain is a slippery thing, if it is a thing at all: how it is registered and measured depends on philosophical and socio-moral considerations that evolve over time and cannot simply be reduced to a technical matter...[however].....The medical discourse on trauma has had heuristic value and some of those diagnosed as having post-traumatic stress disorder do have clinically significant psychiatric dysfunction, however it is labelled (and post-traumatic stress disorder will sometimes do)."

(Summerfield 2001:10-11)

Reactions associated with PTSD do cause considerable distress and can adversely impact on social, occupational and educational functioning. PTSD can cause significant stress in close relationships, strain in families and loss of social relationships. It is common for people affected, to have extended periods of sick leave from work or be unable to return to work through inability to cope with reminders of the traumatic event or more generalised withdrawal, fatigue and difficulties with concentration. The resulting drop in or loss of income and failure to return to previous levels of performance are a common source of additional stress and social restriction and may be contributory factors leading to co-occurrence with other mental health problems including depression, panic attacks, anxiety, social phobias and suicidal ideation. If persistent, PTSD can lead to long term financial problems, relationship breakdown, social isolation, substance dependency and homelessness.

In addition to significant psychosocial effects PTSD is linked with biochemical changes for example with the regulation of the hypothalamic-pituitary-adrenal axis which is associated with 'the fight or flight reaction' (Mezey and Robbins 2001). However

neuroendocrine studies show variability of cortisol levels (tested to determine change in hypothalamic-pituitary-adrenal functioning) in patients diagnosed with PTSD (Mason et al. 2002) and therefore it is not a reliable bio-marker for PTSD (Rosen and Lilienfeld 2008). Neuroanatomical changes in areas of the brain of people diagnosed with PTSD have also been identified (Bremner 1999, 2002) but pre-incident neurodevelopmental abnormalities, learning difficulties, and associated difficulties have also been found (Pitman, 2001) that might adversely affect an individual's ability to cope with traumatic events (Rosen and Lilienfeld 2008). Other possible complications of PTSD include somatisation, chronic pain and poor health (Schnurr and Jankowski 1999; Schnurr and Green, 2004). People with PTSD are at greater risk of medical problems, including circulatory and musculoskeletal disorders, and have a greater number of medical conditions than people without PTSD (Ouimette et al 2004).

Prevalence of PTSD

Variability in prevalence rates across populations is one of the factors giving rise to concern about the validity of the PTSD construct (Spitzer et al 2007). Prevalence variability arising in PTSD studies has been variously explained by referral and sampling biases particularly in contexts of litigation where it is suggested malingering may be an issue (Rosen and Lilienfeld 2008), by insufficient specificity of the PTSD syndrome (Bodkin et al 2007) and attributing a PTSD diagnosis to people who were not functionally impaired but were exhibiting normal human reactions to adversity (McNally 2007).

However large epidemiological studies such as the National Comorbidity Survey Replication (NCS-R) conducted in the U.S.A. between 2001 and 2003 based on a representative sample of the adult population estimated the lifetime prevalence (the proportion of the population that at some point in their life up to the point of assessment had experienced the condition) of PTSD to be 6.8%. Gender was a significant determining factor with lifetime prevalence of PTSD among men at 3.6% and among women at 9.7% (Kessler et al 2005). The type and cause of the traumatic event are significant with intentional acts of interpersonal violence, in particular sexual assault and combat more likely to lead to Post Traumatic Stress Disorder than accidents or disasters (Kessler et al, 1995; Stein et al. 1997; Creamer et al. 2001). Furthermore men tend to experience more traumatic events than women, but women experience higher impact events i.e. those that are more likely to lead to PTSD such as sexual

abuse (Kessler et al. 1995; Stein et al. 1997).

Of particular interest in the context of this research are the experiences of civilian populations exposed to traumatic injuries, accidents or assaults who would seem to exhibit significantly higher PTSD levels than the general population. Flatten et al suggest that Acute Stress Disorder and PTSD have been observed in 15%-20% of people who have experienced physical injury (Flatten et al. 2008) while 25.5% of participants who had a trauma related injury met PTSD diagnostic criteria at 6 month follow-up in a study by Shalev et al (1996). Subjects who developed PTSD had higher levels of peritraumatic dissociation and more severe depression, anxiety, and intrusive symptoms at their 1-week assessment. Peritraumatic dissociation predicted a diagnosis of PTSD after 6 months over and above the contribution of other variables and explained 29.4% of the variance of PTSD symptom intensity (Shalev et al 1996).

Rape was associated with the highest PTSD rates in several studies, for example, 65% of the men and 46% of the women who had been raped met PTSD criteria in the study by Kessler et al. (1995). PTSD prevalence rates among people affected by trauma following assaults, injuries and accidents suggest the need for comprehensive trauma-focused assessment and psychosocial support services in hospital emergency departments. However a nationwide poll researching the psychological treatment and care of accident patients in German emergency surgery departments revealed insufficient training among staff to adequately handle psychological trauma syndrome (Flatten et al 2000).

Protective, Risk and Generative Factors

Studies show that post trauma outcomes are influenced by multiple biological, psychological, social, life history factors that intersect with the nature and severity of the traumatic event. Shalev undertook a review of 38 studies and identified three levels of risk factors for PTSD occurring before, during and after a traumatic event. They included pre-trauma factors (e.g., family history of mental disorders, gender, genetic and neuroendocrine factors, personality traits, early traumatisation, negative parenting experiences, and lower education), factors at the time of the event included the magnitude of the stressor, preparation for the event and immediate reactions to the trauma (e.g., dissociation and coping responses) and finally post trauma factors (e.g., emerging symptoms, social support and other life stress) (Shalev 1996).

Brewin et al (2000) undertook meta-analyses in relation to findings of 77 studies undertaken since 1980 on 14 separate risk factors for development of PTSD. Having identified differing effects of various risk factors across studies, the moderating effects of sample and study characteristics, including civilian/military status, were taken into account. They report

> *"Three categories of risk factor emerged: Factors such as gender, age at trauma, and race that predicted PTSD in some populations but not in others; factors such as education, previous trauma, and general childhood adversity that predicted PTSD more consistently but to a varying extent according to the populations studied and the methods used; and factors such as psychiatric history, reported childhood abuse, and family psychiatric history that had more uniform predictive effects. Individually, the effect size of all the risk factors was modest, but factors operating during or after the trauma, such as trauma severity, lack of social support, and additional life stress, had somewhat stronger effects than pretrauma factors".*
>
> (Brewin et al 2000:748)

The authors conclude that there is no evidence for a general vulnerability model for all cases of PTSD. Instead they suggest investigation of '*more proximal links in the causal chain*' such as the association between pre-trauma risk factors, trauma severity and immediate trauma responses in relation to mediation of risk of PTSD (Brewin et al 2000). Bonanno and his associates have brought a focus to resilience arguing that among adults it represents a distinct and empirically separable outcome trajectory from that normally associated with recovery from trauma (Bonanno 2004, 2005; Bonanno et al 2005, 2007 and Bonanno and Mancini 2008, 2012). For Bonanno resilience is associated with an inherent flexibility in both appraisal and response to potentially traumatising events. He found multiple and sometimes unexpected ways to be resilient and maintained that resilience is more prevalent than generally accepted and merits the same rigorous investigation that has been extended to understanding dysfunction

> *"It is imperative that future investigations of loss and trauma include more detailed study of the full range of possible outcomes; simply put, dysfunction cannot be fully understood without a deeper understanding of health and resilience. By viewing resilient functioning through the same empirical lens as chronic forms of dysfunction and more time-limited recovery patterns, researchers will be able to examine and contrast each of these patterns".*
>
> (Bonanno 2004:26-27)

In their 2012 article entitled *'Beyond Resilience and PTSD: Mapping the Heterogeneity of Responses to Potential Trauma'*, Bonanno and Mancini have moved beyond a juxtaposition of resilience versus risk in relation to PTSD and towards approaches in modelling the heterogeneity of trauma outcome and the factors that influence it. Referring to the body of work on resilience in childhood that suggests

> *"....adjustment to aversive childhood contexts results not from a single dominant factor or even from several factors but rather from a cumulative mix of person-centred variables (e.g., disposition, personality) and sociocontextual (e.g., family interaction, community support systems) risk and protective factors (Garmezy, 1991; Rutter, 1999; Werner, 1995)....."*
>
> (Bonanno and Mancini 2012:81)

The authors claim that studies that have examined individual differences among adults exposed to potentially traumatising events have increasingly pointed toward the same conclusions. Following Hobfoll's theory of conservation of resources (COR) (Hobfoll, 1989, 2002; Hobfoll & Lilly, 1993) which asserts that both the availability of resources and the change in resources that often results from highly disruptive events play a crucial role in human adaptability to extreme stress, Bonanno and Mancini highlight the significance of transpersonal resources such as economic and material resources (e.g. employment or loss of employment, income and income loss) and interpersonal resources (e.g. positive and negative interpersonal support, availability of affinity groups). They propose multivariate modelling of the patterns of association between psychological factors, transpersonal resources, resource loss and diverse trauma outcomes to achieve a better understanding of the variability of responses to trauma (Bonanno and Mancini 2012)

Saleebey too, underlines the recursive interrelationship between body, mind and environment in maintaining wellness and allowing regeneration

> *"The ample literature exploring the relationship between body, mind, and environment and health and wellness suggests that this interaction is complex, recursive, and reticulate and always implicated in keeping people well, assisting individuals in regenerating after trauma, and helping individuals and communities survive the impact and aftermath of calamity and ordeal".*
>
> (Saleebey 1996:300)

Saleebey an early exponent of strengths and resilience in the aftermath of trauma within the social work tradition, makes a case in the following extract for recognition of generative factors in addition to risk and protective factors arising from trauma experience

> *"Many factors, highly variable, interactive, and dynamic, affect how an individual or group will respond to a series of traumatic, even catastrophic situations (Benard, 1994; Chess, 1989; Garmezy, 1994). The critical factors have been termed "risk factors" (they enhance the likelihood of adaptive struggles and poorer developmental outcomes) and "protective factors" (they increase the likelihood of rebound from trauma and stress). I would add "generative factors" - remarkable and revelatory experiences that, taken together, dramatically increase learning, resource acquisition, and development, accentuating resilience and hardiness."*
>
> (Saleebey 1996:300)

Deconstructing the PTSD Construct

It has been argued that post trauma stress has been colonised by psychiatry, which through the mechanism of the DSM, constitutes it as the psychiatric disorder PTSD, with a defined etiology, symptomology and diagnostic criteria (Davis 1999). The diagnostic construct of PTSD with its burgeoning theoretical and research base, validated screening tools and prescribed treatment approaches now occupies a dominant position within mental health discourse. Others argue it has colonialised our very culture (Bracken 2001, 2002; Furedi 2004). Given the reach of its influence as the formal means of validating trauma experience and the implications for those seeking and providing professional support, it is important to critically analyse the PTSD construct.

Deconstruction (Derrida 1976, 1978, 1995) is an approach integral to postmodern criticism that analyses a given discourse to reveal the social and ideological conditions and power relations that underpin it (Lemert 1992). In this section deconstruction is used to un-cover the neutralising effects of constituting trauma as a medical disorder. The formulation of PTSD can be read, in the view of some theorists, as a case study in the social construction rather than discovery of illness (Scott 1990; Young 1995; Bracken 2001, 2002; Summerfield 2001). This is not to say it is an entirely unhelpful

construct as I have argued earlier, however PTSD has been subject to extensive criticism from within and outside psychiatry for example on ontological grounds (Scott 1990; Young 1995; Summerfield 2001); in terms of construct-validity (Nemeroff et al. 2006; Spitzer et al 2007; Rosen and Lilienfeld 2008); individualisation (Davis 1999); cross-cultural applicability (Bracken 2001; Mezey and Robbins 2001) and medicalisation of political and social issues (Davis 1999; Summerfield 2001; Seeley 2005). I will now discuss each of these arguments in more detail.

The Ontological Argument

This argument suggests that PTSD is not a bio-medical entity established by scientific discovery but rather it was constructed and developed as a phenomenon by claims-makers and interested parties. Writing about the politics of diagnosis of disease, with specific reference to the initial delineation of Post-Traumatic Stress Disorder (PTSD) in the 1980 revision of the classification system of the American Psychiatric Association, the Diagnostic and Statistical Manual of Mental Disorders (DSM 111), Scott described how the inclusion of PTSD in the DSM III was brought about by a successful campaign by a core group of psychiatrists and veterans. He argued that this process helps us

> *".....understand in detail how objective knowledge and medical scientific knowledge in particular is produced, secured, and subsequently used to create other objective realities, such as, in this case, acknowledgements of war's horrors, populations of treatable clinical cases of PTSD, patients entitled to insurance coverage, and the like. Each new clinical diagnosis of PTSD, each new warrantable medical insurance claim, each new narrative about the disorder reaffirms its reality, its objectivity, its 'just thereness.'.....This is how facts are made."*
>
> (Scott 1990: 308)

Young, a medical anthropologist concurs. He asserts that PTSD based on what he sees as the heretofore marginal concept of traumatic memory, was introduced into the lexicon of psychiatry at a time when the discipline was radically re-orienting itself on the basis of research technologies adopted from medicine (experimentation), epidemiology (biostatistics) and clinical psychology (psychometrics). PTSD does not he suggests possess an intrinsic unity, instead it is held together by the practices, technologies, and narratives with which it is diagnosed, studied, treated and represented and by the various allied interests, institutions, and moral arguments (Young 1995).

The expansion of DSM diagnoses and

> *"the saturation of the biomedical model leaves physicians and their allies in government less able to perceive health and illness through the lay lens"*
>
> (Friedman 1970 cited in Brown 1995:44)

According to Brown they are therefore more likely to view routine social and bodily phenomena as pathological entities and this tendency to medicalise is likely to increase with specialisation (Brown 1995). From the late 1980s there have been significant changes in the 'behavioural health delivery system' in the USA towards rationing of treatment, criteria of 'medical necessity' and 'observable and symptomatic improvement' as criteria of therapeutic efficacy and efficiency through 'belt-tightening' within the managed care system (Neimeyer & Raskin 2000). As with diagnosis of other mental health disorders a diagnosis of PTSD is the gateway to insurance cover for both psychotherapeutic and pharmacological treatment and medical personal are the designated gatekeepers.

Nayback (2009) outlines the self-perpetuating nature of the PTSD construct, claiming that screening tools such as the Primary Care PTSD Screen, PTSD Checklist-Civilian Version, PTSD Checklist-Military Version, Impact of Event Scale (IES) and PTSD Symptom Scale-Self Report have been developed to establish the presence of the empirical referents for PTSD - re-experiencing, hyper arousal, and avoidance (DSM-IV 1994) and then through the presence of these symptoms, the phenomenon of PTSD arises (Nayback 2009).

Summerfield cautions

> *"...society confers on doctors the power to award disease status and the social advantages attached to the sick role. Current practice, which labels people as being mentally ill when they are not, calls this public duty of doctors into question. To conflate normality and pathology devalues the currency of true illness, promotes abnormal illness behaviour, and incurs unnecessary public costs.....the medicalisation of life....tends to mean that distress is relocated from the social arena to the clinical arena. This is a two edged sword: there are practical gains for some, but costs may accrue for everyone over time if contributing factors rooted in political and commercial philosophies and practices escape proper scrutiny"*
>
> (Summerfield 2001:11)

Construct Validity

Since its inception PTSD has been a contested diagnosis. It has been claimed that

> *"...since its introduction into DSM-III in 1980, no other DSM diagnosis, with the exception of Dissociative Identity Disorder (a related disorder), has generated so much controversy in the field as to the boundaries of the disorder, diagnostic criteria, central assumptions, clinical utility, and prevalence in various populations"*
>
> Spitzer et al (2007: 233).

In a meta-analysis focusing on construct validity (Cronbach and Meehl 1955), Rosen and Lilienfeld found a lack of evidence to support any of the three core assumptions and associated validating criteria underpinning the PTSD construct, namely a specific etiology, distinctiveness of PTSD as a clinical syndrome and the presence of distinctive bio-markers such as psychophysiological reactivity or traumatic memory. They conclude

> *".....rather than conceptualizing PTSD as a taxon (i.e., category in nature; Meehl & Golden, 1982), it may be more fruitful and scientifically supportable to consider PTSD as encompassing a broad range of possible reactions to adverse events...If we have learned anything from the long history of posttraumatic studies, and the shorter history of PTSD, it is that multiple factors and their complex interrelations result in variable outcomes that are unlikely to be explained by a single disorder in nature".*
>
> (Rosen and Lilienfeld 2008:858)

Individualisation

The PTSD construct has been criticised for individualising trauma by failing to address its interpersonal and structural origins, characteristics and impact. Burstow claims that

> *"PTSD is a grab bag of contextless symptoms, divorced from the complexities of people's lives and the social structures that give rise to them. As such, the diagnosis individualizes social problems and pathologizes traumatized people"*
>
> (Burstow 2003:1296)

Davis (1999) advocates intervention with partners, families and wider society through educational, advocacy, media and political work to promote understanding of the effects of trauma and ameliorate frustration survivors may experience at what they perceive as an inability of their families to understand how their world has been shattered. Neglect of the impact of trauma at a relational level is concerning in the light of research. An American study found that 8% of marital breakdown and 21% of partner abuse occurred in families of war veterans (Prigerson et al 2002). Transgenerational effects of trauma have also been demonstrated in studies where the traumatic impact of genocide was found to continue for second and third generations of families who were direct victims (Peskin et al 1997; Bar-On et al 1998).

Universalisation

Criticism of the PTSD construct from a cultural perspective centres on the universalism (assumptions that findings from typically Western contexts are generalizable to the rest of the world) inherent in the exporting the PTSD construct, a product of Euro-American psychiatry, to low-income countries with diverse cultures through the globalised humanitarian aid programmes of governments and NGOs (Young 1995; Summerfield 1999; Zender 2010). Bracken (2002) suggests the the DSM categorization gives rise to normative assumptions about trauma reactions.

Medicalisation of Sociopolitical Issues

The sociopolitical consequences of classification of trauma as mental pathology have attracted critical comment. Lembcke (1998) highlights the depoliticising effect of characterising the problems of Vietnam veterans, as a mental illness. A similar argument has been made by Seeley (2005). Linking mental health practice and politics, she examines the implications of a free mental health programme initiated by the New York State Office of Public Health under the auspices of the Bush administration, in the aftermath of September 11. Seeley questions

> *"What happens when persons harmed by an act of mass political violence are turned into patients with psychiatric disorders? What does it mean to prescribe a course of psychotherapy to treat individuals' emotional reaction to terrorism?"*
>
> (Seeley 2005: 18)

She argues that privatising what is social and political experience militates against political engagement and the development of political consciousness. An overemphasis on trauma and posttraumatic stress disorder (PTSD) in working with refugees in host countries may both undermine peoples' own adjustment processes and detract from issues of justice and human rights (Inglby 2005). In the context of international aid programmes Pupavac (2002) highlights political consequences of the therapeutic paradigm resulting in an *'indefinite international presence to administer a traumatised population'* (Pupavac 2002:5).

Rose too, argues that psychosocial support processes make people governable in so far as they

> *" 'shape conduct'* [in the] *'hope of producing certain desired effects and averting certain undesirable events' "*
>
> (Rose1999: 52).

Counter to these trends Westoby and Ingamells call for

> *'moral engagement and a collective response to injustice as part of healing work'.*
>
> (Westoby and Ingamells 2010:1771)

Categorical Nature of the Diagnosis

Davis argues that the categorical nature of the PTSD diagnosis reduces its utility in addressing a range of trauma responses

> *"....while PTSD has raised public and professional awareness, it also narrows the focus in key respects. The type of 'traumatic stressor' admitted within PTSD criteria is limited. The type and number of symptoms that 'count' for PTSD also limit this conception of trauma. PTSD's categoric nature and status as 'the' post-trauma diagnosis narrows attention to a particular, but by no means exhaustive type of reaction".*
>
> (Davis 1999:771)

While PTSD partially captures the experience of a minority of people exposed to trauma it is one end of a spectrum. There are other possible outcomes: trauma may be countered by resilience (Bonanno 2004, 2005); transformed by resilience and empowerment (Bussey and Bula Wise 2007); or balanced by strengths (Marlowe and Adamson 2011) enabling people to continue without professional supports. Retraumatisation (Ehlers et al 2004) that is a process whereby reminders of previous trauma can lead to renewed and further distress, may be a risk. Secondary/vicarious traumatisation (Figley 1995) referring to situations in which other people including professional helpers, not directly involved in the original trauma, can experience a trauma reaction, may occur. Finally post traumatic growth (Tedeschi and Calhoun 1995; 1996; 1998, 2004; Tedeschi et al 1998; Janoff-Bulman 2004, 2006; Harms and Talbot 2007) which describes peoples' experiences of finding life meaningful again and feeling able to cope with life's demands in the aftermath of trauma may be evident. That may involve reappraisal and rededication of priorities. Harms and Talbot charted positive growth post-trauma occurring at the three levels of self-esteem, relationships and worldviews (Harms and Talbot 2007).

Deconstructing PTSD allows us to dis-cover the neutralising and de-politising effects of the medicalisation of trauma. It therefore illustrates the limitations of the PTSD construct. In the next section the emphasis changes to examining how trauma is socially constructed within discourse and suggests ways to respond that are more culturally and socio-politically aware.

The Social Construction of Trauma

Social constructionism focuses on the significance of how issues are defined, how society responds and how this in turn impacts on the individuals involved. As such Conrad and Barker (2010) argue

> *".....social constructionism provides a counter to medicine's deterministic logic"*
>
> (Conrad and Barker 2010:S76)

In this section I will consider philosophical, feminist and critical social work standpoints on trauma that are underpinned by a social constructionist worldview. This body of work highlights how issues of disempowerment, oppression and control may be inherent in the genesis of trauma experience for example in situations of political, gang-based or domestic violence or may result from institutionalised responses to those who are affected by it. Philosophical and socio-political perspectives therefore contribute to

an expanded frame of reference in interpreting and theorising trauma and signpost alternative responses that can inform social work practice.

Philosophical Perspectives

In seeking explanations for traumatic anxiety, Bracken produces a critique of cognitivism, an approach within the empirical scientific idiom, which understands the mind as separate from and acting in relation to the outside world. Instead drawing on Heidegger's hermeneutic phenomenology he asserts that people's experiences of trauma are mediated through practical engagement in the world, which is, he says

> *'the ground on which our propositional knowledge ('knowing-that') is based.'*
>
> (Bracken 2002:206).

Heidegger, as Bracken (2002) argues, proposes a radically different starting point to understanding human experience, to that of an internal subjective realm relating to an external objective world proposed by traditional psychology.

> *"Heidegger offers us an approach which insists on the embedded nature of human reality, a reality in which the cultural and temporal are not merely additional factors which can be added to an independent psychology but are in fact a priori dimensions of our reality which allow for a psychological world in the first place."*
>
> (Bracken, 2002:130)

Lived experience of trauma is embedded in a series of discursive and embodied practices in an already meaningful social world and is understood as inter-subjective rather than as a disembodied, internal emotional state. Encountering experience

> *".....is dependent on our embodiment (having a body) and our existence in a social world. These elements combine so we are able to encounter a world that is meaningful. Heidegger says that there are two aspects to this understanding (Verstehen) and mood or orientation (Befindlichkeit). These are not present as distinct but are always experienced in a unitary way. Thus according to Heidegger human being is always situated, and as such is always in a position of understanding and is always in some way in a 'mood' or 'state of mind'. We never encounter a world in a 'neutral' way."*
>
> (Bracken 2002:131)

Bracken goes on to quote Gendlin (1988) on the concept of Befindlichkeit

> " 'Sichbefinden' (finding oneself)....has three allusions: The reflexivity of finding oneself; feeling and being situated. All three are caught in the ordinary phase, 'How are you?'. That refers to how you feel but also to how things are going for you and what sort of situation you find yourself."
>
> (Gendlin cited in Bracken 2002:132)

Bracken suggests Heidegger is referring to something like 'mood' or 'feeling' or 'state of mind' but cautions that 'moods' are not simply 'things' that can be analysed unproblematically. Rather they are part of the way in which the world is revealed to us, they allow us to be 'attuned' to the world. They should not be thought of as purely internal or mentalistic, this would be false to the true nature of our experience rather they encompass a background cultural or public dimension. Only in the context of our background cultural orientation to feeling can we have individual feelings and mood (Bracken 2002).

Bracken's contribution to our understanding of trauma is his advancement, drawing on Heidegger, of a cultural basis for emotional capacity and individual emotional experience. He is also concerned with collective emotional experience, suggesting a contemporary preoccupation with trauma, stemming from vulnerability to meaninglessness and anxiety in postmodern, Western cultures (Bracken 2002).

Feminist Perspectives

There are a number of feminist standpoints that can inform our understanding of trauma. Second-wave feminism (1960s-1980s) centred its analyses on concepts of patriarchy and challenged distinctions between personal and political realms of lives and between theory and practice. In line with their commitment to praxis, public campaigns were initiated to raise awareness of and address male violence (Herman, 1992; Fraser 2003). This approach was successful in expanding public perceptions of violence and trauma to include violence occurring in the family home. This wider public recognition underpinned the establishment of support services such as refuges and rape crisis centres (Herman 1992; Jackson and Scott 1996; Fraser 2003). The work of feminist campaigners was also influential in putting violence against women on the agenda of the American Psychiatric Association in their deliberations on the incorporation of PTSD in the DSM (Herman 1992).

However other feminist theorists have been critical of trauma discourse highlighting the tendency for a woman who has been abused to be treated differently and less favourably than survivors of other trauma because she is

> *".....assumed to have contributed to her problem, in particular because of the interpersonal locus of her distress"*
>
> (Brown 1995:102)

In 'A gap or a chasm? Attrition in reported rape cases' a 2005 report published by the British Home Office, the authors report on an evaluation of sexual assault services developed under the auspices of the Violence Against Women Initiative, launched in 2000 as part of the British Home Office Crime Reduction Programme. The study was undertaken at a time when Home Office figures showed an ongoing decline in the conviction rate for reported rape cases, putting it at an all-time low of 5.6 per cent in 2002. The authors concluded

> *"The most important recommendation from this study in terms of the investigation of rape complaints is that a shift occurs from an exercise in scepticism focusing on discreditability to enhanced evidence-gathering and case-building".*
>
> (Kelly et al 2005:89)

Fraser (2003) discusses criticisms advanced by third-wave, post-structural and postmodern feminists of the meta-narratives of second-wave feminism, including those used in representing women's experience of violence, as essentialising women and homogenising their experiences. Morley and Macfarlane further clarify this standpoint

> "*Postmodern feminists contend that women experience various and compounding layers of oppression that intersect with gender on the basis of ethnicity, age, sexuality, socio-economic status, geographical location and other dimensions of difference".*
>
> (Morley and Macfarlane 2012:692)

Morley and Macfarlane are concerned that in moving beyond feminism, gender inequality is denied

> *"...to be replaced by more individualistic, depoliticised, pathologising approaches to policy, service delivery and practice...."*
>
> (Morley and Macfarlane 2012:691)

However drawing on Kenney's reconceptualisation of modernist ideas of power, change and agency the authors turn to the possibilities for social work, inherent in seeing change as

> *'produced by networks of insiders and outsiders rather than exclusively caused by elites in formal positions'.*
>
> (Kenney 2003 cited in Morley and Macfarlane 2012:700)

Burstow (2003) documents the influential role of feminists such as Herman (1992), Russell (1984), Burstow (1992), and Brown and Root (1990) in shaping understanding of trauma including its delineation in the DSM. She describes the differing standpoints of those who worked within psychiatry and those such as Burstow herself who held an anti-psychiatry position

> *"Although some feminist practitioners saw psychiatry as inherently problematic and viewed the feminist theorizing as a sort of counter-dialogue, the more influential—Herman (1992), for example—largely accepted psychiatric underpinnings, while seeing psychiatric conceptualizations as simply restrictively androcentric or otherwise privileged. Correspondingly, feminist practitioners lobbied for and in some cases succeeded in getting changes to the Diagnostic and Statistical Manual of Mental Disorders (DSM) (published by the American Psychiatric Association)".*
>
> (Burstow 2003:1293-1294)

The initial definition of a traumatic stressor in DSM III (1980) which was suggestive of trauma as a single unpredictable event, was inadequate for feminist theorists

> *"Trauma is caused by a stressful occurrence that is outside the range of usual human experience, and that would be markedly distressing to almost anyone"*
>
> (American Psychiatric Association, DSM III, 1980).

They argued that the definition failed to represent the experience of people for whom traumatic events such as sexual abuse occurred repeatedly and further to this it imputed psychopathology to those who could not protect themselves (Brown 1995). The DSM-IV-TR, 1994 produced a more inclusive definition

> *"Posttraumatic Stress Disorder (PTSD) is an anxiety disorder that develops following exposure to an extreme traumatic stressor....."*
>
> (American Psychiatric Association, DSM-IV-TR, 1994)

The definition in the DSM-5, 2013 refers explicitly to sexual violence

> *"The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence....."*
>
> (American Psychiatric Association, DSM 5, 2013)

Notwithstanding the advancements already secured, Burstow (2003) calls for a radical approach to trauma work responsive to the experiences of people living in ongoing situations of oppression which she sees as critical in a

> *"....world in which women, the working class, Natives, people of colour, Jews, lesbians and gays, and the disabled are routinely violated both in overt physical ways and in other ways inherent in systemic oppression and where the psychological effects of this violation are often passed down from generation to generation."*
>
> (Burstow 2003:1294)

She is critical of practitioners including those from feminist, trans-generational and community traditions who work within the language and definitions of psychiatry, albeit while endeavouring to reform it. Burstow advocates a radical break with psychiatry

> *"Mental disorders, whether they are called PTSD or anything else...are a function of the power of psychiatry mediated by the psychiatric text, irrespective of whether the practitioner making the judgment is a psychiatrist or a feminist practitioner. Insofar as trauma practitioners use the texts, we involve ourselves with psychiatry, thereby extending its power. We also violate the person, however benign our intentions and whatever genuine help we give in the process. That is, we take away people's power to name their experiences and subject them to a naming controlled by a powerful international institution at arm's length. Moreover, we increase the possibility of the person someday being subjected to more substantial psychiatric interference, for diagnoses are*

an entry point to more intrusive measures".

(Burstow 2003:1300)

She resists using a deficiency model, which frames psychological and social problems in terms of diagnostic categories. She reminds us that trauma is not a disorder but

'a reaction to injurious events and situations in the real world'.

(Burstow 2003:1303)

She invites us to view trauma along a continuum, generating solidarity and understanding that people or communities may be more traumatised in some respects and less in others. She sees reactions whether conventional or otherwise (such as self-harming) as coping mechanisms and maintains the

"...consequences of not distracting and not dissociating can be the inability to function, utter despair, and in the long run, far more substantial dissociation'.

(Burstow 2003: 1304)

Burstow asserts that if people who have been traumatised, view the world as unsafe that is because they have experienced it as so, not because they have a distorted view of the world. Traumatising actions by others compound the sense of aloneness and despair. Burstow advocates awareness of different layers of trauma, past and present and produced at individual, family, community and society levels. We must be alert to trauma being systematically produced by traumatising structures including psychiatry, refugee application procedures and other institutions of the state. She suggests that

"Co-investigating how these play out with respect to a particular person, community, or nation is optimal".

(Burstow 2003:1313)

Burstow proposes trauma work focuses on traumatised people gaining or regaining the power to name their experiences in their own terms, protect themselves and counter alienation. This approach coupled with advocacy and public means of expression and witnessing for example through community arts, demonstrations, legal actions, ceremonies and rituals and community building forms part of her vision of trauma work as praxis, which she sees as moving towards radical adult education (Burstow 2003).

Feminist standpoints are therefore underpinned by critical theory and practice and offer emancipatory approaches in responding to gender-based and other inter-linking forms of trauma.

Critical Social Work Perspectives

Critical perspectives on trauma have been developed from social work practice with resettling refugee and immigrant communities. Writing in the Australian context Westoby and Ingamells argue that

> *"....multiple and simultaneous practice pathways are required in order to engage responsively across a range of dimensions with people who have arrived as refugees."*
>
> (Westoby and Ingamells 2010:1771)

While acknowledging the need for trauma counselling, following Pupavac (2002) they highlight the dangers of imposing external Western perspectives on individuals and communities who hold other traditions and for whom trauma may have very negative connotations

> *"Where a community's own resources for coping are overridden, rather than acknowledged and engaged, the community itself loses strength. In Anglo-American culture, trauma and trauma stories confirm suffering, and confer moral status and legal rights, so there are benefits for individuals who identify themselves as traumatised. In other societies where trauma does not confer the same entitlements, individuals may see themselves and want to be seen as stoic rather than traumatised."*
>
> (Westoby and Ingamells 2010:1766-1767)

Drawing on anthropological studies from Mozambique, Zimbabwe, Cambodia and Angola (Kleinman1980; Honwana 1997, 1998; Wessells 1999; Eyber 2002) they argue instead for a focus on identifying and strengthening the emic resources of the community, understanding how they have been disrupted and facilitating their re-establishment. However they caution against rarefying culture or seeing it as static or in itself sufficient to resolving distress, instead they acknowledge all cultures may reinforce unequal power structures. Where cultural differences between the worker and community member exists they recommend making those differences explicit, and facilitating a sharing of perspectives and resources, considering expectations and legal

requirements of both cultures, addressing dilemmas and negotiating outcomes (Westoby and Ingamells 2010:1767).

Westoby and Ingamells advocate that workers focus on building relationships and dialogue within and across cultures while being conscious of unequal power relations. Providing inter-cultural opportunities for social interaction through shared interests such as football, music or food highlights strengths, talent and enterprise and challenges negative stereotyping. A long term commitment is required, as is the capacity of workers to work outside agency confines, engaging in partnership with communities to change social and political systems that impact negatively on their life chances in their new country.

Marlowe and Adamson (2011) report similar findings from a study undertaken with Sudanese men who had resettled in Australia to establish how they conceptualise and respond to trauma. Research participants were very familiar with the term trauma as having currency in gaining entry into refugee camps, establishing claims for refugee status, and qualifying for services in Australia. While they acknowledged their experiences of war and migration were traumatic, they did not wish to be defined by them. Instead they wanted to contribute and participate in society (Marlowe and Adamson 2011). It was noted that

> *"adapting to the new social realities in a new host country was as difficult (if not more so) than the adversities associated with forced migration……. Part of promoting well-being on participants' terms is allowing them to express their conceptualisations of, and responses to, trauma rather than making a priori assumptions about it.*
>
> (Marlowe and Adamson 2011: 628)

The importance of building a future was emphasised

> *"….participants responded to trauma through the important social and cultural functions located within the community milieu. Others identified the role of spirituality and agential realisations of employment and education as pathways that embodied hope and offered resonant responses to trauma…..the hope for a better future has helped them to work through and move beyond traumatic experiences."*
>
> (Marlowe and Adamson 2011: 628)

These studies highlight the importance of engaging rather than overriding people's own definitions of their experiences, their belief systems and cultural practices. The findings of both studies suggest the focus of social work needs to expand to encompass past trauma, current adaption processes and issues in relation to the wider circumstances of peoples' lives. Support on these multiple levels "*embodied hope and offered resonant responses to trauma"* (Marlowe and Adamson 2011: 628) .

Conclusion

This chapter has addressed interpretations of trauma across time and space including a critique of contemporary understanding of trauma evident in the utilisation of the diagnostic category Post Traumatic Stress Disorder (PTSD). The chapter concluded with social constructionist perspectives applying philosophical, feminist and critical social work critiques that seek, to varying degrees, to extend or replace the hegemonic PTSD discourse. It has been argued in the foregoing section that PTSD lacks evidence to support its designation as a distinct bio-medical entity and many of its key assumptions have been questioned. Further to this, as will be discussed more fully in the next chapter the PTSD construct is limited in its ability to represent or address the complexity and variability of the lived experience of trauma. Proposals to conceptualise PTSD as the upper end of a stress-response continuum that includes everyday stress reactions at one end, and more severe PTSD symptomatic criteria at the other, rather than the current single clinical syndrome, as discussed by Rosen and Lilienfeld (2008) may have merit. This would allow knowledge of trauma reactions gained through the extensive research programmes launched in the aftermath of DSM III to be retained while overcoming the far reaching implications of labelling wide-ranging and often adaptive reactions to adversity as a mental disorder. The next chapter 'Theorising Trauma-Informed Social Work builds on the critique of the psychologisation and medicalisation of trauma synthesised in this chapter and explores the potential of a social work response in addressing the multidimensional nature of lived exerience of trauma.

Chapter 3 Theorising Trauma-Informed Social Work

Introduction

This chapter seeks to theorise the potential of social work in responding to the multi-faceted experiences of people affected by trauma. The chapter begins by briefly revisiting the critique of PTSD presented in part one of the literature review, focusing on the implications for social work practice. It is argued that trauma, abstracted from the socio-cultural context in which it arises, is a troublesome concept for social work. Notwithstanding this, there is evidence from the literature that trauma is an emerging focus for social work across a diversity of practice areas. In order to situate this localised study on social work and trauma, in the context of wider social work debates and developments, the evolving nature of social work as a human services discipline is discussed and ways in which it is positioned and positions itself in relation to working with people in distress are explored. Key challenges and tensions are elucidated and ways forward drawing on theories of postmodernism and social constructionism are outlined. Building on ideas of social constructionism, the second part of this chapter begins to conceptualise trauma-informed social work, using the spatio-temporal metaphor of the 'third space' which situates social work at interfaces between people and their social situations. However a disjuncture persists between theory and practice. Elsewhere Howe argued

> *"We need a framework that unites the way we understand people with the way we work with them. Relationship based thinking provides that possibility"*
>
> (Howe 1998:55)

Following Howe, I suggest that relationship-based practice both constitutes and underpins the 'thirdspace' of social work in its capacity to engage and respond to lived experiences of trauma.

The PTSD Construct - Implications for Social Work.

The previous chapter has addressed issues in relation to experiences of trauma including a critique of the diagnostic category Post Traumatic Stress Disorder (PTSD). The section concluded with social constructionist perspectives applying philosophical, cultural and political critiques that seek, to varying degrees, to extend or replace the hegemonic PTSD discourse. From a social work perspective key concerns include the labelling of predictable, even adaptive trauma reactions as a mental health disorder, the psychologisation and therefore de-politicisation of oppression and the distortion of subjective and situated meanings that incurs in the imposition of a pre-defined and fixed classification system for PTSD. Instead it has been argued that social workers need to listen, witness and seek to understand people's lived experience without imposing diagnostic categories or other cultural, generational or socio-political filters (Wood and Tully 2006).

By applying postmodern, critical perspectives PTSD was deconstructed to reveal the risks of individualising, labelling, and fixing the meaning of people's experiences of adversity. Thus critically engaging with the PTSD construct highlights the need for resistance to pathologising practices. Ways in which trauma experiences were socially constructed were then foregrounded thus generating broader possibilities in relation to understanding causes of distress, ways to respond and possible outcomes. Feminist, phenomenological and critical social work perspectives were explored which map and respond to social, cultural, political and economic dimensions of trauma according to the meaning trauma holds in the context of lived experiences.

These perspectives contribute to an expanded, contextualised analysis of trauma providing an imperative for more respectful, democratic and hopeful ways of working. Moving away from pathology, a strengths perspective may be adopted in social work practice. A strengths perspective (Saleebey, 1992, 1994, 1996; Sullivan and Rapp 1994; Weick et al 1989) is not a theory but a standpoint (Saleebey 1996) which developed in part to challenge a hegemonic culture of dis-ease in contemporary popular and professional discourse. Saleebey claims that

> *".....US culture and helping professions are saturated with psychosocial approaches based on individual, family, and community pathology, deficits, problems, abnormality, victimization, and disorder...Practicing from a strengths perspective does not require social workers to ignore the real troubles that dog*

individuals and groups....But in the lexicon of strengths, it is as wrong to deny the possible as it is to deny the problem.....[A strengths perspective] does deny the overweening reign of psychopathology as civic, moral, and medical categorical imperative....It denies that all people who face trauma and pain in their lives inevitably are wounded or incapacitated or become less than they might.

(Saleebey 1996: 296-297)

Notwithstanding the warranted criticism discussed in the previous chapter, I would argue that the deconstructed PTSD construct could be subsequently used with greater sensitivity, as one of many possible ways to understand experiences of trauma. It may prove a helpful framework for service users in understanding trauma reactions particularly the intrusion/avoidance dynamic and experiences of emotional numbing and hyper-arousal as outlined in the DSM-5 (2013). Recognition, understanding and normalisation of these reactions can be containing of people's anxiety. Access to knowledge including knowledge of PTSD and its limitations is empowering for service users and workers alike. We need to recognise particularly when working in inter-disciplinary settings, that while receiving a mental health diagnosis is alarming for some people, others may feel relieved. It can restore a sense of control, validate people's suffering and endorse the need for sick leave from work, access to support services and entitlement to legal redress and financial compensation. A diagnosis provides a rationale for changes in social functioning and may be reassuring for family and friends.

In an inter-disciplinary context the PTSD construct provides a common language to underpin interdisciplinary practice, research and policy development, ideally leading to a fuller understanding of experiences of trauma and more adequate responses to people's needs. Working from a social constructionist perspective the PTSD construct may be viewed as a set of ideas, among others (Irving and Young 2004; Gergen 2009) to be explored in conversations with service users which may be of interest to them in relation to what they are experiencing and why it may be the way it is. In this way the PTSD construct becomes one of many 'sensitising concepts' (Blumer 1954) that social workers bring to practice rather than being definitive or diagnostic. Other sensitising concepts in the context of social work and trauma might include theories of attachment, loss, power and control, empowerment and human rights perspectives.

Trauma – A Troublesome Concept for Social Work?

A recent publication in the British Journal of Social Work proposes trauma as a unifying concept for social work (Joseph and Murphy 2013). While trauma-genic life experiences for example child abuse, domestic violence, incurrence of disabling injuries, diagnosis of life-threatening illness and traumatic bereavement have long been of concern for social work, it is only in recent years that commonality of effects and consequences of fear-inducing, life threatening or life changing experiences have been abstracted from underlying causal events or factors and synergised as an area of practice and research in their own right. Perhaps this time lag, relative to the initiatives taken in related fields of psychiatry and psychology is attributable at least in part to a reluctance by social work to reify trauma reactions and a commitment instead to an analysis embedded in the often socio-political origins of trauma for example in the case of domestic abuse. As Kleinman puts it

> *"Psychologists and psychiatrists construct violence as an event that can be studied outside of its particular context.... They place it in an overly simple stress model, as the distress produced in a person who has undergone a traumatic episode".*
>
> (Kleinman 1995:177).

A focus on generalisable trauma responses while giving much needed recognition and validity to their significance and effects also tends towards de-contextualisation and de-politicisation. Social work approaches therefore need to retain a commitment to address issues of discrimination, oppression and inequality of access to resources and opportunities. Caution also needs to be exercised in the professionalisation of pathways to 'recovery'. Strengthening self-efficacy and informal and community support networks should remain central to social work approaches to trauma.

Although trauma is still an emerging theme in the social work literature, Joseph and Murphy fail to take into account the extent of existing engagement in this area of practice and research as reflected in a substantial body of published work by social workers or social workers in collaboration with other disciplines on many facets of trauma for example in relation to direct practice - community-based groupwork with children (Stewart and Thomson 2005); trauma interventions (Regehr et al 2008); trauma counselling (Rowlands 2011); psychodynamic perspectives (Lesser 2007);

ecological perspectives (Adamson 2005); critical perspectives (Davis 1999; Westoby and Ingamells 2010); constructionist perspectives (Butt and Parton 2005); cognitive behavioural therapy (Duffy, Gillespie and Clarke 2007) and empowerment perspectives (Bussey and Bula Wise 2007) and in applied areas of practice - adoption (Berridge 2003; MacDonald 2012); probation (Good and Gustafson 2010; Maschi and Schwalbe 2012) children in residential care (Steckley 2013); domestic violence (Humphreys and Thiara 2003); political violence (Hayes and Campbell 2000; 2005; Kapur and Campbell 2004) and in relation to post traumatic growth (Harms and Talbot 2007; Nuttman-Shwartz et al 2011); on teaching a trauma curriculum (Berger and Joyce 2010; Marlowe & Adamson 2011) and on secondary traumatisation (Gibson and Iwaniec 2003).

I hope this research can contribute to understanding how in the aftermath of trauma(s), service users and social workers with others, conceptualise and co-construct the key issues, social work processes and ways forward, addressing individual experiences and their embeddedness in wider social worlds. The next section contextualises this study by locating it within wider debates and developments in social work practice and seeks to establish how the positioning of social work can make a contribution in responding to trauma.

Positioning and Repositioning Social Work

> *"By hermeneutics I understand the ability to listen to the other in the belief that he could be right"*
>
> (Gadamer 1996, cited in Grondin 2003:250).

Other Voices and the Interface as a Location for Social Work

In extending Gadamer's proposition on hermeneutics to social work we are reminded of the need to be open to 'truth' held by others. In doing so we find that truth is complex and rarely holds still. Our ways of seeing things change. Modernity privileged rational, scientific objectivity as a way of knowing reality while postmodernity foregrounds decentred, situated and subjective standpoints in relation to lived experience. The history of sociological thought may be read as a dialectic between theories of structure and agency in relation to the nature and constitution of society. Social work has been conceptualised at the interface of different, often competing or conflicting truth-claims, discourses or realms of experience, mediating between varying perspectives,

standpoints and needs. With reference to Donzelot's (1980) post-structural critique, Parton positions social work within 'the social', the space between the person and the state, between the family and society, the interface of private and public worlds (Parton 1994, 2007). More generally the interactive relationship between people and their social contexts is integral to systemic thinking in social work (Pincus and Minahan 1973; Payne 2002) and social work's 'person-in-environment' perspective (Karls and Wandrei 1994; Gitterman and Germain 2008). Social work is concerned with the interface of psychological and the social domains to the extent that 'psychosocial' has become an established term to represent the orientation of the discipline. With its theoretical base in the multi-paradigmed tradition of the social sciences, social work, in seeking to understand individual and collective lived experiences, combines sociology's focus on social relationships, social processes and social structures with theories of human behaviour for example attachment theory (Bowlby 1953; 1969; 1980; Parkes et al 2002) and theories of grief and loss (Kubler Ross 1969; Klass et al 1996; Stroebe and Schut 1999; Neimeyer 2000; Bonanno 2004; Worden 2009).

Historical Positioning - Care and Control

Social work, which developed from philanthropic and charitable beginnings and professionalised in the context of nation-states in late nineteen century Europe (Lorenz 1994), is now practiced in all regions of the world and is characterised by a local-global nexus whereby locality-specific practices shape and are shaped by globalised agendas of a more connected world for example in relation to people-trafficking, ethnically motivated violence, the current financial crisis, environmental issues and more positively a renewed valuing of indigenous practices (Dominelli 2010). Initially social work was one of a number of occupations arising in a period of rapid industrialisation and social change. State systems together with non-governmental organisations such as charities and trade unions directed attention to the experiences and behaviour of individuals *'who either suffered or caused distress'* (Donzelot, 1979 cited in Howe, 1996:81). Social work was as Howe argues, thoroughly immersed in one of modernity's key projects *'to bring discipline and order, progress and improvement to human conditions'* (Howe 1996:81). Through the scientific knowledge claims and practices of the new human sciences particularly medicine, psychiatry, psychology, criminology and social work, human qualities were seen as measurable and calculable and thereby could be changed, improved and rehabilitated (Parton 1996). Social work in England and elsewhere became associated with the provision of the welfare state in the post-

World War II period. As a political rationality 'welfarism' was premised on notions of social solidarity and aimed to encourage growth and wellbeing at a national level through the promotion of social responsibility and the mutuality of risk (Donzelot 1980). A consensus was assumed between the interests of the state, its human service employees including social workers and the individuals and families receiving help. However state intervention also resulted in new forms of social regulation, characterised by concepts of normalisation, discipline and surveillance, highlighted by Foucault (1979) with respect to the development of the modern prison but also reflected in the school, the hospital, the family and the community (Donezolet 1980; Rose 1985; Parton1996). Social workers themselves continue to face ethical dilemmas coupled with public criticism in their attempts to reconcile responsibilities of care and social control (Clarke 1993; Banks 2001; Humphries 2004; Pritchard 2006; Dominelli 2010; Seden et al 2010) particularly in statutory services.

Emancipatory Ideals and Polarised Positions

The management and delivery of social control functions such as child protection delegated by the state to social workers and others via their employing organisations need ongoing monitoring, review and evaluation in the light of the emancipatory ideals of the profession as reflected in the International Federation of Social Workers global definition of the social work profession

> *"Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing."*
>
> (IFSW 2014)

Ife (2012) proposes a human rights perspective as a unifying framework within which the various activities identified as social work can be incorporated while still allowing for cultural, national and political differences such as the predominance of statutory social work in the United Kingdom, radical social work in Latin America, therapeutic social work and a tradition of private practice in the U.S.A and community development in 'the south'. Dominelli suggests that social justice has provided a thread of historical continuity through social work practice citing the rise of radical social work in the 1970s,

feminist and anti-racist social work in the 1980s and anti-oppressive practice in the 1990s (Dominelli, 1998). These perspectives are underpinned by structural analyses of the causes and dynamics of oppression, particularly how the use and abuse of power at inter-personal, organisational, national and international levels impacts on personal life experiences (Clifford 1995; Burke and Harrison 1998). Dominelli defined anti-oppressive practice as

> *"...a form of social work practice which addresses social divisions and structural inequalities in the work that is done with 'clients' (users) or workers.....Anti-oppressive practice embodies a person-centred philosophy, an egalitarian value system concerned with reducing the deleterious effects of structural inequalities upon people's lives; a methodology focusing on both process and outcome; and a way of structuring relationships between individuals that aims to empower users by reducing the negative effects of hierarchy in their immediate interaction and the work they do together."*
>
> (Dominelli 1993 cited in Adams et al 2002:7)

Participatory practice approaches of community development in western countries and social development in 'developing' countries (Payne 1997) brought people together to address issues of common interest using empowerment, consciousness raising and campaigning to highlight inequalities and achieve social change (Bailey and Brake 1975; Dominelli and McLeod 1989; Langan and Lee 1989; Cree and Cavanagh 1996; Dominelli 1997; Mulally 1997; Burke and Harrison 1998; Dalrymple 2003; Beresford and Croft 2004; Ferguson and Lavalette 2004; Humphries 2004; Ferguson and Woodward 2009).

> *"Social work is not seen as a neutral, objective or 'value free' activity, but rather as work which is grounded in values and which makes no apology for adopting partisan stances on a range of questions"*
>
> (Ife 2012:13)

Unsurprisingly given its political and moral standpoints, social work became a contested project at various points in its history. Dominelli using historical examples from the U.K context, points out that social workers aligned with social movements in seeking policy change or advocating rights for minorities or marginalised groups such as housing reform, rights for people with disabilities and women's rights have encountered opposition from government, corporations and employers who assert that professional social workers should be politically neutral, yet they fail to recognize that 'neutrality' maintains an also politicised, status quo (Dominelli 2010).

Notwithstanding these challenges social work in diverse contexts assumes or is delegated a mediating role between the mainstream and those who are or who feel marginalised and excluded (Philp 1979, Parton 2007). Structural social work theorists identify processes and structures of capitalism, patriarchy, racism, ageism, disablism and heterosexism that underpin the stratification of societies and give rise to socio-political oppression and social exclusion (Mulally 1997; Dominelli 2002, 2012; Ferguson and Woodward 2009). Social work upholds issues of rights and equality while predominately working with individuals and families often at junctures between what C. Wright Mills (1959) termed *'private troubles'* and *'public issues'* (Mills 1959:8-11). In many social work contexts, this involves *'an uneasy polarization between political explanations and personal solutions'* (Morell, 1996:307). Similarly Healy argues that there is a dissonance between theories of emancipation and the practices of social work. She suggests that lack of knowledge about progressive practice in conventional practice contexts is a loss to social work (Healy 1999). This is relevant to health-related practice settings is an important consideration in undertaking to this study.

Post Structuralist Analysis, Postmodernism and Social Construction.

In embarking on this study the disjuncture between discourses already discussed in this literature review namely the psychiatrised discourse of trauma and the psycho-socio-political discourse of social work are apparent. At a practice level dissonance between structural analyses underpinning social work and the ethos and exigencies of the clinical space of the hospital emergency department as a site of social work practice warrants analysis. Social work itself accommodates discourses that appear antithetical ranging from psychodynamic theory to critical theory. Questions are raised as to how, or indeed if, differing standpoints at these many levels may be reconciled theoretically and practically. Adopting a postmodern perspective, other questions emerge. Should we accept that 'truths', explanatory frameworks, professional standpoints, approaches and philosophies are multiple and variable according to context and therefore contradictions are inevitable and even desirable? Irving argues

> *'The postmodern view is that contradictions are not only inevitable but desirable. To smooth them over in some Enlightenment madness would be bad form, even bad faith'*
>
> (Irving 2007:243)

Practitioner research in 'conventional practice contexts' (Healy 1999) such as hospitals, is well placed to articulate, document, analyse and theorise practice to inform social work and a wider readership of the myriad ways in which lived experience of felt distress and distressing circumstances is expressed, understood and addressed by service users and service providers. In theorising progressive practice, critical social work theorists (Healy 1999, 2005; Fook 2002, 2012) draw on post structuralist thinking to analyse dynamics of power and potential for change. Moving beyond relatively fixed variables such as class, gender, ethnicity and age that are of established concern in social work, poststructuralist and postmodernist perspectives turn to discursive practices of culture and language to understand how meanings and forms of life are created and sustained, thereby extending possibilities and sites for change. This encompasses a revaluing of localised change as different, but not less than the activist aspiration of total transformation (Healy 1999). Postmodernism foregrounds diverse, localised, subjective experiences and multiplicity of meaning thus eschewing grand theories or totalising explanations, which are considered oppressive. For postmodernists, truths and meanings are constructed in language within cultures, are temporary and are relative to something else for example contingent on previous thought, practice and tradition, therefore claims to universalism, absolutism and essentialism are unjustified (Bauman 1988, 1991, 2013; Carter 1998).

Rossiter argues that postmodernism in its assertion that there can be no knowledge independent of the knower, brought about '*a revision of epistemology that social work cannot escape'* Rossiter (1996: 142). She suggests

> *"Our background assumptions, the cultural paradigms in which our vision is shaped are active in the production of knowledge"*
>
> (Rossiter, 1996:142)

Foucault's thesis that the production of knowledge is embedded with power and that power which is complex and non-linear is central to all action, has important implications for social work (Healy 1999, 2005; Fook 2002, 2012). Rossiter argues that postmodern theories expose the way the dominant culture and we as its spokespeople '*make others up, as we need to see them'* (Rossiter, 1996:144) for example as sick, criminal, weak or uneducated in order to justify our control over them or our exclusion of them. This asserts the need for reflexivity and deconstruction of our assumptions in order to avoid imposing our cultural constructions on others, thereby oppressing people we propose to help. If applied to trauma this cautions against reliance on any single classification system to avoid the danger of imposing meaning, control, prescribed

treatments or premature solutions. Instead the focus moves to ways in which meaning and versions of reality are constructed and agreed.

For many practitioners narrative therapy (White and Epston 1990) gave practical expression to their interest in social construction (Dean 2012; Ting 2012). Narrative is fuelled by a need to construct meaning. It is not simply reporting experience but attempting to make sense of it, by searching for coherence in what was done, what was felt and what was believed. Narrative mediates between the world of culture and the world of beliefs, desires and hopes. A discordant linkage between the two motivates narrative (Bruner 1990). Often people present to a social work service with a problem or crisis when their experience does not fit with culturally dominant or internalised discourses.

Weingarten (1998) noted that some stories are complete and require the listener to bear witness to what has been experienced while other stories have gaps and require the listener to participate in creating a more meaningful story. Stories shape lives rather than merely reflecting them back and create 'positions' for people to uphold, sometimes these positions may be overly rigid and need to change. Co-constructing a narrative that fits with the experience but gives new meaning and is less oppressive is an important element of politicised social work. Narratives are interdependent with the narratives of others whether they are currently present in the person's life or not. Raising awareness of discourses within which narratives form can powerfully shape the stories that are held and told. Multiple perspectives are emphasised rather than single truths. Contextualising stories in relation to wider narratives requires careful attention to the stages of problem definition and exploration of meaning, in order to avoid imposing meaning.

White and Epston (1990) developed an approach within narrative therapy called 'externalising the problem', which encourages people to see themselves in relation to the problem rather than constituted by it. This opens possibilities for adopting other more liberating positions. Sometimes a person's life story becomes 'problem-saturated' leaving little energy for other aspects of life. However there are always 'gaps' or 'indeterminate zones' in which to manoeuvre (Ting 2012). The person is encouraged to chart the relative influence of the problem over time. The problem is viewed as an outside agent to be defended against and times when this is achieved are noted as 'unique outcomes' and these are further encouraged. In this way, a person is helped to 're-story' their life including positive experiences of resisting and overcoming difficulties and developing other aspects of life. Drawing on White, Ting sees identity as an arena for negotiated change

"Rather than seeing self and identity as transfixing, narrative therapists take on the poststructuralist position in asserting, "identity is a social and public achievement " (White 2000:63). As such it can be negotiated within social intuitions and communities of people"

Ting (2012:289)

Social work today seems to straddle realist and constructionist standpoints reflecting modern and postmodern worldviews (Parton 2012; Witkin 2012). Those who adopt a positivist, realist view, understand theory to be a reflection of the "givenness" of the world, of an objective reality, based on correspondence theory of language (Rorty 1979) and base their practice on the technical rational application of skills to affect change. Those informed by postmodernism view a given theory as one interpretation of the world and in part constitutive of it. Postmodernist contentions that reality is not objective 'out there, in the real world' but socially constructed in and interpretable through discourse have significantly shaped social work theory and have been taken up by many in practice. Meanings are seen as socially constructed, multiple, dynamic, ambiguous, relational and context specific. The limitations of searching for fixed meaning and for a linear cause and effect are acknowledged. Social workers influenced by postmodernist epistemologies attend to socio-cultural contexts and no longer assume that their context will be shared by others or that, what they say will be understood in the way they had intended. Other postmodern theorists such as Adele Clarke have asserted that *'there is no such thing as context'* as a backdrop for/of social action, rather she argues that the social world is as much embedded in us, as we are in it (Clarke 2003, Clarke 2005, Clarke and Friese 2007)

A postmodern, constructionist approach recognises that people have their own expertise and by validating marginalised voices and standpoints, constructionism decentres the professional from the powerful position of expert to one of collaborator, resource, facilitator, educator and partner in the change process, as required. It is *"taking a position of uncertainty derived from a questioning of expert knowledge"* and instead working to understand client's experiences and co-construct meaning with them that is the essential element of the postmodern practice of social work (Pozatek, 1994:399). A position of uncertainty is seen to represent a more respectful approach to cultural difference, as certainty and objectivity are an illusion. *"Problems cannot be overcome by quick technical fixes and there are no final resolutions to the dilemmas and difficulties of social life"* (Parton, 1996:16). The truth is de-centred. It arises in local contexts. No rational system of thought can legislate what is the truth. The truth can only by interpreted (Howe, 1996:86).

In Irving's words

"Provisionality and heterogeneity contaminate neat attempts to tidy it all up, to get some kind of unifying coherence. Narrative continuity and closure are contested, there are no centres, only margins, fractures, dispersals...Why have we tried to contain everything, instead of embracing the complexity of the world, irreducible to a homogenous vision of single linear codes, single points of view?"

(Irving 2007:244)

Butt and Parton also focus on the meaning of experiences for service users, in mapping a constructionist approach to working with trauma

> *"...A process of personal construction that serves to interpret an ambiguous life-world mediates all the person's perceptions. So the practitioner, for example, will never be able to identify traumatic incidents per se, nor to dictate imposed stages of recovery that a client should go through to achieve psychological reconstruction. Instead, practitioners must focus on clients' processes of meaning making. This does not mean that all notions of evidence and scientific investigation must be abandoned. It does mean, however, that the scientist-practitioner must be a pragmatist rather than a positivist."*
>
> (Butt and Parton 2005: 803)

By sharing information with people and supporting them in accessing resources, their options are expanded and they can make decisions according to their own values, which may contribute, to a resolution, dissolution or modulation of feelings of trauma. Social work can foster interconnections with others who share a similar experience and promote awareness of and challenge to dominant cultural, social, political and economic forces, which underpin many personal traumas. This is social work as social criticism and social action, which challenges dangerous labelling and pathologising of people and contributes to social change. Its reflective, reflexive stance is democratic, respectful and affirming. It makes social work a mutually influenced, participatory process with the social worker aiming to decentralise power in the relationship. However, where different power positions are to the fore for example when a social worker is carrying out statutory responsibilities or dealing with conflicting interests of a number of people, this should be openly acknowledged and where possible the meanings of the situation for each individual should be fully explored to allow equity of participation and negotiation of outcome. Social workers should be mindful that social work encompasses relations of power, which may be both enabling and constraining, liberating and repressive (Rojek et al 1988). Willingness, with the support of

supervision, to acknowledge, reflect on and work openly with different and conflicting aspects of the social work role, is a hallmark of effective social work (Turney 2010).

The Relational [Re]Turn

Having engaged with the influences of political, social and philosophical imperatives in shaping social work perspectives I now return to social work as an inherently practical project and therefore the need to translate theoretical perspectives into practice. Following Howe's contention cited earlier, that a framework is needed to integrate the way we understand people and the way we work with them (Howe 1998) I want to consider the potential of relationship-based approaches, particularly those encompassing reflective practice (Ruch 2005) to this end. Social work is constructed from three elements: the worker, client and context (Payne 1997:15) and is therefore inherently relational.

Kadushin describes the social worker-client relationship as *'the communication bridge between people'* (Kadushin 1990:36) and Goldstein et al assert

> *"It is important for the worker to bridge the two subjectivities of worker and client"*
>
> (Goldstein et al 2009:15)

Service users too, have voiced the significance for them of a positive, friendly and supportive relationship with their social worker (Mayer and Timms 1970; Quinton 2004; de Boar and Coady 2007; Beresford, Croft and Adshead 2008; Howe 2008). Service user research in psychotherapy also highlights the quality of the alliance with the therapist as a significant factor in good outcomes (Miller, Duncan and Hubble 2005). In an Irish study on service-user experiences in the context of child protection social work Buckley, Carr and Whelan report

> *"As in previous studies, the data showed how the development of good relationships between workers and service users could compensate for the harsher aspects of involvement with child protection. In addition, this study demonstrated a high level of discernment on the part of service users, highlighting their expectation of quality standards in respect of courtesy, respect, accountability, transparency and practitioner expertise."*
>
> (Buckley, Carr and Whelan 2011:101)

Service user and carer expectations of social workers, sought in the context of the development of the U.K. National Occupational Standards include relational skills of communication, reliability, working in partnership and advocacy and state explicitly that social workers should *'be good at starting, continuing and closing relationships'* (Topss, 2002 cited in Hingley-Jones and Mandin 2007:179) Doel discusses the consistency of service user feedback over time citing Sainsbury's meta-analysis of client opinion studies undertaken in the 1980s and spanning the previous two decades. The findings show that people value

> *"understanding the intentions and purposes of the worker; contributing to the work of the service; receiving help speedily; the worker's ability to respond to feelings not always expressed; the worker's concern and attention, even if change is not possible and the worker's ability to exercise care even when exercising control"*
>
> (Doel 2010:199-200)

He compares this to outcomes of his own study undertaken with Best in 2008

> *"...When we ask people about their positive experience of social work, we find they are more likely to be concerned with the virtues of their particular social worker – their honesty, trustworthiness and intelligence- rather than whether they comply with an abstract ethical code or a set of moral standards."*
>
> (Doel and Best cited in Doel 2010: 201)

It seems clear from service user research that the social work relationship encompasses personal, interpersonal and professional dimensions that are central to people's experience of a social work service irrespective of the voluntary or involuntary nature of the contact and of the issues the service seeks to address.

Historical Antecedents

Therapeutic use of the social work relationship dates back to the psychodynamic tradition (Sudbery 2002, Ruch 2005, Seden 2008) and its influence on the training and practice of the first social workers. The linage of psychodynamic theory, in turn is traced to Freud's theses on the structure of the *psyche* comprising of the id, ego and superego. Freud proposed that the unconscious is evident in transference and counter-transference relationships and in the use of defence mechanisms and these insights underpinned the theory and practice of psychoanalysis (Seden 2008:160). The

psychosocial model (Hollis 1964) which applied psycho-analytic theory to social work (Ruch 2005) became an established model of social work practice. Considered to be overly individualistic to the neglect of social factors (Payne 1997) the psychodynamic tradition receded in social work in the context of social change agendas of the 1970s through to the 1990s when structural social work was in the assent (Dominelli 1998). A further challenge came from the claims of behavioural psychology, which offered outcome-oriented, short-term interventions that fitted with political imperatives of the time (Ruch 2005). According to Howe (1998) erosion of social work based on relationships, interpersonal psychology and the psychodynamic tradition happened in the light of a series of public inquiries into the death of children, beginning with the Maria Colwell inquiry in England in 1973. Howe argues that the legally driven recommendations of the inquiry reports has shifted the emphasis of social work away from relating with and trying to understand people to managing and controlling them through the use of guidelines and regulations (Howe 1998). This tendency has perhaps come full circle with publication of more recent inquiry reports, which stress the importance of direct work with clients (Gibbons et al 2010; Munro 2011).

Paradoxical Positioning

In recent years the social work relationship has occupied a somewhat paradoxical position, on the one hand it is increasingly seen in procedural, legal and administrative terms (Howe 1998) while on the other hand the limitations of this position have been articulated and a welcome recommitment to the centrality of 'the relationship' and its therapeutic potential has been advanced. Wilson et al (2008: 4-7) suggest that renewed interest in relationship-based practice has developed since the late 1990s as a response to features of postmodern society, reflected in social work including uncertainty, complexity and risk coupled with an emphasis on individual rights and responsibilities and the role of the market in service provision. They discuss the rise of managerialism with its emphasis on administrative requirements, procedurised practices and approaches to eradicate 'risk'. Drawing on Gupta and Blewitt (2007), they argue

> *"..... procedures and bureaucratic practices have become the main framework around which social work practice is structured, at the expense of the professional relationship....in an attempt to simplify or eliminate the complexities, uncertainties and risks....Whilst they have their place, managerialist practice approaches are incomplete responses to the conditions*

they are seeking to address.....[and run] the risk of being insensitive to and inappropriate for an individual's circumstances."

(Wilson et al 2008:5)

There is a risk that resulting practice becomes *"an emotionally-distanced way of managing people in need"* (Woodhouse and Pengelly cited in Wilson et al 2008:7). Cooper and Lousada (2005) also discuss the limitations of procedurised practice with particular reference to child protection work

"Structures, procedures and protocols may be necessary, but they are not sufficient conditions of good practice. They are surface instruments, capable of guiding us and organizing us towards the relevant point of contact with the deeper, more complex and ambiguous realities with which we need to engage in child protection work..."

(Cooper and Lousada 2005:153)

In the American context, Goldstein et al while acknowledging the diversity of social work practice suggest citing Simpson et al that *"....the person-situation perspective and the concept of relationship"* (Simpson et al cited in Goldstein et al 2009:15) have been enduring features of social work throughout its history. Rather than discounting cognitive-behavioural and other evidence-based approaches attributable in part to the exigencies of managed care and broader philosophical and politico-economic factors, they assert

"....the practitioner may draw on diverse technologies in the intervention process but must integrate these into an overall approach that has the client's relational world and the worker client relationship at its core."

(Goldstein, Miehls and Ringel 2009:16)

Contemporary Relationship-Based Practice

Reconfigured practice centred on the social work relationship has been termed Relationship-Based Social Work Practice in the British literature (Howe 1997,1998; Sudbery 2002; Trevithick 2003; Ruch 2005; Hingley-Jones and Mandin 2007; Wilson et al 2008; Ruch et al 2010). Elsewhere the term Relational Social Work is in use for example in Italy (Folgheraiter 2004) and in the U.S.A (Goldstein et al 2009). Relationship-based approaches are established in other fields too for example in health-care (Als et al 1997, Koloroutis 2004). Wilson et al define relationship-based

practice, emphasising dimensions of process and outcome

> *"The central characteristic of relationship-based practice is the emphasis it places on the professional relationship as the medium through which the practitioner can engage with and intervene in the complexity of an individual's internal and external worlds. The social worker and service user relationship is recognized to be an important source of information for the worker to understand how best to help, and simultaneously this relationship is the means by which any help or intervention is offered"*
>
> (Wilson et al 2008:7)

Ruch distinguishes between earlier psycho-social models and a contemporary relationship-based social work practice approach which she argues provides an integrated understanding of individual (psycho-dynamically derived) and structural causes of distress, embracing anti-oppressive practice and empowerment (Ruch 2005:114-115). She argues that relationship-based practice builds on reflective capacities offering ways to respond to the uncertainties and ambiguities of practice (Ruch 2005:118).

'The Logic of Emotions'

A strength of relationship-based social work is its capacity to respond to distress and other difficult emotions which is arguably a neglected area in social work. Sudbery refers to the limitations of models of social work practice and of broader public service that privilege rationality and logic over emotion. He proposes relationship-based practice as emphasising the *'logic of emotions'* and emphasises that responsiveness to people's emotional needs is a hallmark of an effective service

> *'...a core component of social work is the ability to respond to people's emotional needs, to their impulse for emotional development, and to the difficulties they experience in forming and maintaining relationships.....the purpose of social work is empowerment, the approach chosen must be participative and the starting point (as well as the continuing medium) is the social worker's response to someone making demands, in distress, requiring service.....it is the quality of the social worker's response which determines the effectiveness of service'*
>
> (Sudbery 2002:150-151)

Wilson et al propose a model of relationship-based practice based on the premise that people's internal and external worlds are inseparable and on an understanding of human behaviour as complex, incorporating affective, rational and unconscious dimensions. (Wilson et al 2008:8-10). In addition and again uncommonly in much of social work theory and practice equal emphasis is given to issues arising for the worker and the worker's interactions in the practice situation

> *"The model places equal importance... on the unique and complex nature of professionals and the rational and emotional dimensions of their behaviours. This is often referred to in social work literature as the professional 'use of self'. As a social worker one of the biggest challenges you will face is being able to simultaneously focus in professional encounters on what is happening for the service user and what is happening to you. By developing this ability to understand holistically the service user's and your own responses to a specific situation you will ensure you are acting in the service user's best interests"*
>
> (Wilson et al 2008:7)

Relationship-based practice, the authors suggest brings together three aspects of human functioning that are often polarised namely conscious and unconscious behaviours (for example disruptive behaviour may be an unconscious effort to deflect emotional distress); cognitive and affective responses (recognising if service user's/professional behaviours is being overly cognitive/rational or overly emotional, there is need for balance and integration) and personal and professional selves (each social work encounter is unique to the individuals involved and relationship dynamics are the combined result of their individual characteristics within a professional context) (Wilson et al 2008:8-11).

Therapeutic Potential

Trevithick (2003) describes processes through which the therapeutic potential of relationship-based practice may be realised

> *"...[relationship-based practice] may involve providing a 'corrective' or 'reparative' emotional experience-that is, a more intense and therapeutic use of the relationship where this is needed to help individuals to come to terms with, and hopefully to overcome, the impact of failed, abusive and abandoning relationships, or separations or traumatic experiences due to other causes.....A particular strength of this approach is to restore trust in other*

human beings where this has been lost or to provide a place to work through [other problems]..."

(Trevithick 2003:168)

Holding and containing anxiety are particularly important in times of transition or crisis (Trevithick 2003) and relationship-based practice facilitates this work. *According to* Ruch *"the underlying and all-pervasive feature of relationship-based practice is the acknowledgement and management of anxiety (practitioners and clients)...."* (Ruch 2005:114-115). In working with emotions and ensuing behaviours in the context of uncertainty and distress, social workers practicing from a relationship-based perspective are mindful of core psychodynamic concepts of containment, transference, counter-transference, and the person's relationship with self which I will now discuss.

Containment

Containment is a concept developed by Bion, a psychoanalyst who believed feelings of anxiety, produced in unpredictable situations could overwhelm the capacity for cognitive processing of experience. Bion applied this concept to the relationship between therapist and client, proposing that the therapeutic relationship can act as a 'container' for unmanageable feelings, lessening the overwhelming effects of anxiety-producing situations and allowing the person to integrate unmanageable feelings into thought processes. Like Winnecott's concept of holding, the concept of containment emerged from object relations theory and views the clinician/client relationship as creating a holding environment similar to the environment of safety and security provided in the bidirectional mother/child relationship. The containing relationship is seen as mirroring positive parenting and also as potentially reparative when past relationships have been difficult or destructive (Trevithick 2003; Goldstein et al 2009) . Goldstein et al suggest that every therapeutic relationship is a dynamic encounter between two people and is also subject to a myriad of contextual influences acknowledging that

"Race, ethnicity, culture and other diversity factors add layers of external and internal meaning to the understanding of holding and containment".

(Goldstein et al 2009: 161)

Trevithick describes the containment process in the practice setting

"....talking to someone who has the ability to listen, to empathise, to take in and to bear the worries being expressed, and the ability to come alongside the

individual in ways that communicate an understanding and give the sense that the person is not alone. The final stage of this process involves offering back the concerns to the anxious person but in a modified form-where the major anxieties are managed but are altered so that they no longer carry the same 'sting' or sense of turmoil or anguish. This enables 'natural' growth processes to reassert themselves….."

(Trevithick 2003:171)

Transference

Transference is understood to be a re-experiencing of feelings from the past in the context of a current relationship. Trevithick (2003) explains it as follows

"Although feelings are located in the present, they often have an earlier unconscious (unaware) aspect and can involve transferring of positive feelings (trust, affection) towards others or involve transferring more hostile feelings (mistrust, dislike)"

(Trevithick 2003:170)

Drawing on Freud, Sudbery traces these feelings from the past to experiences of being parented or cared for

"……..'transference' refers to the propensity of a helping relationship in the present to have echoes of the situation when the user of the service was a child and needed assistance or care from their parent."

(Sudbery 2002:153)

If the worker is relating with genuine care and integrity as part of a reliable, predictable arrangement and the other person receives acceptance in response to re-emerging residual feelings and needs, it becomes possible for difficult feelings to dissipate, contributing to the person finding a resolution that was not available in the past. Sudbery highlights the importance of self-awareness and containment of the worker's own emotions in order to facilitate these psychosocial processes for the service user

"The 'transference' in social work is thus inextricably linked to real characteristics and behaviour of the worker as well as the expectations, emotional makeup and previous experience of the client. Within their participation in real-world negotiations, however, and genuine commitment to the well-being of the client in practical as well as verbal inter-changes, it

remains important for the social worker to be emotionally 'quiet' and receptive if the transference is to emerge as a medium for emotionally developmental work."

(Sudbery 2002:154)

Counter-transference

The significance of the reactions and role of the worker can be further understood with respect to the related concept of counter-transference which encompasses both being impacted by the emotions of the other person and the worker's own emotional reactions to the issues, emotions or behaviours emerging in the interaction. Trevithick (2003) clarifies what is understood to be counter-transference as follows

"The emotional openness that we, as practitioners, demonstrate in relation to another person's transferred feelings is referred to within a psychoanalytic framework as counter-transference. Counter-transference reactions, in so far as they correctly mirror another person's thoughts and feelings enable us to experience some of the emotions that another person might be feeling or thinking. In social work literature, these reactions are sometimes described as empathy or use of intuitive skills. However when attempting to understand transference and counter-transference reactions, we run the risk that our own unconscious, unresolved fears and fantasies from the past may enter the picture to blur reality and our accurate reading of the situation"

(Trevithick 2003:170)

Sudbery addresses the management of the worker's countertransference during and after meetings with service users. He emphasises the importance of distinguishing between feelings that belong to the worker's past and those that are related to the experience of the service user

".....(the worker's) experience in the present contains echoes - reawakenings or re-experiencing – of the past, which may not be related to the present reality of the client they are assisting.....The countertransference feelings may be understood quickly by the worker in the social work interaction, or.....may have to be 'held' (neither suppressed or acted out) until they receive appropriate attention in supervision.....It teases out the different components – those which purely relate to the worker and those which provide otherwise unavailable insights about the client's communication.....The ability to do what

is right in the social work role requires the ability to enter into troubled and disturbing subjective experiences whilst thinking, making judgments and behaving appropriately in the more objective world of outside reality and organizational procedures "

(Sudbery 2002:155).

Working at this level makes significant emotional demands of the worker and conscious or unconscious defences can include the de-personalising of the practitioner-client relationship and a retreat to procedurised practice or to addressing practical issues (Preston-Shoot and Braye 1991; Hughes and Pengelly 1997; Sudbery 2002; Ruch 2005). Good supervision is essential to monitor, clarify and understand transference and counter-transference reactions and to decide how best, when or if at all to translate this knowledge into practice (Howe 1998; Sudbery 2002; Trevithick 2003).

Relationship with Self

Sudbery suggests that understanding negative internal relationships, often triggered by external difficulties is crucial to social work, particularly where problems focus specifically on emotional states. Sudbery understands a negative relationship with oneself in relation to the idea of the punitive superego (Woodmansey 1972, 1989) which proposes that early conflict situations with parents, result in adults having two sets of attitudes or feelings one which expresses their own impulses and the other which often takes on societal attitudes, is critical and controlling. (Sudbery 2002: 157) Sudbery suggests this is experienced as

" .... living '24-7' with a harsh (internal) taskmaster which wants it to be other than it actually is, which experiences blame and intolerance for qualities and impulses which are natural and unavoidable...responses.....are variously guilt for not doing (or being) what is good, frustration and rebellion.....(although this may be split off and suppressed.....) and ultimately depression....."

(Sudbery 2002: 157)

The dynamics of this negative relationship to the self are often evident in work with people who are bereaved or otherwise impacted by trauma, manifesting in difficult emotions such as guilt, regret and self-blame. Gentle exploration of the origins of these feelings in the context of a supportive relationship can be containing of anxiety and distress.

Relationship-based Practice and Reflective Practice

Wilson et al (2008) propose reflective practice, based on situated, holistic thinking (Fook 2002) as a way to put a relationship-based model into effect in practice. The term 'the reflective practitioner' was developed by Donald Schon, who believed that the complexity and dynamic nature of human interaction eschewed prescribed responses based on received technical-rational knowledge. Schon was influenced by earlier learning theories (Dewey 1933, 1938) in his understanding that knowledge is generated from experience and can be articulated through iterative cycles of reflection and experience. Schon developed the concepts of *'reflection-in-action'* as interaction unfolds together with *'reflection-on-action'* that takes place after the event (Schon 1983). The reflective process allows the practitioner to modify and develop their approach in accordance with emerging information and feedback in relation to the needs of the person with whom s/he is working. The reflective practitioner actively engages with theory according to the emerging insights and needs of the practice situation rather than applying ready-made solutions (Thompson 2009). Wilson et al who differentiate between technical, practice, critical and process levels of reflection explain the reflective practice process in social work as follows

> *"Schon's reflection-on-action and reflection-in-action can be likened to the 'conversations in our heads' that happen when social workers engage in practice. Often, whilst relating to service users, social workers are thinking or feeling things that are pertinent to the encounter but they fail to articulate them…..These feelings….can be experienced as an internal conversation that keeps cutting across the external conversation that is 'focusing on task'….A potentially more informative, relationship-based and reflective response would be to articulate the feelings– the confusion and uncertainty, for example - being experienced. It is often the case that in doing so the service user can articulate their own affective responses – their confusion and uncertainty, perhaps – and a more real and productive conversation and relationship can develop"*
>
> (Wilson et al 2008:13-14)

The reflective process thereby promotes social workers' understanding of their own affective and irrational responses and Wilson et al argue reduces the need for defensive strategies in order to survive professionally. It also enables social workers to be emotionally available to service users who may have varying degrees of awareness in relation to the issues underpinning their responses in a given situation. In summarising Wilson et al state

" Relationship-based approaches recognize the complex emotional dynamics of interventions and combined with a reflective stance are able to constructively engage with them"

(Wilson et al 2008:18-19)

Family, Social and Cultural Contexts

Walsh argues that *"in the individually focused field of traumatology only a few, led by Figley, have addressed the impact in relational systems….."* (Walsh 2007: 208). Yet research shows the damaging effects of trauma in families (Prigerson et al 2002) some of which leave multigenerational legacies (Danieli 1985, 1998). The responsiveness of family and other social networks, within which people live, can be very significant in mitigating or prolonging distress. Families often need to readjust and redistribute roles and responsibilities, in the aftermath of family trauma such as a sudden death. Regaining a sense of group cohesiveness as difficulties are shared and losses are faced together, helps nurture resilience (Walsh 2007). At a broader level Trevithick identifies the socio-political environment as the source of many of the problems people struggle with, which prevent them moving forward in their lives. She argues that many issues would be more effectively addressed at levels of local and central government policy, while acknowledging that for the most part wider social disadvantage remains unchallenged. Trevithick suggests that negative life experiences, crises, feeling 'let down' or experiencing 'failure' may be produced by or lead to defensive behaviour at individual or organisational levels. She sees defences as arising from the interplay of individual life histories and external issues and as operating to protect against aspects of the self that are felt to be threatening or anxiety provoking (Trevithick 2003:171-172). As a way forward Trevithick recommends working with people to protect themselves from negative experiences which give rise to defence mechanisms and deplete their energy and motivation and instead to identify and engage in positive experiences which generate creative potential. Again the therapeutic relationship is seen as significant in *'providing a setting that gives confidence'* (Winnicott 1975 cited in Trevithick 2003:172) in moving towards fulfilment.

Trevithick links this work to a strengths perspective, which sees people as

> *"...essentially imaginative, self-motivating and curious beings who are capable of continual development"*
>
> (Weick 1983 cited in Trevithick 2003:173)

A strengths perspective restores hope and builds people's capacity to move forward in their lives. Saleebey emphasises collaborative and empowering practice and regaining control as underpinning principles of a strengths perspective

> *"In a strengths approach, how social workers encounter their fellow human beings is critical. They must engage individuals as equals. They must be willing to meet them eye to eye and to engage in dialogue and a mutual sharing of knowledge, tools, concerns, aspirations, and respect. The process of coming to know is a mutual and collaborative one. The individuals and groups the profession assist also must be able to "name" their circumstances, their struggles, their experiences, themselves. Many alienated people have been named by others-labelled and diagnosed-in a kind of total discourse. The power to name oneself and one's situation and condition is the beginning of real empowerment....."*
>
> (Saleebey 1996:303)

For many, trauma is an isolating experience. Experiences of interconnectedness with others increase self-esteem, extend possibilities and give people hope that they too can overcome difficulties and oppression as others have. Relationships and alliances with others build courage to resist and challenge sources of oppression at interpersonal and societal level. A relationship approach provides a foundation for strengthening connectedness in existing relationships and bringing people together who have had a similar experience to form new alliances either informally or in a more structured way. Information can be accessed on community groups and organisations, which campaign on issues for example gender-based violence or human trafficking and provide support services relevant to people's needs. Through advocacy and empowerment social workers can work with and on behalf of service users to represent their interests to wider society and to policy makers and service providers thus addressing structural and cultural origins of trauma and oppression.

Networks of Practice Relationships

The quality of wider practice relationships is also central to effective social work for example relationships with carers and concerned others can reduce their isolation and resource them, in their support of the primary service-user. Partnerships with service user communities and organisations provide a platform for advocacy on issues of rights and social justice, facilitates development of resources and keep practice aligned with people's lived experiences.

The development of inter-professional and inter-agency relationships is integral to providing a comprehensive response to people, particularly to people with complex needs. Hudson alludes to negativity in the literature on inter-professional practice arising from the differential status of professionals, professional identity and territory and different patterns of discretion and accountability (Hudson 2002 cited in Wilson et al 2008:4000). Wilson et al identify the application of fundamentally different forms of knowledge as a key division between social workers and many other disciplines. Social workers they argue work from a humanist tradition which can be at variance with the technical-rational scientific knowledge base of many of the other disciplines in healthcare. Wilson et al suggest these tensions can be addressed at a structural-organisational level by providing leadership which develops and empowers practitioners, as well as management; at a professional-cultural level by respecting different skills and having opportunities for collaboration such as regular meetings and finally at the interpersonal level extending principles and practices of relationship-based social work to relationships in the work environment. They also emphasise the importance of shared commitment to the wider aims and purposes of the team (Wilson et al 2008: 402-408). Bronstein proposes five elements of interdisciplinary collaboration between social workers and other professionals:

> *"…. Interdependence, newly created professional activities, flexibility, collective ownership of goals, and reflection on process."*
>
> (Bronstein 2003:297)

In extending relationship-based practice to all working relationships, relationship-based practice is understood as integral to how social work is practiced rather than as one of many practice approaches. Developing this point I will now discuss how relationship-based practice underpins trauma-informed social work by opening up a 'thirdspace' at interfaces where trauma intersect with people's lives.

Trauma-Informed Social Work Practice and the 'Thirdspace'

This literature review has so far, considered many facets of trauma and has analysed competing approaches in understanding its effects. The evolving and multiple standpoints of social work have also been discussed. In this final section I want to draw these two knowledge bases together in bringing the focus back to the person(s) affected by trauma and the processes inherent in a social work response. Taking a psychodynamic perspective, difficulties and distress are manifest when people's needs are met by a hostile external world. Adopting a postmodern view people experience distress when their lived experience does not fit with dominant cultural expectations. Both perspectives contribute to understanding experiences of people faced with trauma. It may be that they have lost the person closest to them or their circumstances have changed to an extent that irrevocably alters future expectations, hopes and dreams. The 'taken for grantedness' of the everyday world proves unreliable and people's capacity to commit to the 'meaningfulness' of life is undermined. As Bracken argues

> *"... concern with psychological trauma is not simply a clinical issue, it would appear that it is also a cultural event.....a loss of meaningfulness is understood by many trauma researchers to lie behind the characteristic symptoms of PTSD.....PTSD, as currently defined, is a syndrome which is intimately bound up with the cultural dynamics of post-modernity".*
>
> (Bracken 2001:736)

Trauma, ruptures perceptions of continuity and brings binary divisions of health/illness, hospital/home, safety/risk, life/death, past/present, present/future, mind/body, self/other, individual/society etc. into sharp focus often giving rise to painful feelings of fear, anger, loss and despair. In conceptualising trauma-informed social work I will draw on the trauma literature particularly Herman's three stage recovery process (Herman 1998:98); the five empirically supported principles developed by a group of trauma professionals and researchers to guide and inform intervention and prevention efforts at the early to mid-term stages of disasters and mass violence (Hobfoll et al 2007:283) and four principles to guide organisational approaches to trauma proposed by the Canadian Council on Social Work Education 2012.

Herman 1992, 1998	Hobfoll et al 2007	Canadian Council on Social Work Education 2012
Establishing safety	Sense of safety	Incorporation of Trauma Awareness
Retelling the story of the traumatic event	Calming	Safety
Reconnecting with others	Sense of self- and community efficacy	Rebuilding control and Empowerment
	Connectedness	Strengths-based Approach
	Hope	

Table 3: Principles of Trauma Work (Herman 1992, 1998; Hobfoll et al 2007, Canadian Council on Social Work Education 2012)

The common elements of safety, calming, retelling the story, rebuilding control, empowerment, self and community efficacy, a strengths-based approach, restoring connectedness and hope will be used to benchmark good practice in developing trauma-informed social work through this research. Herman and Hobfoll and colleagues, prioritise relationships and connectedness as both a means of and end points in working through experiences of trauma. More generally, the capacity for interdependence in relationships is a hallmark of good adult mental health (Wilson et al 2008:349). In the context of trauma the need to work with, through and towards relationships is therefore central to practice at individual, family and community levels. In this section I will argue that these principles can be achieved through relationship-based social work practice underpinned by reflexivity and a social constructionist standpoint. A theoretical framework is needed to connect these perspectives and provide a sense of continuity and cohesion in combining them in practice. Returning to the idea of social work as located at interfaces between different dimensions of lived experiences and particularly in the aftermath of trauma where binary divisions are most acute, I am interested in the potential of the metaphor of the 'thirdspace' (Bhabha 1994,

2003) to conceptualise social work as opening a space at 'the interface', a resource in the context of lived experience of trauma. This spatio-temporal metaphor, has been proposed elsewhere as transcending dichotomies and enabling negotiation of new (inter)subjective positions, narratives or relationships (Walter 2003; Irving and Young 2004). It seems a worthwhile concept for social work practice in accommodating issues of uncertainty, fluidity, diversity, multiplicity and hybridity, that are seen as emblematic of life in postmodern societies and are further amplified by trauma. Similarly the metaphor of borderlands has been employed (Williams and Parrott 2012) to capture the dynamics of interfaces, 'in-betweenness' and hybridity.

Origins of the Concept of the Thirdspace

The post-structural cultural theorist Homi Bhabha sees the third space as 'in-between' polarities, where new possibilities emerge without repressing contradictions but in coping, resisting or managing through contradiction in the everyday, people develop social agency, become aware of the ways they are oppressed and structure resistance. Bhabha sees this happening through small changes which he considers as significant in processes of subversion or transformation (Bhabha 1994). Earlier Winnicott (1971) a child psychoanalyst, described a third space between inner and outer worlds, an area of experience, he called the transitional space. The transitional space opens up as the child moves between phases of concrete and symbolic attachment and represents a time of unknowing. The concept has been extended to other 'in-between' situations imbued with possibility but also loss of what has gone before.

Bhabha links his work to Winnicott's theorising of the transitional space

> *"My own speculations on the ethical and existential 'location' of such cultures of 'border' living owe something to the work of the psychoanalyst D. W. Winnicott's meditations on the process of 'contiguity' as a form of space and time.....Contiguity, Winnicott suggests, explores a third area of life, between the individual and the environment. It is 'an intermediate area', a potential space between subject and object in which cultural experience is located. An area of 'intermediate living' is, in Winnicott's words, a third space of psychic and social 'variability', whose agency and creativity lie in experiences that constellate or 'link the past, present and the future'. It is the contiguity of these space-and-time frames that constitute the 'cultural' as a practice that can both signify, and survive, the turning points of history and its transitional subjects and objects.....*

It was a shuttling back and forth between continuity and contiguity.....Between them emerges 'this third space', a contiguous relationship between older and newer social and psychic forms."

(Bhabha 2003:32-33)

Using Bhabha's concept of the third space to characterise social work as described by the three groups of participants in this study evokes a tradition in Ireland of using spatial metaphors in establishing possibilities to take a new look at value-laden, often polarised positions we assume or 'find ourselves in'. In instituting the literary and cultural journal The Crane Bag in 1977 founding editors, philosophers Richard Kearney and Mark Patrick Hederman sought a *'.....neutral ground , where things can detach themselves from all partisan and prejudiced connection....'* (Hederman 1985: 110). They drew on the legend from pre-recorded history, of the Fifth Province of Ireland, understood by some to be territory in the centre of Ireland at the Hill of Uisneach or at County Meath, where the four provinces met, a crossing point, where oppositions could be resolved. Others view it as a 'dis-position', a space for each person to discover in him/herself (Hederman and Kearney 1977; McCarthy and O'Byrne 1988; Keenan 2012). The Crane Bag set out to promote the *'excavation of such unactualized spaces within the reader, which is the work of constituting the fifth province'* (Hederman 1985: 110). Since then, the idea has been taken up by artists and critics including the Derry based, Field Day Theatre Company. It has been applied in therapeutic work with people in distress by a team of Irish family therapists from a range of disciplinary backgrounds including social work, who working together as the Fifth Province Associates from 1981-1995 developed the Fifth Province Approach (McCarthy 2010). This thinking continues to inform creative developments in therapeutic practice (McCarthy 2010; Keenan 2012).

Contemporary Applications of the 'Thirdspace' in Social Work Theory

Postmodern social work theorists view 'thirdspace' opportunities as allowing for exploration of multiple, shifting, fluid views of self and other (Irving and Young 2004) Keenan and Miehls who consider the 'thirdspace' in relation to psychodynamic and social theories understand it's potential as follows

"This space is understood as both physical and psychological. As such, third spaces are places or states of ambiguity in-between different "realities" that exist within and between subjects....Whether one is considering various views

alone or with others, the goal is not to reduce the views into polarities or essentialist categories, but rather to observe, describe, and understand the complexity"

(Keenan and Miehls 2008:166-167)

They discuss two concepts integral to achieving third space potential. Firstly recognition of the validity of the separate motivation of 'the other' and the related concept of 'paradox' an acceptance that

".....mutually contradictory elements of experience co-exist.....paradox is held, it is not resolved.....[preparing] individuals to tolerate the inevitable tensions associated when one is interacting with others or systems that complicate our own experience."

(Keenan and Miehls 2008:166-167)

Thereby the 'thirdspace' can be understood as a bridge between differing subjective or inter-subjective sets of experiences, values and beliefs and is a construct to allow recognition of the validity of other views and divergent experiences and expectations. Rather than discounting or trying to change either one, both are held as valid as a position from which to move forward. I would suggest the metaphor of the 'thirdspace' has particular relevance in conceptualising trauma-informed social work given its capacity to accommodate seemingly opposing ideas such as psychodynamic and postmodern perspectives on trauma. It would also seem to be a helpful construct in the context of relationships between the self and others and between inner and outer worlds where conflicting beliefs, values or perspectives are a source of distress.

Conclusion

The literature review (incorporating the trauma literature reviewed in the previous chapter and the social work literature reviewed in this chapter) sets out to establish a theoretical basis for trauma-informed social work. I began by mapping two sets of ideas on trauma, the first from the scientific rational idiom of psychiatry underpinned by principles of professional objectivity and evidence-based practice. The second based on social constructionist epistemology giving emphasis to the subjective, emergent, mutable, negotiated and symbolic elements of human experience. I similarly examined realist and social constructionist traditions within social work. In both traumatology and social work, scientific rational theories provide one of many possible ways to

understand lived experience. Theorising trauma within the scientific idiom for example, produces an incisive yet partial conceptualisation of trauma experience focusing on psychological and physical effects and is thus restrictive in indicating ways to respond. Reliance on this perspective can result in the psychologisation and therefore de-politicisation of oppression and the minimisation and at times distortion of subjective and situated meanings in an effort to fit experiences within pre-defined categories.

Social work approaches focusing on presenting problems have also been criticised for their individualistic orientation to the neglect of the structural causes of inequality and the cultural constraints that impact on individual lives. The need to stay open to lived experiences and to understand trauma in relation to the broader contexts of people's lives signalled the need for a wider lens to understand the totality of trauma experiences. Social constructionist approaches give emphasis to the continuous, inter-subjective construction and deconstruction of trauma experience within language and discourse, thereby bringing a focus to relationships, social interaction and cultural practices. This expanded view of how trauma is understood, replicated, maintained and mitigated in relationships and socio-cultural contexts points to the efficacy of a social work response to the subjective, inter-subjective and situated nature of trauma experiences. Reflecting the impact of trauma at both emotional and relational levels, a relationship-based social work approach has been proposed and extended to engage with people both in relation to their inner worlds and in their multiple roles and interactions within their living environment. This approach is conceptualised as creating a 'thirdspace' or resource at interfaces where trauma intersects with people's lives.

Chapter 4 Methodology

Introduction

The discussion in this chapter centres on developing and implementing a research design to address the primary research questions articulated in this study in relation to the nature of the lived experience of trauma and the elements of responsive social work practice in this context. It was therefore necessary to select a research approach that could engage sensitively, safely and ethically with the experiences of people living in the aftermath of traumatic event(s). Further to this, the research approach needed to allow for a deep engagement with social work practice from service users' perspectives. In addition the research process would involve other key stakeholders including all social workers providing and managing the service. As a practitioner researcher I was interested to explore how we as a small group of social workers, within the larger hospital team, envision, co-construct, situate and evaluate social work practice in this setting. Finally I wanted to involve a representative sample of other hospital emergency department staff, accessing the social work service as a resource for service users. Again, I wanted to achieve in-depth understanding of their experiences, perceptions and expectations of social work and more generally to explore the role and positioning of social workers in the inter-disciplinary context of emergency health care. The involvement of three distinct groups of research participants allowed for data triangulation, the practice of viewings things from more than one perspective to deepen understanding (Denscombe 2010:347). I wanted a research approach that would allow for analysis of data within and across each of the three data sets. Finally while not discounting well-founded caveats in relation to transferability of small scale naturalistic research (Lincoln and Guba 1985) I hoped this research process would contribute to the development of a conceptual framework to underpin social work practice in healthcare contexts, with people affected by trauma. Ultimately, the transferability of the findings would be a decision for others according to their contexts. My role as researcher was the provision of sufficient detail to enable such decisions to be made. Therefore the research approach while primarily exploratory in nature, needed to support a level of theory development.

Research design involves decision-making in relation to the research paradigm, research methodology and methods of collection and analysis of data and the articulation of an approach, consistent at these three levels that would be appropriate, effective and efficient in addressing the research questions. This chapter examines the

selection process at each of these levels. In Section 1 The Research Paradigm, ontological and epistemological positions are explored, associated philosophical and sociological perspectives are discussed and ontological and epistemological positions are established in relation to this research. In Section 2 Methodology, research approaches consistent with the adopted ontological and epistemological positions are considered and a rationale is offered in relation to the selection of Grounded Theory and more specifically Constructivist Grounded Theory as the methodology for this research. Processes of data analysis consistent with Grounded Theory are discussed including the use of the computer assisted qualitative data analysis software (CAQDAS) NVivo, primarily employed in this study, as a data management tool to facilitate initial levels of coding. Section 3 explores Methods and semi-structured interviewing and a mini-focus group are identified as methods most appropriate to data collection given the nature and context of the study. Issues in relation to access, sampling, data gathering, storage of data and data analysis are specified. In Section 4 Ethical Issues, qualitative research ethics are discussed and ethical issues arising in this study including issues in conducting insider research are addressed. In Section 5 Reflexivity, the mediating influence of my position as a biographically situated, researcher is further considered. In Section 6 Conclusion: Framing the Research, discussions from the previous sections are drawn together to specify the methodological frame for the study.

The Research Paradigm

Guba defined a paradigm as *"a basic set of beliefs that guides action"* (Guba 1990:17). In designing research, choices are made at the levels of paradigm, methodology and methods, which taken together, cohere in mapping the study. Firstly, a research paradigm or meta-theory to inform the research is identified, subsequently methodological approaches are selected to shape and enable the research process and finally decisions are made in relation to the collection, management and analysis of data and reporting of findings. These choices set up ontological (referring to the nature of reality) and epistemological (referring to how such reality may be known) assumptions (Tyson 1994: 98) and therefore frame both what we can come to know through the research and how this knowledge and understanding is realised with particular consideration to the position of the researcher in relation to the research. The combination of paradigm, methodology and methods determines if the research is

considered to be primarily qualitative or quantitative. While Denzin and Lincoln (2013) maintain that

> *"...all research is interpretive: guided by a set of beliefs and feelings about the world and how it should be understood and studied"*
>
> (Denzin and Lincoln 2013: 26)

They distinguish between qualitative and quantitative research as follows

> *"The word* ***qualitative*** *implies an emphasis on the qualities of entities and on processes and meanings that are not experimentally examined or measured (if measured at all) in terms of quantity, amount, intensity or frequency. Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry. Such researchers emphasize the value-laden nature of inquiry. They seek answers to questions that stress* **how** *social experience is created and given meaning."*
>
> (Denzin and Lincoln 2013: 17) (Original emphasis)

In contrast they suggest

> *".....quantitative studies emphasize the measurement and analysis of causal relationships between variables, not processes. Proponents claim that their work is done from within a value-free framework."*
>
> (Denzin and Lincoln 2013: 17)

Trinder (1996) articulates a dialectical relationship between social work research, social work practice and wider social, political and philosophical standpoints

> *"...how one goes about doing research is intimately connected to what is going on in the world and how one sees social work. Research perspectives are not ahistorical and methodologies are not innocent sets of techniques. Certain methodologies matter because they support and sustain particular approaches to social work practice."*
>
> (Trinder 1996: 234)

Thus social work research is inextricably linked to social work practice and both practice and research are situated historically and socio-politically in wider contexts. The practitioner researcher cannot therefore claim a detached objectivity and instead assumes a position of reflexive participant in the research process. In moving beyond the pursuit of objective, value-free inquiry it has been argued that social work

researchers can integrate more achievable standards of recognition and regulation of bias together with social work's traditional values such as respect for the client's experience, anti-discriminatory practice and concern with social justice (Goldstein 1983, Heineman Pieper 1984).

As the paradigm, methodology and methods selected for this practitioner research study need to align with social work ethics and values and be consistent with the nature of the practice it seeks to research, a qualitative approach is indicated for its emic sensibility and methodological capacity to get close to the perspectives of the research participants in order, to generate rich descriptions of their lived experiences. Qualitative research assumes an idiographic (case-based) position best suited to a small scale in-depth, exploratory study in contrast to nomothetic quantitative research which seeks generalisable results based on a large, representative research sample. The aim of qualitative research is instead to contextualize the findings in the interactive world in which they are generated (Denzin and Lincoln 2013:19). Qualitative research may be delineated with reference to four major interpretative paradigms: positivist and post-positivist, constructivist-interpretative, critical (Marxist, emancipatory), and feminist-post structural, with each paradigm encompassing multiple perspectives within the overall tradition (Denzin and Lincoln 2013: 26)

The relative merits and shortcomings of various research paradigms have generated heated debate over a number of decades, giving rise to the term 'paradigm wars' (Guba 1990; Guba and Lincoln 1994; Denzin and Lincoln 2013). Teddlie and Tashakkori identify three phases of contestation: "*1) the post positivist-constructivist war against positivism (1970-1990), 2) the conflict between competing postpositivist, constructivist and critical theory paradigms within the mixed methods arena with arguments in relation to paradigm purity and incompatibility (1990-2005), and 3) current conflicts between evidence-based methodologies and the mixed methods, interpretative and critical theory schools* (2005-present)" (Teddlie and Tashakkori 2003 cited in Denzin and Lincoln 2013: 2-3). It has been argued that Evidence-based methodologies utilising randomised, controlled experiments signals a re-emergence of scienticism to the neglect of biography, history, culture and politics (Denzin and Lincoln 2013). However as Denzin and Lincoln put it

> *"There are no objective observations, only observations socially situated in the worlds of - and between - the observer and the observed."*
>
> (Denzin and Lincoln 2013:24).

The constructivist-interpretative paradigm which assumes a relativist ontology (many possible realities), a subjectivist epistemology (understandings are co-constructed by the researcher and research participant) and naturalistic (non-experimental) methodologies (Denzin and Lincoln 2013: 26-27) seemed most appropriate to this study at a number of levels. Given the profound nature of trauma experience and its impact on people's beliefs and assumptive worlds (Janoff-Bulman 1992) a relativist ontology would allow for feelings of both devastation and possibility to emerge. As trauma is often a fundamentally disempowering experience the subjectivist epistemology fitted with the imperative to employ empowering practices (Herman 1992, Dunn 2001; Bussey and Bula Wise 2007) and restore control to people affected by trauma. Naturalistic methodologies, basing research in familiar locations and allowing for a relationship between the researcher and the researched seem most ethically solid in engaging with sensitive issues. In many ways the constructivist-interpretative paradigm reflects processes of interpretation of lived experience and co-construction of meaning already occurring in social work practice. However in so far as constructionism and interpretive approaches focus on meaning attributed to events rather than the events themselves and tend towards a present-day interpretation of the past; there is an inherent danger of decontextualising experiences and neglecting linkages between personal distress and socio-cultural and political events and issues. Therefore the critical or post structural feminist paradigms with their critical realist ontologies and emancipatory commitments seemed a better fit with the anti-discriminatory and social justice values of social work. However in the initial stages of the research design Laird's (1994) arguments in relation to 'the family therapist as anthropologist-constructivist' and Gubrium and Holstein (2000) work on analysing interpretative practice helped me to think beyond polarisation of constructivist and critical perspectives.

Laird (1994) is critical of the constructivist 'narrative turn' reminding us that in our socio-political context, all stories are not equal and that many conversations are not possible because certain voices have been repeatedly silenced, some silenced to the point where the story cannot be told even to the self and lived experiences cannot be voiced. She argues too that certain voices are privileged in every conversation and that our personal voices are strengthened or weakened by virtue of our abilities to locate ourselves in, and shape the larger social discourses that in turn shape and define us and these abilities. She suggests our narratives are privileged or constrained by sex, sexual orientation, income, wealth, education, skin colour or in narrative terms how these narratives are storied in the larger social discourse. She urges us (as practitioner

researchers) to be constantly aware of and committed to fighting the oppressions that silence such voices and warns that abuse and oppression cannot be "languaged" or "storied" away (Laird 1994:182-185). Laird concludes that notwithstanding her reservations

> *"... the post modern clinician has much to offer the burgeoning area of qualitative research.... Clinicians by default are in contexts where they can "hover low over the data", where description can be thickened...The disciplined exploration of the client narrative, using ethnographic and narrative strategies encompassing power and contextual issues, can be a valuable research endeavour."*
>
> (Laird 1994: 186)

A way forward within the constructivist-interpretive paradigm would therefore encompass a critical consciousness of power and a co-constructionist approach linking lived experience with the political and socio-cultural contexts within which it emerges and is given meaning. Gubrium and Holstein (2000) further progress the inter-linking of a critical consciousness in the research by advocating turning back and forth between an emphasis on 'talk-in-interaction' and the wider contexts of social organisation and social control as parallel sources of change or stability (Gubrium and Holstein 2000: 503). They argue that a constructivist approach helps us overcome assumptions that '*the world as it now is, is the world that must be*' thereby opening new or alternative possibilities

> *".... The everyday realities of our lives - whether they are being normal, abnormal, law-abiding, criminal, male, female, young, or old - are realities we **do**. Having done them, we move on to others, producing and reproducing, time and again, the worlds we inhabit. Politically, this presents the recognition that we could enact alternative possibilities or alternative directions, although the apparent organisation of our lives might appear to make that impossible. If we make visible the constructive fluidity and malleability of social forms, we also reveal a potential for change."*
>
> (Gubrium and Holstein 2000: 503) (Original emphasis)

The interplay of discourse (talk-in-interaction) and discursive practice (wider social forms and forces) produces a reflexive, critical consciousness (Gubrium and Holstein 2000) which I see as the key to grounding constructivist-interpretative research practices in a socio-political context thus illustrating how meanings people deploy are

embedded in social structures and historical situations, which when surfaced may if meaningful for people, be subsequently challenged and changed.

The Constructivist-Interpretative Paradigm

Constructive-interpretive perspectives include constructivism (Kelly 1955; Franklin and Nurius 1998; Parton and O'Byrne 2000; Raskin 2002), social constructionism (Berger and Luckmann 1966; Gergen 1985; McNamee and Gergen 1992; Gergen 2009; Witkin 2012) and symbolic interactionism (Blumer 1969; Stryker 1980; Denzin 2008; Charon 2009). These perspectives are linked in the understanding that people construct the realities in which they participate. Their focus is the study of what people in particular situations and at particular points in time take as real, with a view to understanding the processes by which this comes to be. The locus of attention for constructivism is individual processing of new information or experience in the light of what is already known while social constructionism and symbolic interactionism focus on how meanings and 'realities' are constructed collectively in interaction. Symbolic interactionism posits a dynamic relationship between meaning and action. It highlights the active processes of meaning making, whereby meanings arise out of and in turn influence action. These processes constitute social life (Bryant and Charmaz 2007: 607-610). Besthorn considers constructionist perspectives as part of the sociocultural postmodern challenge to a heretofore, privileged position of logical positivism by instead foregrounding

> *".....embedded knowledge in localized contexts. In so doing constructivist metatheory seeks to reinvigorate human agency by liberating it from the totalizing narratives of privileged worldviews."*
>
> (Besthorn 2007:172)

The significance of language and cultural practices or discourses in shaping our worlds and mediating what we know is emphasised in much of this work

> *"...constructionists assert a primary, human mediated, dialogical view of the world. This assumes human language, negotiated through individual cognition and collective social discourse, becomes the avenue for making meanings.....This reflexivity of meaning making leads to permeable and fluid identities of self and world...."*
>
> (Besthorn 2007:174)

Constructionist theories have been variously influenced by and developed from earlier work in philosophy, sociology and science including phenomenology, symbolic interactionism, anthropology, deconstructionism, critical theories including Marxism, feminism and post-colonial theories, Kuhn's paradigms and cybernetics. This diverse body of work in various ways foregrounds the contribution of situated experience in how we know the world. Critical of notions of objectivity, value-neutrality and existence of a single discoverable *Truth,* these theories suggest that all situations are approached from a particular standpoint, point-of-view or position-of-interest, which in turn shapes interpretation of experience. This argument is explicated in George Herbert Mead's classic article 'The Objective Reality of Perspectives' in which Mead a Pragmatist philosopher and early sociologist, argues for '*the ontological primacy of interpretation',* suggesting that a perspective, whether long-held or newly acquired is a way to stratify and order nature and that ensuing stratifications are '*the only form of nature that is there*' (Mead 1927/1964 cited in Leigh Star 2007: 88-89). Denzin a leading author on qualitative research concurs

> *"In the world of human experience there is only interpretation"*
>
> (Denzin, 1989: 8)

Methodology

Methodological approaches consistent with qualitative research include ethnography, phenomenological approaches, narrative approaches, grounded theory, case-study analysis and action research (Padgett 2008). Case-study analysis may be discovery led or theory led and if theory led may be experimental in approach with the aim of theory testing (Denscombe 2010). All of the other research methodologies listed enact an emic, idiographic approach to inquiry and seek rich, detailed, holistic description and understanding of issues and experiences and of the meanings attributed to them (Schwandt 1999). Therefore all were potentially suitable to this study in so far as they would allow for a meaningful, ethical engagement with research participants and foreground their experiences and perspectives. Sensitivity to contextual contingencies could be achieved through the inter-linking of a critical consciousness in the research process (Gubrium and Holstein 2000) as discussed in section 1. A number of other criteria had to be considered. New to research, I looked for a well-charted strategy for data analysis to support my transition from social worker to practitioner researcher and guard against the production of an overly descriptive account of peoples' experiences. I was also interested in articulating emergent approaches in social work practice,

integrating various participant perspectives and therefore I needed to select an approach that would support localised, contextualised theory development. Taken together, these criteria led me to Grounded Theory. Strauss and Corbin defined Grounded Theory as

> *" a general methodology, a way of thinking about and conceptualizing data"*
>
> (Strauss and Corbin 1994:275)

Practitioner Research and Grounded Theory: A Good Fit?

The next consideration was the fit between this methodology and social work practitioner research. Shaw (2005) contextualised practitioner research as follows

> *"Practitioner involvement in research - evaluation, research, development, or more general inquiry that is small-scale, local, grounded, and carried out by professionals who directly deliver those self same services - is embraced across a wide range of professions as an essential ingredient of good practice"*
>
> (Shaw 2005:1232)

The 2009 statement on practice research, from The 'Salisbury Forum' an international group of academics and practitioners convened by SPRING – the Southampton Practice Research Initiative Network Group emphasises the grounded nature of practice-based research

> *"Practice research involves the generation of knowledge of direct relevance to professional practice and therefore will normally involve knowledge generated directly from practice itself in a grounded way".*
>
> (Practice Research: The Salisbury Statement 2009:3)

In addition to arguments in relation to a responsibility to evaluate the efficacy of practice, the complementarity of social work and qualitative research skills has been highlighted in promotion of practitioner research (McIvor 1995; Shaw 2005). Gilgun is her much quoted, article 'Hand into Glove: The Grounded Theory Approach and Social Work Practice Research' proposes that

> *"…. The processes of doing grounded theory research are similar to the processes of practice. Learning how to do this type of research*

and the use of findings may feel natural to social work practitioners, like sliding a hand into a well made glove."

(Gilgun 1994: 115)

Gilgun charts numerous parallels between practice and qualitative research including the need to think inductively and deductively while examining information from a variety of sources before drawing conclusions, the need to modify one's approach in response to new information, the use of in-depth interviewing, observation, document review, process recording and case reporting in both social work and research and an emphasis on naturalistic settings (Gilgun 1994). Padgett (1998) while accepting these similarities is less convinced of an easy 'fit' and sets out differences which span the domains of paradigm assumptions, goals, education and training, the clinical versus the research relationship and criteria for research. She is vehement in her assertion that qualitative research should not commence until social work intervention has been completed or suspended to guard against clients feeling coerced into participation in research in fear of losing the services or goodwill of the social worker (Padgett 1998).

Lang (1994) conceptualises the transition from practice to 'practitioner as knowledge builder' using the axes of 'knowing' and 'doing'. She suggests a focus on 'knowing' (central to the participant observer role in qualitative research) is present in areas of social work such as new areas of practice, new client groups, new interventions and more continuously as the social worker seeks to comprehend the specific meaning of events, situations and relationships to each client. When practice is more habituated 'acting' and 'doing' may be more in focus than 'knowing'. Qualitative researchers stop short of 'doing' and become immersed in 'knowing'. In social work practice, she argues observation is used mainly to develop practice directives for immediate use as social workers function in the developing present (Lang 1994). Action focused social workers tend to link data to practice theory while the qualitative researcher compares data to other data, purposely avoiding the influence of existing theory at the initial level of data processing in order to work towards the generation of new theory. She asserts that the practitioner 'names' the data through reference to theory (deductive thinking) while the researcher 'names' the data through a conceptualising process that derives from the features of the data (inductive thinking). Both draw on the same competency that is the ability to identify 'like' phenomena. Lang believes that

"if a dual purpose can be established for practitioners, giving "knowing" equal importance with "doing", and if a pattern for managing both activities concurrently can be established, then the

social work practitioner will be able to incorporate a knowledge-developing dimension into the processing of practice data."

(Lang 1994: 271)

She argues that qualitative methods could become widely used for theory building purposes making visible, practice phenomena otherwise overlooked and unrecognised. This she believes would advance one's competence as a practitioner by highlighting the details of one's practice and would advance practice knowledge. In fact she suggests that

"...without such documentation of practice, uniquely processed through the experiential and perceptual lens of the participating practitioner, this avenue to theory building is lost to the profession."

(Lang 1994: 268)

While further work on the processes in undertaking small scale practitioner research have been produced more recently (Carey, 2009; Orme and Shemmings, 2010) Lang's well-theorised proposal for the integration of practice and qualitative research based on grounded theory made a significant contribution to the literature on practitioner research at a time when much of the published work emanated from the U.S.A and was based on quantitative methodologies within single-case designs (Kazi 1997; Thyer 1998) forming part of the empirical practice movement although others such as (Reid 1994; Kirk and Reid 2002) championed qualitative methodologies within the evidence-based practice tradition. In Britain many early advocates of practitioner research adopted a pragmatic position regarding methodology (Broad and Fletcher 1993; Fuller and Petch 1995). Cheetham, espousing this approach argued that

".... evaluative research in social work requires the disciplined use and adaptation of research methods and designs chosen to suit the matters to be studied. There is therefore no one research method to be preferred above all others; the matters to be studied drive the methodology, not vice versa."

(Cheetham 1998: 12)

Fuller whose priority was *'to study social work as it is'* advocated

'.....the suspension of not-to-be-resolved philosophical conundra in the interests of getting on with the job'

(Fuller 1996: 59).

The pragmatists' paring down of the research endeavour has arguably been helpful in encouraging practitioners (who may otherwise have considered research methodology to be too involved, too academic, or at the very least too time consuming) to engage in practice research. Trinder however points out that the pragmatists have been restricted to asking certain types of questions

> *"The 'what social work is' tends to be what is visible or evident. Research questions are descriptive and evaluative - how is the system working and what are the outcomes? What we do not get is a response to the more open and searching question of 'what is going on here?"*
>
> (Trinder 1996: 236)

Trinder's concern with achievement of greater depth of understanding has I would suggest been addressed in embracing reflection and reflexivity as integral to practitioner research (Fook 2001, 2002; Ruch 2002; The Salisbury Statement 2009). Ruch identifies three approaches in developing reflective research: reflective supervision which extends beyond the academic level to explore practical, critical and process issues; peer dialogue which provides support, is containing of anxiety and allows a challenge to unproven assertions and assumptions; and a reflective research approach which is dialogical in nature neither negating or privileging the views of research participant or researcher (Ruch 2000: 210-211). Fook also suggests the inclusion of the perspectives of the practitioner/researchers themselves as part of a focus on practice experience (Fook 2002).

However notwithstanding such developments there are many barriers to social workers engaging in practitioner research including those identified in an Irish context for example the relative absence of a research culture in social work practice, the more immediate demands of direct practice taking precedence over longer term projects, lack of provision of dedicated research time, lack of the required skill set, lack of access to library facilities and concern about beneficiaries of research which were predominantly seen to be professional researchers rather than service user participants (Carter Anand and O'Connor 2010). Further to this Karvinen-Niinikoski cautions that the imperative towards research-based or knowledge-based social work

> *'carries with it many professional and managerial interests and could be called a kind of neo-professionalism'*
>
> (Karvinen-Niinikoski cited in Beddoe and Harington 2012:90).

Nevertheless, Beddoe and Harington suggest that social work practice-based research is worthwhile and provides unique insights

> *"It can encompass dimensions not easily available to parachute researchers who drop in, conduct their study and leave".*
>
> (Beddoe and Harington 2012:90)

In recent years academic-practitioner alliances have formed to build and support practitioner research capacity through local research networks for example in England and Northern Ireland (Waldman 2005), Northern Ireland (McCrystal 2000), Scotland (Shaw and Lunt 2011) and New Zealand (Fouche and Light 2011; Beddoe and Harington 2012). In the Scottish context the initiative was developed in response to government policy, which sought to establish a research and development strategy for social work services ('Changing Lives: The Report of the 21st Century Social Work Review', Scottish Executive, 2006:55)

Undertaking my research as a PhD student, registered with a university, provided the support and guidance of my supervisor, access to library facilities and participation in a research environment ordinarily unavailable to practitioner researchers. In my work as a social worker relating, listening and seeking and facilitating understanding of people's experiences were at the centre of practice. It is these relational, dialogical and meaning making processes that for me, most closely link practice with qualitative research. Cohler elaborates on the benefits of telling of experience and being listened to, regardless of whether the context is one of research or in this case psychotherapy

> *"…. The very act of telling….and of listening…..provides an enhanced source of coherence and integrity. A universal human characteristic appears to be that we like to be understood by others, and the very act of attempting understanding, whether in psychotherapy or the process of the research interview, promotes enhanced solace."*
>
> (Cohler 1994: 170-171)

However clear distinctions need to be drawn in order to ensure the well-being and rights of research participants and to protect the integrity of both endeavours. This imperative will be addressed in Section 5 Ethical Considerations in a discussion on conducting Insider Research .

From Grounded Theory to Constructivist Grounded Theory

In the following extract Clarke, a leading exponent of the postmodern turn in grounded theory (Clarke 2003, 2005) and her colleague Friese, analyse the contemporary constructivist developments within grounded theory in the light of the symbolic interactionist background of one of the two original authors Anslem Strauss

> *"Initially developed and elaborated by Glaser and Strauss and later by others, grounded theory focuses on systematically analyzing qualitative data to elucidate the key forms of action undertaken by participants in a particular situation. Some more contemporary versions of grounded theory have deeply enhanced the constructivist tendencies of one of its originators, Strauss, opening it up to more directly address recent poststructural/postmodern concerns with difference, reflexivity, relationality, positionality, and so on (see Charmaz 2000, 2006). These emphases both sustain and enhance Strauss's own deep symbolic interactionist commitments"*
>
> (Clarke and Friese 2007: 363)

Glaser and Strauss (1967) in their book 'The Discovery of Grounded Theory: Strategies for Qualitative Research' articulated a systematic, qualitative research methodology. In their collaboration, they brought elements of two different sociological traditions together: quantitative survey methods of sociological research from Columbia University (Glaser) and the symbolic interactionist tradition of qualitative research from the University of Chicago (Strauss). Their work challenged the hegemony of quantitative research methodologies in the social sciences at the time, by producing a systematic approach to qualitative research and empirically grounded theory building, based on an inductive method. Charmaz defines induction as

> *"A type of reasoning that begins with a study of a range of individual cases and extrapolates from them to form a conceptual category"*
>
> (Charmaz 2006:188)

This approach contrasted with the deductive approach of theory testing, established in empirical sociological research. Instead they proposed a method for the

> *"...initial, systematic discovery of the theory from the data of social research"*
>
> (Glaser and Strauss 1967:3)

Their grounded theory method involved recursive processes of data collection, coding, memo-writing and theory building through the emergence of categories in the data. A method of constant comparison of new data collected through theoretical sampling, with both existing data and the emerging analysis was utilised to delineate the properties of emerging categories until a point was reached where no new information came through (this they termed 'theoretical saturation'). Categories were then analysed in the light of existing knowledge to form 'core categories' or concepts, which informed the substantive grounded theory. Kelle argues that Glaser and Strauss's idea that through the use of 'constant comparison' and 'theoretical sampling', categories would 'emerge' from the data, was difficult to realise in practice and was refined in subsequent developments of grounded theory leading to a range of complex concepts such as *theoretical coding, coding families, axial coding, coding paradigm* and others which supplemented or in some cases displaced the original approach (Kelle 2007:191-192). Kelle summarises that

> "*The most basic challenge in grounded category building is to reconcile the need of letting categories emerge from the material of the research (instead of forcing preconceived theoretical terms on the data) with the impossibility of abandoning previous theoretical knowledge.*"
>
> (Kelle 2007: 192)

Glaser and Strauss address this dilemma directly

> *"Of course the researcher does not approach reality as a tabula rasa. He must have a perspective that will help him see relevant data and abstract significant categories from his scrutiny of the data."*
>
> (Glaser and Strauss 1967:3)

Essentially they envisaged an empirically grounded theory as combining categories and ideas emerging from the data with concepts drawn from the researcher's prior knowledge *"....the trick is to line up what one takes as theoretically possible or probable with what one is finding in the field"* (Glaser and Strauss 1967:253)

This required the researcher to have

> "*....an armamentarium of categories and hypotheses on substantive and formal levels. This theory that exists within a sociologist can be used in generating his specific theory*"
>
> (Glaser and Strauss 1967:46)

However they cautioned against allegiance to *'one specific preconceived theory'* (Glaser and Strauss 1967:46) particularly grand theory, to avoid forcing categories related to a favoured theory on the data. Kelle endorsed the need to

> *"....distinguish between theoretical notions that force the data and concepts that support the emergence of new categories"*
>
> (Kelle 2007: 192)

Glaser and Strauss (1967) and later Glaser (1978) used the term 'theoretical sensitivity' to explain the use of extant theory at an advanced stage of the coding process to describe and delimit core categories and concepts which have emerged through iterative cycles of inductive reasoning and abstraction. They define 'theoretical sensitivity' as an

> *"ability to have theoretical insight into [one's] area of research, combined with an ability to make something of [one's] insights"*
>
> (Glaser and Strauss 1967:46 cited in Kelle 2007:197)

The significance for Glaser and Strauss of 'theoretical sensitivity' has led commentators (Byrant and Charmaz 2007; Reichertz 2007) to consider their work to encompass abduction (Pierce 1931-1935) as well as induction. Charmaz explains how abduction is applied in data analysis

> *"Abductive inference entails considering all possible theoretical explanations for the data, forming hypotheses for each possible explanation, checking them empirically by examining data, and pursuing the most plausible explanation"*
>
> (Charmaz 2006:188)

Reichertz proposes that

> *"....attending to the process of abduction reunites the topics of logic of discovery with the logic of validation or justification; bringing both into the realm of methodological consideration".*
>
> (Reichertz cited in Bryant and Charmaz 2007:16)

After some years of collaboration Glaser and Strauss discontinued their joint work in the late 1970s, although both continued to work with grounded theory and published separately giving rise to the first of a number of variants in relation to conceptualisation and practice of the grounded theory method. Strauss's subsequent work 'Qualitative Analysis for Social Scientists' (1987) and in particular his collaboration with Juliet Corbin 'Basics of Qualitative Research' (1990) proved influential with grounded theory

scholars. Through these texts Strauss suggests the use of a coding paradigm, which is a framework of theoretical terms influenced by theories of Pragmatism and symbolic interactionism, used to structure data and specify relations between categories during the advanced phase of coding. Strauss proposed the term axial coding which

> *"consists of intense analysis done around one category at a time in terms of the paradigm items."*
>
> (Strauss 1987:32)

Kelle explains the coding paradigm focuses on the intentions, goals, action and interaction strategies of the actors in relation to phenomena, contexts, causal conditions and consequences of the issue being researched (Kelle 2007:202). Although in his 1978 book 'Theoretical Sensitivity', Glaser had specified the need for 'theoretical codes' which

> *"conceptualize how the substantive codes may relate to each other as hypotheses to be integrated into a theory "*
>
> (Glaser 1978:72)

and went on to suggest 'coding families' or clusters of related theoretical concepts such as properties, dimensions or social processes which could be applied to the emerging categories he was highly critical of Strauss and Corbin's work on axial coding and the coding paradigm. In a monograph entitled 'Emergence vs Forcing' (1992), Glaser suggested such approaches would force categories on the data instead of allowing them to emerge through induction and cycles of abstraction, a process essential to grounded theory. He reasserted 'the constant comparative method' as the primary analytical strategy of grounded theory which integrates emerging substantive theory with the data

> *"In grounded theory the analyst humbly allows the data to control him as much as humanly possible, by writing a theory for only what emerges through his skilled induction. The integration of his substantive theory as it emerges through coding and sorting is his verification that the hypotheses and concepts fit and work and are relevant enough to suggest. They are not proven; they are theory"*
>
> (Glaser 1992:87)

Selecting a Constructivist Grounded Theory Methodology

The clearly defined processes of the grounded theory method (Glaser and Strauss 1967; Glaser 1978, 1992, 2002; Strauss 1987, 1993, Strauss and Corbin 1990; 1994; Charmaz 1990, 1991, 2000, 2006; Dey 1999, 2007; Bryant and Charmaz 2007; Clarke 2003, 2005; Clarke and Freise 2007; Olesen 2007) provided a much-needed data analysis map for a relatively new researcher. Importantly too in the context of a practitioner research study the grounded approach would ensure that interpretations were first and foremost based on the collected data and that pre-understanding from social work practice and extant theory would be applied for its relevance to the emergent issues rather than pre-imposed on the study. Strauss and Corbin's state that the procedures of grounded theory

> *".....force the researcher to break through assumptions and to create new order out of the old."*
>
> (Strauss and Corbin 1990:27)

and Gilgun's suggests that

> *"Researchers use a grounded theory when they want to take a fresh look at phenomena"*
>
> (Gilgun 1994: 116)

Yet, the approach did not sit easily with the interpretive-constructivist paradigm which underpins the study. The grounded theory approach especially as outlined by Strauss and Corbin (1990) is quite technical, drawing on the use of a complex architecture of processual diagrams and conceptual maps (Charmaz 2000: 525). Glaser and Straussian grounded theory assumes the existence of an external reality, which researchers can discover and record. It has been criticised for its '*naïve Baconian inductivism*' (Haig 1995).

The interpretations of the researcher are privileged over those of the respondents positioning the researcher at the centre of the research, retaining the powers of interpretation and analysis and thus reducing research subjects to a passive respondent position. The approach focuses on the development of analytic schemes which may be somewhat to the neglect of the content of the data. There is a lack of reflexivity with little discussion of the data collection process, the standpoint of the researcher and the relationship of researcher to the research. In traditional grounded theory conceptions of knowledge and truth are positivistic in perspective. Referring to criteria of *"...significance, theory observation compatibility, generalizability,*

consistency, reproducibility, precision and verification" for judging a grounded theory (Strauss and Corbin 1990: 250) Strauss and Corbin state

> *"the usual canons of "good science" should be retained but require redefinition in order to fit the realities of qualitative research"*
>
> (Strauss and Corbin 1990: 250)

However reflecting postmodern and constructionist thought Reichertz argued that abductive inference can never be verified

> *"all that one can achieve, using this procedure is an intersubjectively constructed and shared truth"*
>
> (Reichertz cited in Bryant and Charmaz 2007:19)

Charmaz points out that neither Strauss and Corbin (1990) or Glaser (1992) seem to have engaged with epistemological debates or postmodern critiques. However she argues that grounded theory offers a flexible set of strategies, not rigid prescriptions, which may be used with sensitising concepts from other perspectives. (Charmaz 2000: 513). A new generation of researchers have developed grounded theory approaches that are consistent with constructivist and postmodern worldviews while retaining grounded theory's inductive approach and stages of data analysis and theory development. While early grounded theorists sought to discover patterns of behaviour in the data and conceptualise their properties through abstraction (Glaser and Strauss 1967; Glaser 1978; 1992) constructivist grounded theorists seek to understand difference and variation among research participants and to co-construct meaning with them (Charmaz 2006). Constructivist grounded theory formulated by Lincoln and Guba 1985; Charmaz 1990, 1995, 2000, 2006 and Clarke's postmodern situational analysis 2003, 2005, fit very well with the objectives and parameters of my research and therefore will guide data collection and analysis in this study.

In her 2006 book 'Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis', Kathy Charmaz adheres to the central processes of the grounded theory method specifying its inductive and abductive characteristics as follows

> *"Grounded theory involves taking comparisons from data and reaching up to construct abstractions and then down to tie these abstractions to data. It means learning about the specific and the general-and seeing what is new in them-then exploring their links to larger issues or creating larger unrecognised issues in entirety. An imaginative interpretation sparks new views and leads other*

scholars to new vistas. Grounded theory methods can provide a route to see beyond the obvious and a path to reach imaginative interpretations."

(Charmaz 2006:181)

Charmaz developed a constructivist grounded theory (Charmaz 1990, 1991, 1995, 2000, 2006), which she encapsulates below, building on and deepening Glaser's focus on *'the main concern being faced by participants'* and *'what accounts for the continual resolving of this concern?'* (Glaser 1998:140) but also encompassing meaning for the researcher

"....Constructing constructivism means seeking both respondents meanings and researchers' meanings. To seek respondents' meanings we must go beyond surface meanings and presumed meanings. We must look for views and values as well as acts and facts. We need to look for beliefs and ideologies as well as situations and structures. By studying tacit meanings we clarify, rather than challenge respondents' views about reality.

(Charmaz 2000: 525)

Glaser argued against Charmaz's approach of inclusiveness of the researcher's concerns, which he felt could obscure those of the research participant

"She uses constructivism to discount the participant's main concern, which is always relevant to ongoing resolving behaviour, in favour of the researcher's professional concern, which is most often irrelevant to behaviour in the substantive area...."

(Glaser cited in Holton 2007:279)

Constructivist Grounded Theorists extend the focus of grounded theory to

"...*postmodern deconstructions, interconnecting social worlds, arenas, matrices of structure, trajectories of action, resources, hierarchies of power and influence, social policies, hierarchies of suffering, situated and local readings of ordinary people and their lives."*

(Charmaz cited in Denzin 2007:456)

Charmaz acknowledges that a risk in any inductive method such as the constructivist approach is overemphasis on the individual, emphasising the active, reflective actor to the neglect of the larger social forces acting upon him or her and she is mindful that the

researcher needs to learn how social forces affect the actor and what if anything the actor thinks, feels and does about them (Charmaz, 2000). Concern with 'the social' is essential to Clarke's work on grounded theory. Clarke (2003, 2005) developed a grounded theory using situational analysis, as a postmodernisation of Strauss's concern with situated negotiations in the social world (Clarke and Friese 2007:364). Strauss through the development with Corbin of the analytic tool the 'conditional matrix', sought to bring focus to the context of the research, including organisational, community, national and international conditions and how contextual elements condition the action. Clarke's analysis differed in that she argued '*there is no such thing as context*' (Clarke 2005: 65-73 cited in Clarke and Friese 2007: 364). Clarke and Friese expand on this proposition as follows:

> *"In sharp contrast, in situational analysis, the conditions* ***of*** *the situation are* ***in*** *the situation. The conditional elements of the situation need to be specified in the analysis of the situation itself as* ***they are constitutive of it,*** *not merely surrounding it or framing it or contributing to it. They* ***are*** *it. In situational analysis the situation* ***itself*** *is a key unit of analysis per se. The fundamental question in doing situational analysis is 'How do these conditions appear-make themselves felt as consequential-****inside*** *the empirical situation under examination?'"*
>
> (Clarke and Friese 2007: 363-365) (Emphasis in the original)

The authors who present situational analyses in the form of maps and matrices view everything in a situation - people, things, discourses, disciplines, symbols, institutions etc. as both constituting and affecting everything else in the situation, all are "*mutually consequential*". In this way "*macro/meso/micro distinctions*" give way to "*presence/absence*" (Clarke and Friese 2007: 365). Therefore structure and agency are at the same level, both encompassed in a given situation and co-constitutive of it. Clarke assumes that *"...origins, meaning and change lie in relationality"* (Clarke 2005:66). With respect to the problem of representation of often unspoken experiences of injustice for example social deprivation or sexual or ethnic oppression Clarke advocates a political and ethical standpoint for the researcher

> *"....we are ethically and morally responsible and accountable to seek out data that can speak to such areas of silence and difficulty in situations we choose to study"*
>
> (Clarke 2005:74)

In her 2006 text Charmaz distinguishes between a 'constructivist grounded theory' (CGT) which she sees, as part of the interpretive research tradition and what she terms 'objectivist grounded theory' (OGT) and traces the latter to positivism (Charmaz 2006:129-132). In OGT data is seen as real and representative of objective facts while in CGT data and analysis are social constructions reflecting underpinning processes of production. In OGT the researcher takes an objective stance in relation to the research and those researched, applying procedures to uncover patterns in data and developing theory that may be verified. CGT recognises diversity of experience and multiple realities and *"...addresses how people's actions affect their local and larger social worlds"* (Charmaz 2006:132). Each study has a specific index of time, space, culture and situation and theories generated are evaluated as *"plausible accounts"* (Charmaz 2006: 132) rather than as objectively verifiable. Charmaz avoids OGT concepts of a 'basic process' (Glaser) or 'core category' (Strauss) as they would *"excessively freeze up the social reality in the researching process"* (Charmaz 2006: 132). Charmaz clarifies that CGT offers

> *"an interpretive portrayal of the studied world, not an exact picture of it"*
>
> (Charmaz 2006: 10)

Therefore in embarking on data collection I was working towards a situated study, reflecting meanings of trauma experience and subsequent involvement in a social work process, co-constructed by the research participants and myself as the researcher, at a particular point in time.

Methods

Having discussed conceptual issues in relation to Grounded Theory and Constructivist Grounded Theory in the previous section, I will now discuss the operational issues in applying a Constructivist Grounded Theory methodology in this research including methods of data collection and analysis. According to Denscombe

> *"research methods are tools used for the collection of empirical data"*
>
> (Denscombe 2010:326).

Methods used in sampling and data gathering in this study are in line with Fook's vision of an inclusive approach to theorising from social work practice, which is oriented

> *" to minimize the influence of pre-existing formal theory; to maximize the number of perspectives available; and to maximize the fit between the method*

for accessing the experience, with the practice experience itself; and where appropriate, to include the perspectives of the practitioners/researchers."

(Fook 2002:88)

Access to the Research Site

Padgett suggests a general tendency to study what is familiar, particularly in situations such as social service agencies, hospitals and schools where

"professional interests and accessibility converge"

(Padgett 2008: 20).

Access to the research site is seen as a key advantage of insider research which I will discuss in the next section of this chapter. I gained formal approval from the hospital to undertake the study on the basis that research was an extension of my job; it fitted with the hospital's and the social work department's quality assurance programme, contributed to the hospital's research agenda and it was a central element of my postgraduate studies. However Brannick and Coghlan point out that secondary access to departments, functional areas and hierarchical levels other than one's own may remain a challenge (Brannick and Coghlan 2007: 67). This did not prove to be a difficulty in this case as the research project grew organically from practice in an interdisciplinary practice setting. As a practitioner researcher with pre-existing relationships with many of the people I wished to include in the study, I had no difficulty in recruiting and obtaining formal consent for participation from research participants. Familiarity between me as the practitioner researcher and the research participants created a positive, relaxed, and trusting climate in the interviews which facilitated depth of engagement with sensitive issues, fulfilling a key objective of qualitative research. My 'insider status' also facilitated access to practical resources including private and comfortable interviewing facilities. Although a choice of locations was offered, all participants opted to meet at the hospital citing familiarity and convenience as reasons for their choice.

Sampling

According to Padgett decisions on sampling

'...are driven by the study's research questions and goals. As a general rule, qualitative researchers use purposive sampling – a delicate process of selecting

respondents based on their ability to provide the needed information.....qualitative sampling is done for conceptual and theoretical reasons, not to represent a larger universe'

(Padgett 2008: 53)

As discussed in the introduction to this chapter, this study involved three groups of research participants: people who were personally affected by trauma and had availed of a social work service from the hospital emergency department; all social workers providing and managing the emergency department social work service and a cross disciplinary sample of non-social work emergency department staff who accessed the service for patients and others impacted by their illness or injury. In this study data collection and initial analysis took place over a three-year period beginning in 2001. The first phase of data collection focused on service users, the second phase on social workers and the third on non-social work staff. A grounded theory approach specifies purposive sampling (based on the relationship of participants to the topic being researched) as opposed to random sampling in recruitment of research participants. New participants are recruited until no new discoveries are coming through from analysis of the data. This position is termed theoretical saturation (Strauss 1987:21). This sampling strategy may be augmented by the use of theoretical sampling, whereby additional participants are recruited due to their particular experience or role where additional data is needed to understand emergent issues.

Sampling – The Service User Group

The hospital Emergency Department where the study was located provides a service to in excess of 45,000 people each year. The service is provided 24 hours a day, 365 days per year. Based on annual figures the mean daily attendance (24 hour period) is 123 people for emergency assessment and treatment. At the time the study was undertaken approximately 8-10% of emergency department patients were referred to the social work service constituting approximately 10-12 new referrals on a daily basis. There were two dedicated social work positions for the emergency department (staffed by three social workers-one full-time and two part-time) from a total of 26.5 social work positions (both managerial and main-grade) within the hospital at that time. The range of work undertaken was typical of hospital-based social work in Ireland as represented in a study undertaken by Irish hospital-based social work managers. This study suggests that significant social work time (60%) is spent in direct work with patients focusing on assessment, risk intervention and counselling with liaison, complex network management and case management also significant elements of the role (NHMSWF, 2008). Much of emergency department work is crisis driven and requires

an immediate response. Social workers based in the emergency department also provide a follow-up social work service to people affected by trauma including traumatic bereavement. At the time the study was undertaken approximately twenty people attended this service on a weekly or fortnightly basis according to their needs. This cohort of service users are the subjects of this research. For ethical reasons to avoid any potential role confusion or compromise it was decided that service users would not be included in the study until their involvement with the service had concluded. In consultation with colleagues and the social work manager it was agreed that from a specified date all service users concluding a period of work in relation to trauma with the emergency department social work service, would be approached by their social worker, about potential participation in the research. As the study centred on a model of practitioner research I was interested to interview people with whom I had worked directly but also people who had worked with my two colleagues in order to access a broader range of experiences. As a group we agreed that at any given time our combined caseloads reflected the range of issues typically arising for people accessing our service including traumatic bereavement, domestic violence, psychosocial issues resulting in self-harm and road traffic accidents. Therefore this range of issues was likely to be represented in the research sample. If that did not prove to be the case it was agreed that theoretical sampling could be employed as the research progressed. An information leaflet (see appendix 1) outlining the nature and aims of the study was developed to be given to people at an initial discussion of the study with their own social worker, to take away for consideration. The voluntary nature of participation was emphasised. If people were interested to get further information I was available to meet with them for a further discussion and clarification of any issues arising for them. Information on the research study including the voluntary nature of participation, people's right not to discuss any issues they were uncomfortable with and access to further psychosocial support if required for example in the event of research topics causing distress was outlined in the explanatory leaflet. The right to withdraw from the process at any time and issues in relation to confidentiality, limitations to confidentiality and subsequent utilisation of research findings were also addressed. This information was reiterated at the beginning of each research interview and time was allocated for questions and discussion in advance of signing a content form. Written contracts were used to achieve fuller understanding of the purposes of the research, to obtain participants consent to involvement in the research process and willingness to work within the conditions under which it was conducted.

Through this process fourteen former service users were recruited over a period of eight months. Nine of the fourteen participants had worked with me and the remaining five had worked with one or other of my two colleagues. The take-up rate was high with everyone approached who could practically take part, agreeing to do so. Two people declined, one due to holiday commitments and the other because of demands of work.

Sampling – The Social Workers Group

It was decided that all three social workers working in the emergency department (two were part-time with additional work responsibilities elsewhere) and the social work manager who had both a prior practice background and current managerial responsibility in the emergency department should be included in the sample. A mini-focus group was selected as the best means of data collection with this cohort in order to explore practice issues in depth and also to capture my perspectives as a practitioner researcher. However in the role of facilitator I presented my ideas as tentative or in the form of questions inviting discussion and comments from the other participants.

Sampling – The Emergency Department Non-Social Work Staff Group

The third and final phase of data collection was with non-social work emergency department staff. Sampling was purposive and potential participants were approached according to their role and level of involvement in making referrals to the social work service. The key referral system to social work was the emergency department's liaison nurses' office who managed referrals from the department to both in-hospital services and community based G.P and nursing services. The office comprised of two senior nurses and an administrator, all of whom worked part-time. All three were approached and agreed to participate in the study. The emergency department Consultant (one of two Consultants working at the department at the time) was approached during the planning phase of the research and he also agreed to be interviewed. At this point a snowballing approach to sampling (Patton 2002) whereby one research participant nominates other potential participants known to them, was integrated. The Consultant nominated a second doctor to participate on the basis of his interest in service development. A nurse manager (one of sixty four whole time equivalent nursing staff at the department – four of whom participated in the study) with responsibility for post-graduate education in emergency nursing was interviewed due to her role in developing inter-disciplinary work. Again she suggested a potential research participant from the main nursing team who I approached and subsequently interviewed. The emergency department Occupational Therapist and Liaison Mental Health Nurse (both single handed posts) were also recruited for the study. In total nine non-social work

emergency department staff were interviewed representing all key disciplines that regularly referred to or co-worked with the social work service. These participants were working at a combination of main grade and management levels.

Phase One of Data Collection-Service User Interviews

The research interview may be viewed in a number of ways according to the research paradigm for example for a discourse analyst it may be viewed as a speech event (Mishler 1986) to be analysed in its totality, a positivist may see it as a data gathering process (Glaser 1992) while constructivists see it's interpretive potential (Charmaz 2006). My hope was that the research interview would be an opportunity to jointly explore and interpret experiences and their meaning with the research participant and therefore my constructionist perspective aligned with Holstein and Gubrium's (1997) who saw the interview as

> *"...a dynamic meaning making occasion"*
>
> (Holstein and Gubrium 1997:117)

An in-depth, semi structured interview took place with each participant, twelve of whom were interviewed individually and two further participants, a couple, chose to be interviewed together. A schedule of questions and themes for discussion was prepared in advance (see appendix 3) to act as a guide for each interview; this schedule was informed by the research questions and the literature and refined through conducting three pilot interviews before initiating phase one of the fieldwork. The questions were open and exploratory in nature structured around experiences of trauma and of availing of a social work service. The aim was to move from descriptive accounts to reflexive understanding of lived experience. To achieve this questions such as 'what were things like for you then?; what were your first thoughts when you knew something was wrong?; what was the hardest part for you?; were you able to talk about it with anyone?; what would you say to someone else experiencing this?' were posed as a supplement to initial questions to further explore experiences and ideas. The pilot interviews highlighted the benefit of being flexible in the approach to sequencing questions in order to follow people's own narratives.The value of open questions in enabling reflective and analytical rather than descriptive responses was also evident.

Qualitative research interviewing, involves complex communication processes intersected by differences and potential power dynamics between the researcher and the research participant. Tutty, Rothery and Grinnell (1996) suggest that the quality

and quantity of data gathered are substantially influenced by these dynamics and by the knowledge, skills, values and experience of the researcher in addressing them. The research interview process itself has potential to open up new areas of personal, cultural or political awareness for the researcher and research participant and act as a catalyst for personal and social change. Awareness of power imbalance and differences of social class, gender, race and ethnicity together with viewing the research participant as expert on his/her situation help redress inequalities in the researcher - researched relationship. Instead diversity of ways of knowing, values and experiences are valued. (Tutty, Rothery and Grinnell 1996).

In conducting interviews Patton (1990) suggests the following dimensions of experience might be explored

- Experience/behaviour – questions such as 'what did you do when you heard that?', 'what was it like for you hearing that?' may be helpful
- Opinions/values - how a person interprets a situation/what s/he thinks about it – questions might include 'how did you explain that to yourself?' or 'what would you tell other people about the difficulties coping with -?'
- Feelings/emotions
- Knowledge/facts - 'what did you learn?'
- Sensory - 'what did you experience?'
- Background/demographic.

(Patton 1990)

As a social worker I was experienced in interviewing and in exploring difficult, sensitive and painful issues. I had experience in assessing when topics became distressful, acknowledging that and allowing the other person to decide if they wished to discontinue or continue to talk about a given issue. I knew I could draw on this experience in research interviews. However I needed to be very aware of my change in role and purpose as a researcher. I found Lang's work as discussed in the section on Practitioner Research very helpful in guarding against slippage into the social work role. Tutty, Rothery, Grinnell, Jr remind practitioner researchers that as a researcher it is unethical to try to modify, change or justify the interviewees feelings. At the same time the researcher must maintain respect and sensitivity towards the pain people may be experiencing. (Tutty, Rothery, Grinnell, Jr. 1996: 50-87) I also incorporated

processes of reflective practice (Schon 1983) before during and after each interview and found the concept of reflection-in-action as discussed in Chapter 3 very useful.

Using a schedule of themes and questions had the benefit of ensuring that key issues in relation to the primary research questions were addressed in each interview. Additional questions and discussion prompts were included under each theme/question on the interview schedule to be used as required for example if a research participant did not understand or relate easily to the phrasing of the initial question. Interviews followed the schedule of open questions in a flexible way, allowed for prioritisation, reflection and discussion according to the participant's interests. Research participants were encouraged to add detail, give examples, and ask questions as seemed appropriate. Issues that seemed of particular significance were explored in an open manner and at the time that seemed to fit with the person's unfolding narrative. The semi-structured format allowed for digression and in-depth exploration and discussion in a way which exceeds what might be possible with a more structured format. Further questions and topics emerged from the interactive process and issues raised in previous interviews were explored where relevant. The interviews ranged in duration from one to three hours, the average length being an hour and thirty minutes. The three-hour interview was with the couple and a coffee break was organised half way through. I was mindful of potential power differences and sought to address them for example by explicitly valuing the experience and views research participants contributed towards the development of social work practice in this setting. Familiarity between the researcher and many of the research participants enabled a relaxed style of interviewing. The interviews with people I had not worked with directly as a social worker or colleague tended to be somewhat more formal and in some instances shorter. As discussed all interview participants chose the hospital as the preferred interview setting. All participants gave permission to audio-tape the interviews and all interviews were transcribed in full.

At the end of each interview I asked the research participant to reflect on how they had found the interview and their views on participating in the research. A reflective research approach, which is dialogical in nature allows for an exchange of views between the researcher and research participant neither privileging nor negating either perspective (Ruch 2000: 210-211). Discussions usually ensued on the research process more generally. I also summarised my understanding of key points in the discussion to ensure I had understood their perspectives accurately. This served a number of functions - it was a way to check that the interview was complete and reach areas not already addressed, it served as a member checking mechanism regarding

my interpretation of their perspectives (Lincoln and Guba 1985), it was a helpful debriefing process and it prompted reflexivity in relation to the research process more generally thereby involving research participants as collaborators in making sense of emerging findings. Initial data analysis (coding) took place concurrently with interviewing and saturation was reached after participation of fourteen people.

Phase Two of Data Collection - Mini Focus Group

The second phase of data gathering focused on the perspectives of the social workers. As three of us worked closely together in the emergency department and our manager had a previous practice background there also, pioneering much of the by then established trauma-related work, we agreed to meet as a mini-focus group.

> *"Group interviews are useful because they draw on the synergy between members....focus-group interviewing can bring clear advantages to a qualitative study, including savings in time and resources and the elicitation of insights from individuals stimulated by the group dynamic. It is particularly well-suited to studies in organizations or communities where there is a web of social networks already in place"*
>
> (Padgett 2008: 100-103)

I prepared a schedule of themes and questions for discussion in line with my research questions and the emerging findings from phase one of data collection. Before commencing the focus group the aims of the research were re-iterated, issues of confidentiality and its limitations and intended use of the research findings were clarified and consent was obtained to proceed and to audio-tape the group discussion. During the group meeting I both facilitated and contributed to the discussion. The duration of the group was one hour and twenty minutes. A full transcript of the mini-focus group discussion was subsequently produced.

Phase Three of Data Collection – Emergency Department Staff Interviews

The third and final phase of data collection was with non-social work emergency department staff. The purposive sampling process with this group has been outlined. Theoretical saturation was reached following analysis of interviews with nine research participants representing key disciplines that regularly referred to or co-worked with the social work service. These participants were working at a combination of main grade

and management levels. Again an interview schedule was prepared informed by the research questions underpinning the study and by findings from phases one and two. Before commencing each interview the aims of the research were re-iterated, issues of confidentiality and its limitations and intended use of the research findings were clarified and consent was obtained to participate in the research within the terms outlined and to audio-tape the discussion. An exploratory approach to interviewing, with flexible use of an interview schedule, was adopted similar to that outlined in relation to fieldwork phase one. Potential power differences were addressed through acknowledging the change of focus from practice to research and again in valuing each person's experience and views as a contribution to the development of social work and inter-disciplinary practice in the setting. Relaxed conversational styles of interview ensued which allowed for elaboration and discussion of issues raised and provided opportunities for clarification. As with previous interviews the discussion concluded with an invitation to reflect on participation in the research process, clarification of the main issues and discussion of the research more generally. All interviews were audio-taped and transcribed in full. Interviews with this cohort were of an average length of one hour.

Recording and Storage of Data

All interviews were audio-taped and transcribed in full. I completed transcription of a number of the tapes myself as part of the process of familiarisation with the data. The remainder were transcribed by a colleague at the School of Social Work and Social Policy at the university who had extensive prior experience in transcribing qualitative research interviews and worked in adherence with confidentiality requirements. Tapes and transcripts are stored in a locked filing cabinet in my office. Electronically stored data is stored on an encrypted database stored on a personal, password protected computer.

Data Analysis

Having reviewed all the data as it was collected to ensure tapes and transcripts were complete and made sense, steps were taken to address any missing areas through further interviewing, thus ensuring that the range of issues typically addressed by social work were represented in the sample and that there was cross disciplinary representation in phase three of fieldwork. There was a gender, class and age mix in both interview samples. However the focus group sample was all female reflecting a

predominately female social work workforce. There was only one non Irish-national participant in the study. This decision to stop collecting data was taken during open coding, the first phase of data analysis with the emergence of overlapping themes, patterns and duplications. Practical parameters of time and resources was also a consideration as time had to be negotiated within work in order to undertake interviews during office hours which was most convenient for a majority of research participants.

Data analysis was achieved through the application of the grounded theory method consistent with constructivist grounded theory (Charmaz 2000; 2006) and informed by postmodern thinking (Clarke 2003, 2005). A central aim of the analysis was to understand how experiences of trauma and subsequently of social work evolve and are grounded, that is given meaning and played out in research participants' lives (Dawson and Prus 1995).

My first task was to become familiar with the data through listening to the tapes and producing and reading the transcripts. Mason's (1996) work guided this initial reading. She suggests data may be read literally, interpretatively or reflexively and that many qualitative researchers make readings of their data on all three levels. I found the levels overlapped and as Mason points out, a purely literal reading is not possible. Reading in itself is interpretation. However my initial aim was to get a sense of each person's narrative and the sequencing of their meaning making processes before the data would be fractured through coding. Use of language, repetition of words, issues and points of reflection and expressed emotion were also of interest. I was interested that many passages of text were lengthy, detailed, and dense and constituted mini narratives on a given theme. This was particularly evident in people's retelling of trauma experiences and of their distress in the aftermath of painful experiences. Following Mason and moving to an interpretive reading of the data I looked for passages in the transcripts that elucidated how people interpreted and made sense of their situations and indications of belief systems or cultural norms or broader discourses that were influential for them. I was struck that a number of men talked about 'macho culture' as prohibitive of showing vulnerability and seeking emotional support, particularly on a professional basis. Some of the women, who were mothers talked about balancing self-care with the competing needs of family. People's accounts of the positive and negative impacts of the myriad of relationships in which they were immersed were engaged and forceful. Mason explains the process of interpretive reading of data as follows

> *"You may be mostly concerned with, what you see as your interviewees' interpretations and understandings, or their versions*

and accounts of how they make sense of social phenomena, or you may place more emphasis on your own interpretations…..Whatever form of interpretative reading you adopt, you will be involved in reading through or beyond the data in some way…"

(Mason 1996: 109)

Finally in a reflective reading I needed to locate myself as part of the data and to explore my role as the researcher in the process of generation and interpretation of data. I found this hardest to do falling back on old ideals of objectivity. I could see that my insider status and approach seemed to be successful in generating data of sufficient quantity in that all texts were detailed and all areas specified in the interview guide had been addressed. The quality of the data was evident too in that the interviews and focus group had clearly gone well beyond surface description. I was conscious of the need for reflexivity to balance the multiple accounts of both trauma and social work that were present in the data and to integrate my own interpretations yet not to do so prematurely without as full a sense as possible of meanings contained in the data. Initial ideas were noted and I was then ready to embark on coding. At this stage the transcripts were imported into the NVivo data management system.

Using Qualitative Data Analysis Software

I have combined traditional writing based approaches to data analysis with the use of computer assisted qualitative data analysis software (CAQDAS) NVivo. In this study qualitative data analysis software was used primarily as a data management tool to facilitate the first and second coding cycles. In using NVivo interpretative processes remain entirely a task for the researcher. The computer does not in any way perform analysis, it does however provide a reliable and efficient system for storing the original data, tools to use in fracturing and recombining data and capacity to record coding activity. The latter function whereby movement of data and coding patterns are logged, analytical thinking may be recorded and conceptual categories are mapped, furnishes a comprehensive audit trail. The software therefore is also a tool for achieving transparency and establishing the plausibility and trustworthiness of the study. It meets a need for qualitative researchers who as Fielding and Lee (1998) outline *"want tools which support analysis, but leave the analyst firmly in charge"* (Fielding and Lee 1998 *:167).*

Coding, Categorising and Conceptualising

Codes, categories and concepts are the building blocks of grounded theory from its foundations in the data to eventual generation of a theory that explains what is going on in a given situation, as it is represented in the data and as it relates to other situations, issues and ideas extending beyond the data. Bryant and Charmaz offer a simple hierarchal model but acknowledge scope for greater complexity in the relationship between these terms

> *"It would seem the best working model places these terms in a hierarchy from bottom to top: respectively code, category, concept. The resulting hierarchy will not however appeal to those GTM researchers who see the hierarchy between category and concept as far more intricate.*
>
> (Bryant and Chamaz 2007:18)

Coding at any rate is a point of departure in a cycle of meaning making, from the data to the theory that is ultimately produced, through processes of induction and abduction happening in tandem, with the researcher, in Charmaz's words

> *".....taking comparisons from data and reaching up to construct abstractions and then down to tie these abstractions to data..... learning about the specific and the general-and seeing what is new in them-then exploring their links to larger issues or creating larger unrecognised issues in entirety...."*
>
> (Charmaz 2006:181)

For Holton coding *'gets the researcher off the empirical level by fracturing the data'* (Holton 2007:266) which is then brought together in new ways that conceptualize and explain what is happening in the data.

Open Coding

A coding process is applied to the data. Transcripts are accessed and examined line by line to identify features of the data for example themes, thoughts, feelings, actions, issues or events which are coded or named. This phase generates the initial set of codes and is known as 'open coding'. Code names may be taken directly from the data (an in-vivo code) as in the example of 'bridging the gap' in table 4 at the end of this section). Alternatively the researcher may apply a code name that captures something essential to the coded data for example 'loss of meaning' in table 4. Coding proceeds systematically across the entire data set, with words, lines or entire passages either

forming a new code or being added to an existing code that is adequate to capture the intrinsic meaning expressed in the text.

Focused (Substantive) Coding

At this next level of abstraction codes are grouped together according to emerging issues and themes. In the example in table 4 all codes that related to themes of loss or pain from the social work service users sample were collated. Therefore 'loss of meaning' was collated with other codes such as 'loss of direction and purpose', 'loss of interest', 'loss of intimacy' 'loss of confidence' 'pain', 'sadness and sorrow' and so on, and were coded as 'pain and loss'. Codes emerge from the data and are not imposed on it. Patterns are seen to be

> *".....empirical relationships (and not just superficial regularities) identified within the data."*
>
> (Dey 2007:177)

Categorisation of Codes

Using analytical approaches such as 'asking questions of the data' (Strauss 1987) and what grounded theorists call 'the constant comparative method' (Glaser and Strauss 1967) similarities and differences between codes are identified and codes that fit together are clustered in more abstract patterns or categories. Analytic memos are written to record the relationships among the clustered units of data in order to maintain a close link between analytic interpretation and the empirical data. Extracts from memos written when developing the category 'Feelings and Effects of Trauma' in the example below include

"Exploring the effects of the traumatic experience at the time of referral (to the social work service).....feelings and experiences associated with the trauma. Differentiation of feelings over time.....especially from numbness to sorrow and grief (e.g. Brigid and Therese, also Dave).....Experiencing pain of loss and a changed reality, a changed life. Having to go through the pain. Feeling almost in a vacuum – in suspension"

Categories are refined through a process of checking the fit of each category with the coded data it represents and also with each of the other categories and thereby the entire data set. Theoretical sampling (further data gathering in relation to a particular theme) and negative case analysis (instances in the data that disprove an idea or vary

from a theme) may be used to explore problems, refine ideas and clarify emerging themes. Further theoretical sampling did not seem warranted in this study as the existing data was detailed and offered rich descriptions in relation to emotions, beliefs, values, physical reactions, actions taken and interaction. There was triangulation of data sources in the existing data that contextualised the emerging findings. Negative cases examples did not arise but there were notable variations within categories, in for example, the intensity and duration of distress, which related to the teleological or non-teleological nature of the losses endured and the circumstances of the original trauma. The refined categories, clearly named and their properties well defined, then form the basis of theoretical constructs or concepts.

Theoretical Concepts

In this phase of the analysis the categories are reviewed and analytical memos are re-read and synthesised. Final analysis is undertaken and themes emerge at a further level of abstraction, which capture the issues, processes and relationships identified and described in more detail, in the earlier phases of analysis. In this phase I moved from NVivo to traditional writing and to mapping the relationships and processes found in the data. This led to the development of trajectories of living through trauma and of a relationship-based social work process that supports people in this. These trajectories were made available for member checking and peer review and were further refined. They underpin the model of 'Relationship-based Social Work - A Thirdspace In Responding to Trauma' discussed in the final chapter of the thesis. This final stage of analysis also involved processes of abduction whereby the analysis was related back to the primary research question in relation to the nature of the lived experience of trauma and the elements of responsive social work practice in this context. It was also related to the literature.

> "*Careful analysis of relevant extant literature after developing one's grounded theory can provide cues for raising its theoretical level....*"
>
> (Lempert cited in Charmaz and Bryant 2007:19)

From this synthesis of research questions, analysis and the literature, concepts of liminality and of the 'thirdspace' seemed fitting to represent the experiences that were recounted in the study. The feelings and effects of trauma gave rise to an experience of liminality. The 'thirdspace' denotes the positioning of relationship-based social work in responding to experiences of liminality. These concepts relate to each other as spatial

metaphors and suggest a trajectory of being dis-placed and of co-creating an in-between space in which one can re-place oneself in relation to trauma and other dimensions of life.

Bryant and Charmaz summarise the systematic inductive and creative abductive processes integral to producing grounded theory which underpin the identification of the key theoretical concepts in this study.

> *"Grounded theory strategies allow for imaginative engagement with data that simple application of a string of procedures precludes. This engagement with data creates a space where the unexpected can occur; thus unexpected events and experiences may emerge…..an emerging phenomena has new and different properties than its antecedents. If so, then a grounded theorist's categories would have new and different properties from the pieces of data that prompted the researcher's idea for the category. Emergent categories arise from the researcher's skill in defining these new properties through the successively more analytic comparative processes of combining data with data, data with code, code with code, code with category, and category with category. In short, grounded theorists can build on an epistemologically sophisticated view of emergence that allows for possibilities of emergent (but never wholly inductive) categories in the practice of theorising."*
>
> (Bryant and Charmaz 2007:25)

The following examples illustrate the coding process:

Data Source	Transcript Extract	Open Coding	Focused Coding	Coding to Category	Theme	Theoretical Concept
Social Work Service User Interviews	"Well I was devastated. I didn't know what to be doing with myself, you know, I just felt everything you know, my world had collapsed, I kind of felt that nothing was worthwhile because you had no one to go home to, the person that was there had just disappeared and you didn't know what to do with yourself....."	Loss of Meaning	Pain & Loss	Feelings and Experiences of Trauma	Effects of Trauma	Trauma-Entering a Liminal Space
Emergency Department Staff Interview	"...it's bridging the gap to the community and to make sure they're followed up and there is something done you know...and not just sending them out again....."	Bridging the Gap	Liaising and Co-Working	Role of Social Work in the Emergency Department	Co-constructing Social Work in Context	Social Work a Thirdspace
Social Workers Focus Group	"we're far less assessment guided than other disciplines...and more about the meaning for the person and the person's perception of the problem...rather than someone else's diagnosis or diagnostic model"	Focusing on Meaning	Developing a Social Work Process	How Social Work Works	Co Constructing Social Work in Context	Relationship-based Social Work -Creating a Thirdspace in Responding to Trauma

Table 4: Examples from the Coding Process

Reporting on the Findings

In Chapters 5, 6, and 7, I report on the conceptual categories that emerge from the grounded theory approach, showing how each integrates the themes represented in the substantive categories. Following Charmaz I build stories of peoples' experience around these categories, thus adopting a narrative reporting style while remaining consistent with grounded theory (Charmaz 2000). Grounded theory requires that

> *"...an analytical rather than a descriptive report is produced towards the aim of theory development."*
>
> (Hood 2007:154).

Ethical Issues

Introduction

In undertaking social work practitioner research, both research ethics and social work ethics need to be considered. Descombe (2010) traces the origins of codes of research ethics to the regulation of medical research in response to atrocities committed in the name of science during the Second World War. Through the Nuremberg Code (1947-49) and later the Declaration of Helsinki (1964) the international community established the fundamental principle of research ethics that

> *'the ends do not justify the means in the pursuit of knowledge'*
>
> Descombe (2010:331)

Subsequently adapted for social research, codes of ethics require that research is conducted in a way that

- *Protects the interests of participants*
- *Ensures that participation is voluntary and based on informed consent*
- *Avoids deception and operates with scientific integrity*
- *Complies with the law of the land*

(Descombe 2010:331)

Research Ethics as Applied Ethics

Research ethics are an application of broader ethical beliefs and generally encompass deontological ethics (Kant) which refer to the duty to uphold moral principles such as honesty, justice and respect as well as utilitarian ethics of consequence (Bentham; Stuart Mill), in relation to maximising the benefits (beneficence) and minimising the harms (non-maleficence) which flow from research (Kvale 1996; Shaw 2003). Virtue ethics underpin a focus on the character and credentials of the researcher (Kvale 1996; McBeath and Webb 2002; Shaw 2003). Relational ethics based on feminist communitarian philosophy emphasise contextualisation and negotiation of research ethics within a commitment to a wider community of interest, reflecting shared values of care, self-governance, neighbourliness and kindness (Denzin 1989; Christians 2000; Peled and Leichtentritt 2002; Peled 2010).

Social Work Ethics and Research Ethics

National social work associations (in the Irish context the Irish Association of Social Workers) adhere to the International Federation of Social Workers' Ethics in Social Work (IFSW 2012) which in turn is informed by International human rights declarations and conventions, principles of social justice and standards of professional conduct. Banks (1995) compared fifteen national social work codes of ethics and proposed four common values: respect for the individual person; promotion of client's self-determination; promotion of social justice; and work for the interests of others (Banks 1995)

In 2011 the Irish social work regulatory body and registration board produced a Code of Professional Conduct and Ethics for Social Workers informed by social work values of respect for the inherent dignity and worth of persons; pursuit of social justice; integrity of professional practice; confidentiality in professional practice and competence in professional practice. The code specifies that research must be undertaken ethically and provides guidelines in relation to ethical procedures in undertaking research. (CORU 2011: 4-12)

Therefore in undertaking research there are extrinsic principles of autonomy, beneficence, non-maleficence and justice emanating from a biomedical approach to ethics (Beauchamp and Childress 1989) to adhere to. According to Clifford these principles inform requirements in relation to informed consent, non-deception, the

absence of psychological or physical harm, privacy, confidentiality and a commitment to collecting and presenting reliable and valid empirical data (Clifford 2000) and are enforced by Institutional Review Boards of universities and medical and ethics committees. Principles intrinsic to the researcher and the research context such as moral integrity and reciprocal care and understanding which are underpinned by value and relational ethics and are agreed through non-hierarchical dialogue rather than formal consensus are significant considerations in qualitative research (Clifford 2000; Peled and Leichtentritt 2002). Research commissioners, funders, employers, organisations which serve as settings for fieldwork and professional organisations are all likely to have research polices encompassing ethical procedures which must be adhered to. Richard Hugman recognises the complexity inherent in research given that research participants, researchers and other stakeholders have distinct sets of rights and duties which may intersect in many ways from harmoniously to antagonistically. To take this into account, he suggests a need for moral pluralism in approaching research (Hugman 2010).

Ethical Issues in this Research

Shaw (2008) cautions against viewing ethics as a discreet issue to be addressed at the beginning of a qualitative research study and then set aside when the requirements for ethical approval are met. Instead he identifies ethical issues emerging at three phases of research: at the design stage in relation to informed consent, confidentiality and privacy, social justice and practitioner research; at the fieldwork stage in relation to power, reciprocity and contextual relevance and finally in relation to analysis and uses of qualitative inquiry (Shaw 2008:403-404). I will now address the ethical considerations raised by Shaw and others in relation to the design stage, the fieldwork stage and the analysis and use of findings in this study.

Ethical Issues in the Research Design Phase

In conceptualising this study I was confronted by the ethics of researching sensitive issues. Having worked through this issue I proceeded to seek formal approval for the study, address the requirement for informed consent from all potential research participants and clarify issues in relation to insider status, confidentiality and limitations to confidentiality.

Researching Sensitive Issues

The following passage from Gilgun and Abrams (2002) reveals what a powerful instrument qualitative research can be

> *"Qualitative approaches allow researchers to connect with other people in deeply personal ways. The two main types of qualitative methods, in-depth interviewing and observation, bring researchers into close contact with lived experiences of the persons with whom we do research. These interactions often involve personal and sometimes painful topics that can evoke powerful emotions in researchers and informants. In such evocative situations, researchers have opportunities to explore deep meanings of the phenomena of interest and thus develop new theories and understandings that have rich and nuanced dimensions. The knowledge we gain, therefore, is not information that simply passes through the central processors of our brains. It also arises from our hearts and often our deeply held emotions. Understandings gained through an engagement of heart and mind have an immediacy that potentially connects to the hearts and minds of audiences."*
>
> (Gilgun and Abrams 2002:42)

The passage summons the intensity of connecting with people's greatest hopes and their worst fears, their sense of being loved or being abandoned, included or rejected, having enough or going without, of opportunities seized and possibilities missed, of times of happiness and times of great pain and the spectrum of experiences in between. How intense must it feel for the people telling of their lives? It reminds me too, of feelings of shared humanity that such encounters evoke, the real potential of talking and listening, the appreciation and validation of feeling understood and the frequent recalibration of what is important. The authors make the point that the portrayal of connected experience is compelling for research audiences. I agree. I also find the passage disquieting and I question as Liamputtong (2007:25) does in her book 'Researching the Vulnerable' if *'mining the minds'* of people already disempowered by suffering can ever be ethical? Is research a fitting context to evoke personal and painful memories? To extend Liamputtong's metaphor, research in this context can be an ethical minefield. After much deliberation, Liamputtong concludes that to omit people from participation in research is to disempower them further; therefore researchers must proceed with attention to ethical considerations at every stage of the research process.

Mertens and Ginsberg (2008) who also recognise that social work researchers, due in part to the sensitivity of the issues they address, stand *'deep in ethical waters'*, have made a contribution to the debate that for me restores confidence in research with people experiencing difficult life circumstances. From a standpoint in line with social work values, they suggest ethical choices are those that support the pursuit of social justice and human rights. They contrast this basis for ethical decision making with the positivist tradition where they suggest *'knowledge is sought for its own sake regardless of where, how or by whom the information will be used'* (Mertens and Ginsberg 2008:486). They raise questions of power and privilege advancing a critical analysis of cultural and societal configurations that permit *'....those in positions imbued with formal authority and power to define reality for those who do not share this privileged position'* (Mertens and Ginsberg 2008:486). They illustrate this argument with an example of the designation of young people as *'at risk'* by staff on a youth programme suggesting that the young people and their parents would define and interpret their situation differently. They advocate for support to young people *'....without burdening them with a stigmatizing label that suggests the likelihood of failure'*. (Mertens and Ginsberg 2008:487). The opportunity to define and interpret one's own experience and to have that interpretation accepted as valid is integral to overcoming the disempowerment of trauma. For some this may be achieved through close relationships, through religious or other meaning systems, through social work or other psychosocial support services or/and through participation in research. Of these various forums research supports knowledge development in a structured way and may serve as a channel for the experiences and perspectives of people centrally involved with issues to inform both public and professional discourse and to change practice and policy. The hope being, that this can be an empowering, democratising process for research participants with sensitising effects for researchers and research audiences. Tensions of course remain and formal steps as will be outlined in the following sections of this chapter, must be taken to protect people's interests and rights.

Formal Approval

The next step was to seek formal approval (Shaw 2003) for the study. My PhD proposal based on this study was accepted by Trinity College and I was allocated a supervisor. My registration as a PhD student preceded the establishment of a Research Ethics Committee within the School of Social Work and Social Policy at the university. I made a formal application to the Chief Executive Officer and management team at the hospital where the research would take place, for approval to undertake

this study with both adult service users and staff. The C.E.O and management team considered the research was evaluative rather than medical in nature and therefore granted approval and as part of the hospital's quality initiative. Formal research proposals were also submitted to and agreed by the social work manager and the emergency department consultant.

Informed Consent

In recruiting participants an information leaflet was prepared outlining the aims and approach of the study, the voluntary nature of participation, the commitment required of participants, freedom to withdraw from the research at any time and issues of confidentiality, limitations of confidentiality (as discussed in the next section), steps to be taken to protect participant identity and data storage. The information leaflet clarified that the decision to participate or not participate, did not in any way affect the person's relationship with the hospital or the social work service. Further to this the study was discussed in person with each prospective participant, by his or her social worker. In instances where the social worker was my colleague I was available to meet the person to discuss any questions they had. Prior to each interview the above information was reiterated and discussed in full and written consent (see consent form in appendix 2) was obtained. With social work and non-social work colleagues who participated in the research, relational and value ethics pertained as discussed in the previous section and consent was obtained through non-hierarchical dialogue rather than written agreement. (Clifford 2000; Peled and Leichtentritt 2002). However information leaflets were also made available to them in the recruitment stage.

Confidentiality and the Limitations of Confidentiality

Shaw (2008) problematises the perception of alliance between the researcher and research participant in qualitative research due to its potential for fuller disclosure by research participants than they might wish to or be likely to engage in if for example quantitative methodologies were used. I was particularly mindful of this in the context of practitioner research in my workplace and took steps as discussed to differentiate between social work interviews and research interviews. While Padgett acknowledges that qualitative researchers cannot offer the extent of anonymity that quantitative researchers can offer she emphasises the centrality of confidentiality and the need to make every effort to ensure that identities of participants are never revealed or linked to the information they provide without their permission (Padgett 2008: 67). In this study

research participants were assured that their anonymity would be protected in the production and storage of the research data and in any publications ensuing from the research. This would be achieved through the use of pseudonyms and altering of personally identifiable details. The limitations of confidentiality was also specified. I clarified with research participants that disclosures of imminent risk of harm to themselves or others would be dealt with outside of the research interview by bringing the research interview to a close and addressing the risk for example if someone was actively suicidal. The availability of a follow up social work service from a colleague should issues of imminent risk arise, was discussed as part of acquiring informed consent. However if past or potential future risk was disclosed for example someone anticipated the likelihood of suicidal thoughts around the time of a partner's anniversary a number of months ahead my approach would be to return to address the issue after the research interview concluded and make a referral to appropriate support services with the person's consent. In addition I advised research participants of my legal responsibility as a hospital employee to report disclosures of risk or actual abuse or harm to children to statutory child and family services who would also report to the police.

Ethical Issues in the Fieldwork Phase

Issues in conducting what has been termed insider research or *"research by complete members of organizational systems in and on their own organizations."* (Brannick and Coghlan 2007: 59) gave rise to a number of ethical concerns in the fieldwork phase of the research.

Conducting Insider Research: Insider Perspectives and Insider Status

> "When researchers seek verstehen (deep understanding), they pursue studies that are emic (i.e., focused on the insider point of view, rather than etic (the outsider's perspective)"
>
> (Padgett 2008: 16)

As discussed in chapter 1, in my work as a social worker I had experienced a disconnection between available theoretical perspectives and the emotional intensity and extensive sociocultural dimensions of trauma encountered in practice. A desire to understand trauma from the 'inside' perspectives of people who live through it and service providers who work with them, was the motivation for this insider research

study. I also wanted to understand how and why social work interventions are helpful or unhelpful, succeed or fail in this context. As Padgett put it, I wanted to "get inside the 'black box' of practice...." (Padgett 2008: 16). In gaining understanding of *"things from the point of view of those involved"* (Denscombe 1998:69) I hoped to develop more responsive, trauma-informed social work practice. As a practitioner researcher in my own organisation I had insider status and my study constituted insider research. Perry et al note that researchers studying a social world, of which they are a part, inevitably have an emotional orientation towards the study and complete detachment is neither achievable nor desirable. They argue that

> *"an appropriate blend of involvement (to remain sensitive to the interviewee and the emergent data) and detachment (to ensure that appropriate lines of inquiry were pursued)* should be maintained*".*
>
> (Perry et al 2004: 142).

Acknowledgement of my dual role as a practitioner and researcher, careful planning in relation to the research approach and well-developed reflexivity throughout the research process were required to uphold ethical standards, maintain a balance of involvement and detachment, minimise risks of bias and reduce potential for participants to feel constrained by an 'interviewer effect' in the research interviews.

Brannick and Coghlan identify access, pre-understanding, role duality and managing organizational politics as the key issues in insider research (Brannick and Coghlan 2007: 59). Padgett suggests many advantages of insider status which include access to a research site, acceptance of the researcher, easier development of rapport, enhanced cooperation and generally higher comfort levels. The researcher's prior knowledge of the topic is also seen as an advantage (Padgett 2008).

I found pre-understanding of trauma based on theoretical knowledge, practice experience and wider lived experience allowed for acknowledgement from the outset of interviews of the significance of people's experiences and the impact on their situations, allowing discussion to proceed easily from descriptive accounts to more detailed discussion of meanings attributed, interpretations made, influences of tacit cultural norms and rules, expectations and responses of others, needs met and unfulfilled, hopes and fears and wider connections and consequences. I used extant, theoretical and practice knowledge of trauma in planning themes for discussion to ensure issues highlighted in the literature as significant, such as common reactions to trauma and the impact of secondary stressors were raised with research participants

and that lines of inquiry were pursued in response to intellectual as well as emotional 'leads' (Perry et al 2004: 143). However Brannick and Coghlan highlight the danger that an insider researcher might be overly reliant on prior understandings leading to assumptions and failure to explore, probe and challenge their thinking as much as if they were outsiders (Brannick and Coghlan 2007: 69). I was careful to use prior knowledge as *sensitising concepts* (Glaser 1978) guarding against it becoming overly deterministic in relation to what might be discussed or how things might be understood. The choice of semi structured interviewing and a mini focus group as the methods of data collection ensured active engagement with interviewee(s) in shared interpretation of experiences and generation of data (Popay et al 1998; Perry et al 2004). Each interview was transcribed in full to ensure the interviewee's emphases were fully captured. Constructivist Grounded Theory was selected as the methodology for the study for its structured and primarily inductive approach to data analysis.

Brannick and Coghlan proposed that role duality can create role and value conflict for the researcher where divergences occur between roles (Brannick and Coghlan 2007: 70). This research grew organically from my practitioner role. As discussed in the earlier section on practitioner research, social work and qualitative research have common philosophical foundations thus reducing the potential for role conflict. However there were other aspects of role duality that needed to be recognised and managed to ensure good ethical practice. Padgett suggests service users may find it difficult to accept someone in a new role and they may feel obliged to take part, fearing negative impact on their relationship with the service or they may feel inhibited in their ability to be open and frank. For the researcher there may be a temptation to overstep boundaries to intervene or effect change if the content of the interview raises concerns (Padgett 2008). Avoiding these traps, calls for transparency, role clarity and reflexivity. At the recruitment phase there was explicit discussion on absolute freedom in the decision to participate or not to participate without any consequences whatsoever and informed consent was obtained as already discussed.

Marking difference between my roles as social worker and researcher was achieved in a number of ways; firstly people were not recruited for the research project until their involvement as service users had ended and it was agreed they were no longer in need of a social work service. This was to ensure as far as possible that people had time and support to go through the trauma they had experienced. I was very aware that otherwise engaging in this research could be re-traumatising. Even with this safeguard in place I was aware that participation in the research could trigger distress. This risk was discussed with each research participant during the recruitment phase and before

commencement of each interview. Research participants were made aware that I had arranged provision of psychosocial support by a social work colleague if this were to happen. It did not prove necessary. It was also made explicit that they could opt out of the interview at any point they felt uncomfortable without any repercussions whatsoever. The purpose of the research was clearly explained. As the interviewer I was clear that research interviews were exploratory rather than change-oriented and I needed to avoid engaging with the participant in problem-solving or being directive in any way. I was aware of cues and responses that might inhibit participants' ability or inclination to share experiences and perspectives especially where they differed from my own. Seeking permission to audiotape each research interview and the presence of the tape recorder between the interviewer and interviewee served as a constant reminder of the research orientation of the interview and the existence of a wider audience.

Potential reluctance of participants to be open and critical was addressed by acknowledging, normalising and exploring difficulties in engaging with the social work service. This proved effective in that many participants were very frank about their negative preconceptions of social workers. Participants were also open about other barriers to engaging with the service such as reticence or reluctance to talk about difficult experiences and to face painful feelings.

For Brannick and Coghlan a further challenge in undertaking insider research is *managing organizational politics.* This relates to differentials in power and varying interests of relevant stakeholders in relation to the project. Conflict at this level may be particularly to the fore when the research report is being produced (Brannick and Coghlan 2007: 71). Again this didn't present in the context of this study although my need to produce a dissertation based on the research was additional to the otherwise shared interests of all stakeholders in relation to protecting the interests and confidentiality of service users and in service development. Protecting professional and organisational reputations may have been a concern for research participants but this was not voiced by anyone during the research process.

In conclusion I would argue that as a practitioner researcher my insider status improved both the feasibility and quality of the study and provided opportunities for the research findings to translate into social work practice. In addition addressing the potential difficulties of insider status and insider research more generally improved the rigour of the study and helped ensure the ethical integrity of the research process.

Ethics and Reporting and Utilising Research Findings

It is important in reporting, that the researcher is faithful to the narratives of research participants and doesn't alter their meaning through personal, professional or political interpretations (Mills 2002: 109 cited in Shaw 2008:409)

Finally regarding further utilisation of the findings, Gilgun and Abrams (2002) remind us of the importance of dissemination of research to a wider audience that includes practitioners, policy makers and service users

> *"Values provide qualitative social work researchers not only with guidance on what we choose to research or how we interact with participants, but also how and why we disseminate our findings. In keeping with our commitments to social work, we present and narrate participants' stories for audiences that reach beyond academia, such as clients, practitioners, community organizers, and policy makers. It is important that this dissemination of knowledge occur at the ground level, where social change and social justice struggles are taking place. We are once again called to return to our professional grounding in a field that keeps commitments to social justice at its core".*
>
> (Gilgun and Abrams 2002:45)

Reflexivity

Reflexivity is integral to each phase of the research process and essential in addressing methodological and ethical issues in qualitative studies. There is no *'view from nowhere'* (Nagel 1986). As researchers our personal, professional, cultural and political perspectives cannot be eliminated. As embodied actors we carry our history, biography and the symbols of our social location into the research process. As previously discussed, mine is that of a white Irish woman, from a rural middle class background. While our own experience provides a powerful template in understanding the experience of others, reflexivity is important to ensure it is used as just one of many ways of interpreting data in the research process.

In undertaking this research I wanted to avoid a polarisation of the researcher and research participant and saw no place for an objectivity that constructed a binary of 'a knower' and 'a known'. This research is based on relationships and inter-subjective understanding of a continuum of human experience to which most people could in some way relate. My experience as a teenager, of my father's death contributed to my

capacity to understand, as did many experiences from my work as a social worker in drug and HIV services and hospitals.

The power to interpret the experiences and meaning systems of others is arguably the significant source of power in undertaking qualitative research. Reflexivity is therefore critically important and involves the researcher problematising how she or he "is" towards the research participant (Schwandt 1999). Inherent in this is critical awareness of issues of power and control and inclusiveness and exclusiveness arising from differences in knowledge acquisition, status, class, gender, race, age, ability/disability and sexual orientation (Lincoln and Guba 1985). For Mason reflexivity is achieved by researchers

> *"constantly taking stock of their actions and their role in the research process and subjecting these to the same critical scrutiny as the rest of their "data""*
>
> (Mason 1996: 6).

Reflexivity is also significant in reporting of the research findings, thus confronting the 'myth of silent authorship' (Charmaz and Mitchell 1997). Reflexivity requires the researcher's voice is distinguished from that of the research participant in the research text. Clandinin and Connolly (1998) illustrate the importance of the researchers' voice and signature (who they are and how they choose "to be there" in the research) in allowing three-way dialogues between research participants, researchers and research audiences

> *"As researchers, we cannot work with participants without sensing the fundamental human connection among us; nor can we create research texts without imaging a relationship to you our audience. Voice and signature make it possible for there to be conversations through texts among participants, researchers, and audiences."*
>
> (Clandinin and Connolly 1998: 176)

Conclusion: Framing the Research

This section draws together discussions from the previous sections to specify the methodological frame for this study. The research set out to address primary research questions in relation to the nature of the lived experience of trauma and the elements of responsive social work practice in this context. Qualitative research was selected as most appropriate approach to small-scale research in this context, to allow for

meaningful engagement of three groups of research participants all of whom were connected to the hospital setting where the study was set. The research was designed within the constructivist-interpretive paradigm (Denzin and Lincoln 2013) and utilised a constructivist grounded theory methodology (Charmaz 2000, 2006). In-depth semi-structured interviews and a mini focus group were the methods, used in data collection. Data analysis was conducted using computer assisted software NVivo as a data management tool. Interpretation and conceptualisation followed grounded theory (Glaser and Strauss 1967) and constructivist grounded theory (Charmaz 2000, 2006) methods informed by Clarke's situational analysis (2003, 2005). The findings, which conceptualise the lived experience of trauma, will be reported in Chapter 5, findings in relation to a trajectory of living through trauma are reported in Chapter 6 and the findings in relation to how social work is constituted in this setting in responding to the needs of people affected by trauma are reported in Chapter 7. The findings discussed in these three chapters underpin the model of Relationship Based Social Work – A Thirdspace in Responding to Trauma which is presented in the final chapter of the thesis as part of the discussion of the overall findings of this study which have been developed idiographically and are now presented as part of a dialogue with the relevant academic literature. Lincoln and Guba (1985) are tentative in relation to the transferability of findings of idiographic research because *" mutually shaping influences may vary markedly from setting to setting; and because value systems, especially contextual values, may be sharply at variance from site to site"* (Lincoln and Guba 1985:42) and state that *"the naturalistic inquirer can make no statements about transferability for his or her findings based solely on data from the studied context alone"* (Lincoln and Guba 1985:217). They suggest the researcher should supply detailed contextual information 'thick description' in the research report to allow others, in other settings to form judgments in relation to compatibility. While agreeing with the validity of their core argument which emanates from a constructivist perspective, I would suggest it may be possible for the researcher to abstract core principles and processes that are epistemologically 'open' and therefore may be adapted to local contexts, knowledge and culture. I hope the key findings of this study may be utilisable in this way.

Chapter 5 Experiencing Trauma: Entering a Liminal Space

Introduction

The findings of this study are reported in three chapters. This chapter "Experiencing Trauma: Entering a Liminal Space" reports on the individual, lived experiences of trauma recounted by the social work service-user participants in this study, the meanings they attributed to their situations and the socio-cultural forces that shaped their experience. Findings are presented in relation to three key themes (i) changed situation or circumstances: (ii) changed sense of self; (iii) feelings of trauma and loss. A range of sub-themes, arising from the data analysis are discussed. At a further level of abstraction a meta-theme of 'entering a liminal space' is proposed.

In Chapter 6 "Attributing Meaning and Responding to Change" the reflexive experience of living through trauma, the ensuing search for meaning, oscillation between coping and not coping, negotiation of changed circumstances and re-evaluation of priorities are explored. The individual initially displaced in a liminal space, is relocated as central to change and transition.

The role of social work in relation to these change processes is explored in chapter 7 Social Work Co-Constructing a 'Thirdspace', drawing together the perspectives of the three groups of research participants to contextualise the role and practice of social work within the culture of the Emergency Department and the context of trauma experience. At a further level of abstraction the concept of social work as a 'thirdspace' at the interface of these and other realms of experience is proposed. The elements and processes of social work practice in this 'thirdspace' are discussed illustrating the inter-subjective nature of the change process. Finally service users' reflexive views on the contribution of social work to the phenomenology of self-(re)enactment through trauma are presented.

This chapter focuses on the lived experiences, feelings, issues and concerns that emerged for participants of this study who had availed of the Emergency Department follow-up social work service, following a traumatic life event. The meanings people have attributed to their experience, the impact on relationships, parenting, work, study and friendships together with more generalised effects on their orientation to the everyday, social world are discussed. Research participants outlined a range of painful and difficult experiences and emotions, intensely felt and enduring for periods from weeks to months, following experiences such as road traffic accidents (Dave, Kathy,

Richard and John), self-harm (Alison, Paul and Sarah) wrongful incarceration (Michael) and occupational injury (Anna) and in excess of a year following domestic violence (Paula) and traumatic bereavements (Brigid, Linda, Eileen and Therese). However Dave's initial trauma experience was a road traffic accident further to a sequence of secondary stressors he became depressed and suicidal. He was diagnosed with Post Traumatic Stress Disorder and was the only participant in the study to have this diagnosis. Dave's trauma reactions also endured for in excess of a year but lessened in intensity following medical and social work intervention. The collective experiences of the participants would suggest that although people affected by trauma have many feelings and experiences in common, trauma is not a fixed, teleological experience but is situated and localised and is experienced as shifting and changing over time.

Although the emotions and experiences recounted will be familiar to many people who have experienced potentially traumatic events, others do not seem to experience significant trauma reactions. In discussing criteria for referral to the social work service, a senior member of the emergency department nursing staff who participated in the study suggested that a person's response to a traumatic experience may be more significant than the nature of the experience itself

> *"....I suppose really it depends on how they present at the time and if they're particularly anxious and upset and it is particularly traumatic for that person, then yes, I would refer on - but it wouldn't be every situation, definitely I wouldn't send every person who comes in with a traumatic event....."*
>
> (ER Nurse 1)

In undertaking this practitioner research study I found ample evidence of the ontic reality of trauma and of the trauma reactions commonly documented in the literature including intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity (DSM 5). However these reactions were not articulated as discrete phenomena but rather in relation to their meaning in relationships and in orientation to and participation in the everyday social world. Lived experience of trauma, is already meaningful as it impacts (Heidegger 1927/1962; Bracken 2002) and is shown in the analysis to be embedded in everyday interactions and cultural practices. Trauma is therefore understood as embodied and inter-subjective in nature arising in the context of relationships and circumstances rather than a discrete, internal emotional state. This reflects Heidegger's hermeneutic phenomenology which asserts that people's experiences are mediated through practical engagement in the world. According to Bracken, Heidegger's position is

radically different to that of traditional psychology which proposes an internal subjective realm of the mind relating to an external objective world:

> *"Heidegger offers us an approach which insists on the embedded nature of human reality, a reality in which the cultural and temporal are not merely additional factors which can be added to an independent psychology but are in fact a priori dimensions of our reality which allow for a psychological world in the first place."*
>
> (Bracken, 2002:130)

A key finding of this research was the inter-relatedness of three levels of experience (i) feelings of trauma and loss; (ii) changed sense of and experience of self; (iii) changed situation or circumstances in the narration of trauma experiences. In telling the story of their experiences the participants moved readily between these dimensions. Eileen described the fundamental changes she experienced in bereavement

> *".....so when I came home..... I had no-one only myself, you know, and I'd no purpose or any reason in my life at all, so I just.... nothing meant anything to me, you know, you were just confronted with this emptiness and you know, everyone was going their way and although everyone was nice to you and good like, at the end of the day, you just had to go home and you didn't even know where to sit or what to do, you know, it was just a very empty lonely time, you know."*
>
> (Eileen)

Feelings were seen to arise from changed circumstances and were often co-articulated with ways of modifying, avoiding and coping with these feelings.

> *"It's overwhelming, like absolutely beyond belief, and I never would have ever, ever believed the black hole was just so big and vast I'd never have believed your world would fall apart. But it in fact does, you know. I couldn't believe the emotional pain, it's absolutely staggering, really was staggering, you know....But em, that busy, busy, busy thing is how I coped .....I wasn't avoiding it, I was just waiting until I was stronger and able to let it in, you know. That was really, really important because I couldn't stop being busy....."*
>
> (Brigid)

Some people described the ways experiences and feelings of trauma constrained social interaction and social functioning thus shaping the experience of daily living and impacting on the situations and circumstances people 'found themselves' in. Following

an altercation with another driver Michael was charged and wrongfully incarcerated (he was released on appeal). He was very traumatised from the experience, resulting in referral to mental health services for assessment and to the social work service

> *"…. I was put in prison for something but I didn't do.... and.....I was fined a lot of money, my car was taken away, my livelihood was taken away and that's what brought me down….At that time there was more bad days than good where as now things have turned around ... There's more good than bad..... it still comes back… you like you still think back that you were put in prison for no reason."*
>
> (Michael)

Heidegger's concept of 'Befindlichkeit' as explicated in Bracken (2002) is applicable to analysis of the emerging data. Bracken suggests Heidegger is referring to something like 'mood' or 'feeling' or 'state of mind' but cautions that 'moods' are not simply 'things' that can be analysed in an unproblematic way. Rather they are part of the way in which the world is revealed to us, they allow us to be 'attuned' to the world. They should not be thought of as purely internal or mentalistic, this would misrepresent the true nature of our experience rather they encompass a background cultural or social dimension. Accordingly it is only in the context of our background cultural orientation to feeling that we can have individual feelings and mood. (Bracken 2002:132-133)

Drawing on Gendlin's translation, Bracken shows that the concept of Befindlichkeit captures the dimensions of being situated, one's sense of how things are and how one feels – all components of a response to the everyday question "how are you?"

> *"'Sich befinden' (finding oneself)….has three allusions: The reflexivity of finding oneself; feeling and being situated. All three are caught in the ordinary phase, 'How are you?'. That refers to how you feel but also to how things are going for you and what sort of situation you find yourself in."*
>
> (Gendlin (1988:44) cited in Bracken 2002:132)

Taken together these three dimensions, correspond closely to the emergent themes in the data and address the interactive relationship between people and their social contexts integral to systemic thinking in social work (Pincus and Minahan 1973; Payne 2002) and social work's 'person-in-environment' perspective (Karls and Wandrei 1994; Gitterman and Germain 2008). Therefore they are used to structure the remainder of the discussion of the research participants' narratives of their experiences in the immediate aftermath of their trauma experience up to the time they first attended the social work follow-up service at the hospital. The timespan prior to referral to social

work ranged from same day referral in situations of self-harm to six months for some of the people experiencing bereavement. Following the thread of peoples' narratives, the discussion begins with Changed Situation, moves to Changed Experience of Self and then to Feelings of Trauma and Loss. However, as discussed, these dimensions were experienced and recalled as being inter-related.

Changed Situation

This tended to be the entry level for narration of trauma experience whereby people told a story of what had happened and how their life had changed, for some irreversibly, particularly those who were bereaved but also people who had a very significant trauma reaction which had negatively impacted on relationships, work life and on their own well-being in a fundamental ways. Others talked about 'having got their life back' and ultimately re-living a fulfilling life or being in process of re-building their lives. Change was an all-pervasive theme in the study and for most people the change in question was completely unexpected, although for some it was already feared but unarticulated, although no less shocking for that. While change triggered by the traumatic event(s) people endured was painful and unwelcome for all, in time some people chose change for example from familiar places and routines as a way of coping. The sub-themes in this section are changed circumstances, warmth gone out of life and choosing change as a coping strategy.

Changed Circumstances

Most research participants described a radically changed life at the time they first accessed the social work service. For people who were bereaved this encompassed a profound sense of displacement and loss. Brigid remembered the moment of realisation that her life was changed forever

> *".....you're going home from work and it's the realisation that he wasn't going to be there, and I was driving home to a completely different life. A completely different life.....you know."*
>
> (Brigid)

For some people the irreversibility of the change brought a sense of despair and loss of hope of life ever being better given what had happened. This was Linda's experience

> *".... and I just you know keep thinking you know the only thing that would make me feel better is if my dad was standing in front of me and I was just after having a nightmare basically you know...."*
>
> (Linda)

For others it was a change in their mood and perspective that triggered changes in close relationships and in the material circumstances of their lives. In a joint interview Dave and Kathy (a couple) described the all-pervasive change in their situation due to Dave's loss of interest, tiredness, withdrawal, low mood and irritation with family and friends in the aftermath of his accident.

> *"Absolutely everything [changed].....Yeah, I mean I had so many hobbies and everything else, I was taking lessons and all that, I didn't care, I just stopped.....Em, work was affected by it, you know, absolutely every single part of your life that you can think of your hobbies, your general life, your friends, your family, the whole lot, just completely changes and at the time you think it's everyone else who's changed, you know, I mean, when I was fighting with most of my family, I honestly, honestly believed that it was their fault."*
>
> (Dave)

On the other hand for Michael it was change in his material circumstances and work life that contributed to feelings of depression

> *"....I was fined a lot of money, my car was taken away, my livelihood was taken away and that's what brought me down...*
>
> (Michael).

For all participants feelings, perspectives and circumstances appeared to be held in relation to each other and change at any one level triggered changes at other levels with significant consequences.

Warmth Gone Out of Life

Experience of changed situations extended beyond the actual changed circumstances to their meaning at a more existential and social level.

Brigid talked of the warmth being taken out of life

> *"But after the numbness, there were quite a few times, there was a sense of just blackness that would come in on top of you. Just this….like somebody just vacuumed out the warmth…… in life."*
>
> (Brigid)

Many aspects of day-to-day life lost former meaningfulness. While many participants continued to part-take in social activities the joy and enjoyment of being involved had gone, replaced by a sense of duty to others or an idea of doing the right thing which translated for some people as *'going through the motions'* but being quite detached. Therese explained as follows

> *"I don't really enjoy them; I couldn't say afterwards well I'm glad I did that. I wouldn't feel that sort of, I'd feel a relief that I had actually done it and it was over and that was something out of the way for another time…..I would like to be able to take pleasure in some things, and to look forward to doing some things without having to go through them as a chore and something that you have to do, or doing them because friends expect you to do them or because they're doing it for you and I would find it very hard to say No in that situation. No I don't want to go. I would rather go because I know if I said No, they'd try and persuade me to go. So it's easier to just say yes and be there in body but not in spirit."*
>
> (Therese)

Linda's experience was similar and she found she was withdrawn and distracted in the company of others

> *"…..you go into work and you know you get into conversation with the girls....I was taking part for the sake of being polite and answering yes and no ahmm not necessarily only in work but with my friends outside like you know just going down to the pub, I was finding there for a while that I just didn't want to be... I just basically wasn't interested like you know and it's not because they'd be boring or it'd be nothing to do with that it'd just purely you couldn't care less who they were talking about because you just weren't interested in it you know....."*
>
> (Linda)

Choosing Change as a Coping Strategy

Change wasn't always viewed negatively and some changes were deliberately made as ways of coping. Brigid temporarily changed her living arrangements to avoid encountering the absence of her husband and the emptiness in their home. However she soon became worried that this could be avoidance of grief on her part. Understanding her reactions and coping strategies in a wider frame of bereavement was very reassuring for Brigid and was identified as a positive outcome of social work. Others found an expanded knowledge of trauma helped them understand and be less frightened of their own often overwhelming feelings and negative reactions. Brigid explained

> *"Like I moved in with my parents for a while....like I was keeping everything deliberately different so that I wouldn't have to face the gap, because it's when you go back to the routine of life, that the gap appears, you know. But I did know what I was doing, and when I met [social worker], I found it great because she was reassuring me that this was Okay to do, because I would be always very very very afraid of avoidance..... that has been one of the critical things for me....the constant reassurance and reminder that all this is normal, and that everything is going on, as bizarre as it feels, that it is going along within some normal frame of bereavement or grief....."*
>
> (Brigid)

For others changes sought were more permanent. Therese found moving house to be a necessary long-term survival strategy

> "..... I found being in the house that we had lived in since we'd got married and the kids had been born in, and I came home from the hospital to, I found that very hard, and I found I hated being around it. Some people prefer being around familiar things, but I actually hated it....things that had been associated with Martin, I found that extremely hard and I eventually ended up selling the house and moving."

Changed Experience of Self

The second dimension of Heidegger's concept of Befindlichkeit – 'how one finds oneself' or 'how things are going' proved very relevant to this study. Participants' reflexive experience and sense of themselves centred the following thirteen themes – the impact of pervasive, all-encompassing loss; loss of confidence; confronting

internalised cultural beliefs and norms, mood changes; hyper-vigilance; physical effects and embodied trauma; re-living trauma; withdrawal, detachment and avoidance; not coping; negative thinking; poor concentration and memory; altered sense of time; and shaken sense of safety and security. For some people these changes prompted existential questioning and a quest for meaning. For others they gave rise to increasing self-doubt and self-loathing, leading to social withdrawal.

The Impact of Pervasive, All-Encompassing Loss

Participants who were bereaved explained their loss as all-encompassing and pervasive, impacting on their capacity to interact with others and participate in everyday situations. They carried an enduring pain and sadness. Eileen felt her world had collapsed

> *"I was devastated, I didn't know what to be doing with myself, you know, I just felt everything, you know, my world had collapsed, I kind of felt that nothing was worthwhile.."*
>
> (Eileen)

Although participants reported fleeting happy and fun times, light-heartedness proved difficult to sustain. Many struggled with not knowing if or how these painful feelings could ever resolve as Lynda explains

> *".... you know somebody you love that died and it's a loss, it's a big loss and I mean you just feel your heart is broken basically and you're never going to be the same after it..... but there's just this ache inside that even where I do have a genuine laugh for a couple of minutes or an hour or whatever it just, it just goes like it doesn't seem to stay you know and like.....I can never see myself getting back to the old ahmm Linda say..... I can't ever see that happening you know maybe I'm..... it's wrong of me to expect that to happen I don't know it's just something I would like to happen..... but that's just not going to happen."*
>
> (Linda)

Loss of Confidence

Many participants described a loss of confidence after a trauma, which affected their ability to interact effectively with others. For some this meant a withdrawal from others thus closing off potential sources of support

> *"...Yeah I'd lost everything confidence, the will to do things like everything was just taken from me....it felt easier just to shut everything out rather than open up and talk everything through..."*
>
> (Michael)

Anna had also become withdrawn and had strong feelings of inadequacy

> *"....I was actually kind of feeling low in myself and I was feeling so inadequate, inadequate in a lot of things because everything that I was doing, I felt, everything that was going wrong, I was blaming it on myself, because I was feeling so low in myself, like.....anything that was going wrong, I was saying it was my fault.....I was gone quiet in myself ...It didn't do my confidence any good at all, like you know."*
>
> (Anna)

Feelings of inadequacy were commonplace with other participants feeling they could do nothing right or that everything they were involved in ended badly. For others, loss of confidence was further reinforced by negative reactions of others particularly people who held positions of power in their lives such as employers, managers or supervisors. The obstructive attitude of Dave's boss was a significant secondary stressor for Dave

> *"Because my confidence was completely knocked. A crash like that knocks your confidence anyway, but then you're up against you know, you're not allowed the time off work and they were fighting with me over wages, it cost me a fortune and all this kind of carry-on, and I was just thinking, that didn't help the situation whatsoever... I think that made it a lot worse than what it was, em, I'd lost my confidence, whatever confidence I had, I lost, and he was just giving me the odd kick, just to remind me to stay down there, type of thing, you know"*
>
> (Dave)

Confronting Internalised Cultural Beliefs and Norms

Many people struggled with cultural norms and internalised discourses, which no longer fitted their lived experience. A number of the men in the study talked about how troubling it was when their feelings and behaviour contravened their internalised expectations of how men should act. Their reaction was to try to suppress their felt vulnerability, however this tended to backfire. By minimising the effects of the accident to his family Richard evoked their concern and his daughter suggested his reluctance to talk about how he felt was *'a macho thing'*

> *".....ah I have two sons married, they don't live with me..... them comin' over saying "dad are you alright?" "of course I'm alright, there's nothing wrong with me you know....." And as I said.... my daughter said it's probably just a macho thing with fellas you know like sayin' ah sure there's nothing wrong with me...you know....I have to just face it, you know. It's not easy. It won't be easy to do that, it'll be a little emotional hurdle, but I'll have to, I'll have to, you know..."*
>
> (Richard)

Dave also had an internalised model of how men should behave which on reflection he feels he learned from his father and those around him. This led him to keep his distress to himself. He also had a strong sense of responsibility as the main breadwinner in the family, which was experienced as an added pressure

> *"I mean...ahmm it's not the kinda done thing for a fella to crumble, know what I mean, that's what I thought then, I don't think that now, but you know, you had to be strong, you had to keep the chin up you know what I mean, I had to...ahmm, like I wouldn't discuss it really with Kathy.... so I just kept it to myself.....that's the way me father was, that's the way..... everyone around me was 'know what I mean.... it was just the done thing, you had to .... yeah society, the man had to be the strong one you know what I mean although Kathy [laughing] is probably that bit stronger than me, you know it made no difference, I had to keep the chin up, I had to keep going although I wasn't really keepin' going, I was fallin' apart you know what I mean ahmm but.....I felt totally responsible financially that I had to..... I mean in fairness I was earning good money, you know, I had to keep this money coming in every week you know or things would just fall apart ahmm do you know what I mean?"*
>
> (Dave)

Fear of reputational damage in the event of taking time off work meant that some of the men returned to work prematurely as they saw it. For Therese an issue was loss of her former valued identity as an independent woman in her marriage, a self-concept she found she had to revise in her changed situation. She found it difficult to acknowledge dependency on her late husband but her feelings were compelling for her.

> *"I suppose I would have always felt that in our relationship....we did our own thing and we weren't totally dependent on each other, like some couples can't do anything without the other. Like we would have had separate lives in one way. Yet we lived together and did a lot of things together, but that we had our own space as well and I suppose having to admit...I would have always felt that I wasn't totally dependent on Martin and that I wasn't... like I could survive very well, I didn't need a man.....and I suppose to have to admit that actually I couldn't survive. And I suppose to have to admit that to yourself and admit that you were far more dependent on the person than you actually thought"*
>
> (Therese)

Mood Changes

Many of the participants described significant mood changes, the impact this had on others and their unease with their changed way of being. These mood changes, which were mainly characterised by irritability and angry out-bursts may be associated with hyper-arousal, an established trauma reaction (DSM 5 2013). John, who was a professional driver, felt that following a road traffic accident *'he wasn't himself'* and this had a negative impact on his relationships with his family and on his work. He went on to describe how he regained his former positive disposition

> *"I was absolutely unbearable to live with....but I felt after the accident...I was just biting at people, being sarcastic with people, snappy at people. Very frustrated.....But at the same time as you know, there were times there when I was awful in my car and I actually ended up going home, because I wasn't level headed. And I just felt that I wasn't only a liability to myself, I was a liability to the people in the car. Now, as I say, that wasn't me... but at the end of the day, when you know there's something wrong, don't moan about it, do something about it. That's what I done."*
>
> (John)

John went on to explain that growing in insight and understanding of his negative reactions and switching to positive thinking allowed the negativity to dissipate

> *"I just felt angry, I felt angry. You know, I felt angry with the person that hit me, I felt angry with myself at that time, you know, because I felt I could do something to prevent the accident but when I looked at it realistically, I couldn't do anything, I couldn't do anything to avoid the accident. And then I was looking at the positive side of things, that's why, and that was the change that I felt…*
>
> *Because I was looking at negative things, negative ways. I was looking negative, negative, negative, in my head all the time. Whereas I changed, the tables turned and as I say now I am looking positive and that's how I succeeded…."*
>
> (John)

Dave described severe moods and overall personality change and the consequences for him, his partner and their child following a road traffic accident

> *"……..I put Kathy and Hugh through sheer hell……I was a bastard, you know what I mean….morning noon and night….I never smiled. And I was the most smiliest, happy-go-lucky messer you ever met in your life, you know…. So I did change like that……Also like, before the accident, I was great with Hugh, I was always, there just wasn't enough hours in the day for me to spend time with Hugh, you know. That changed completely……..Most of it just became completely shut off…."*
>
> (Dave)

Trauma clearly impacts relationships, families and wider networks. Dave's partner Kathy described how she changed too, as a reaction to Dave and how her stress manifested in work

> *"You know, and he [Dave] wasn't the person that he had been, I wasn't the person that I'd been, you know….. I also built up a lot and I think how I let it out was through work…..by working extra hard, you know… my boss….I had screaming matches with him which was SO out of character."*
>
> (Kathy)

Hyper-vigilance

Hyper-vigilance is part of the cluster of trauma reactions associated with heightened arousal (DSM 5 2013). Many people involved in accidents found they were on alert for dangers on the road when driving or travelling as a passenger. Following an accident at work Anna found she was constantly warning her colleagues of potential hazards

> *"I'd be saying 'Oh, be careful, be careful!'"*
>
> (Anna)

Dave described the escalating seriousness of hyper-vigilance for him

> *".....it went from being shaky all the time to... a cup sitting at the end of the table. I became nervous then that the cup would fall off the table. You know, em, it could be you know, it started small, it started with small things...It could be driving up the road and you think the child on the opposite side is going to cross over the line, or he could be five feet away and he looks like he's about a foot and a half, or sometimes it looks like as if it's an inch and a half away from you. It started off small and then it started to get bigger, you know....."*
>
> (Dave)

Physical Effects and Embodied Trauma

People reported a range of physical reactions including muscle aches, headaches and diarrhoea. Tiredness and inertia were experienced by a majority of participants

> *"I was coming home from work and I know I was tired, but I was really, really jaded, and I felt that I used to have to go to bed some days, like you know, granted I know I was tired, but I think mentally I was tired as well.....as well as physically to an extreme, I know. I used to have to go to bed and stay there for two hours at least to unwind..."*
>
> (Anna)

Insomnia was also common. Some people managed it with resignation and adjusted their sleeping pattern accordingly while for others it was troubling and plausible explanations were sought

> *"There was no point in going to bed, I was wasting my time, I couldn't go to sleep, so I would stay up...."*
>
> (Paul)

"I was sayin' that's only a fright.... that'll go, there's nothing wrong with me, like I say the macho thing there's nothing wrong with me, yet I was twisting and turning, two hours sleep and I was saying go asleep, yeah it's the pillow, my head's killing me, it wasn't the pillow..... it was me twistin' and turnin' 'cause I couldn't sleep you know "

(Richard)

Sexual problems were also identified

".....the problem that I had was after the accident is that I had a problem with me trying to get an erection.....which means that as well, that I couldn't have sex with my wife"

(John)

Re-living Trauma

Many of the participants relayed accounts of incidents and moments when something would catapult them back into the feelings experienced during the initial trauma and its aftermath. This may be understood in relation to intrusion symptoms, a criterion for diagnosis of PTSD (DSM 5 2013). Some people in the study were very conscious of what their 'triggers' were. Some went to lengths to actively avoid them. Others faced them every day. For Michael who had a driving ban the trigger was his car

".....the car was sittin' in the garden for nine months, so like that was there every day and even when I was working through the scheme I'd have to get on a bike and I'd be lookin' at me car, that, that was hard enough to go through that and that was like reminding you every day that something bad had happened to ya and it was just... it was wrong.....If I had done something then it wouldn't have them as bad, I wouldn't have felt as bad anyway..... and that was it then."

(Michael)

Similarly for Kathy

"we'd pass someone by on the road that was in a truck and that would be the spark. So there was so much of my life was just triggered off, you know, it was almost like electricity, you know."

(Kathy)

For others items in their home environment, arranged as they had been on the day a family member was found dead, had become symbolic reminding them of the circumstances of the death and re-engendering feelings associated with it. Some people found re-attendance at the hospital difficult, as they re-lived the sequence of events leading to the death of their loved one. Other people relived the moment they encountered or had news of a trauma and re-experienced the associated painful feelings. Often being asked about and talking through what happened set this process in motion. Continuously reviewing the events leading to the trauma, questioning if things had been different, could there have been a different outcome was a very common experience particularly early on. This is usually troubling, often evoking feelings of guilt and regret. Therese explained this experience as follows

> *"Oh reliving things that had happened, and trying to make sense of them, and coming up with no answers and feeling that, had I done something differently, or had I been there the day he died, or had....a hundred and one things went through my mind.... if things had been different."*
>
> (Therese)

Withdrawal, Detachment and Avoidance

Many of the research participants found themselves to be withdrawn, detached and engaged in avoidant behaviour as a means of escape from reminders of what had happened. This had significant implications for their ongoing participation with others in their day-to-day lives. The intrusion/avoidance dynamic is a hallmark of diagnosis of PTSD (DSM 5 2013). Avoidance can take the form of both physical and emotional distancing from others, avoiding significant features of the environment for example an area where an assault took place or a room in a house where a person died or avoidance of the actuality of one's circumstances for example not acknowledging the finality of death. In addition to practical difficulties such as having to take longer routes to work to avoid the site of an accident, avoidance can lead to isolation from usual sources of support and cause concern to others. Avoidance can be a conscious coping strategy or an unconscious defence mechanism to protect against overwhelming sensory stimulation and painful feelings associated with the traumatic experience.

Linda who had found her dad following his death by suicide, avoided talking about her experience to her family and explained how threatening it would feel if she were asked

> *".....I think deep down I'm more afraid, I don't know whether afraid is the right word ahmm I just didn't want to kinda go into any of that with anybody you know, I just, I mean I don't know like I think that's what I am afraid of deep down is if anybody asks, I don't think anybody is actually going to come out and say Linda what was it like or what way was he, I couldn't imagine my family, comin' out with that but at the same time I'd be a bit afraid if they kind of said oh well how was it for you.....even if they feel they would be doing me good I just wouldn't be ready for that kind of confrontation about it you know."*
>
> (Linda)

Anna describes her reaction on initially re-entering the room where she had been injured in an accident in her workplace and had subsequently avoided for as long as possible

> ".....when I went back up into the room, I just froze. I couldn't understand what was wrong with me. Now, I kind of pottered around, the sweat came over me, like you know and I just felt like I was going to collapse..."
>
> (Anna)

People outlined various strategies they employed to avoid painful feelings and realisations. Michael's painful memories, evaded the myriad efforts he made to avoid and control them

> *"..I tried everything like goin' for walks, read a book, read the newspaper, but everything would bring you back to square one, like it was still there, you were trying to block it out at that time whereas you couldn't face up to the problem you'd do things to occupy your mind but none of them would work until you've actually been able to deal with problem, face up to it. Like you'd pick up a newspaper and see something and that would bring you back to square one and you could only keep occupying your mind for so long. You'd be sitting down watching the telly and that, it brings you straight back to what you're trying to block out...the way you were feeling bad, feeling down, depressed and what had gone on, the injustice that you'd gone through and things like that....."*
>
> (Michael)

Therese experienced discomfort in social situations, which she tried to deflect by telling people she was 'fine'. This was typical of many people's experience of having a version of events at the ready or phrase to use in response to questions about how they were or what happened. Otherwise they found these situations more threatening or confrontational

> *""I hated going out.....people would ask how you were and I'd just say fine, and that was, some people, that was all they wanted to hear really. I suppose if you really did tell them, they wouldn't have been able to cope with how you really felt. So most of the time, I would just say I was fine and leave it at that."*
>
> (Therese)

In a joint interview Dave's partner Kathy recounted a cycle of Dave's anxiety, distancing from her and inability to sleep which in turn exacerbated the problems they were both experiencing

> *"The accident had its effect and that made you nervous and jittery and his confidence was strapped, you know, he couldn't talk about it, I would try and bring up the subject to try and get him to talk about it, but that was like a red rag to a bull.... nothing was working smooth, and I do think that was as a result of everything building and building and building, it was just escalating I was just was like, I cannot handle this anymore..."*

Dave went on to describe how extreme distancing from others can come to a point where feeling bad is all that feels real and how suicide can seem like a desirable option

> *".....although you knew you were there, although you knew, you know, like, people were beside you, blah blah blah, it wasn't real. You know, the only thing that was real was your feelings or how you felt inside. And that was CRAP. That was depressed, you know and such a downer, you know, did you ever get in a bad humour and you get depressed, where you kind of, you know, yeh, you kind of get a grip and you shake it off and whatever, no matter how hard you try to do that you couldn't do it. In fact, the more you tried the worse it got... everything else wasn't real, it was all, you know and it's funny because it's nearly like what I said earlier, you nearly what's the word romanticise suicide....."*
>
> *(Dave)*

Therese talked about distracting from the depth of her loss by being busy with her children's lives until she couldn't rely on that anymore and then overwhelmed by the responsibilities she had to face alone, she too fleetingly saw death as an escape

> "*I probably felt that if I kept myself busy, I didn't have to think about things too much and that suited me - because I think the thought of having to make decisions... I didn't want to think that Martin's dead, I didn't want to think that I was going to have to face this on my own; I didn't want to be the sole person making decisions, to have the whole responsibility of the children. I remember being in a car park one day and crossing the road, and there was a car coming up, and I actually wouldn't have minded, I remember feeling that I didn't care if I was knocked down*"

Paul used alcohol to avoid facing stress but this in itself had become a significant problem

> *"You know because I was getting worried I was getting really worried I was going off the beam just drinking cans.....no sleep no nothing now at least I am getting away from that and you can see the effects of it."*
>
> (Paul)

Not Coping

Many participants described instances of feeling overwhelmed and being unable to cope, for some people this emerged immediately while others coped in the initial aftermath of trauma and felt more vulnerable as time went on and as others seemed to be getting on with their lives. Kathy described the immediate impact of the accident on Dave's ability to cope

> *"...he was back to work, like, the day after the accident, the following day, and he was a nervous wreck, from day one in every sense, he would be on the phone to me, em, everything was knocked, he didn't know where he was going, he'd be ringing me saying, how do I get to this place? And I knew that he'd been there before..."*
>
> (Kathy and Dave)

Michael found he wasn't coping and was staying in bed as a refuge from pressures he felt

> *"I just couldn't cope, couldn't cope like I was spending more time in bed than the average person really...."*
>
> (Michael)

Negative Thinking

Negative thinking was commonplace. For most people who experienced it, they felt they had little to contribute and thought others thought badly of them. For some, negative thinking became very entrenched and they experienced paranoia. Sarah a young person who had self-harmed found it difficult to believe people would like her

> *"Ahmm you know I wasn't, I didn't understand why anyone would like me and because I was so quiet and had really low self-esteem...."*
>
> (Sarah)

Anna described how negative thinking in relation to the contribution she could make to conversation led to her withdrawal from her friends

> *"Even my friends said, like you know, I was kind of staying away from them, because I said, no matter what I was saying, I would feel I was saying the wrong thing, and I wasn't in the humour to be even listening to them, to be honest, you know. Because I think I felt as if I was miles away, as well, you know"*
>
> (Anna)

Dave went through a period of feeling a failure

> *"I'm not saying that I was a failure, or that I am a failure, because I'm not. But I felt like it back then, you know, as a person I'm a failure, everything I touch is going sour, you know, everything I touch, you know, every person I touch like Kathy, I mean I was fighting with absolutely everyone. I'd lost 90 per cent of my friends, I'd lost 90 per cent of my family, they weren't talking to me. You know, my wife, Jaysus, God only knows how she stayed with me. You know, even my own son didn't want to be with me! You know, now that in itself, on top of what you're going through doesn't help, but it's you, it's me, who caused it, nobody else and it's me who has to fix it, nobody else!"*
>
> (Dave)

Dave described negative thinking turning into paranoia

> *"....a kind of paranoia, which I never went through before...my head started going I used the expression like jelly, started turning to mush, you know, because you'd be analysing and you'd be mulling everything over in your head, over and over again, the same thing, you know, and you'd be looking for an answer, but you'd be, it sounds.... everything is repetitious, it's always the same thinking, the same.. you know.....I've come out of it and because I understand it a little bit better, it's just been simplified by yourself [social work practitioner researcher] and by Kevin [psychiatrist], which makes it easier for me to look back and say, well Jesus, I was making a mistake, I was taking things up wrong, I was being paranoid. But that's Okay, because now, I can kind of right the wrongs and you know, not be so het up and caught up and depressed about the whole thing, you know what I mean?"*
>
> (Dave)

Poor Concentration and Memory

Participants described being preoccupied by their loss and distress to the exclusion of everyday commitments

> *"You can't concentrate on anything only the pain and the loss."*
>
> (Eileen)

For most participants inability to concentrate and forgetfulness eventually led to frustration for themselves or others. Therese described her children's' reaction

> *"I wouldn't have even thought of the things, you know.....I suppose my mind was just distracted and I wouldn't have thought of all those things that needed to be done, you know. So I was quite happy to let anybody who wanted to take over and do it.... And I found that I was very forgetful, and that used to irritate the children because they'd tell me things and I'd forget, or they'd ask me to get them things and I'd forget about them....."*
>
> (Therese)

Altered Time Structure

People described an altered sense of time in the early aftermath of trauma coupled with a sense of going through time on 'auto-pilot' as these extracts from interviews with Brigid and Therese illustrate

> *"Things were very... early on, I think, I really don't have recollection because everything just zooms up into days, even though it has been months and I had no sense of time, but it was maybe two months or something, I don't really know, but I was very numb, so I was very unaware of what was happening, I just carried along, I had no sense of time at all, none at all, just about functioning, I suppose, just getting up every day, I suppose wandering through a day, arriving at the other end. I don't realise it until I look back, that 90 per cent of what you do in a day is I suppose on auto-pilot, because you're still getting to go ahead with 90 per cent of stuff, you're still getting up and dressing and eating and going through the motions of a day, the same as everybody else, like, I wasn't lying in bed, falling apart, you're still getting up and going through motions."*
>
> (Brigid)
>
> *"I remember the day Martin died, the next day, you know, that day, well the next day, friends just came to the house and just took over and started organising things that I hadn't even thought of, you know, things that needed to be done, or things seemed to...it was like being on a merry-go-round, and you just had to stay on it, you couldn't get off and these things were all happening and you were part of it, but you weren't really in control of it. It was just happening, you were a part of it, but you weren't in control of it."*
>
> (Therese)

Shaken Sense of Security and Safety

For many their ease with 'being in the world' and their sense of safety and security was undermined. This corresponds to Janoff-Bulman's work on shattered assumptions in relation to the order and meaningfulness of life/the world which cause people to move from feeling safe in the world to feeling vulnerable (Janoff-Bulman 1992). Loss of control over one's life and one's destiny and a sense of powerlessness are significant features of trauma (Herman 1992, 1997; Dunn 2001). It has therefore been argued that trauma support services should re-establish safety (Herman 1992, 1997, 1998) be

person-centred (Dunn 2001) and empowering (Bula Wise 2007). Some people in the study, feared something else bad could/would happen. This often translated in intense worry for the well-being of family members especially when away from them and for some a compulsion to keep checking if they were ok. Linda spoke of her fear of something else bad happening in her family

> *"....and then you have this fear that because you know what it's like to lose someone like that, you fear then that you're going to lose somebody else..... and you're kinda saying well I, my mam is going to bed at night....I keep thinking am I going to see her in the morning you know.....my sister going out or my brothers or whatever you're kinda sayin' am I going to see them again because..... I don't know whether it's because of the fact dad's death at the end was very sudden, it was just..... he was there and then he was... and I don't know if it's because of that or..... that's just what happens when somebody dies, I don't know..."*
>
> (Linda)

Brigid described a heightened sense of her own mortality

> *"....just drive, you know, keep driving. At the same time very aware that Eamon had been killed like, on a bike, and feeling like, shit, that could happen to me any time, and you know."*
>
> (Brigid)

Many people found they had become very conscious of the fragility of life and empathised with others in traumatic circumstances

> *".....I suppose when you're before anything happens like that, everything is you feel you're indestructible and everything, you can do everything and you can do everything up to a point but I suppose you realise that the reality of life, that life is for living and if something happens, I mean when I look around and when I hear people on the radio every day, a young man, twenties, after having an accident, he's killed. Someone was cycling along the road and they were young. Well, like, they're all kind of like, just snippets of news and someone is dead. But you know, when you lose someone, you realise the consequences of that, that, that person is just gone, like they're just lying there dead....they're gone. And the people that they left behind, all the trauma....."*
>
> (Eileen)

Michael had lost confidence in the state judicial system to deliver justice or protect his rights

> *".....it was like a nightmare, terrified sorta all the time even to the moment when you were told you had made an appeal and you were going to court...I was still terrified then, when you were out of there I was still terrified in case the appeal was unsuccessful and you were put back in..... but to have another judge going against him and to say I was wrongfully incarcerated, that made things ....you felt a lot easier from there on, like you knew it wasn't your fault, that something was after happening and that the justice system was wrong. That was hard knowing that you're actually put in, that someone else had the power to say well 'lock him up' and 'remanded in custody' was supposed to be the same as being on bail that's how out of his mind the judge was.... like sleeping in my bed was the same as sleeping in a prison cell the way he was looking at it.'*
>
> (Michael)

Feelings of Trauma and Loss

Participants in the study relayed experiences of intense fear, sorrow, loss and despair. Many of the feelings expressed correspond to those associated with loss and grief (Kubler Ross 1969; Klass et al 1996; Stroebe and Schut 1999; Neimeyer 2000; Bonanno 2004; Worden 2009). The interface of trauma and grief is well documented (Lindemann 1944; Raphael & Maddison 1976; Hobfoll 1991; Green 1993; Brewin et al 1996; Figley et al 1997; Horowitz 1997; Raphael and Martinek 1997) and co-occurance of feelings of loss and grief and PTSD reactions is most likely in experiences of traumatic bereavement (Pynoos and Nader 1988; Zisook et al., 1998; Bonanno & Kaltman, 1999; Barry et al 2002; Kaltman and Bonanno, 2003).

For the people in this study, the sudden onset of painful feelings was often a marker of change from their life before the trauma and life since. A number of people had suicidal feelings and a number had self-harmed. Feelings tended to be experienced as mutable, recursive and layered. Feelings changed in nature and intensity over time with some feelings subsiding and others surfacing. Feelings of trauma and loss identified from the research data are now discussed further in relation to the following twelve sub-themes - numbness and shock; pain, loss and sadness; despair and depression;

suicidal feelings; fear; panic; upset; guilt and regret; anger; feeling pressured; and loneliness and isolation.

Numbness and Shock

Numbness and shock seemed to affect people who were bereaved more predominately than those who had experienced other traumatic events. The experience of shock and numbness is well documented in the bereavement literature and is understood to be an adaptive mechanism in the early stage of grief (Kubler Ross 1969; Worden 2009). Shock can take 'the edge' off the acute sense of grief and allow a slower adjustment to the reality of what has happened. A number of people described being carried along by ritual in the early days following a death, as if they are playing a role or were outside of their own life. Often, they were subsequently overwhelmed by grief. For some people the finality of the loss took several months to sink in. For Eileen although initially somewhat cushioned by shock, she was faced with the realisation that her life had changed irrevocably when others around her resumed their usual routines

> *".....you're in shock. You don't really..... and it's only when everyone goes off and everything is over, the funeral is over and everything goes back into.... it slots back into position, but your life has not gone back because you're standing out there and your routine is gone, you know....."*
>
> (Eileen)

Therese's experience was different in that she didn't face the finality of her loss for some time

> *".....so it kind of initially didn't feel that he was never going to come back. That dawning didn't come for, I suppose, a good while after.....but even at the funeral time..... it felt like I was at somebody else's funeral, I didn't feel as if it was my husband that had died. I felt that those days just happened and other people kind of took over and did the things....."*
>
> (Therese)

Brigid also described numbness that endured for some time but there were stark instances that cut through the numbness to unbearable grief

> *"..... the day that we put the cross in the grave was probably the only day I can remember where it was quite unbearable (crying) but after the numbness, there*

were quite a few times and I was... there was a sense of just blackness that would come in on top of you."

(Brigid)

Pain, Loss and Sadness

Research participants who had experienced traumatic bereavement described deep emotional pain consistent with findings of studies of sudden death (Fielden 2003). Eileen discussed intense feelings of pain and loss and the importance for her to face her pain fully and in her own way

"I was just full of this pain.....people have done everything for me, they've travelled to be with me, they've done everything and all, but at the end of the day, you have to face your own pain, that is the fact, that you really, you have to go through the pain and you have to sort it out. And that's why I always felt, I always felt even from the beginning that you know, reluctant; the doctors would say 'Why don't you take the tablets?' I said 'No, I said Dr .....I know myself, if I take that, it's not going to do me good. I have to face the pain. That's the kind of a person I am. I have to face it, even though it's killing me. I know that....I don't know, but I feel that, I think that I have to go through that....."

(Eileen)

Brigid described the extent and depth of the 'black hole' of emotional pain she experienced

"It's overwhelming, like absolutely beyond belief, and I never would have ever, ever believed the black hole was just so big and vast I'd never have believed your world would fall apart. But it in fact does, you know. I couldn't believe the emotional pain, it's absolutely staggering, really was staggering, you know "

(Brigid)

Brigid went on to describe a trajectory of feelings which moved from generalised, overwhelming distress to more defined feelings such as sadness and regret

"It's all about feelings, it's all about senses and feelings.....but ...the feelings change, so they shift from those big huge scary feelings to being more specific as you go on, they turn into a lot of sadness, a lot of regret, a lot of, an awful lot of just SORROW Really missing Eamon. And they just become different, they

become, I suppose emotions you can almost identify and in the beginning they're not, they're unidentifiable"

(Brigid)

Despair and Depression

Brigid captured a sense of despair at times felt by a majority of people who took part in this research in saying

"...there were a couple of nights when you just don't know, you don't know how you are just going to get through it, you know."

(Brigid)

Therese linked despair and depression. Like many of the research participants she differentiates between 'feeling down' and being depressed. Therese also talked about on how hard it is to do everyday tasks when feeling depressed

".....that awful feeling that you have..... that awful, overwhelming feeling of I suppose despair really like that nothing can shift that. And I suppose part of it is maybe a depression, that you just CAN'T.... it's not just like being in bad form, that you can kind of shake it off it's just like as if there's a weight on your shoulders the whole time and you just cannot, you don't have the energy to even motivate yourself to do basic things in the house like the shopping would have been a chore, the cleaning would have been a chore, making decisions was just impossible....."

(Therese)

Dave attributed his reluctance to say he was depressed to social and cultural stigma attached to depression

"....I wouldn't admit that I was suffering from depression, you know. Because there is such a stigma or whatever around the word 'depression'. You know what I mean?.....I think a lot of it is to do with ignorance, ignorance as in like first of all people don't want to admit they're suffering from depression. People don't want to admit they're failures. I'm not saying that I was a failure, or that I am a failure, because I'm not. But I felt like it back then, you know....."

(Dave)

Suicidal Feelings

A number of participants in the research had suicidal feelings and some people had self-harmed. Alison had taken an overdose of tablets following the break-up of her relationship

> *"I felt that nobody understood me. I felt I don't want the kids to see.... I don't like the kids being....I just didn't want to be there any more, I just...I'd had enough of relationship breakdowns basically..."*
>
> (Alison)

Paul talked about a very bad time he gone through and his desire to end his life

> *"Oh, it was rough it was really dog rough I can't believe I got through it. I really felt like killing meself, you know, I'm surprised I didn't do it just everything just sort of caved in on me you know like a massive cloud hanging over ya..."*
>
> (Paul)

Dave talked of his fear of telling anyone of his suicidal feelings coupled with fear of the consequences of disclosure

> *"It was like the night that I sat down with Sheila and Jim [sister-in-law and her husband] that I was suicidal and everything else it came to a point that I had to decide for myself do I want to get better or am I going to keep going the way I am and I'll end up six feet under d'you know what I mean? Ahmm..... and when you're suicidal and when you're thinkin' about killin' yourself that's one of the.... that's the peak of..... you know if you tell, if you can sit down and say to somebody yeah I've been suicidal, I've tried to kill myself ahmm you know and go through what I went through you have to have that same level of trust.... with the person that you talkin' to , but I never had that, I have it now.... d'you know what I mean.....when, when I first told Kathy and her sister and brother-in-law that I was suicidal, it's it's very hard, up to that point I wouldn't discuss it with anybody and when I discussed it that night, when I said it, I regretted sayin' it because I thought to myself what are the implications of what I've just done? At the same time I says to myself I'm glad I've said it because I really do need help. Now the most important thing to me when I was sayin' it was Kathy. I was afraid Kathy was goin' to leave me that that was huge...."*
>
> *(Dave)*

Feelings of Fear

Fear is one of the core reactions to trauma (DSM 5 2013). Here Richard articulates feelings of fear engendered by thoughts of his accident

> *"I know that after the accident.....I keep seein' this, I emphasise I might be repeating.....but the thoughts of a big ' artic ', that's the one thing that stuck in my mind, looking out the window of a car and you see someone at the same level as you and you have a bang or something, it's fine but when you're looking up and you see something big..... and you go shit and I just keep saying.....sugar.... you know that's one that stuck in my mind more than anything else.... though it wasn't a mad bang it was a good bang..... it wasn't a mad one but it was a good bang and that was the frightener to me, you keep sayin' this is not for me anymore, good luck.... you know?".....So it's just sittin' down and like you said yourself, sit down and look and no there's not, is that wrong and this and that, then how did I get such a shock out of such a.....like I said you pick up the paper and see.....I'll pick up the paper and say "look at that, there's two or three people killed..... I mean that family'd have to come and get counsellin'.....", me I only had a little, a small little thing you know.....so it was the frighteners that got me, there was nothing mad wrong with me it was just the frighteners you know, I put it down to that."*
>
> (Richard)

Paula re-lives fear when she sees her father who was violent and verbally abusive through her childhood

> *".....just seein' him there just makes me ah tremble all over you know.....It just has the same effect as he did in the house you know, makes me nervous....."*
>
> (Paula)

Feelings of Panic

While a number of people experienced panic in relation to fulfilling work roles or being out in public *'getting up in the morning, panic about going to work...'* which tended to relate to loss of confidence other people experienced panic attacks which were triggered by reminders of the trauma. Anna experienced panic attacks in the aftermath of an accident at work, she associated the onset of panic with returning to the site of the accident.

Here she recounts her doctor's response

> *"I had a lot of headaches after the accident and he had me on different tablets, then I had the panic attack, but he said to me about the panic attack, he said he couldn't give me anything for the panic attack, that's just time….."*
>
> (Anna)

Upset and Tearful

Dave described frequently being upset and tearful.

> *"……sitting watching television every single time I sat and watched television, I sat and bawled my eyes out for no reason absolutely no reason! I could be watching the News, or you know, something happy would happen, I mean, watching a happy programme with a happy ending and I'd be getting upset, but it wouldn't be happy upset, it would be, you know, be on a 'downy' upset"*
>
> (Dave)

Brigid identifies the need to slow down, feel her feelings and cry as almost another phase in her grief. She refers to the difficulty managing this socially saying it isn't always appropriate or convenient to cry.

> *"You know. I mean, every now and then the urge to keep moving forward stops, you know! But I feel the urge to slow everything down now. Well, I'll wait to see what happens. I'm not as scared about it as I was. Like last week, when it was beginning, I was terrified, absolutely terrified to think that it's going to be, because when it was coming in, it was just so overwhelming. And I'm not as scared of it now, because I'm so tired now, I haven't even the energy to be scared, it's just what is going to happen and the feeling is going to be. It's not always convenient, that's all, like I want to cry quite a lot and it isn't always convenient or appropriate"*
>
> (Brigid)

Guilt and Regret

For research participants particularly those who were bereaved, guilt and regret are very persistent, difficult and commonly experienced emotions. For some of the participants these feelings precipitated seeking professional support as people find it

hard to talk through more difficult feelings with people close to them or they receive premature reassurance or reassurance that doesn't ring true, which tends to close down the conversation. Linda spoke of her guilt after her father died by suicide and recounted a conversation about it, with someone she knew who was also bereaved by suicide

> *"what he was saying to me was I still feeling guilty and that you know and I said ah I have my moments you know, you kind of, even though I would feel guilty more than moments as such, you just kinda try to gloss it over because you don't want to upset them either you know so ahmm I said ah, yeah I have my moments you know, I have my times where I'd do and I said I just have to put it out of my mind which I don't, but I just said that to him you know and he said like he did as well.....but (sighs) he came to the realisation that it was something that had it not, had happened when it did, it was possibly going to happen you know six months down the road or a year down the road and that's what everybody says about people who commit suicide, you can' t be around them 24 hours a day…."*

She had found it difficult to go to her dad's grave and explained that in talking in the social work sessions she realised her hesitancy was related to the guilt she was feeling

> *"I just couldn't bring myself to going up myself but I think you know the more I was up here and I think basically I was.....ahmm how do I put it.... I just....I was dealin' basically in my own way with what had happened and facing the fact that my dad was dead ahmm (coughs) where I was feeling so guilty about what happened to him and the way we hadn't spoken for weeks before, I kind of felt maybe he didn't want me to go up to the grave....."*
>
> (Linda)

Regret was also a very difficult emotion for people to bear as is evident from this extract from Therese

> *"Well, I would have gone through a period of regrets and oh reliving things that had happened, and trying to make sense of them….I felt maybe that I didn't support Martin enough….he suffered from depression and at the time I could never understand how that felt, and I would have said to Martin, before he died, that I didn't know how he felt, but after his death, I know that feeling, that awful empty feeling that he must have been going through…I really couldn't understand it and I couldn't empathise with it, and I think quite a lot about that, that had I really known how badly he felt, I might have done things differently, or*

I might have I mean, he was talking about giving up work and I'd dissuaded him from doing that and in hindsight now, and knowing what I know now, I probably would have supported him in doing that…..like, for me, when Martin would talk about being depressed, it was what I would have imagined being in bad form, or being but it is obviously much more than that but I couldn't have any idea what it was like at the time. So things like that, I would regret a bit, that I hadn't made myself maybe more aware of how it really was for him."

(Therese)

Kathy also felt guilty that she had not picked up on the extent of Dave's depression and realised her tendency was to contextualise and explain indicators of distress

"…….why didn't I pick up on this, the guilt, how could I have not known? You know, we were supposed to be so close to each other, you know, but going through that night, he came in, he sat down and he cried. He just said to me 'I was feeling suicidal, I wanted to commit suicide' and I remember pretending I didn't hear that, it was 'What?!' and I nearly thought for a second, he's been out drinking, this is going to pass, you know the way, when you're out and you have a couple of drinks, and things always look different in the morning….."

Guilt can be all emcompassing particularly following a death

"……..initially the huge thing after Eamon died was the guilt, the guilt, the guilt about all the things you'd done, you'd said, the over-riding guilt……..."

(Brigid)

Feelings of Anger

Anger and difficulties with anger control were common especially for the men in the study. Again this may be understood as a factor of heightened arousal associated with PTSD (DSM 5 2013). John's reaction was typical of many involved in accidents

"I just felt angry, I felt angry. You know, I felt angry with the person that hit me, I felt angry with myself at that time, you know, because I felt I could do something to prevent the accident but when I looked at it realistically, I couldn't do anything…."

(John)

Kathy was angry and upset about the effects the trauma had on their family life including its over-shadowing of significant family occasions *'I just feel that time of our life was tainted'* because of it. She found it hard to look back on that time

> *"I know that really wasn't us, so I don't really want to know about it....but I have to accept yeah that was us, that was the horrible time we went through"*
>
> (Kathy)

Feeling Pressured

Brigid and Therese describe feeling pressured to meet increased practical demands following their partners' deaths. Such demands come at a time they felt least able to meet them. This highlights the need for information and support in addressing issues of income continuance, legal matters and practical arrangements in the aftermath of trauma, particularly traumatic bereavement.

> *".....a lot of pressures, an awful lot of practical pressures, you know. There were an awful lot of practical things that needed to be taken care of. At the time they felt so urgent because there was half a million things sitting there ready to be tackled, but even though people would tell you 'Oh, everything will sort itself out', that doesn't seem to make any sense at the time, all you know is they're all sitting there looking at you and saying I need to be taken care of here, I need to be done, you know, but you kind of get used to that. Because you have the pressures that you always had plus you've new ones. You have the pressures you always had, minus your partner. And then you have all the stuff that you didn't have before, that didn't exist....."*
>
> (Brigid)
>
> *"Like there would be a lot of things like that that when somebody dies suddenly that you're left to sort out and that you're really not able to sort out. You know, and those sort of things are never addressed in anything there's never even if you read books on bereavement, they give you Okay, addresses of places or whatever, and they tell you you are probably entitled to a pension, but to actually be able to go and find the number and ring the place and fill out the forms and do all that is a huge, huge, huge thing. .....so you really are left on your own. It's like being on an island on your own, and you are just left to sink or swim, really - And then you're feeling rotten anyway, so it's doubly hard....."*
>
> (Therese)

Loneliness and Isolation

Eileen encapsulated the inherent loneliness of trauma and particularly traumatic bereavement

> *"..... it was just a very empty lonely time, you know"*

Therese compared her situation to that of other bereaved women. She felt that although having friends was a protective factor in terms of isolation, loneliness was still unrelenting.

> "You know, if you are sitting at home at night, times like that I found it very lonely.....just the whole idea that there wasn't going to be somebody there, Martin was never going to come in....I would have had an extended amount of friends where I think a lot of people, especially married people, they kind of live with their husband and their family and they lose contact with a lot of their friends, so they probably feel more isolated. You know, I met a woman recently whose husband had dropped dead very suddenly and she had actually tried to commit suicide"
>
> (Therese)

Experiencing and Living Through Trauma: Entering a Liminal Space

Themes from this section of the study centre on life-altering experiences of loss and change that impacted at the three levels of changed circumstances, changed sense of self and feelings of trauma and loss. The narratives of trauma shared by the research participants are characterised by deprivation of a familiar past, suspension in an uncertain, painful present where usual ways of life are radically altered and the prospect of what is often perceived to be a diminished future. The profound sense of loss, change and uncertainty associated with trauma constitutes an experience of liminality. The origin of the word liminal is from the Latin word 'limen', meaning threshold. The concept of liminality is associated with the anthropologist Turner's (1969, 1974, 1977) development of Van Gennep's work on rites of passage from one cultural state to another. Turner specified three phases of change: separation, transition, and incorporation.

He saw the liminal phase as

> *'.... the pivotal point of the transformation from phase to phase or state to state.....at one and the same time, the conditional negation of both states or phases of secular social identity, the common ground of both and the power to transform the one into the other.'*
>
> (Turner 1977: 54).

The idea of transitory negation of both past and future inherent the anthropological concept of liminality captures the experience of the acute phase of trauma. Little et al define the acute stage of liminality as follows

> *"Acute liminality represents a discontinuity of subjective time, in which powerful forces operate to change perceptions of time, space and personal values."*
>
> (Little et al. 1998: 1492)

Following Turner (1967) Simich et al suggest

> *"Liminality is experienced as a psychologically powerful state when moving from one status or role in life to another....Full of risk and potential, liminality often involves a state of heightened awareness and self-realisation...."*
>
> (Simich et al 2009: 257)

Liminality generated heightened self-awareness, reflection and at times existential crises for participants in this study. Some people were unable to share this with those close to them for fear of upsetting or worrying them (Paul, Linda, Michael and Richard). Many felt singled out from people who had not had a similar experience and tended to withdraw or stay on the periphery of groups and social gatherings (Dave, Anna, Linda) . In the aftermath of trauma people often found the day to day preoccupatations of others to be trivial, hard to relate to and at times irritating. This also served to create distance in relationships (Dave, Linda, Brigid, Therese). For most people, their thoughts and feelings were overwhelming and voicing them seemed unsafe and unwise (Eileen, Dave, Linda, Paula). Simich et al also consider the social implications of liminality

> *"Social liminality may be experienced as marginalisation from mainstream culture and society and the inability to exercise power and control...."*
>
> (Simich et al 2009: 257)

While there was evidence in the data of distancing and of marginalisation in social situations, most people were able to confide in one or more people who were close to them (John, Sarah, Linda, Brigid, Therese) and all were able to engage with the social work service although some were initially apprehensive (Alison, Richard). There were also instances especially as time went on where people felt heightened awareness and empathy with others who were suffering (Michael, Eileen, Therese, Richard).

Conclusion

A key finding of this research was the inter-relatedness of the three dimensions associated with Heidegger's concept of Befindlichkeit (i) feelings (ii) experience of self; and (iii) one's situation in the narration of trauma experience. People often co-articulate feelings with ways of understanding, modifying, avoiding and resolving them. Processes in responding to experiences of trauma were associated with experiences of daily living and the impact on the situations and circumstances people 'found themselves' in. Connections at these three levels of experience tended to be recursive and layered. Experiences of trauma are underpinned by a continuous dialectic between the individual and the social environment even when a wish for withdrawal from the social world becomes the predominant experience. At a further level of abstraction the concept of liminality was an overarching theme, in understanding the experience of trauma.

The experiences reported in the study of displacement, of being adrift in the world, of a widening gap between self and others, between present and past, and fear of a lost future draw attention to the spatial and temporal dimensions of trauma and hence highlight its contingent, situated and dynamic nature structured by socio-cultural forces.

As discussed the narratives of trauma shared in this study are characterised by a separation from the past, an uncertain radically changed present and shattered hopes for the future. Therefore issues of continuity, meaning, coherence and reconnection are central to understanding and living with these experiences and for some to moving beyond them. These themes of meaning making and responding to change are addressed in Chapter 6 Living Through Trauma in the Everyday World.

Chapter 6 Living Through Trauma in the Everyday World

Introduction

> *"Experience is not first individual and then social. Each individual is continually involved in a succession of joint enterprises with others, which form and shape his mind. Consciousness is not a given; it is emergent"*
>
> (Coser 1977:335).

This research study sets out to explore the lived experience of trauma and the nature of social work in this context. A key finding as discussed in Chapter 5 Experiencing Trauma – Entering a Liminal Space was the inter-relatedness in the narration of trauma experience, of the three dimensions of 'being' associated with Heidegger's concept of Befindlichkeit (i) feelings (ii) experience of self; (iii) one's situation. Feelings are often co-articulated with self-activated ways of understanding, modifying, avoiding and resolving these feelings. The ways in which feelings of trauma impacted on relationships, social interaction and other experiences of daily living were embedded in the wider circumstances people 'found themselves' in.

The experiences reported in the previous chapter of displacement, being adrift in the world, of a widening gap between self and others, between present and past, and fear of a diminished future draw attention to the spatial and temporal dimensions of trauma and hence highlight its contingent, situated and dynamic nature structured by socio-cultural forces. At a further level of abstraction the concept of liminality was proposed as an overarching theme in relating acute experiences of trauma.

The findings reported in this chapter explore how people negotiate the meaning of trauma in interaction with others in the everyday world, while also trying to meet other responsibilities and commitments. In interaction with others they co-construct life through trauma. At times this takes them to the extremities of their resources (Kelly 2008) and beyond which is often the point at which they access professional support. People's expectations of and sensitivity to the reactions of others; the implications of this in relation to defining and attributing meaning to their experiences; and in coping and relating in everyday life emerged as a set of inter-linked themes from the data.

Blumer's (1969) three basic premises of symbolic interactionism were therefore relevant to the analysis

> *(1) People act on the basis of meaning that things have for them*
>
> *(2) Meanings derive from social interaction*
>
> *(3) Meanings are modified by their interpretations in practice*
>
> (Blumer 1969: 2)

However, mindful of Brown's argument that there must be a *'context for talk'*

> *"....symbolic interactionism emphasises the human agency in people's exchange of meanings. Yet to focus on talk is a simplification of the larger meaning of interaction. In creating meanings and interpretations, people's interaction also includes how they play out their social roles, and how they relate to professional and institutional structures where interaction takes place. Put otherwise there must be a context for talk".*
>
> (Brown 1995:35)

A wider social constructionist perspective is also maintained to incorporate a focus on hegemonic and localised discourses that may be influential for people in constructing meaning. The data in this study illustrates the dialectic between the individual and the social world whereby participants experiencing intense feelings of trauma engage in iterative cycles of naming and narrating trauma experiences; framing and interpreting experiences; navigating day to day living; and reflexive interpretations of traumatic experiences. At different points in the cycle people focused inwards on their thoughts and feelings and outwards into 'everydayness' (Heidegger 1927/1962; Fielden 2003) although these two dimensions are inextricably fused and cannot be understood in isolation (Heidegger 1927/1962; Bracken 2002).

Talking of Trauma: Issues in Naming and Narrating Trauma Experiences

The people in this study reported times when they felt consumed by difficult, invasive feelings and a sense of trauma and loss that was all encompassing. They tended to experience feelings of isolation, despair and uncertainty, not knowing if or how these feelings would resolve. As described, these feelings had inter-subjective underpinnings, arising in the context of current relationships, lost relationships or other social experiences. For some people such as Dave and Anna, what was most difficult

was not the initial traumatic event, but the post-event reactions of others and the playing out of the consequences of this over time in social and work contexts (Marlowe and Adamson 2011). Reactions of others were further shaped by cultural norms that were embedded in a range of discursive practices, for example norms in relation to an acceptable timeframe for grieving and 'sanctions' by way of disapproval, concern or a degree of withdrawal of social contact for those who exceed it.

Opportunities and capacity for talking of trauma experiences within family and social networks were both important and problematic for a majority of participants for a range of reasons. Difficulties in talking with others, including being censored or self-censoring, were often a reason for eventual contact with professional services. Three sub themes were identified; telling of trauma and loss; naming and defining feelings of trauma; and defining feelings over time.

Telling of Trauma and Loss

Many of the research participants found it very difficult to talk to family members about their experience. For some this was an attempt to protect those close to them from the despair and sadness they felt. Others did not want to be a 'burden' or a cause of concern or worry. Some people feared the consequences of disclosure, which included fear of rejection and handing over control to others. Timing was also an issue, people would contemplate talking with a family member about how they were feeling, but the momentum seemed to have passed when there was opportunity to do so. People feared re-traumatisation for themselves and others in talking through the circumstances of a traumatic experience. Linda deflected questions that related to the trauma of finding her dad's body and actively avoided a *'confrontation'* about it, which is how she viewed such a conversation even with people very close to her

> *"...I couldn't discuss about the circumstances, you know about him dying the way he died [by suicide] and whatever I just, I just couldn't bring myself to talking about anything you know.....I don't know whether afraid is the right word ahmm I just didn't want to kinda go into any of that with anybody you know.....I just wouldn't be ready for that kind of confrontation about it you know....."*
>
> (Linda)

Others reacted defensively if encouraged to talk about their feelings. Kathy tried to encourage Dave, her partner, to talk about the effects of the road traffic accident he was involved in, but he found it too difficult and would become angry. Eventually that

changed and talking to Kathy and others, was the turning point for Dave. However by then Dave was very distressed and was feeling suicidal

> *".....the very, very, very first time when I sat down and told Kathy, we sat up all night and I bawled me eyes out and she cried an' I mean I rang the Samaritans and was talking to them and everything else but just that one night was the beginning..... of the I don't know if you'd say the end, was the beginning of the change. That one night was the first night of me changin'.....it was at that point I felt I could speak.... if I'm feelin down then I'll say well I'm not feelin' great I'm feelin' a bit down because there's no point in me saying to you I'm feeling fine, by doing that I'm not doing myself any favours and I'm not going to make myself any better..."*
>
> (Dave)

Other participants explained that people tended to look for and accentuate positives when they talked about their feelings. This frustrated their need to talk through difficult feelings and their sense of loss. Brigid explained her ambivalence about feeling better at that time, which she felt wasn't understood

> *"I don't want it even to be better, I don't want it to be better, I don't want to feel better, this is what I need to do. I need to do this for Eamon [her partner who had died], it's the least I can do."*
>
> (Brigid)

It seemed to be difficult for people to access 'listening', which was focused on understanding how they really were. Rather, people they talked to tried to problem solve or re-assure or empathise. Some people met with frustration and intolerance when they did not show signs of 'recovering' or 'moving on' with life. Some of the participants were advised to go to talk to their doctor when they seemed pre-occupied with aspects of the trauma or loss or appeared upset or unable to sleep. Many of them interpreted this as a suggestion that they needed to take medication. Others found their timeframe for grieving was not in line with the expectations of others, which had implications for the availability of support as Therese describes

> *"It probably was almost a year later before I really realised that I was only beginning to grieve then, and by that stage, people thought well, you've survived the first year, so you're on the road to recovery and that, you know, you're getting on with your life and things seem to be... normal".*
>
> (Therese).

Therefore it emerges that the act of talking with others, interpreting their reactions, aligning one's own behaviour accordingly and eliciting support is complex in the context of trauma. There appears to be a dynamic of self-censoring as both a self-protective mechanism and as a means of protecting others. People also feel censored especially if their distress is intense, unrelenting or prolonged. Other people seem to want to negotiate positive outcomes in conversations and become uncomfortable, demoralised or frustrated if this does not ensue. The reactions of others are powerful in their potential to mitigate or compound distress.

Naming and Defining Feelings

For many of the research participants in addition to the challenges of talking to others of their experiences, it was difficult to name and define them for themselves.

Some people had difficulty identifying what constituted grieving. If they had no prior experience of significant loss, they were unsure what feelings were attributable to grief. Therese found traumatic grief completely different to other experiences of loss and felt unprepared for the intensity of the feelings she experienced

> *".....I didn't realise that I was going to feel like this. You kind of feel it's a loss and it's a loneliness and it's like as if somebody went away .....but I wasn't taking into consideration that feeling that comes over you, that you have no control over, that stops you functioning that stops you doing the things that you would normally be able to do. That was something I hadn't anticipated or hadn't, hadn't consciously thought about. But when I look back now, I know that it was a totally different feeling....."*
>
> (Therese)

Dave needed professional intervention to help him name and understand his reactions. It reassured him to believe his experience was typical of PTSD and others affected were likely to react in the same way. He felt enormous relief when he was given a diagnosis

> *"But I needed somebody to tell me that, if somebody hadn't have sat down and said to me, well, you know, what you're saying is caused from and is, you know, this is what it is.....I'd have gone off the walls, like, you know. But just to have somebody there, just to say, well, look I know what you're going through... and they put a name on it, and they say, well that's the name of it and you're not the only person who's going through it. In fact, anyone that goes through a*

posttraumatic stress disorder is going to go through that more than likely. You kind of feel, phew… you kind of feel, you're normal, you're not totally mental, you're not totally gone off the walls. Well, I mean, at one stage, I thought I was mental, you know, really and truly gone off the walls. Because it's starting to take over my life….."

(Dave)

Defining Feelings Over Time: The Dynamic Nature of Trauma and Loss

People described changing feelings over time with different aspects of trauma and loss becoming accentuated as new issues were encountered. Brigid explained that as her energy levels dropped and she became less busy, deeper feelings and new realisations surfaced

"I don't have the energy to keep as busy as I used to, and that brings its own sort of downside because I am not as busy now so I'm thinking about things more and realising things more and even through it all, I've always been kind of optimistic, you know, but that's starting to wane a little bit….It's tough, you know…..But I mean, what can you do? What can you do, you know… maybe that will come down the road, maybe I'll start getting myself upset about those things down the road and it'll start to sink in because the realisation of the fact that I'm struggling on my own has only started to come into play now…..other things get resolved and then they get left behind and that frees up a space for something else to move in".

(Brigid)

John described managing two parallel 'realities' in relation to his feelings following a road traffic accident. Privately he felt '*down, rough, frustrated and emotional*' but when he met people he masked his feelings and *'put on a brave face'*. Through talking in social work sessions he was able to reconcile these two dimensions of himself and to feel more hopeful about his future.

"……I felt down…..I was feeling rough…..it was very, very frustrating….and I was very emotional in what I went through but at the same time, you know, when I met people I would put on a brave face, it was sort of a cover-up, and in looking at me, you'd never think that anything happened me, because I had that face on, but it was like somebody putting on a mask and then taking it off. So what I'm saying is, that after a couple of visits with [social worker] and sort of

talking about the situation, I went along and then I started feeling relaxed, starting looking at the positive side of things, and started trying to, slowly but surely I felt things coming around slowly but surely because at the same time I was knocking out the negative things out of me head. It was a slow process, it was a frustrating process but at the same time, I felt I was getting there. Because I could see light at the end of the tunnel....".

(John)

The mutability of feelings emerged and it seemed like people needed to achieve a balance between pain and optimism as part of the trauma trajectory, in that people who started out optimistically tended to encounter upsetting feelings at a later stage while people who were down at the start, in time became more hopeful. Others located themselves at many points along this continuum of hope and despair and moved over and back according to emergent feelings and the circumstances of their lives. Interaction with professionals was seen as helpful to understanding and naming feelings and identifying them as part of trajectories of trauma or grief.

Attributing Meaning: Framing and Interpreting Trauma Experiences

The research participants variously described their attempts to interpret their unfolding experiences. Their accounts illustrate their investment in trying to understand the meaning of these experiences in the context of their lives. These processes have spatial and temporal dimensions often arising in relationships in people's family and friendship networks and places of work and commonly referencing a timeline spanning from pre-trauma, trauma, immediate aftermath, present through to the future. The following six sub-themes were identified; rationalising and seeking coherence with values and beliefs; realising implications; searching for answers; reviewing, regretting and rebalancing; understanding own reactions; choosing to go on and focusing forward.

Rationalising and Seeking Coherence with Values and Beliefs

Many of the participants worked hard to understand the circumstances leading to the traumatic event, in order to have a coherent account of the contributing factors, the order in which events happened and an explanation as to what went wrong. People sought to fill gaps in their account, due to memory loss, confusion or their absence when something happened. A number of participants had sought meetings with doctors

to get answers in relation to their loved one's final illness, care and cause of death. People who were drivers in accidents tended to review their own decision-making and questioned if they could have done anything to avoid the accident. People tried to believe there was nothing more they could have done, as everyone urged them to, but although seemingly logical, this often proved difficult to accept or acceptance took a long time. Sometimes people struggled to rationalise a loved one's death by comparing it with other possible scenarios such as the person being critically injured and dependent on intensive health care into the future or the whole family being in the accident. Brigid explained her need to rationalise the circumstances of her husband's death to avoid blaming him or others

> *".....there are facts about how he died, and of course I'm trying to come to terms with this and put it in some sort of perspective, how to make it not be Eamon's fault, you know, trying to neutralise it, you know so that I don't have to be annoyed with anybody, that it wasn't anybody's fault, you know, so that I could feel it was something that couldn't be helped, it was unavoidable, because that's really important, if I don't have that, I... that's the scenario I want. I don't want to have to blame anybody....This is hard enough without having to blame anybody, you know. And not even Eamon, I don't want to have to blame Eamon, you know. It was just one of those things that happened.....I just don't want him to have been wrong, you know. I don't want him to be fallible....."*
>
> (Brigid)

Realising Implications

Many people described the moments when they realised their lives had changed. Brigid described the moment of recognition that Eamon's death had radically changed the context and circumstances of her life

> *".....it was about four weeks after Eamon had died and I was driving home..... and this big feeling came again...I remember the sensation that somebody had just got a rubber and rubbed Eamon out of the world. Out of existence! And it's like it doesn't make sense, the words, the feeling is kind of so ENORMOUS whereas before, you know, up to that, there was still a strong sense of him being around, it was like THAT (She clicks her fingers), he was disappearing on me, ...it was just that sensation that I was driving home, the same route and it was from work and just you go into that feeling that you're going home from*

work and it's the realisation that he wasn't going to be there, and I was driving home to a completely different life. A completely different life. You know."

(Brigid)

Therese had a similar moment of recognition that her and her children's lives were radically impacted by her husband's sudden death

".....it kind of hit me, that this was for real, and this was for ever, that he wasn't going to come back and that my life had changed and Kim and Tony's lives had changed, and that I couldn't make their lives better, I couldn't put that bit of their life back together again."

(Therese)

Searching for Answers

Some of the participants described a prolonged period of not understanding their own feelings and reactions, which greatly exacerbated their distress and their desperate attempts to make sense of the negative changes ensuing in their lives, as already discussed. However family members are often engaged in a parallel quest for answers as Dave's partner Kathy describes

"I suppose I was so afraid of our relationship was so threatened, you know what I mean. And to have come from being very secure and very happy and to having such a threat. I was like how did this happen? And the only thing I could say was that it was the accident, because it only started after the accident.....But then when you know, the psychiatrist said it was post-traumatic stress disorder, I nearly felt like, yes, Thanks be to God, we know what it is, we can deal with it, we can get rid of it and we can go back to normal! You know that way....It's really when you recognise something, you say, right, we can deal with that.....Yeah, it's like, I can put a circle around all that time"

(Kathy)

Reviewing, Regretting and Rebalancing

In reviewing events leading to the trauma, many people were upset by the role they played themselves or the roles played by others. Some people felt they should have noticed signs of deterioration in their loved one's condition and sought medical care sooner. Others felt they should have confided in someone before their distress

escalated to the point of self-harm, having found close family members to be more open to hearing their distress than they previously imagined. Others who were bereaved, felt their relationship with the person who died had been cut off mid-stream and so much that perhaps could have been worked out would now remain unresolved. Therese faced the ultimate loss of hope that things could be better someday for her and her husband (who had an alcohol dependency)

> *".....at least while he was alive, there was always that little glimmer of.. maybe some day. Or maybe that it just might work, that it just might. But all that is gone now..."*
>
> (Therese)

Following a death people tended to continue to try to work unresolved issues through with their loved one, even though the relationship with the person had changed from a physically present relationship to an internalised, symbolic one.

> *"...even though there were negative things, there were a lot of positive things as well"*
>
> (Therese)

Understanding Own Reactions

Growing in self-understanding in relation to one's values, priorities and coping mechanisms and seeing coherence in one's overall approach was a source of relief and reassurance for many people in the study. For Alison making a link between her fear of being alone and staying in a difficult relationship, helped her grow in confidence and make changes in her life

> *"....I knew things weren't right, but I still stayed with him, I still wanted to, for the simple reason I didn't want to be alone, I was always afraid of living on my own, but now I'm actually looking forward to it, it's something I want to overcome, it's something I want to achieve, to live on my own, have my space with my kids.....six months ago I couldn't see that, I could never see myself living on my own with the kids"*
>
> (Alison)

Others found information and 'official' confirmation that they were responding in the best possible way was affirming and allowed them to go on with confidence. Kathy

described the affirmation she received during a social work session and the significance that held for her

> *"But it was only when you had said to me, and this is what I think is extremely beneficial for me, was when you had said to me it is so important for Dave for me to be there with Dave, because that actually made you wouldn't believe it, but saying that made me feel like, Oh, I can do something right!..... I wanted somebody or some literature to tell me, this is what you do, this is how you cope. And again, that's I suppose it is, it's all about coping.....I think lack of knowledge can be very frightening, you know... I didn't know how to cope, eh, in that instance, but now, I do, now I can recognise it.....but I thought Oh, I have to be qualified at this and I had to do something instantaneous that's going to make him alright, which, you know, isn't and doesn't happen..."*
>
> (Kathy)

Choosing to Go On and Focusing Forward

Many people described a 'turning point' where they either made a choice to go on or reached a sense of resignation that this is what needed to happen. Eileen described a gradual process of accepting the need to go on and saw that this would be achieved through '*living every day*'

> *"....and then, as I said, you know I was going to the doctor, I felt so depressed and nearly suicidal, and I suppose by degrees, I suppose it was more by degrees that I came to.....by stopping and starting I kind of you know, came to realise that I had to live, what can you do....But what can you do? You have to live, I suppose by living every day..."*
>
> (Eileen)

Brigid concluded that she needed to keep focusing forward

> *".....It's tough, you know, but sure what can you do? There's no point, it's a waste of time and waste of energy to you know, regret it, or feel resentful about it. Maybe if I needed to let that out or that, but I have to keep focusing forward."*
>
> (Brigid)

Having future oriented goals was also helpful as Alison described

"So I just - there are a lot of things I haven't done, I want to do, you know, silly things, like I want to go to America, and I will achieve that someday....."

(Alison)

Coping and Not Coping: Issues in Navigating Day-to Day Living.

The research participants' accounts of coping and not coping indicate social practices used in negotiating their day-to-day lives. Inherent in their efforts to face the practicalities of their situations were attempts to modulate the pain or pressures experienced as they were confronted with the realities of their changed situations. Their narratives show how the effects of trauma play out at relationship, social and community levels across time and space. The range of social practices deployed in coping and in negotiating difficulties highlights people's agency and counters perceptions of a trauma event in itself as determining of subsequent reactions. The following extracts show processes of self-enactment in interaction with others producing emerging social realities. Three major sub themes - ways of coping; barriers in coping; and oscillation between coping and not coping, were identified each containing further sub themes.

Coping Strategies

People deployed a range of practices and drew on values, support networks and resources in their communities to help them to cope. These strategies proved successful to varying degrees.

Avoiding Painful Feelings and Difficult Situations

As previously discussed, many people found it too hard to talk about the details of a traumatic experience and either avoided such conversations or told people they weren't '*ready to talk about it*'. The anticipation of being asked about an event, of being singled out as the focus of attention was a source of considerable fear for some people and contributed to reluctance to re-join everyday activities such as returning to work, going to the supermarket or even walking down their street. The enormity of this is often under-estimated by others. For other people in the study avoiding certain situations was an unambiguously positive decision.

Paul who had self-harmed and had an alcohol dependency problem in the past, was conscious of avoiding situations that would be potentially difficult for him

> *"...But eh I am always conscious of keeping myself out of situations that may start me thinking mentally too much you know and that....Avoiding confrontations.....That's all I can do and stay away from any temptations during the day and avoid any functions that are coming up that would involve the whole family cos the would set me back....."*
>
> (Paul)

Keeping busy was a coping strategy for many of the participants especially those who had young children

> *"If I kept myself busy, I didn't have to think about things too much and that suited me"*
>
> (Therese)

Others tried to divert and distract themselves from feelings of trauma usually initially at least, to little effect

> *"I tried everything like goin' for walks, read a book, read the newspaper..."*
>
> (Michael)

Using Conventional and Complementary Medicines

The research participants differed, in their views and practices in relation to use of medicines which seemed to have been commonly offered, recommended or considered to enhance ability to cope. Brigid found homeopathy helped her to avoid being completely overwhelmed by her grief

> *"I go to a homeopath and there's a remedy, Agnesium that I take when it gets really bad like that, I take the remedy and ....like you're still down, but it's not that bad..... I remember things being particularly bad.... It was too big, it was too much, you know and that's why like the homeopathy for me has been wonderful because it paces things...."*
>
> (Brigid)

Paul found conventional medicine helped him to cope

> *.....I really put it down to them tablets that Serenase whatever they were giving me because the only thing that's changed is me medication and that's made me feel better so it has to be a good ahmm remedy you know...."*
>
> (Paul)

Anna and Michael resisted suggestions they take medication

> *" .....at that stage now the panic attacks were bad and Dr. Kelly (G.P) had said to me..... will I give you some medication? And I said are you talking about tranquillisers or something like that? And he said yes. And I said well, Oh God, I don't really want to go down that road. Can I try it another bit longer.....and I don't know what I would be like now, fighting those bloody things, it's getting off them like, which is the hassle, so I heard."*
>
> (Anna)
>
> *".... I was asked about medication and I said no."*
>
> (Michael)

Eileen explained her belief in the necessity to go through the pain of loss in order to eventually heal. She too felt medication would not have been helpful

> *"I think really, you have to go with the kind of a person that you're dealing with. Like some people are more inclined to take medication, they'd be taking tablets for everything, but I'm not like that myself. God knows, I could turn out that way, I'm not saying what I'm going to do in the future! But no, I think I was trying to face the thing, that's the way I kind of logically and even to feel the pain, even though I didn't want to feel the pain I wanted to get rid of it. I wanted to just go unconscious and wake up and feel it was gone. And that doesn't work. But, I'm glad that I did what I did, in a way, because I feel that I responded to myself, to my own healing, if you know what I mean."*
>
> (Eileen)

Fulfilling Responsibility Towards Others

People variously talked about how fulfilling responsibilities and caring for others helped them to go on, however this was not always easy and at times they felt conflicted and ambivalent. Parents in the study knew they had to function to support their children's lives on a day to day basis but at times found the sole responsibility for this overwhelming. Others tended to say to them *'Oh, you're lucky, you have the children'*

but at times some parents wished someone else could make decisions or take over. Visiting relatives was sometimes undertaken as a duty rather than a source of pleasure and relief was felt when the duty was fulfilled *'…..that was another thing done and out of the way'.* For Eileen, although it was difficult to find motivation, doing voluntary work in her community helped her to engage with others and to re-establish a routine

> *"….I felt I had to get out and do something and meet people, or help like I went around to the old lady and I helped her and I was going around different things and my heart sometimes, wasn't always in it, my feelings, my emotions weren't always but it kind of kept me….it kept the kind of a routine for me, and then I'd be out and I'd be going here, I'd be going there and then when I'd go home, I'd have less time…"*
>
> (Eileen)

Being 'other-focused' was generally helpful. Caring for and sensitivity to others in her family helped Linda to contain her own grief

> *"....it's taken me away from my bereavement to a certain extent because I'm afraid to grieve in front of them because I don't want to upset them eh or get upset I should say really ahmm but that's what kind of has kept me kind of I wouldn't say on top of things but it's kept me going……."*
>
> (Linda)

Dave and others talked about the sense of responsibility to provide financially for their family

> *"…..I felt totally responsible financially that I had to....I had to keep this money coming in every week you know or things would just fall apart ahmm do you know what I mean?"*
>
> (Dave)

Eileen found having responsibility for her dog was helpful as she needed care and taking her for walks provided opportunities for interaction with others.

> *"Well I suppose one of the things that probably helped me through was i got the little dog as I told you and she kind of eased things for me because I had to look after her, I had to put my mind on to her as well….. and I suppose moving out towards people and going for walks and meeting people. I met so many people with the dog …..… and that kind of helps, you're not really completely on your own, so I feel I have that little connection at home and I have to think of her as*

well so that gives me that little bit of responsibility. I suppose a little bit of responsibility does help you to get back on an even keel"

(Eileen)

Working

Of the thirteen social work service user participants in the study, nine were working on a full or part-time basis, two of whom were self-employed. Of the others one person was a student, one was retired, another person was on long-term disability benefit and another was a full-time mum. Following traumatic events most people were on sick leave for short periods of time and then returned to work undertaking the challenge of managing the demands of work and their experience of trauma. However many saw work as a diversion and sometimes as an outlet to discharge stress, but as Kathy explained sometimes people found themselves to be inpatient with colleagues or subject to angry outbursts

"....I think how I let it (stress) out was through work....you know, by working extra hard, you know.....I won't say lashing out at people at work, but they had a hard time as well....and a screaming match with my boss....which is so out of character..."

(Kathy)

Michael found temporary distraction and respite from his feelings at work but found it to be helpful in the short term only

".... because I was going back to work I was putting myself into work and that was my way of forgetting about it..... but I knew at the end of the day it was always there and I had to face up to it before I could get over it...."

(Michael)

For others continuing to work proved very stressful in the aftermath of trauma and compounded existing difficulties

".....getting up in the morning, panic about going to work, coming home and there was a lot of conflict then that I was saying to him, Oh, just, I was saying to Dave to leave the job because it was too much really, you know what I mean....."

(Kathy)

Drawing on Own Strengths and Innate Ways of Being

It worked for people to be attuned to their own innate way of reacting and to follow that through. It was helpful when that was recognised and valued by others. Eileen reflected on finding her own way through her grief

> *"...I have to get on with my life.....there's other people in the world that are ready and willing to help you....because I was a very independent person and.....I find it very hard to ask people to help me.... I'm kind of very resourceful and determined and I was always like that, probably and I'm still like that!"* (Laughs) *.....that's the way I am and that'll get me, my life going because that's the way I am, you know....as you said to me...I have to find myself again, really...when you lose someone like that, you can't just get up and go immediately.....there's a process you have to go through, you have to go through all that to get back to....so with that in mind, that nature is strong and it'll get back, you know....."*
>
> (Eileen)

Other people described Therese as strong and she recognised this was accurate to some extent

> *".....Like people say I am strong and I suppose I am to a certain extent, in that I could make myself do things even though I don't really want to do them and I don't feel like doing them, I can actually make myself do things that have to be done."*
>
> (Therese)

Brigid's independence and her need to deal with things herself had significance for her that was sometimes missed by others

> *"....I was always incredibly independent....people who would come from a different like 'personality' is too small a word for it but it's a different way of looking at life, would see a lot of what you're doing as very insignificant, you know, and see that you're putting yourself under a lot of pressure and that's an expression people would say to me 'You put yourself under so much pressure'. They don't seem to understand that this is so important for me to do. That if I can get through it and come out the other end, there is a sense of having accomplished something....if it's handled by somebody else, there's just the sense of it still hanging over me, no resolution at all, you know..."*

Yet she resisted bringing her characteristic competence to her new unwelcome role

> *...in the beginning as well, I didn't want to be good at it, I didn't want to be good at being a good widow and holding it all together and like, coping very well because I'm always good at everything....I just desperately wanted to be not good at this. So that everybody would know this is different, I can't do this this time, you know...but I suppose we have the capacity to pull ourselves together and like, I did realise and everybody says you're going to be fine I do realise I will be, because humanity couldn't go on if everybody who experiences someone dying fell part, there would just be no society left, I do know I will come out the other side. But it's not relevant to me whether I will or won't at the moment, all I care about is what I am going through now. You know..."*
>
> (Brigid)

Focusing on Positives

The following two extracts from interviews with John and Alison respectively illustrate how focusing on the strengths in their situations helped them to overcome barriers and move forward with their lives. Using sporting analogies John described how adopting a positive attitude helped him through the effects of a road traffic accident

> *".....if you think positive at the end of the day....no matter what obstacles come in your way, you'll knock them to one side.....That's the way I was sort of looking at it, I was looking at that aspect, you know. It's helped me tremendously.....whereas I had the negative ways before the accident, sorry, when the accident actually happened, and then whereas you know, I was told to start thinking positive, in that manner, which I started doing and by you know, practice makes perfect and if you start practising thinking positive, at the end of the days, you will succeed. You mightn't succeed overnight but at the end of the days, down the line, you will succeed, you know what I mean."*
>
> (John)

Alison too, reflected on the importance of focusing on positives in order to find strength to make changes in her life

> *"If I had of sat down myself and looked for positive things, you find the strength, like, whatever the problem is, like in my case I should have found the strength to walk away from Frank, I thought if I walked away from him, that would be it, like, I'd have nowhere to go. And still at the end of the day, I am still homeless as such, but I should have had the strength, for me and the kids, to walk, and*

find a better life, like to, Okay, it's going to be hard, it's going to be hard, but at least you can be happy, have a hard life but still be happy, rather than getting so down, letting things get so on top of you that you just can't see any way out, you know, basically…."

(Alison)

Maintaining Supportive Relationships

Close relationships with friends and family were ultimately very important both as a reason to go on and as a way to do so. Despite this, trauma experiences were isolating for many people. Levels of closeness, meaningfulness and ease in relationships changed in some cases and eventually needed to be re-negotiated. For some participants inability of family and friends to fully understand the extent and impact of their trauma led them to seek professional support. While acknowledging the support of friends, Eileen emphasised that each person has to face their own pain

"….people have done everything for me, they've travelled to be with me, they've done everything and all, but at the end of the day, you have to face your own pain, that is the fact….you have to go through the pain and you have to sort it out.."

(Eileen)

For many people having a family helped them to go

"You know, having…. family, they got me through that period….."

(Paul)

"The kids, they're a major part of my life, I don't know how to explain that, they just…..without them, it just wouldn't… they're very important to me'

(Alison)

Support and loyalty from partners was deeply appreciated

"Now, in fairness to me wife, who is very very understanding, very very patient…"

(John)

"…..I was fighting with ninety per cent of my family and friends, I don't know how my wife stayed with me…"

(Dave)

Friendships were very significant too with a number of people identifying a particular friend who recognised and understood how they felt and didn't try to change them

> *"...his insight is remarkable....like, he's, he's like the only person who isn't trying to fix it...."*
>
> (Brigid)
>
> *"...she would say, like, 'I know I lost my parents and the way I feel now, but it must be much worse for you', so she could identify what I was going through and she would have been a great support."*
>
> (Therese)

Sarah, a student, found that the quality of her friendships improved since her friends realised she was in distress

> *".....and my best friends both of them, they have been really supportive you know, they realise I go to (social worker) and they realise why I go....they realise.... all this negativeness was coming over me when I took the overdose.....and you know it just makes you feel this is O.K. you know I can survive this, kind of thing."*
>
> (Sarah)

Therese valued having close friends with whom she could 'be herself' and didn't feel the need to act in a conventional way

> *".....I have...the sort of friends that you could say nothing, you could just sit in a room and say nothing or you could walk out of the room and leave them sitting there and they wouldn't be offended.....they'd be comfortable enough and I'd be comfortable enough with them to be able to do that, where with people that you wouldn't be that close to, I think it would be more difficult to behave like that, that they wouldn't accept that as kind of normal behaviour"*
>
> (Therese)

For others, friends and family were unable to fully understand the depth of trauma endured leading them to seek professional support

> *"Yeah, family, friends.... but I think.....none of them knew exactly what you were going through, but they knew there was something, something was wrong so.... at the end of the day counselling, it was the answer at the end of the day."*
>
> (Michael)

Paula too found it easier to confide in her social worker

> *"....well I've told my friends but not in the detail that I go into it with (social worker)."*
>
> (Paula)

Spending time with family members who were also affected by the trauma or bereavement helped people feel less alone, and planning and doing things together fostered a sense of belonging and provided a welcome diversion from difficult feelings. Extended family were also a support for some of the participants

> *".....and my cousin and my auntie they know everything that goes on....."*
>
> (Paula)

Barriers in Coping

People described a range of barriers to coping including reminders of the original trauma or threat, cultural norms and role expectations, competing needs and conflicts in the family, lack of prior experience, not knowing how to make it better, inadequacy of usual coping mechanisms, negative responses from others and a loss of confidence.

Facing Reminders

Facing reminders of traumatic experiences was difficult for all participants. People developed strategies to avoid people or places that were re-traumatising. Some people took a different route to work to avoid the scene of an accident. One of the professional drivers who had had an accident contemplated changing jobs. Some people moved out of home on a temporary basis while another research participant moved house permanently. Another, where possible, avoids seeing her estranged father

> *".....just seein' him there just makes me ah tremble all over you know?.....It just has the same effect as he did in the house you know, makes me nervous....."*
>
> (Paula)

Cultural Norms and Role Expectations

Richard talked about his reluctance to acknowledge or seek support with the emotional impact of his road traffic accident. When the doctor first referred him to the social worker Richard was very resistant and attributed this to a 'macho' culture

> *"I was thinkin' first you know what do I want to go down there for, it probably is a bit of a macho thing you know, because like I said you go through life and you think ah that's alright, no problem and then when there is a problem you're not going to.....you keep sayin' no that's alright.....whereas I was saying what do I feckin' want to go down and see her for, what's he sending me for..... you know, there's nothing wrong with me....that's probably the macho end of it you know..... until you come in and listen in the session and have a session or two and then you go back and you think different, the macho goes out of it then because you're just a normal person then aren't you?.....and like I said it's probably a macho thing with fellas..... you know if you look at yourself and you says there's nothing wrong with me....you know....."*
>
> (Richard)

Dave also felt constrained by expectations of how he should act as a man

> *".....I was going through a mid-life crisis or whatever they'd call it, but I couldn't, I couldn't sit down and have a chat with anyone about it, you know, because society.... and I'm not blaming society, it's just that's the way I felt, you know I couldn't sit down because if you sat down you were a weaklin'..."*
>
> (Dave)

Dave went on to explain he had learned he 'had to be strong' from being with his father and other men around him. When he was distressed, these cultural norms and expectations associated with social roles constrained him from accessing the support he needed

> *"...it's not the kinda done thing for a fella to crumble...., that's what I thought then, I don't think that now, but you know, you had to be strong, you had to keep the chin up you know what I mean, I had to... like I wouldn't discuss it really with Kathy because I knew by me sitting down talkin' to Kathy about it Kathy would end up getting stressed out about it know what I mean?.....Yeah, it was just you know that's the way me father was, that's the way..... Everyone around me was, know what I mean.... I had to keep the chin up, I had to keep*

going although I wasn't really keepin' going, I was fallin' apart you know what I mean ahmm but.....

(Dave)

Professional Interventions Not Meeting Their Needs

Some people reported not feeling understood when they sought medical help. Initially Dave felt the hospital-based doctor minimised his symptoms and concerns

"...I kind of felt at the very beginning, like I knew that the back of my head was sore, I knew my arm was sore, I knew my leg was sore, but he was saying 'You're fine, there's nothing wrong with you!' I kind of felt that you know, do you ever feel when someone is saying 'You're grand!' and you're going 'But I'm not grand!' and they're going but 'you ARE grand. I'm the expert, I know you're grand'. .....and you kind of feel, not paranoid but you feel Jesus what is wrong with me, if an expert is telling me I'm grand, it must be in my head or something, I kind of felt that way.."

(Dave)

Later when Dave felt suicidal his G.P's suggestion that he be referred to a psychiatric hospital felt like an over-reaction. Dave wanted his doctor to offer a care plan that was more resonant with his experiences and his own ideas of what would be helpful.

"Like you know, even going into hospital, like you [said to his wife] reckoned I needed to go in and everything else, and Mike even asked me would I go in, I don't think it's the solution, you know. Em, if somebody is going to send you somewhere you don't want to go, you're just going to make matters worse. I didn't want to go and that was it, full stop and I wasn't going. And although I may have gone and I may have recovered a lot quicker, I'm happy enough just the way things are going at the moment, you know what I mean?....Had I gone into hospital it would have been ten times worse, you know.....to put somebody in an environment where they feel they don't belong is damaging, you know, it's not going to cure you."

(Dave)

Michael also had an experience of his doctor discounting his own felt need for counselling

"...Well first of all I went to see a doctor [G.P] and..... he wasn't very sympathetic.....It was like what do you want to go to counselling for there is nothing wrong with ya. So you just say well.....that was hard but when I did get

to counselling I found it a lot easier even to explain that particular situation, that the doctor didn't understand properly…"

(Michael)

Issues, Conflicts and Change Within the Family

In addition to trauma many of the participants were also coping with other onerous responsibilities or experiences in their family life that impacted on their capacity to cope. Family conflict was an issue for a number of participants. Family divisions occurred in relation to contact with an estranged family member leaving Paula somewhat isolated from her siblings

"…we don't really bring it up because they talk ahmm to my da and I don't, so we don't really have a good relationship really....."

(Paula)

Paul found family occasions difficult because he was separated from his wife

"Because it (family wedding) brings together the whole family unit and I am not a part of that unit and that's what kills me…"

(Paul)

Therese was experiencing conflict with her teenage daughter

"…Kim was very angry and very resentful of me, so that was a huge problem as well, trying to cope with that."

(Therese)

Eileen's loss of a significant relationship was she felt more difficult given her own stage of life

"I suppose it depends on the stage of your life, if you're only starting off in life, you know, I mean when I was younger I had people die but I was able to make new relationships and time was on your side, you know…."

(Eileen)

Not Knowing How To Make Things Better

Many people struggled to find ways to feel better and were uncertain what would constitute a good outcome in the circumstances they were in. This difficulty envisioning a better future was central to the experience of liminality encountered by many people in the study, particularly those who had endured a traumatic bereavement. For Linda nothing made a substantial difference

".....you know you don't know how to.... like what do you do to kind of make yourself feel better because no matter what you seem to do it doesn't make you feel any better you know, you're in the house, you wanna go out, you're out you wanna go home, O.K. if I go home I might feel better or if I go out I might feel better whichever way you turn it doesn't seem to be.....I mean we had books you know on bereavement and I don't know whether it makes you feel any better, I mean I read a bit on it but I didn't you know.....because.... you know, I don't think you can, how do I say it ahmm ..... I don't think you can change like the way you wake up in the morning and the feeling that you're going to have for the day.....how does that feeling come on you compared to the next day, you know, I know like it's bereavement or whatever but.... to me the only thing that could sort out bereavement is if the person came back to ya..... Ahmm reading up on things.....they don't do it for me you know because while I can associate my feelings with what I'm reading about but it doesn't make me feel any better when I close the book, so then I say ah what do I want to know, I know that already....."

(Linda)

However information on trauma was useful for Kathy and Richard

"....it nearly seems like if you could put a reason to something, you can deal with it, or a name to it, or something, it's easier to deal with it....."

(Kathy)

"...after the first session (with the social worker) I sat down and thought, well maybe she's right I don't know because it's never happened to me before....."

(Richard)

Finding Usual Coping Mechanisms Inadequate

Participants' past coping mechanisms were inadequate in their current situations. Alison tended to avoid facing difficult issues but found they accumulated and re-surfaced when things were difficult

"Well, basically, you know, that's I think, that's half the problem... I just put everything to the back and block it out but it doesn't go away, it stays there and if some event comes up in my life, it could all come back out again."

(Alison)

Many people felt unable to 'bounce back' as they would have when faced with difficulties in the pa

> *"....it's not like in another situation where whatever things happen in your life, whatever setbacks or whatever..... I was always the type of person who got up and got over it maybe didn't get over it but just said feck it like, I have to get on with it you know ahmm I was never the kind of person who would dwell on a situation..... I would have given myself a day or two at the tops and said right just, just get your act together."*
>
> (Linda)

Trying to put on a brave face was ultimately counter-productive for Dave

> *"I was lettin' on I was getting better and I wasn't you know, because I felt I had to.... I was like.. you know you're foolin' nobody but straight away I said to myself no you have to soldier on, you have to keep your head above it all... like you know."*
>
> (Dave)

Experiencing Negative Responses from Others

For many of the participants their initial distress was compounded by the responses of others. In some situations this proved more troubling than the initial traumatic event itself. For example for Anna, the reaction of her boss was more traumatic than the workplace accident

> *".....now she never said 'how are you?' 'How are you feeling?' Like you know 'If you don't feel well or anything, go home', or anything like that...What happened then really was that...was really the way she was treating me, and I was kind of running in early and running out because I was so hurt....I was getting all these panic attacks and I didn't tell her because she didn't want to know anything, she wasn't interested in what happened."*

Anna considered quitting her job as her distress in the workplace had become so extreme

> *"I was saying to the solicitor 'I'm going to have to leave this job.... I can't manage it'. He was saying 'but you like the job, don't you?' And I said 'yes' and he said 'why should you leave because of this lady?' And I said 'well, she's making it very uneasy for me, I can't like you know'. I was having diarrhoea every day, I was shaking going into work. I was like a child going to school. And, em, I'd lost between half a stone and a stone in weight, like you know."*

(Anna)

Kathy and Dave were angry with Dave's employer for his lack of concern for Dave and his refusal to allow him time off which they felt would have allowed him access support which could have prevented a build-up of stress

> *"....all that Peter [her partner's employer] was interested in was the money he had paid on the truck; he wasn't a bit concerned about Dave's welfare..... The consultant had said to take the days or a week or something off to rest, and Peter was on the phone the next day saying you have to get back; you have to get straight into the truck! Which I didn't agree with, because....I think initially there was....stress, then it built, so every bit of, everything that was affecting him was building and building and building and maybe if he had of been here say... it would have been talked about, like you talk things through.....that was definitely a major factor, that he wasn't allowed time off"*
>
> (Kathy)

Eileen found people tried to prescribe solutions and were exasperated by her pace of change

> *"Like people would say take tablets, go to the doctor and take tablets....friends and that would say well, if you don't take these, if you don't do what people tell you, but people don't realise that, the main thing I think that you really need, is someone to listen and just let you go ahead as you....you will heal in your own way without kind of telling, like people I know suggest things, but like everyone is different....people are very good, but like, people do get tired listening to you, they think you're moaning but you see what you're going through and it takes time for these things."*
>
> (Eileen)

Therese felt people did not want to go past a surface level of enquiry as to how she was and failed to appreciate the enormity of her loss

> *And then the fact that people don't talk about a physical relationship or talk about the closeness of a couple or you know, like people say to me 'How are you'? And I'd say 'Fine' and then they'd say 'And how are the children?' End of conversation. You know and in a way that's really what they want to hear..."*
>
> (Therese)

Losing Confidence

For Dave and Anna the trauma, coupled with negative responses from their employers resulted in a loss of confidence

> *".....my confidence was completely knocked. A crash like that knocks your confidence anyway, but then you're up against you know, you're not allowed the time off work and they were fighting with me over wages, it cost me a fortune and all this kind of carry-on, and I was just thinking, that didn't help the situation whatsoever.....In fact I think that made it a lot worse than what it was, em, I'd lost my confidence, whatever confidence I had, I lost, and he was just giving me the odd kick, just to remind me to stay down there, type of thing, you know.."*
>
> (Dave)
>
> *".....I would be an in control person, like, of the house and the family because I'd be the one to run all the bills and get everything in the house and everything like you know, the same with the children..... And I had lost that. I had lost that like you know....And anything that was going wrong, I was saying it was my fault....., I was gone quiet in myself because I think I was afraid.....It didn't do my confidence any good at all, like you know.*
>
> (Anna)

Oscillation between Coping and Not Coping

A common feature for all research participants was a sense of oscillation between coping and not coping; for example having good days and bad days or coping in one domain of life but not in another. Oscillation patterns have been previously identified in the bereavement literature and inform the Dual Process Model of bereavement (Stroebe and Schut 1999, 2001) whereby grief is understood as a process of both confrontation and avoidance of painful emotions and is lived between absorption with grief and involvements in a now altered social world.

In this study, most people tried to take part in work and social events but struggled to find the motivation to be involved and sometimes, feigned interest in conversations to be polite.

At home Anna felt more in control and she was also able to enjoy a holiday but on her return to work, where her accident happened panic attacks returned

> *"....the break did me good and I have to say. When I went back then, the panic attacks were still bothering me in work, mostly in work.... But in my own house, I have to say, they weren't so bad. They weren't so bad at all like you know....."*
>
> (Anna)

Therese on the other hand could cope in work and get things done but 'fell to bits' afterwards

> *"...when I went back to work after Martin's death, I operated while I was in work and I did the things while I was at work and then fall to bits afterwards. But if something has to be done, I can deal with it. Pretty much so."*
>
> (Therese)

Linda described her experience of having good days and bad days

> *"....there are days you get up and you get on with it..... as they say you have a good week and a bad week, a good day and a bad day.... well you deal with good days it's great, but how to know how to deal with a bad day.... you know and you just say oh get up, get on but there are times you just don't want to go on you just.... you just want to sit anywhere and just, just go asleep basically you know and when you can't go asleep...it's difficult."*
>
> (Linda)

Reflexive Interpretations of Trauma Experiences

People were spontaneously self-reflexive when given the opportunity to review and re-evaluate their experiences during the research process. It felt like a reprieve of many inner and voiced conversations they had over the course of their experience including those that had taken place in social work sessions. Trauma experience would generally appear to be generative of reflection and reflexivity.

Re-viewing and Moving Forward

Eileen's experience led her to question the meaning of her life, to face her own mortality and ultimately to reach a resolution that made sense for her

> *"I suppose really you should really take more stock of yourself and sometimes when you're rushing around and you're with people and you're closely associated with them, sometimes you don't think of yourself and you don't know, you're living somebody else's life sometimes, you're going and doing everything for them and you don't stand back and say 'Well, what do I want'? 'And what can I do'? And when something happens, you are faced with yourself and what am I about? I'm glad now to be alive today, the way I can, I know that I'm happy in myself, I know and I know I can help people, I can make myself happy, now, I suppose, you know…."*
>
> (Eileen)

John felt he had 'been through the mill' but was now able to do the things he wanted to do in his life

> *"……, I went through the mill, at the end of the day, I succeeded in me objective, which was getting my head together, you know, being able to do the things I want to do in life and at the end of the days, no matter what obstacles were in my way, I succeeded in what I've done…And at the end of the day, I got help. And that was half the battle."*
>
> (John)

Re-Viewing and Living With Loss: Non Teleological Aspects of Trauma

For a number of research participants there was a sense that their trauma and grief could never be fully resolved.

> *"But like, as I say, the loss is still there and I only have to think of Ellie and think of her and I get upset, but I suppose that's normal, you know. But at the same time, I'm getting on with my life, and I'm doing things and I mean, I'm looking forward and doing things in the garden, so I'm planning things, each day and I'm doing things and I'm going out to people and I'm doing that course….."*
>
> (Eileen)

Linda questioned if it was possible to be happy again in the way she had been before her father's death

> *"I don't think I'm ever going to be a hundred per cent for the want of a better word ahmm " cured"....I would love to be the way I was before, but I can never see myself getting back to the old ahmm Linda say..... I can't ever see that happening you know maybe I'm....it's wrong of me to expect that to happen I don't know it's just something I would like to happen..."*
>
> (Linda)

Paul had re-built relationships with his adult children but had to accept his separation from his wife

> *They [adult children] are delighted now, they were up with me at the weekend and they said I looked brighter...looked a bit better so you know and they are getting on with their lives which I am happy about that but the marriage is the missing link and I just have to accept that that's the way it's going to be. There is no point in grieving me head about it you know."*
>
> (Paul)

Re-Viewing: Re-Thinking Dominant Belief and Value Systems

Many participants became conscious of being constrained by established social roles and cultural expectations and values. They found they needed to rethink their impact in order to live more freely and fully. Dave and Richard both felt constrained in expressing emotion and accessing emotional support and attributed this to 'Macho Culture'. The discourse of 'Macho Culture' has led to the structuring of emotion as a social category associated with femininity (Lutz 1988; Harré and Parrott 1996, Kelly 2008). Dave discussed his changing beliefs and practices in dealing with emotions, how he enacted these changes, influenced others and how he understands this has underpinned his survival.

> *".....but that's helped me to change, it's like I understand myself better, I understand people better ahmm and I'm only using the expression like "I'm in touch with my feminine side" .....not that I'm effeminate, but the emotional side of me and the you know..... which I absolutely love, I think it's brilliant you know what I mean because now if I start to feel down or depressed I you know I kind of step over to the emotional side and I kind of.... or I think about it and I'd go to Kathy and say I really feel down today or... where I wouldn't have necessarily have before....You know and of course Kathy would then cheer me up or*

whatever so in that sense I you know....ahmm, but that.... yous helped me , yourself and an Mike me G.P. and Kevin Jordan (psychiatrist),Kathy and close friends all helped me to kinda make that change you know what I mean ,without that change I wouldn't be here today ...do you know what I mean....d'ya understand?

(Dave)

Dave also explained how his increased comfort relating at an emotional level positively impacted others

.....one particular friend of mine who was an absolute macho man he's the prime example, now we sat down and he bawled his eyes out because he lost his father, but he hadn't done that before with anyone and in fact by him doing that helped me, it's goin' to sound funny but by you know me own family and friends gettin' upset and tellin' me what their problems were, it made me feel better, it made me feel like Jesus I'm not the only one out there with serious problems, I'm not the only one that can sit down and cry an' get upset and it doesn't make me any less of a man, I'm not a coward do you know what I mean....ahmm.....it actually it's funny because lookin' back I'm so.... I don't want this to sound weird but I'm so glad it happened because as a result of it happenin' ...I'm not ,I don't mean, I'm not glad it happened as....in the crash.....[laughing].....No, what I mean is in the sense that I've learned so much from it and I've changed as a person, I'm not, exclude all the bad things, the bad changes, but the good changes are like I can express myself now, do you know what I mean, I can...you know I can sit down and if I'm upset about something I can say it, I've no problem sittin' down and saying it you know and if I feel like I need to cry, I cry... do you know what I mean, I mean on that kind of level, you know I'm glad it's happened...."

(Dave)

Women in the study were also negatively impacted by gender role conditioning in their lives. Alison who had left a difficult relationship in the aftermath of taking an overdose outlines her changing beliefs concerning her relationship status and her own self-worth as a woman

"Six months ago....I could never see myself living on my own with the kids, I mean, to me that was, I mean six months ago that's sad, that's no life to have, you have to have more, you have to have a man there, but now, like my goal now at the moment, is to get somewhere for me and the kids and to be on our

own for as long as whenever, you know... and that's the first step....I have three beautiful kids, that will keep me happy regardless, you know, so in that sense, it made me see like, obviously the kids were important, I'm important, and to do things I want to do, like I have dreams, and they're important and for me to fulfil those dreams is important. And, just because someone doesn't think they're important, as in a man doesn't think they're important, that doesn't mean I shouldn't have those dreams. So it's kind of made me more adamant to get my life back....I'm more aware, I think I have had my eyes opened up to a few things, you know, and I've just realised that I am a person and I do deserve things as much as anybody else, and you know, the kids are as well.

(Alison)

Sarah re-considered hegemonic cultural prescriptions of body size, which would have negatively impacted on her self-image in the past

"I'd like to be a little bit thinner but it ain't the end of the world you know there are bigger things. Ahmm I think everyone...., most people would want to be thinner, want to be bigger, want to do something....."

(Sarah)

Re-Evaluating

Many of the research participants while acknowledging at times they thought about their trauma experiences and felt upset, spoke of having reached a better place in their lives

I feel about ten times better like I mean, much better than what I did..... I would say I'm looking forward....6 months ago I couldn't see that. And now, through your help, I can.....Although I still feel hurt sometimes, I still feel the pain off and on, but it was a relief, I'm glad to be out of that situation. And obviously I had to go through what I did to get here.....to go forward. I'm a strong person through that. I think.

(Alison)

Viewing Life More Positively

"Things are better now. I'm more confident, say if something happens now you tend to look on the bright side and you know like there's other people out there with bigger problems.... like there's a lot of pressure around, everybody's under

pressure so when you are under a little bit of pressure it's just getting on with it and dealing with it, dealing with the pressure and problems of life."

(Michael)

John had a renewed appreciation of his life

"Now I looked, you know, it's a song 'Always look on the bright side of life'! And that's what I did. I actually looked at the bright side of life, you know what I mean. Because at the end of the day, you know, I look at life ...whereas there are people there in wheelchairs, there are people there that can't do the things I can do and that's what keeps me going....You know, because it's great to look at life like that, because whereas you know, it's a pleasure just waking up in the morning, you know, being with your wife, being with your kids, and doing what you want to do in life....It's very important, it's very, because I feel that I'm actually getting back to something that was lost, I won't say taken on me, you know, you can't say in that capacity, but it's not taken on me, it just went away for a while. And I actually managed to get it back."

(John)

Re-Connecting

Re-Connecting is seen as an important indicator of 'recovery' from trauma (Herman 1992). There is evidence from the data already discussed that this happens at a number of levels including a reconnection with oneself and with others in inter-personal relationships. Here a reconnection with a broader community of people who are suffering is evident. Reconnection with a future that holds possibilities is also discussed.

Re-Connecting: Identification with Others in Distress

Through experiencing trauma themselves, people strongly identified and empathised with others in distress.

They differentiated between a theoretical understanding (from books) a common sense understanding (which they had in the past) and the felt understanding they now possess

"....it opened your eyes and you know other people have bigger problems and it wakens ya to see other people with problems....it helps you listen to their problems because you've been through something bad and you're willin' to listen to what they've been through. It doesn't explain why they have happened or things like that but it helps you to be able to sit and listen to them and you feel that they know that you're listenin' because you have been to counsellin'.... that's basically it."

(Michael)

"....you pick up the paper and see.....I'll pick up the paper and say "look at that, there's two or three people killed..... I mean that family'd have to come and get counsellin'....."

(Richard)

".....when you've gone through something like that, you realise in depth, it's not just you're not just looking at a book and saying, which I used to do.....But you really and truly know what they, and you know what a shock it must be..."

(Eileen)

"I suppose I would have thought before this, that you know, people get through the funeral and you forget that the loss is so great for them. I mean I know that I wouldn't have had the same sympathy before. I would have gone to funerals and been very sorry for people, but you return to your life and as time goes on and you meet that person, you never suspect that they could be as miserable.. they could portray a very "getting on with life" and everything is fine, but I know now that that's more than likely untrue and that it takes quite a long time, if ever, to kind of feel any sort of way Okay....."

(Therese)

".....it has made me more aware that you never know what's going on in a person's mind even though I mean I always knew that but..... it makes you that bit more wary of people that you're I think maybe in one sense a bit more considerate of people because you really don't know when they're at breaking point, you know, you know ..."

(Linda).

Re-Connecting: Becoming Future Focused

While Dave and Eileen talked explicitly about taking responsibility for their futures many of the other participants articulated future focused goals. Dave felt the turning point for him was making a conscious decision to go on

> *"....ahmm I think it's up to the person themselves, I firmly believe with my hand on my heart now looking back that the only reason I'm here today....I made the decision (coughs) excuse me to save my marriage, to be a father, to have a family, you know to get better - I made the decision nobody made it for me, I was helped along the way but inevitably it's down to the person themselves d'you know what I mean?... I have too much to live for, you know what I mean.... I've come out the other side, you know what I mean, where I do understand it a bit better, which makes me cope with it a bit easier..."*
>
> (Dave)

Eileen also asserted the importance of taking responsibility for oneself

> *"....at the end of the day, we're responsible for ourselves...so we have to do what we feel we have to do and you know, if you don't do something, nobody else can do it for you.....like if I sit there, it's a day lost... I can go out and I can meet people, I can go in and talk to someone, if I want something, I'll ask people...."*
>
> (Eileen)

Paul, Sarah and Alison gave practical examples of plans their plans for the future

> *"Well the simple things of going shopping now again doing meself casseroles and looking after meself and always doing something in the house.....I'm in the credit union now as well and I'm planning a holiday now sometime before the end of the year. I'm going to get meself off for two weeks somewhere".*
>
> (Paul)
>
> *"...I'll join the gym....and go twice a week....I can do that, you know and you feel great afterwards. I was on holidays and I came back yesterday and I went to the gym yesterday for an hour-and-a-half and I felt great....you feel good for doing it".*
>
> (Sarah)

".....like my goal now at the moment, is to get somewhere for me and the kids ... and that's the first step"

(Alison)

Therese was happy with her decision to move house

"And I am happy that I have moved..... I wanted to put that all behind me and part of me wanted to start afresh and part of me wanted to bring Martin with me to a new beginning and to a new house".

(Therese)

Conclusion

The narratives of trauma shared in this study are characterised by people's sense of separation from the past, their uncertain, radically changed present and shattered hopes for the future as discussed in Chapter 5. For many people it is the disconnection or conflict between the lost, imagined or hoped-for life and current lived experience that is in itself constitutive of trauma.

This chapter explores the reflexive experience of living through trauma, naming and defining experiences, the ensuing search for meaning, oscillation between coping and not coping in socio-cultural contexts and for many a re-evaluation of their priorities, social practices and *'ways of being in the world'* (Heidegger 1962; Bracken 2002). Socio-cultural contexts in turn shape the discourse of trauma and may be both enabling and constraining in relation to the process of incorporation of the trauma experience and re-orientation in the social world. The data from this study suggests that divergence of lived experience from normative cultural expectations is often in itself traumagenic and people struggle with and seek to resolve ensuing tensions. This process of actively coping with cultural tensions was also identified in Simich et al's research and termed 'cultural negotiation' which they define as follows:

" First social liminality refers to a relatively powerless, transitional social status....second, arising from the liminal experience cultural negotiation refers to a transformative process of resolving cultural contradictions which..... may help resolve psychological stress and promote mental wellbeing."

(Simich et al 2009: 258)

The phenomenological experiences of the individuals in this study, capture the embodied nature of a process of survival and transition in the aftermath of trauma as people respond on individual and social levels to their changed situations. Inherent in the lived experience of trauma therefore, is a dialectic between its socio-cultural and emotional aspects whereby, following Blumer (1969) action is based on meaning and meaning in turn derives from and is interpreted through social interaction.This dialectical process by which people, already oriented in particular ways (Heidegger 1927/1962) (in this instance a trauma-dominated orientation) engage the social world, and in turn internalise and act on that experience, illustrates the inter-subjective nature of self-enactment through trauma and highlights how in turn these psychosocial processes are constitutive of social worlds. It has been argued that in this way there is no such thing as a seperste social context rather the social world is as much embedded in us, as we are in it (Clarke 2003, Clarke 2005, Clarke and Friese 2007).

This study shows that through meaning-making and social negotiation, occurring in response to trauma, individuals, initially displaced in a state of liminality are relocated as central to the change and transition taking place in their lives. These change processes occur within interconnected, interdependent relationships, social interactions and social institutions such as the family, the workplace and the hospital. As evident in this study meanings and interactions are shaped by hegemonic discourses and their localised interpretations, which are in turn modified in the process. Meanings emerge from the data as socially constructed, fluid and dynamic, highlighting the limitations of searching for fixed meaning or a simple linear trajectory of post traumatic stress reactions.

Chapter 7 Co-constructing Social Work: Creating a 'Thirdspace' in Responding to Trauma

Introduction

While the liminal nature and the lived experience of trauma have been discussed in Chapters 5 and 6 respectively, this present chapter presents research findings on the role and approach of hospital-based social work in this context. The first section situates social work practice in the interdisciplinary setting of the emergency department. Cultural norms, roles and expectations that influence both referral practices and take-up of the service are considered. At a further level of abstraction perceptions of the social work role are explored, and the parameters of social work as a bridging or 'thirdspace' at the interface between the patient and the hospital system, the hospital and home and between people's inner and outer worlds emerge. The second section of the chapter explores how social work 'works' in this 'thirdspace' illustrating the relationship-based, inter-subjective nature of change processes. Finally service users' reflexive views on the contribution of social work to the phenomenology of self-enactment through trauma are presented in the final section.

Context – Social Work in a Hospital Emergency Department

In this section the role and purpose of social work as understood by the three groups of research participants – non-social work staff, service users and social workers are explored, together with the ways in which different expectations are negotiated. The extent to which the norms of the Emergency Department and wider cultural contexts influence practice is considered. The section begins with issues referred by Emergency Department staff, services sought and indicators for referral. The discussion then turns to the ways service users accessed the social work service. It emerged that many of them held negative preconceptions of social work, which seemed to be modulated initially through discussion with referring staff and subsequently through meeting the social worker. The theme of social work as opening up a 'thirdspace' is explored, the nature of which is further analysed in the following section of the chapter.

Role of Social Work and Referral to the Service

The data showed that non-social work staff commonly referral people to the social work service for the following interventions:

Assessment of Need and Risk

Counselling and Psychosocial Support

Follow Up Liaison between the Family and Hospital Services

Ensuring Continuity of Care between the Hospital and the Community

Assessment of Need and Risk

Staff identified a social work role in assessment of risk particularly in relation to child abuse or domestic violence.

> *"...if there's children at risk or if there is ahm violence.....people being abused"*
>
> (Staff Nurse)

Assessment of people's capacity to return home safely or need for an increased level of care was also seen as part of the social work role

> *".....assessment....to determine....suitability for discharge or admission or further rehab - often it involves a care package review and a care needs assessment and [assessment of] family and social supports"*
>
> (Occupational Therapist)

Counselling and Psychosocial Support

A role in providing counselling and psychosocial support to service users and their families was identified

> *"....young people coming in, particularly teenagers, who come in with some small self-inflicted laceration, something like that - who are having problems at home....they would need support or counselling...maybe their family needs to be involved as well and I think that's when the social worker gets involved."*
>
> (Nurse Educator)

Counselling was seen as particularly helpful in the context of Post-Traumatic Stress

> *".....counselling is, I think of benefit for people who have Post Traumatic Stress, particularly after accidents, and on occasions that I have referred and followed up afterwards, the vast majority have said they felt it was a positive experience, you know - it obviously doesn't work for everybody but certainly in my own experience, it does seem to work for the majority. So if somebody has symptoms of anxiety, difficulty sleeping at night, you know situations of travel anxiety, or nightmares, etc. then I would consider them to be suitable."*
>
> (Doctor – Consultant)

Follow Up Liaison between the Family and Hospital Services

The social worker was seen as a key hospital-based contact providing support, information, liaison, advocacy and referral services for families

> *"....and they [social workers] would be a resource for the other professions and for the patient's relatives - another link person.....they would provide.....ongoing emotional support, information....liaise with maybe the Coroner Service, with the inpatient hospital service, with the inpatient teams, if they've queries about the care that was received, who to talk to....and generally linking up with the services that are available for them."*
>
> (Doctor – Registrar)

Provision of a follow-up service and further support as required, was reassuring for Emergency Department staff.

> *"..... nurses don't follow anyone through, once you leave the Department that's it, you know. Sometimes you need someone just to make sure that they're going to be alright.... and you don't feel you're sending them off without anything that can give peace of mind too"*
>
> (Staff Nurse)

Ensuring Continuity of Care between the Hospital and the Community

Social work was seen as a means of accessing appropriate services to meet people's needs on discharge.

".....I'd say at least 80% of the patients who come through would be going [home] ....so we have a responsibility to make sure that the discharge is safe so the social worker is the person who I would call on most to try and help ensure that that happens."

(Nurse Educator)

Psychosocial issues contributing to or compounding illnesses and injuries were discussed and it was suggested that the Emergency Department is sometimes a place for people to come when they don't know where else to go or have difficulties accessing other services

"..... a lot of times when people need help they don't know where to go to.....I think it's [social work] vital in the A & E...because so many people come in here as a last resort, with problems, social problems, they don't come here easily or lightly. And then it's to pick up - people might come in with a medical problem and it's not necessarily the medical problem, it's another underlying problem. You know, it could be a range of things- domestic violence or homelessness, drink, drugs, again it's the people falling through the net...."

(Administrator).

Addressing people's underlying needs was seen as critical to effective discharge planning and thereby part of an approach to avoid unnecessary re-admissions.

"...if you just don't know what services you can provide for the person.....social workers can have suggestions really.....to bridge the gap between your day's work and what's going to happen to them tomorrow or .....they're [patients] not just going to go back outside and be hit by the problems that caused them to come in the first place again...you know, when...things are followed through that you're not bringing patients back again .....at least they have more of a chance not to re-attend at A &E."

(Staff Nurse)

Indicators for Referral to the Social Work Service

Difficulty Coping

Non-social work staff tended to use 'difficulty coping' either articulated by patients or their families or directly observed, as a screening criteria for referral to the social work

service. Referral tended to be reactive and a preventative role for social work was not identified.

> *"I don't routinely ask patients after accidents when I review them, you know, "have you had any psychological upset?" but generally you can tell from their demeanour as whether they have difficulties in that regard so if I did notice something, I'd ask them directly or they may volunteer it themselves."*
>
> (Consultant)

Social and Emotional Issues

Staff distinguished between emotional issues referred to the social worker and those addressed by the psychiatrist, emphasising the social components of distress in relation to social work referrals

> *"...it would be more of an emotional problem, but not a psychiatric problem, like, I don't think that they were clinically depressed or something like that, but actually having difficulty coping with something social with..their children, or families, or you know....."*
>
> (Staff Nurse)

Normative Practices

Cultural norms and expectations with respect to age and gender influenced decisions regarding referral to social work in some instances. Deaths out of sequence with the normal life cycle were seen as particularly traumatic. Women and young people were considered to be more in need of support following an assault.

> *"If somebody died in the department and it was a young person and there was family, a young family, I would ring Social Work, and ask them to come down and help relatives to cope...".*
>
> (Liaison Nurse 1)
>
> *"If it's an assault, I think and it's a young person, we tend to send those to the social worker, but I think if they're not that young, we don't really tend to do that. Not unless they expressed a wish to see a social worker, but I don't think that that would happen straightaway anyway, I think, it would take them a while to think about it ..."*
>
> (Liaison Nurse 2)

"An assault - a young fellow walking home from the pub....I wouldn't think of that in terms of social work, I think he'd have coping skills enough to cope with it....a female - this is a big thing for them being assaulted - they would maybe have difficulty down the line and...if I thought it was appropriate, I would mention it [the social work service] to people - sometimes they'll say 'No I'm fine' and sometimes they'd say 'Yeah, I'd like that. ...' "

(Staff Nurse)

Self Referrals

Requests for a social work service from the service user or family tended to take precedence over other referral criteria. Therefore a pragmatic and service user centred referral process was evident

"It depends on every person that sees the patient and how they perceive them to be coping with their problems... or if they have expressed that they are not coping, you know...if they express a wish that they do need some counselling or they do need some follow up, then you know, it's straightforward enough...families in that case, kind of take over, don't they? They just - they decide that this person needs something, I think. So if we don't pick up on it they will..."

(Liaison Nurse 2)

Accessing the Service as Service Users And Barriers to Engaging with Social Work

The service users in the study all accessed the social work service following experiences they found to be traumatic. Referral by hospital staff, family members or community contacts accounted for most referrals. Receipt of a bereavement outreach letter from the social work service was another point of access. Many service users identified barriers to engaging with social work including negative preconceptions of social work, the hospital-based setting and cultural taboos in relation to seeking professional emotional support. In the following extracts from their interviews they discuss processes of referral, barriers to attending and how these were overcome.

Processes of Referral

Anna who had had an occupational injury was very sceptical about a referral to social work for counselling but was persuaded by the referring doctor to make an initial call. She was further reassured after speaking with a social worker.

> *"Well, he [Emergency Department Consultant] said "have you ever thought about counselling?" and I said like "you're not for real?!" [Laughs]. "...counselling, I don't think I need that.." But, he said '..it's good', he said it's not like saying that there's anything mentally wrong with you or anything like that. He said "it's social workers and they're very good, you can talk to them, they're very good for the likes of this, like you know, without taking the tranquillizers which you don't want to take, like you know, you don't want to take medication..."Well, I said ' I'll give it a try'. So he said 'what have we got to lose anyway, it won't cost you anything.' ....he gave me this card and he said now ring up. So I went home and I think I rang it there and then actually you know. ...and I spoke to [social worker] on the phone.....and even talking to her on the phone, she just sounded great. She was asking me all questions like, over the phone, like you know, about the situation, and it really felt good..."*
>
> (Anna)

Eileen and Therese found it easier to envisage making contact

> *"...although she had had a lot of complaints and was frail, when she did die, it was an awful shock and the nurses....probably realised that and they were sympathetic and they suggested that I come and see somebody...."*
>
> (Eileen)
>
> *In the letter that I had received from you after Martin's death, it said that if I ever needed any help in the future, so that's what prompted me to contact you.*
>
> (Therese)

Barriers to Attending: Negative Preconceptions of Social Work

The extent of negative preconceptions of social work held by participants or perceived by them to be commonly held by others was worrying. For some service users these preconceptions were a barrier to attendance, while for others motivation to attend outweighed negative stereotypes. Therese although unsure what the service could

offer chose to make contact. She believed popular perceptions of social work might be prohibitive for others

> *"...I would think they would feel social work is for deprivation and deprived and.....you're not performing the way you should be and I suppose people would have this idea that social workers only deal with "bad cases", you know, you can't cope, your family is dysfunctional or that, that's the reason you have to seek a social worker. I suppose if you're "middle class" and have a job and you have all these things, that you're not a "social case", so you don't need a social worker. Social workers are only for people where the family is dysfunctional, where the children are going into care, or they would think of it along those lines..."*
>
> (Therese)

Alison, a young mother who attended the Emergency Department following an overdose was very fearful when referral to the social worker was suggested

> *"...when they said 'social worker' I thought, because of what I had done, this person is going to talk to me about the kids, and you know, and I was very nervous and when I got here, it was totally different like....calm and relaxing ....I don't think people realise what a social worker is really...You know, at the time I was going to be in trouble, like, I said to one of the nurses 'are they going to take the kids off me now?' 'would I get the baby taken off me?' and she said 'not at all' and when I came here to you I asked the same question and it was so reassuring...I didn't know what to expect from coming to see a social worker, now when you see in pictures like, in the movies and that, like you know, they are always in their suits, with glasses and they're real stern and it was totally opposite when I came, like. There was this friendly person sitting there, you kind of go wow, I wasn't expecting this person.*
>
> (Alison)

However for Dave referral to psychiatry was considerably more anxiety provoking

> *".....when I was told I was going to a psychiatrist - I was panicking.....there's something about.... 'psychiatrist' you feel intimidated...I think maybe because psychiatrist is associated with somebody who's gone 'lala', you know, a counsellor is associated with someone who is having problems, you know, there's a big difference, you know."*
>
> (Dave)

On referral to social work Richard felt both rejected by the doctor and perplexed at suggestion of a social work service

> *".... the doctor said "you're after coming back twice with the same symptoms", he says "we have this [social work service] in the hospital now and we're referring people to them...." I don't know if he was kinda saying that we can't do any more for ya, maybe this..... and I said " ah feck he's throwin' the can onto someone else" d'you know what I mean?... I didn't think this came into a social worker's job...I thought.. looking after people's [material] needs... rather than the injuries or anything that's happened to them you know..... I didn't think this came into it until I came down and met them".*
>
> (Richard)

John on the other hand felt positive about the referral

> *".....he [Consultant] gave me a name, he got me help and at the end of the days, it is much appreciated, you know what I mean.*
>
> (John)

The priority for Paul was that the person he saw was part of the hospital service

> *".....I don't [know] what your proper credentials [are]....you know whether you are a social worker but the thing is you are here...you work in the hospital so that's good enough for me."*
>
> (Paul)

Sarah was keen to have a social work service and having engaged with it, no longer linked images from television to the name 'social work'

> *"...I needed someone to get everything out into the open.. because my whole life I was sort of building things up and it ended a bad way so ahmm I thought yes good idea...to me I knew social work from the TV where they take children away from parents who cannot look after them... and that's all it meant to me ahmm but now it's just a name doesn't mean anything so I don't mind it at all."*
>
> (Sarah)

Barriers to Attending: Prior Associations with the Hospital

For some people it was difficult to attend due to memories associated with the hospital.

> *"..I suppose that was facing another hurdle, coming up here…. you have to, you know, in another way, you can't avoid things all your life….."*
>
> (Eileen)
>
> *"…it was hard for me in the beginning because the hospital is where dad was a good bit….you remember when he was here you know…but in saying that it doesn't stop you coming up."*
>
> (Linda)

Barriers to Attending: Cultural Taboos

Although not an issue for him personally, John identified 'macho' culture as a barrier to men acknowledging they have difficulties

> *"…there is people out there, they are macho men and…they don't like to say that they have a problem… but at the end of the day, I knew I had a problem there and……I wanted help."*
>
> (John)

Similar views were expressed by Richard (already quoted in Chapter 6) who thought that men would be reluctant to use a social work service and suggested it

> "*probably is a bit of a macho thing…"*
>
> (Richard)

Promoting Social Work and Overcoming Negative Preconceptions: The Role of Other Professionals

A central gatekeeping role of non-social work staff in accessing and defining social work for service users emerged from the research. The ways in which staff understood, explained and promoted social work had implications for take up of the service and management of service users' fears, apprehensions and expectations. Staff discussed the range of reactions from service users when a social work referral is suggested and highlighted referrals in relation to parenting as giving rise to most concern and

resistance, while referrals in relation to trauma counselling or home care planning were more positively received.

> *"if it was a parent who had a 15 year old ...brought in drunk and unconscious and slept here overnight and I'd say to the parent that I want you know, routinely, a social worker to follow you up on an outpatient basis, they would be concerned...they might think....."Oh God, this thing has spiralled out of control, before I know it, they'll take my kids off me....." there might be that kind of fear....but not for Post-Traumatic Stress..."*
>
> (Consultant)
>
> *"..... elderly people into the A & E Department.... they realise that their family is having difficulties coping so when you mention social workers, they're delighted first of all that there's somebody going to be talking to them who knows the services.... that they need....I don't think I would be referring anybody on that didn't need, you know, follow up...and that were aware themselves that they needed follow up and you'd always discuss with them what their role is..."*
>
> (Liaison Nurse 2)

In introducing a referral to the social work service, staff took on the task of clarifying the social work role

> *".....the community I don't think appreciate what social work - the broadness of social work - and [think] "they're only happy when they are taking away children" and things like this - you know and sometimes it's easier to mention to people that you might contact a social worker and say why you might contact them."*
>
> (Staff Nurse)
>
> *"....you'd always discuss with them what their role is. I think we go more into what the role is when we're dealing with younger people about what the social worker does, rather than we don't really tell them exactly what your role is when it's an elderly person because I think....they know well it is linked with community and this is who we need to speak to....."*
>
> (Liaison Nurse 1)

In some instances staff focused on the approachability of the social worker and her experience with trauma-related work in order to reassure the service user in relation to the referral

> *".....Well, we've a lovely girl - who's one of our social workers - and she deals with an awful lot of traumatic problems of people who come in whether they are assaults, or whatever and I could ask her to have a chat with you about the assault, you know, as you may have difficulty coping in the future or you may have problems at the moment coping and I feel that you could benefit from it..."*
>
> (Liaison Nurse 2)

Perceptions of Social Work: Social Workers' Views

The Social Workers recognised the need to clarify their role with service users and experienced a higher take up rate for the service when they had an opportunity to do that in person or by telephone. They also felt the social work role was interpreted well by other staff in their discussions with service users.

> *"I think initially...it might be a little bit unclear .....people's experience of social work might be child protection or...social welfare...so...I think.... to clarify what our involvement is about would be one of the primary things. No matter what area of the hospital you work in, I think people do that now as a matter of course, almost.....clarify what we have to offer and what our role is and we should negotiate that from a very early stage, but I think we do that."*
>
> (Social Worker 1)
>
> *".....the disciplines in the A & E Department are very good at saying "We have a social worker and this is her role....." But they're actually quite good, so when you go to your client, the patient, she or he may know what you can do for her. That's been quite positive for me down there .....sometimes....a new client comes in and you think "I wonder what that client is going to think that I can provide for her/him?". I'm always surprised at how the client seems to set what they want from you. So they start talking and the whole momentum is really round them."*
>
> (Social Worker 3)

Social Workers discussed the need to address the expectations of service users

> *"...I find that's something I always, from experience now, address a little bit in the first session and if, you know, what my approach is and not saying how unlimited it is, but "this is in the hope to help you" You know, I don't suggest they're going to have huge expectations, letting them know that maybe, over time, that we would hope that some of these symptoms will lessen ..."*
>
> (Social Worker 3)
>
> *"....and also around say, our ability to access resources for them....maybe housing or welfare – there are a good number of people that come to A & E and ask to speak to a social worker in relation to services.....there's a long process for them to actually be able to access it, but also we're very limited in what we can – so maybe they need medical backing – letters, you know, because sometimes I find that it's within that area that there's a big difference between what I can do for somebody and what they need done."*
>
> (Social Worker 3)

From this research it is clear that Emergency Department service users were very influenced by prevailing negative images of social work, and therefore discussions about referral to a social work service created ambivalence for some and anxiety and fear for others. The degree of discomfort this engenders would seem to be under estimated by social workers. However for many service users, negative preconceptions appeared to dissipate through reassurances offered by non-social work professionals and on meeting social workers and engaging with them. In this context the central importance of investment in positive inter-professional practice emerges. At a broader level these findings would suggest a need for the social work profession to engage with negative public perceptions of social work.

Social Work in the Emergency Department - Creating a 'Thirdspace'

Notwithstanding barriers to engaging with social work as outlined above, it is evident from the data that these barriers are overcome to enable social work to locate itself at the interface of medical and psychosocial realms creating an autonomous 'thirdspace' (Bhabha 1994, 2003: Irving & Young 2004; Keenan and Miehls 2008) which from the data in this study is seen to encompass spatio-temporal, relational, dialogical and phenomenological dimensions, through which people articulate and explore feelings, experiences and responses to trauma. Social work theorists influenced by postmodern

and social constructionist thinking consider 'thirdspaces' as allowing exploration of multiple, shifting, fluid views of self and other (Irving and Young 2004). From a relational standpoint Keenan and Miehls suggest

> *".....third spaces are places or states of ambiguity in-between different "realities" that exist within and between subjects....Whether one is considering various views alone or with others, the goal is not to reduce the views into polarities or essentialist categories, but rather to observe, describe, and understand the complexity."*
>
> (Keenan and Miehls 2008:166-167)

Creating a 'Thirdspace' in the Hospital Emergency Department

Professional Autonomy

Professional autonomy was identified as a significant feature of social work in mediating between medical and psychosocial domains. One research participant believed that social work was seen to be outside the hierarchy of the main disciplinary structures in the Emergency Department and therein lay its strength

> *I see it [social work] .....perceived as a little freer to act because they're not quite stuck in "the system" and there's no Big Brother really dictating down to them....social work practitioners would be perceived as being more autonomous.....a little more outside the system, a little more independent of the system, more in control of what they themselves are doing,.....I think that's a good thing.*
>
> (Doctor- Registrar)

Independence from the agency was also significant for social workers

> *"....I think the challenge to social work is that we hold on to that kind of person centred approach when we're surrounded by disciplines whose objective is evidence-based work and.....you have an ability to be more independent of the agency .....The needs of the client are, you know, paramount really....."*
>
> (Social Worker 1)

The relative independence of the discipline left it well placed to open up dialogue and relate across interfaces of person and hospital; and hospital and community. This allows for the co-creation of a 'thirdspace' whereby hopes, expectations, differences, tensions, fears and apprehensions can be defined, understood and addressed. A further five dimensions of this transitional space emerged from data analysis.

Spatio-Temporal Dimensions

Dedicated time and protected space to focus on psychosocial needs was seen to be important. Commenting on people's needs post trauma and the capacity of a social work service to respond, the Consultant emphasises both expertise in addressing social issues and having dedicated time to do so.

> *"The major need is...to actually talk to somebody who has the time to talk to them in this regard ....You know, I'd spend some time saying to them "Look this is all normal - don't worry, this will improve and will settle down". But I don't have a lot of time to do that and I don't have any specific training in teaching coping strategies so really that's where the social workers would come in...They'll [service users] go to a psychiatrist and they'll be going on medication whereas you guys won't be prescribing medication, but you'll have a greater insight into their social difficulties and how that might be impacting upon them and what could be done to facilitate them in that regard as opposed to certainly a psychiatric registrar....so they have a psychiatric problem but it may be more that it's a social crisis than a psychiatric crisis and that's where your expertise lies."*
>
> (Doctor – Consultant)

The Liaison Nurse discussed the importance of giving time and providing a safe physical space to address psychosocial issues. She also envisaged the social work role as an interface between the service user and other Emergency Department staff.

> *" I think really it is a matter of talking to people, listening to them, you know, in a quiet room like this [social work office], sitting down and listening, giving your full attention to somebody which...we don't do - I mean while they [ED staff] might give some kind of counselling, it's not in a quiet area, you can't give them your full attention because you've other things...so I suppose listening to them, talking through whatever issues they have to deal with, explaining stuff to them, I suppose, you know surrounding the trauma....."*

(Liaison Nurse 2)

Service users also had a sense of the social work relationship as allowing time and creating a space, which facilitated expression of difficult feelings and access to support

> *"... I suppose the fact that somebody is there to help you... and just are patient, you know all the time no matter how long it takes...I think that's really important, you know."*
>
> (Eileen)
>
> *I found the neutral space important because...everybody else tries to make it okay, that's very frustrating and you're trying to...and they say 'oh it's going to be alright' and you go 'you're not listening to me then....' you know and they're over talking you and trying to point out positives and you go ' no, I'm trying to explain, explain, explain, I just need to let it out, that's all, I just need to go through it'*
>
> (Brigid))

Phenomenological Dimensions

In describing her resistance to medicalisation of her grief and her need instead for someone to listen as she faces her loss, Eileen evokes the essence of what this 'thirdspace' space provides

> *".... I felt that I needed more than medication I think I needed more of the human touch...and someone to listen to me like I did here with you. I felt that was better than for the doctor to come and start writing out a whole lot and telling me that I had clinical depression and I was nearly feeling I was going into a state of mental ill health...I wanted to keep on, I wanted to be sane and I wanted to be able to face the thing, because.... I think myself really, when I look into it now that it's a natural and normal thing to react when you lose someone..."*
>
> (Eileen)

In intervening, social workers began with people's own interpretation of their situation and what was of significance for them?

"....we're less assessment guided than other disciplines....more about the meaning for the person and the person's perception of the problem....."

(Social Worker 2)

Dialogical Dimensions

The G.P. Liaison Nurse observed a service delivered through talking which focuses on people's emotional needs and supports them in coping

"...other services we have ... look after more physical needs... I think it [social work] distinguishes itself because it's more of an emotional... and you know, sometimes I think that the social workers just need to talk to people, to actually give them a tool to help them cope..."

(Liaison Nurse 2)

Talking was seen as a process whereby issues can be contextualised and prioritised, responses normalised, and follow up support accessed.

".... they might need just to sit and talk to somebody so that something can be put into perspective and their needs can be prioritised, so it makes it look or seem that it is easier to actually tackle the issues, the main issues.. ...They need just to say that this is, you know, that 'it's alright to be like this now and that we can meet you later on to discuss it in more detail if you want to'. Sometimes they might need to just know that there is a service available for follow up or ...they might need follow up with other groups."

(Nurse Educator)

Relational Dimensions

Social workers emphasised a person-centred approach and the centrality of building a collaborative relationship with service users as differentiating features of social work

"...a GP's perspective will be different, it will be much more about the treatment of presenting symptoms, whereas for social work, it's much more about.....how is it now..... how the person...presents..."

(Social Worker 2)

"....we do work differently even from psychiatry – the whole relationship, the rapport and the relationship building and then how people can use that

relationship...to resolve their own problems....or to work through feelings and traumas....."

(Social Worker 1)

For John, a collaborative relationship was central to effective social work intervention

"....you were picking up things and that's what made me think and think positive, and it was very good in my view, the way you were doing it and that's what made me feel very comfortable. And that's what made me get on the road to recovery, you know... you explained the situation perfectly and I listened to you and then I went along and explained my situation and at the end of the day, you know, meeting me half way, which was very good, you know what I mean ...you don't interrupt, you let them talk ....and then just try and pick up on something..."

(John)

One of the social workers talked about importance for her of engaging personally and professionally

"I think from my own perspective, I bring a lot of me – you know my personality and my values and my own experiences to the job....I would want the client to experience me as I'd like to experience somebody if I was looking to them for help....The relationship is very important and the respect and kind of that it's ok to be here, it's ok to be talking to me – and I am a social worker but I'm Anna, and you know, it's ok to have this space just to work through stuff ....obviously you feel it is a professional role ....it's based on the relationship really....it's valuing differences as well and being non-judgemental....but valuing...people....and it mightn't be the route that I would choose to go down ... but to have the capacity to work with somebody who's making those choices and still respect their choice..."

(Social Worker 2)

Relationships with service users were underpinned by theoretical frameworks

".....it's [theory] another tool that can give structure to the way we relate and form relationships with our clients."

(Social Worker 3)

Ethical Dimensions

Social workers drew on theories and models of practice such as bereavement theories and crisis intervention and were further informed by in-service training in responding to issues such as grief and loss, domestic violence and suicide risk. However foundational principles of the discipline were seen as the enduring guide to practice

> *"….we can draw from ….a number of models, but still I suppose we use that fundamental humanistic approach that I suppose is very much part of social work…..the fundamental principles have never changed…..but the approaches that facilitate those principles…..have developed and grown over the years.."*
>
> (Social Worker 1)
>
> *"…..I have moved from believing that CISD debriefing was a kind of panacea for every trauma…..now, I see it much more….that the client is identifying what their needs are and we are trying to match our response to it rather than going in there with a blanket approach"*
>
> (Social Worker 1)

Social Workers were aware too of power imbalances in working with service users in this context

> *"….I would be very aware of what I would say or if people are looking for advice or looking for guidance in something, really I'd be looking for them to find their own answers, because I am aware that if somebody is very vulnerable and I say something that…..mightn't fit into the situation in reality at all…… I'm certainly very mindful of not increasing their distress or you know, not saying or doing anything that's going to make things worse for them…… you [need to] stay where the client is coming from.. You work at their pace or work with their agenda".*
>
> (Social Worker 2)

The following extract from the Focus Group with the Social Workers highlights the structural bases of power inequality and the need to uphold peoples' rights and choices. There was also recognition of need for greater consciousness of how the biography of the social worker might impact on the quality of the social work experience for service users.

> *SW 2. "Something that jumps to mind…..is the vulnerable older person and respecting their decision in a very sort of complex frightening environment, and being really mindful of that as a social worker because we can really swept up with the family's concern about them, you know, probably other people within the*

network of concern, that there is that element of ageism that happens throughout the health system….

SW 3. I'm clearly aware of my different set of….not values, just different perspective, I'm coming from middle class society, when you're working with people who are maybe working class or from a Traveller background, with very different priorities, and different expectations about what their life is going to be like, and mine might be completely different…..but it's not about me…what do they perceive me as, the middle class social worker –what choice do they have? They just get me, you know. We don't really give them a choice – I suppose they can vote with their feet….I'm inclined to see me as me - I don't see me as being an agent of the agency or you know, white, 30 something person that you know, yeah, it's not something that I'm currently aware enough of…."

This section of the chapter has located social work in the specific context of this study, the Emergency Department of a large general hospital and examined issues and practices in referral for social work intervention. The discussion of the findings went on to explore how practices are shaped by the norms, roles and expectations of this context and the broader cultural matrix of which it is a part. A sense of social work's professional autonomy in this healthcare setting and of spatio-temporal, dialogical, relational, phenomenological and ethical dimensions of social work practice have emerged from the data. These elements are proposed as constitutive of a transitional or 'thirdspace' between medical, psychosocial and other realms of people's experience post-trauma.

The next section of this chapter examines the nature of this 'thirdspace' as explicated in the data and seeks to identify how social work actually works in this context.

Relationship-based Social Work: a 'Thirdspace' in Responding to Trauma

The findings suggest that the relationship between the service user and social worker provides a spatio-temporal locus conceptualised as a transitional or "thirdspace' where anxieties and concerns are encountered, explored and negotiated. The experience, knowledge and skills of the service user and social worker are combined in this context leading to exchange of ideas, expanded understanding and new ways of proceeding. This is akin to Saleebey's vision of strengths-based, collaborative social work practice arising from

"....dialogue and a mutual sharing of knowledge, tools, concerns, aspirations, and respect. The process of coming to know is a mutual and collaborative one...."

(Saleebey 1996:303)

The components of the social work process are now explored from the perspectives of service users and social workers. Four key inter-active components emerged from the analysis of the research data: Relating/Listening and Re-telling/Defining; Responding and Reflecting; Re-focused Listening and Resourcing; and Re-viewing and Re-connecting. For analytical purposes, I have separated these out into phases and deconstructed each one to further understand the key elements underpinning the social work process. However this analytic phasing is not necessarily reflective of how service users experienced social work. On a phenomenological level, these phases were often co-articulated and individual research participants moved between and within phases as they recounted their experiences.

The following extract from the social workers' focus group provides an illustration of the work from their perspectives. Emphasis is given to dialogue, which happens in the context of a social work relationship and leads to changes in both perception of troubling issues and in self-belief

SW 3 "....if you think of.....domestic violence... eventually hopefully, if you're working with someone over a period of time, she will have changed her perception of herself, her self-image, of what's going on, of her in the environment, the difficult environment that she's in....you're working on people's self-belief and their perceptions, even of them as a victim in the situation or not a victim in the situation or their ability to control a situation and ability to change.

Interviewer. And how does that change... happen?

SW 3 I think it [the social work relationship] gives people the opportunity to explore problems in their lives – you're the forum, or you're that 'wall' that they bounce stuff off... that exploration of feelings and....the meaning of something..... people talking through stuff, that they then come to another understanding or another realisation which changes their perception and beliefs...so it's kind of a resolution – and it may be the resolution is that change in perception....an understanding of why life is difficult, why it's difficult for them right now....."

SW 2 I think you're also encouraging people and they're getting more self-confident and may be confident to change their own perceptions about themselves, or I mean I would encourage quite a lot ....when people ask, like 'how am I doing, like what do you think?'.... And I kind of feedback...and you can see the visible change like 'I'm doing Ok'.....try to be encouraging and use a strengths perspective

SW 1 And information – giving someone time and information and listening ...and normalisation – 'it's Ok to feel like that, it's Ok ...that not unusual, it's a normal response to a bereavement, you see it in post trauma work'.....things like that....."

(Social Workers' Focus Group)

Changes in understanding, perception and self-belief can generate hope and promote a sense of agency that exceeds the transitional space of the social work relationship and impacts on other relationships. Thus what is achieved through social work is integrated in other areas of the service user's life. The following four sub-sections examine the processes by which meaningful conversations happen and changes are achieved.

Relating/Listening and Re-telling/Defining

Attending a social work service opened a space to talk about persistent and difficult feelings. The was facilitated by

Finding Safety and Acceptance

In availing of the social work service Eileen found an acceptance and tolerance of her need to tell and retell of her experiences

"I had no-one only myself, you know, and I'd no purpose or any reason in my life at all... nothing meant anything to me.....it was just a very empty lonely time.... it takes time for to come to terms with your situation and it's good to have somebody to come and talk to that will listen and won't - even though you're telling the same story over and over again, that they don't get fed up listening to you."

(Eileen)

Although Anna had a close relationship with her family she did not share her difficulties with them, as she didn't want to worry them.

> *"... I kind of distanced it a bit away from them because I didn't really want them to be worrying about it...but when I'd come to [social worker] then, it was great, because she was a stranger and she could understand you know, where the others were too close to me".*
>
> (Anna)

Michael wasn't sure he would be understood in his family and didn't want to add to people's own difficulties

> *"... talking to.... someone in your family or someone like that, whether they're taking it in properly or whether they have the time or whether they have problems themselves so you say to yourself well you just don't feel like talking to anybody then.... where when you come to counselling then you know that they can deal with it an' they listen....."*
>
> (Michael)

The approach in social work sessions enabled Sarah to overcome her reluctance to talk

> *"...you come in here and like I really don't want to do this you know talk, but you come in and you're sitting here and you can't stop talking, well I can't anyway..."*
>
> (Sarah)

The Developing Social Work Relationship

The service users variously cited feeling comfortable with the social worker, finding her easy to communicate with and having confidence in her commitment and capacity to help as key factors underpinning the relationship

> *"....I think if you're confident with the person...if you feel they're sympathetic to you and they understand you and they know what hell you're feeling and they really want... you get that impression that they really want to lift that burden and lift that pain, that that makes a difference..."*
>
> (Therese)

"I felt then that you knew what to do and how to help me, I was confident…you were able to help me…You wanted to help me, that was the main thing and you were there and you didn't pass any judgments, you just listened and you just said well I'll see you…. when will you come up again?

(Eileen)

"It's been great, it's been someone to talk to and you know your stuff otherwise I wouldn't have come back.."

(Paul)

"I felt, you know, as I say, I felt very, very comfortable with the person…I met a person that was willing to help me, at the same time as I got on with and could communicate with and at the end of the day, she understood my problems."

(John)

"…it's very relaxed like it's not a ahmm, I don't feel there's any pressure.... and I don't feel I have to be talking about a certain thing or have, or maybe I should talk about it like that, the way I'm talking just seems to come from what I'm feeling at the time...."

(Linda)

"… there's no pressure you know, like, if I don't want to talk, I don't have to, you know, but you're listening and you're not judging me, and you're telling me positive things about me like…… you helped me see the real me, apart from just a mother and a housekeeper, like you showed me there was more, you know, that I have a sensitive side. I must say I enjoyed coming to you…."

(Alison)

"…. I used to think about it, going, 'what am I going to say? I can't think of anything.. .' and then once you get here, it just all flows, you know. And I would say that is because you make it very easy and very comfortable and you know, a very relaxed environment, you know, to fill, and you know we can or speaking for myself, build up a trust and be able to talk easily…"

(Kathy)

"…. Compatibility…has been the critical thing, I think, you know…she understands the context of where you're coming from…. she gets where I'm at… you don't have to explain it as much."

(Brigid)

The importance of a supportive relationship with the worker was further heightened when people described how painful it is to talk about their experiences yet they considered it helpful.

> *"…. I have always felt a bit anxious about coming up, because I've had to face what we talk about in the sessions, I have to face what's going on inside me and even though I feel great after it because I feel like, I feel you know that little bit uplifted after it you know, it is difficult when you think about it you know you're coming up and you're going to be talking about you know basically the bad things that has happened in your life ahmm it's upsettin' like to think… and although there were good times and all, on account of our circumstance …..You're dealing with all that is difficult....."*
>
> (Linda)
>
> *"I know I've hurt people…..so it does be hard to talk about, I'm used to just putting things to the back and blocking them out, you know…But talking about them does help me deal with them…It does make me feel better, and it does make me feel that I'm not such a bad person, you know."*
>
> (Alison)

For others sharing their feelings with a stranger was counter to their usual way of being and coping and it took time to adjust and build trust.

> *"…I wouldn't be somebody who wears my heart on my sleeve really…. that was hard and to come and talk about yourself, and talk about your feelings which would be something I probably wouldn't do by nature…"*
>
> (Therese)
>
> *"…. It's hard because like I'm not used to counselling, I am now but I was never used to counselling ahm I was always ah...I mean myself and Kathy…could tell each other absolutely anything ….So I was always used to that with Kathy but I was never used to that with anyone else… you have to have that same level of trust.... with the person that you talkin' to, but I never had that, I have it now...."*
>
> (Dave)

Unburdening and Containing

Michael describes the process of talking and knowing the social worker was 'taking in' what he was saying and feeling

"…. It helped by talkin', talking everything through, what I was going through and what way I was feeling…The days, some days I'd come and I'd be feeling low and then when I'd be leaving I'd be feeling better because I'd be after talking it through…It got easier as the sessions went on, like at the start it was a little bit hard to understand that talking actually does get you through it.... because you hear that talking helps like.... until you actually sit down and talk everything through then you realise that it is helping…It was more someone there to listen and take everything in…it's havin' someone there to be able to take in what you're sayin' and understand you... it helps you to understand yourself then…..you go away with more confidence…..and you start lookin' on the good side instead of the bad side".

(Michael)

John described a sense of unburdening which was similar for Paula

"….I felt I was taking the weight off my shoulder….it was a fantastic relief to take that weight off my shoulder"

(John)

"…. just knowin' that there's somebody to talk to..... somebody that's easy to talk to I suppose.....you know, it gives you a chance to get things…. off your... back I suppose".

(Paula)

Unburdening was facilitated in different ways. For Therese it was through being able to be 'real' and not to have to make an effort to appear less distressed than she felt

….. you didn't have to be making an effort, I suppose that was the big thing….you could be yourself and be the way you really felt….There was understanding, there was sympathy, there was a recognition of how you felt. And you could say whatever you wanted to say, that there was nothing that couldn't be said…. you felt you could get what was on your chest off it, and you could say it without being judged….."

(Therese)

Elements of unburdening, being held and being understood were important for Eileen

> *Well, I felt when I came in, I could pour out all my thoughts and feelings to you, and that kind of unburdening too was a good thing. And then you were non-judgmental. And you were there to help me and you were in a position that you could help me in lots of ways, you could direct me onto, you know, if I needed to go to a doctor or if I needed to go to somebody…. but you were there like as a…you were kind of a figure there holding me up all the time, if you know what I mean, you were kind of like, em, somebody that I could relate to and that…but I think if I hadn't been able to come up to you and talk to you, I think that, I don't know what, you know, you needed someone to go to and then it kind of relieved you and then you kind of felt that there was somebody that understood …."*
>
> (Eileen)

The quality of listening and timing of the social worker's response were important for John

> *"….an awful lot of people go along in life and when you're explaining yourself, people keep interrupting which can be very very frustrating….I felt you were a fantastic listener [social worker]…..you were absolutely brilliant in the way you listened to me and whereas, you know, down the line….you picked up things, you knew there were things there, but yet you didn't jump in with both feet, you just went along and when I was finished, then you, then you approached them, which was very good…"*
>
> (John)

Dave felt unburdening was achieved through gaining understanding of his emotions

> *"And being able to understand it lifts that kind of frustration away….and just that one little thing gone, helps. And then, you know, you take the emotion and there's loads of different parts to it, and as each one is taken away, as you understand it, the clearer it becomes and the easier it becomes, you know what I mean, and emotionally it's a lot less what's the word I'm looking for it's not as heavy or you know what I mean, you don't feel as weighed down…"*
>
> (Dave)

Responding and Reflecting

Through telling of and defining experiences, processes of responding and reflecting lead to a sense of understanding and being understood. This facilitates making sense of feelings and reactions at both a cognitive level and at a more existential level of meaning.

Understanding and Making Sense of Feelings and Reactions

Exploration, feedback and summarisation by the social worker were closely linked to the service users' narratives and experiences and were therefore immediately meaningful to them

> *"...I was blaming myself all the time, and [social worker] was so reassuring in that respect, like you know. Whatever she said just seemed to click in... she'd turn back and she's saying the right things, and I say oh, God, yeah, you're right....I would realise that what she's after saying is probably the way I was feeling, you know...which you wouldn't realise it, like you know. And she'd bring it to my notice, so definitely when I go, I actually feel great walking out of there, that's all I can say, like you know.....and no matter what way I felt, she always made me feel there was a reason for everything."*
>
> (Anna)
>
> *You'll [social worker] pick up on the things that are most important, you know ahmm..and you might skip one or two but you'll come back to them do you know what I mean and you start kinda puttin'...it's like a jigsaw, you're startin' to put the pieces together bit by bit you know what I mean? [laughs]....*
>
> (Dave)

Therese and Alison described a process of being encouraged to analyse experiences for themselves

> *...You would go through the things and say, "well, you did this and you did that you know, what other choices could you have made?" And I suppose, yes, it would make you analyse the situation and I suppose come up with the result that you probably couldn't have done any more.... but it came about because of the discussions...even if it wasn't the right decision, the reason for the decision was right, even if the outcome wasn't right or if you look back and say that that*

decision wasn't the right decision to make at the time NOW with hindsight but at the time it was the only decision or it was the only option you felt you had....I wouldn't have been able to work that all out for myself. I wouldn't have been thinking along those lines, I would have been just simply blaming myself and saying If only I had done this, or if I had done that...so that would be very positive".

(Therese)

"...You know, I have to think about it and you're getting me to think about it...you're helping me make that decision without putting the pressure on, without someone saying, 'well, what are you going to do?'. You would come across in a nicer way, like 'now what would you think would be the best way to overcome this?' like rather than someone saying 'pull up your socks and do it!"

(Alison)

Sarah found this process difficult at times

'.... I'd have to back up what I said, why I said it, eh...sometimes I couldn't do that, I didn't understand why I said these things or why I did these things that was hard.'

(Sarah)

Dave found the social worker's awareness of trauma reactions contributed to a sense of being understood

....there's nothing worse than when you are going through something in your own head and you don't understand it and you can't explain it to somebody.... but it's great when you're sitting down and somebody turns around and tells you what's going on in your head... you're kinda goin' Jesus they know what I'm talkin' about. That is the best feeling in the whole world an'.....it's funny because you pick up on the important things.... "

(Dave)

The social workers discussed their use of a psycho-educational approach which helped to reduce people's anxiety

"The psycho-educational component I think is important...a little bit about the physiological elements to trauma, as well as psychological...can bring relief for a person because by understanding what's going on, you can take away a lot of the fear and...anxiety and then actually take away some of the symptoms...stress

management…[to] find ways to deal with some of the anxiety levels that may arise from trauma….that's another element – sometimes for me it's an early part of the process…..because it seems to be something that can hold the person and then we can see if we can get to other issues that have arisen …"

(Social Worker 3)

Brigid and Therese found this approach reassuring

"…. But I'd say that that has been one of the critical things for me, was the constant reassurance and reminder that all this is normal, and that everything is going on, as bizarre as it feels, that it is going along within some normal frame of bereavement or grief..."

(Brigid)

"…coming here to see you, definitely, that was my lifeline…. you could say things here and you could cry if you wanted to and you could, you know, well you would say well, that's a normal reaction, or you know, I suppose the reassurance that you weren't going cracked, and that you, that this was normal…"

(Therese)

Following psycho-educational input Richard was prompted to self-analyse and challenge culturally prescribed responses

"… I think after two sessions you kinda sit down and analyse yourself... what she was saying because how, how she explained it to me I sat down…and thought to myself that girl is right, because for four or five or six weeks I was snappin' at people...it's just having to sit down and admit to yourself that whatever is wrong is inside you and it mightn't be outside, it mightn't be in the flesh you know, it's inside you and that can be hard sometimes to sit down and swallow….and like I said it's probably a macho thing with fellas..... you know if you look at yourself and you says there's nothing wrong with me…..but you can't analyse yourself until you sit down with someone else and they explain it to ya....."

(Richard)

Service users variously attested to the benefits of gaining knowledge of trauma and grief

> *"...I think lack of knowledge can be very frightening, you know...there's so much that I wouldn't have known if it hadn't have been for counselling, sometimes I think when you put a name on it, or you can relate to it then, it's not so bad any more, you know... up until that point, I was very naive and isolated that I didn't know what the hell was going on....I didn't know the symptoms so I couldn't say why Dave was so much under pressure...I could recognise, em, that there was suffering.....but I didn't know there was a name for it...."*
>
> (Kathy)

Dave explained how the social work response helped allay his frustration and fears

> *"...It was me explaining it, or me telling you what happened and you explaining it back to me, translating it for me, basically, you know, and what emotions that were involved.....that I would understand it, you know what I mean. I mean, not understanding it is frustrating, you know...and being able to understand it lifts that kind of frustration away..... I understand it a bit better. So I don't worry about it as much, you know."*
>
> (Dave).

Expanding Meaning

Brigid distinguished between understanding her experience on a rational level and going on to find meaning in her situation on an emotional level

> *"...there's a certain level of realisation now like on a rational level, I understand what has happened.....I understand my circumstances...emotionally like I find it very difficult to catch up....."*
>
> (Brigid)

Brigid went on to explain how the neutral space of the social work relationship allowed her to access her emotions without engaging in comparisons as she might do with other bereaved people

> *"...One of the key benefits of [social worker's] expertise...is that she's dealt with these situations before and understands the range of emotions, because you discuss it in a general way so there's not comparisons. You know, I just feel that I move along within a framework and that's it...but the neutrality is critical*

for me. That safe space where I can just stop, like judging, comparing and figuring out…"

(Brigid)

After engaging with a bereavement group Therese began to understand her reactions and feelings within a wider frame of reference, allowing her to move beyond self blame

"… after a couple of [groupwork] sessions with other people who were bereaved ….that reduced feelings of self blame. *That would have been something that I found by coming here…and by attending the talks on bereavement, that everybody is in that same boat and that everybody has those feelings and it's not because you're weak and it's not because you can't cope and it's not because of anything YOU do, that it's more to do with the situation you find yourself in*

(Therese)

Increased self-confidence resulted from changing the meaning situations held for people

"I have a lot more confidence ahmm you know, before I was afraid to go over to talk to people… to walk down the street, I had really low self-esteem...[social worker's] after helping me to go you know no one's perfect….so my self-esteem has come up a lot…."

(Sarah)

Linda was able to resolve some of the conflict she felt in the aftermath of her father's death

"…When we'd be talking and ah I'd be saying say for instance…deep down I wanted to go up to the grave but …. I suppose part of the reason why I wouldn't go to the grave was I didn't know whether he would have wanted me there or not ahmm but then... as the weeks were going on, the sessions were going I should say you made me …a bit more aware of the circumstances that surround it ahmm I think the sessions helped me kinda come to terms with it in that sense. Ahmm so when I kind of thought about it and the things we discussed ahmm I just.... I felt it easier then to go up to the grave you know I felt well I think he would have wanted me to be at the grave and the day I went up to him on his birthday, the sun was out and I kinda felt that was dad saying he was happy I was there….."

(Linda)

For some of the research participants, new meaning came through awareness of how constrictive dominant cultural norms can be

> *"...I think it's just the stereotype pressure from the media, you see all these pop-stars and they're stick- thin and you're like I'm never going to be like that but in reality no one is...I don't know how she [social worker] turned it around but I sort of felt..... once you're happy with who you were no matter what you are, who cares what everyone else is..."*
>
> (Sarah)

[Re]Focused Listening and Resourcing

Reliable Alliance and a Secure Base

Eileen explained how having a reliable relationship with the social worker contained her doubts and hopelessness and resourced her to 'keep going'.

> *"You're just devastated and you need to cry on someone's shoulder and you need to go and pour out your soul to that person and you know that they're listening and they're not going to give out to you and say...."pull yourself together!" Because that's what you want to do but you can't do....you just listened and pointed out what you can do and how you will get back and you felt that no matter what you said or what you did, it was like - it was like the contact that you had to keep yourself going, you know, for me, anyhow."*
>
> (Eileen)

Eileen went on to suggest that the social work relationship provided a secure base she returned to for support as she took on new challenges

> *I mean I started to help people, I did things....I felt I had to get out and do something and meet people.... my heart sometimes, wasn't always in it....but.... it kept the kind of a routine for me...and coming up here and having you in the background was there all the time....."*
>
> (Eileen)

Kathy too viewed the sessions as a reliable and regular resource

> *"It's been like a life-line, I mean, that there were literally weeks when I was like, dazed….it was nearly like 'Oh, I'll keep myself going until I get there' you know that way. And then there was a huge sense of relief, you know, that you were able to get things off your chest and, you know, I could say anything, you know, and I think if you hadn't have been here in that sense, that I'd probably be insane…. (laughs) you know what I mean"*
>
> (Kathy)

Brigid too saw the social work relationship as providing a secure base she 'reported in to' on a regular basis

> *"I do actually keep my promises, and having somebody to account to is just a mechanism that works for me…the guidance, I don't think I would have been able to get through without it…"*
>
> (Brigid)

Therese saw the social work process as supporting her in coping and problem solving

> *…It's you talking about how you feel and somebody there who listens and who supports you and who…gives you that support to keep going…while you were functioning on a day to day basis or if there was a huge problem, you knew that in whatever a fortnight or whatever, you were going to meet this person who really understood how you felt and who really was there to help you through this…..'*
>
> (Therese)

Goal Setting and Task-Centred Work

Agreeing goals and tasks was experienced as motivating and generated hope

> *…After each session there was homework for the week like that you talk to Dan (brother) or ah the time before I was saying I hadn't been to his grave and I went to his grave….we would kind of say well for the next time you do this or for the next time try that or you know whereas I'd be more aware that I had to do them things, it's not that I had to but I know that it was better for me to do those things you know so I was kind of a bit more aware that.... it kinda gave me a that bit of a push is what I suppose is what I am trying to say….."*
>
> (Linda)

"...There was always the little bit of advice that there was maybe a way to change it or maybe a way to make you feel better...something to keep you going, something, a goal kind of. Even if it was far down the road or even if it was far in the future...it was kind of there and it was something you could think about and it was kind of a positive.... gave you the bit of hope as well".

(Therese)

Empowerment Using a Strengths Perspective

Non-social work professionals saw empowerment as part of a social work approach

"I think with...domestic violence, you nearly have to instil..a confidence that they can actually take that step to change things for themselves, I think that must be very hard - but that's where you would be trained and you 'd have a very good knowledge how to ... give them the confidence to get on to the next step".

(Administrator)

".....you empower them and you probably reassure them that they're doing whatever, whatever they're doing is right. And em, I suppose then where you'd see there'd be gaps where you could fill in and maybe give them a bit of support if they needed to do something themselves or to take something on themselves".

(Liaison Nurse 1)

Social workers too emphasised the importance of seeing people as best placed to determine their own solutions

"....the strengths perspective ....and the belief in self-determination and that people are going to find the best solution to their own problems...that's what we aspire to. And feeling comfortable with that...."

(Social Worker 3)

Paul found a focus on strengths helpful and in keeping with his own thinking

"...You opened me mind you know as to certain things like you instead of the glass being half empty it's half full what do you call it its some saying like that you know and that's been there.....and I know the ideas you have I mean it's the same I'm on the same wavelength you know..."

(Paul)

Many service users were aware of conscious emphasis on strengths and on positive reframing

> *"Just have a chat and then go on the positive things which you are, you are a very positive person and that rubs off on the person that's ill..."*
>
> (Paul)
>
> *"I don't think she notices your faults or she won't mention them. She only ever notices good points ahm... which not many people do, you know people usually mention if there's a good point but there's always a 'but' but [social worker] has no buts....."*
>
> (Sarah)
>
> *"You helped me. You just make me feel life is not all that bad, like, you know, although you have ups and downs, you made me see that there's more everyone has ups and downs like everyone deals with things in their own way, but, you made me see things in a positive light. I can't explain it".*
>
> (Alison)
>
> *"I would have an awful habit of knocking myself as well, of you know, looking at all different sorts of scenarios, picking the worst one....so she has been very good in pointing that out to me and it was something I didn't realise I did until she told me well, she didn't tell me directly but until we worked through it and worked it out (laughs!) Well you know, I'd do something and she'd go God that was a lovely thing to do".*
>
> (Brigid)

ReViewing and ReConnecting

This final phase explores issues and processes in reviewing experiences and integrating insights outside of the social work sessions.

ReConnecting with and Integrating Support Networks

There was recognition in the Social Workers' Focus Group of the need to support connections with significant people in the service user's life by either involving them in the social work process, with the service user, or offering them a separate service or creating opportunities for integration of the work done within the social work relationship in other relationships and important areas of their lives.

"....we do consider the wider systems and family being one of them. Em, for me, it's always on my mind you know, if there's a partner..... if at all possible to take that approach, of either to start working with them together or work separately with the other relevant family members. Looking after their needs, but also looking after the client's needs...and the other thing too is looking at – if you're not working with family members but helping the person identify their own supports – because our input is relatively small - but it's to try and help them identify who can support them outside of this relationship....be that a partner, or a friend, or family or whatever, you know."

(Social Worker 2)

"....in the post trauma work...I have often suggested to somebody that they go home and talk to their partner or family about what they are doing and try and educate the family a little bit about why they are in such crisis or in such stress, or physically unwell or whatever, as a result of the trauma. I would certainly encourage it in that situation where it's having a big impact on communication at home or family life ....."

(Social Worker 2)

Varying interpretations of what is said in sessions and the implications of this at family level was raised in the focus group.

"*People sometimes give you an idea of what they're actually saying to their family members, like there's.....a woman, and when she comes back in, she seems to tell me 'I was telling my family that you were telling me that it's ok to cry' or 'I was telling my family that you were saying that it might be good for us to sit around and talk about it'...I'm not directly saying that, but you often hear clients actually come back and say that you know.... 'because of you, this has happened', but it isn't because of you, it is because..They've reached an understanding .....maybe...assessing ....who would be the person that they'd talk to about this 'do you talk to any of the family?' 'Can you be upset with any of your family?' And they're saying no, 'what would it be like?' and then suddenly when they come back to you, they're saying I told them that [social worker] had told me that we should be sitting around and chatting, and that's how they perceive what's going on and that you're giving them this advice and I'd actually not like to see it like that, because it isn't actually the reality of the session."*

(Social Worker 3)

Of the fourteen service users participating in this study, five had one or more joint sessions with family members, a further three had family members or close friends attend the service separately and five did not have direct family involvement.

Dave and Kathy described their experience attending as a couple and how this changed over time

> *"...Kathy's included in the whole process. Now I know at first it wasn't such a good idea, myself and Kathy were knockin' heads together, that is because I think Kathy needed to see somebody separately herself, you know and I needed to see somebody separately... I don't know if it's normal for you to let the partner be included and everything else, but that in itself has made Kathy see clearer, has made me see clearer and it has made us understand what the other is going through a little bit better, which obviously helps the two of us, you know, so I think that is a brilliant thing... I found as well... at the beginning, sometimes I wasn't telling you everything, and then Kathy would give me a nice kick in the arse to tell you ...which is all part of the process of helping me to talk..."*
>
> (Dave)
>
> *"...You made me feel very welcome, as well...I am actually part of it....it's just when you're included it makes you feel better, it makes you feel you can deal with it easier....just feeling so welcome and part of it, you know, and like, you know, a team..."*
>
> (Kathy)

For many people the social work sessions were a catalyst for better communication sometimes spoken, sometimes unspoken with others. For others it was difficult to talk to family members who themselves had different ways of coping or did not seem to understand. Talking about painful memories and difficult feelings with the social worker was sometimes a rehearsal for conversations with close family

> *"... We hadn't spoken at home, well I hadn't spoken at home I should say, you know about my dad and that and I felt ah after the six weeks passed by I wanted to talk about him ahmm but I just couldn't bring myself to doing that at home whereas I felt when I came up here ...I felt grand then after being talking about him you know..... [brother] just happened to ask me how the counselling went that day and I was sayin' how it went, how I felt about it and that and we*

just.... he just asked me how I was, how I was doin' ahmm and I just took it from there basically, it was just.....after being talking about it that day you know a kind of, it was a bit easier to talk about it..."

(Linda)

Sarah suggested the social worker helped open up communication with her mum

"... [social worker], you know... she has helped me realise that I can talk to my mum..."

(Sarah)

In response to being asked if she talked to anyone about the sessions, Anna replied

"Yes, like my husband, the minute I'd come home from the session, he'd ring me and ask me how did I get on today and I'd be telling him....what was happening"

(Anna)

Progress was more implicit for John and his wife and for Michael and his family

"I talked to my wife, but not in depth....when I started getting help, I wasn't moaning about it as much....my wife knew I was getting help...."

(John)

.... Just that I was feeling good after the talk. I think people around knew then, they knew the way you were feeling, the way you were acting...Like after the first few sessions although you were tired it wasn't like straight back to bed and lock yourself in a room and feel depressed, it was helping.

(Michael)

Alison found the norm of not seeking outside support, in her family, prohibited talking about her experience with the social work service

"My family doesn't really...they're not ones that would agree with counselling, they don't... they think they know best, like. My mother is...she was brought up like to deal with things; you don't go here there and everywhere, you know that kind of way.... I have one friend in England, and I do talk to her, she's good."

(Alison)

Paul said his adult children were pleased he was linked into the hospital social work service

> *"…. They know I go to see you I says a medical social worker… and she is seeing me on a weekly or a two weekly basis they say "that's great Da" you know cos they are delighted…I said "just to keep an eye on me..it's someone that I have an input with in the hospital you know"*
>
> (Paul)

Eileen, Dave and Sarah talked about integrating what they had taken from the social work sessions in their lives outside

> *"……you come to somebody….but I suppose it's up to yourself to try and put these things into practice….you still have to go out and face the practicalities of your loss, you know…I suppose as time goes on, as you are getting a bit better, as you are integrating with people again and doing things, the meaning of everything falls into place….."*
>
> (Eileen)
>
> *"I've learned so much from it [the accident, diagnosis of PTSD and counselling] and I've changed as a person…. I can express myself now. If I'm upset about something I can say…."*
>
> (Dave)
>
> *"... I can't do it all the time but I'm managing slowly to do it by myself... I think that's the way it should be I can't rely on [social worker] for the rest of my life every time oh my God... but I think slowly I can see where other people are coming from - that was the main thing I couldn't do. It was my ideas and other people's ideas I blocked them out".*
>
> (Sarah)

For Therese this included the need for self-care and a balance in meeting her own needs and those of her children.

> *"…something that I probably would have become aware of, coming..here, that you have to make a space for yourself and you have to look after yourself as much as you have to look after everybody else…..that while you do think of them and do things for them, that you also have to think of yourself and take time for yourself which I wouldn't have done ……"*
>
> (Therese)

Connecting with Others in Similar Situations – Groupwork

Through attending the Social Work Department's Bereavement programme (series of bereavement lectures, each followed by facilitated small group discussion) Eileen and Therese found a commonality with others in relation to loss and grief regardless of people's circumstances

> *".....having the public sessions...that's a good idea... you realise that you're not just on your own, that there's other people feeling the very same, going through the very same things as you are, only the circumstances might be it might be a husband or a wife or a child or whatever it happens to be, but at the same time, the emotions are the same... "*
>
> (Eileen)

Therese felt the Bereavement Programme helped reduce her sense of isolation however she had reservations about sharing in the group forum

> *"...That's when I began to think well....it's not just happening to me, it's happening to other people and other people feel the same way and I suppose the fact that you're not alone, that it's not an isolated thing and it's not just you that feels that. I would have felt that the talks were a very good idea and people that are in the same situation meeting, the chance of that happening - Okay, you'd meet somebody on the street or whatever, and they might be widowed or widowered or whatever, but you wouldn't get into that kind of a conversation ...but a bit of me would probably feel a bit disloyal to Martin, to be talking about him and I suppose to talk about him in a negative way, I would feel disloyal...so I'd prefer to just sit and listen, I am quite happy to let somebody else do all the talking....I would talk to one or two people, but I wouldn't, I actually don't like that setting, sitting in a circle and talking about yourself, I don't like it...."*
>
> (Therese)

Accessing Further Support and Follow Up

Social Work was seen as the discipline with established links to community services, which could be accessed as a resource for service users

> *"...when you're a social worker you have all the links as well to all the different services....whereas we don't have all those links as well... you know who to ring, you can offer all that, you know".*
>
> (Liaison Nurse 1)

"I've noticed that you do tend to act as a great resource for bouncing people on to whether it's a stress management or sort of a carer's group or some sort of other support agencies.... in that way so it's a fairly patient-centred but a fairly broad community kind of focus as well, you'd have".

(Occupational Therapist)

The community/hospital liaison role worked in reverse also. Paul described the security for him in maintaining a live link with the hospital following discharge, through the social work relationship

".... I'd come in here and...say I'm really ill or I feel whatever....you can go into A&E and say look I've got Paul here.....you are in the middle there all the time as the person who's sort of directing it. ...it's someone that I have an input with in the hospital you know...and you're more or less on the same wavelength as I am as regards what I am trying to do."

(Paul)

Service users also felt they could access their social worker after work had been completed if the need arose

"Well even still, I know I can always come up and I wouldn't abuse it, but I know I can always ring you and ask you and I know you'd be there for me, and that makes it great, that really helps me."

(Eileen)

ReViewing, ReEvaluating and Supporting Reflexivity

Dave recommended regular reviews as a way of assessing and recognising progress.

"...I would say...at the end of every three months, just to sit down and have an evaluation type of, you know, to ask a person how they feel they're doing, but set that session completely separate and aside, so it is solely an evaluation, you know what I mean? A couple of sessions and another evaluation, so that the individual themselves can sit back and take stock, see how far they've come, or haven't come, you know what I mean? ...."

(Dave)

In the foregoing discussion, exploring the perspectives of both service users and social workers, four key inter-active components of the social work process were identified: Relating/Listening and Re-telling/Defining; Responding and Reflecting; Re-focused Listening and Resourcing; and Re-viewing and Re-connecting. These components tend to form in iterative cycles, focusing inward on meaning-making and outward to interaction and negotiation in the social world (Heidegger 1927/1962; Fielden 2003). The process is predicated on and maintains a collaborative relationship between the social worker and the service user and is consistent with Wilson et al's view of the relationship as

> *"..... the medium through which the practitioner can engage with and intervene in the complexity of an individual's internal and external worlds."*
>
> (Wilson et al 2008:7)

The importance of containment emerged from the data. People talked about 'unburdening', 'getting things off their back', 'being held' and 'feeling lighter' after social work sessions. The also had confidence that the social worker would 'tune in to what was most important', 'take in' what was said and had the capacity and commitment to help. These features used to convey the benefits of the social work process, suggest the achievement of containing relationships between the social workers and service users in the study. The concept of containment which is attributed to Bion (1962), suggests the therapeutic relationship acts as a 'container' for difficult and overwhelming feelings, reducing their negative effects and opening ways to manage their impact. A containing relationship is seen as mirroring positive parenting and also as potentially reparative if past relationships have been negative (Trevithick 2003; Goldstein et al 2009). Trevithick describes the containment process as

> *"...talking to someone who has the ability to listen, to empathise, to take in and to bear the worries being expressed, and.....communicate an understanding and give the sense that the person is not alone. The final stage of this process involves offering back the concerns to the anxious person but in a modified form..... so that they no longer carry the same 'sting' or sense of turmoil or anguish. This enables 'natural' growth processes to reassert themselves....."*
>
> (Trevithick 2003:171)

The relevence for working with people affected by trauma is very clear. Containment is central to establishing safety which is the first principle of trauma intervention (Herman 1998; Hobfoll et al 2007; Canadian Council on Social Work Education 2012). As Trevithick states containment of overwhelming anxiety and other difficult emotions

allow people's own coping mechanisms and growth processes to reactivate (Trevithick 2003). The final section of this chapter explores research participants' reflexive understanding of the processes of moving beyond acute trauma.

Outcomes: Reflexivity and the Phenomenology of Self (Re)Enactment Post Trauma

Research participants reflected on transitions post trauma and their views of social work as part of a transitional process. Experiences ranged from those of John and Anna who had come to the service following an accident and an occupational injury respectively and felt that they overcome a difficult experience to others whose trauma experiences were more enduring.

> *"I'm back to myself, I'm…I can only say that now…… I'm being emotional now, when you asked me that question. I'm happy, I'm happy now…and I'm like somebody that won the lottery!"*
>
> (John)
>
> *I have come through it now, good at the end I'd say now. But it was only through talking to [social worker]…I don't think I would have come out of it as good, I know I would have come out of it, that's the type of person I am, I'm a fighter, but …..I probably would have been still quite a bit insecure, you know, and that to me, is not good, like you know what I mean. I like to be able to talk to people, like you know and I am a people's person….and I'd hate to know that I'd lost that, you know, because at the end of the day, that's me…*
>
> (Anna)

For Eileen and Alison although they had reached new perspectives on their situations and much positive change had been achieved, they also experienced persistent loss and loneliness

> *"You know, you couldn't go on the way you were like, you know, because you feel like dying yourself, you just, you didn't want to die…but you wanted to get rid of the pain, you know, it wasn't that you wanted to die because really life is good, I suppose, it's just that you couldn't live with your situation……. it takes you know, it seemed to take forever like. I never thought I'd get anywhere beyond a certain point, you know. But I have got on much better than I had, you*

know……..as I say, the loss is still there…….I'm glad now to be alive today…I know that I'm happy in myself and I know I can help people……"

(Eileen)

"…..things are good now, I am happy. Some days, I feel a little bit lonely but I'm happy and content with the way things are at the moment…I'm more aware I think I have had my eyes opened up to a few things, you know, and I've just realised that I am a person and I do deserve things as much as anybody else, and you know, the kids are as well".

(Alison)

For Linda progress was temporary respite from pain and a greater understanding of the circumstances of her dad's death.

. *"Put it this way before I started coming up... I never had a moment's rest to say you know what I mean, because there was that much going on in my mind about everything whereas….after the sessions….I would walk out and feel even if I was to have two hours….where I was to relax a bit well then that's two hours that I wouldn't have had...I know it's not going to bring dad back ahmm talking about it has helped me ahmm understand it more especially the circumstances of his death ahmm has certainly helped me understand to a certain point of what happened and that you know..."*

(Linda)

Participants felt they had developed a more positive outlook, more empathy with others and more constructive ways of dealing with their own problems

"Things are better now. I'm more confident, say if something happens now you tend to look on the bright side and you know like there's other people out there with bigger problems.... pressure, like there's a lot of pressure around, everybody's under pressure so when you are under a little bit of pressure it's just getting on with it and dealing with it, dealing with the pressure and problems of life".

(Michael)

"…. between yourself and that medication it has done, it has done absolutely wonders. You know because I was getting worried I was getting really worried I was going off the beam just drinkin cans… no sleep no nothing now at least I am getting that and you can see the effects of it…. you opened me mind you

know as to certain things….you have been there to listen otherwise I'd be talking to the wall you know……..."

(Paul)

Finally people reported being perceived more positively by others

"They [adult children] are delighted now, they were up with me at the weekend and they said I looked brighter… looked a bit better so you know and they are getting on with their lives which I am happy about…"

(Paul)

"I think my friends….see me differently because I will act differently..."

(Sarah)

Conclusion

This chapter explored how social work is understood, articulated, utilised and thereby co-constructed by social workers, people who use social work services and non-social work Emergency Department staff who require, request and observe social work services as part of patient care. It is noteworthy that doctors and nurses who are primarily concerned with people's physical health care, recognise and value the contribution of social work with people whose needs extend beyond the core approach of emergency medicine. The highly relational nature of social work emerged and in the enactment of relationships the opening of a transitional or 'thirdspace' as a bridge between medical and social realms, hospital and home, workers and service users and pre-trauma and post-trauma experiences. The 'thirdspace' of the social work relationship allows conversations of loss and change, expression of difficult feelings and expansion of understanding to reduce tensions and conflicts. It supports resilience and coping strategies, resists oppressions and enables reconnections. This chapter has explored how 'ways through' trauma are sought and found by considering context, change processes and outcomes in relation to the social work practice under research.

This research highlights the profound challenges and changes trauma inscribes in people's lives, some of which are transient, some are enduring, some extremely damaging and some ultimately enriching. Living through trauma may lead to a meaningful resolution for some people but for many, the experience is non-teleological in nature. Therefore the different elements of the change process described in this chapter as occurring in and exceeding the transitional space afforded by the social

work relationship should not be understood as stages or phases to be reached and moved through but instead are continuous, overlaid and iteratively integrated in the process of self-(re)enactment. Through this process, social work itself is co-constructed by those who refer to, use and provide social work services.

Chapter 8 Discussion and Conclusions

"…. I felt that I needed more than medication I think I needed more of the human touch…and someone to listen….I think myself really, when I look into it now that it's a natural and normal thing to react when you lose someone…"

(Eileen, Research Participant).

"Suffering ceases to be suffering at the moment it finds a meaning."

(Frankl 1969:23)

Introduction

This final chapter begins with a brief overview of the aims and contextual issues underpinning this research. The trauma literature reviewed in Chapter 1 and the social work literature reviewed in Chapter 2 is then summarised with a particular emphasis on what might constitute trauma-informed social work. The next section provides a summary of three primary and two secondary research findings. The discussion then moves to a reconsideration of the findings in the light of the literature and the research questions. This analysis underpins the development of a model of trauma-informed social work practice which is discussed in depth in the following section. This model conceptualises social work as creating a relationship-based 'thirdspace' at intersections of trauma and lived experience. Through processes of talking, responsive listening and reflecting, suffering and the subjective meaning and significance of trauma are recognised and understood. The issues arising in living through trauma are considered and contextualised. Possible ways to respond are [re]viewed and made practicable. This relationship-based process which may take place in one session or regularly over an extended period of time, in itself supports capacity for [re]connection with self and others, thus meeting the fundamental objective in trauma work (Herman 1992; Hobfoll et al 2007). The chapter concludes with final observations and discussion of the implications of the findings for social work practice, inter-disciplinary practice and practitioner research in this context.

Reviewing the Aims and Context of the Research

This research set out to explore what constitutes responsive social work practice with people who are living through trauma. The question arose in the context of my own practice and that of my colleagues, as hospital-based social workers providing a follow-up service from the emergency department, to people affected by trauma, including traumatic bereavements, domestic abuse, self-harm, road traffic accidents and occupational injuries. There were wider contexts too for exploring local practice. Since the 1970s, the effectiveness of social work has been questioned in public and professional discourses in the light of a series of public child protection inquiries held in Britain and more recently in Ireland. Consequences of this included an identification of social work with child protection and an erosion of public confidence in the profession.

In a range of practice contexts, social workers themselves questioned the adequacy of the social work skill-set in undertaking work that was seen to be therapeutically-oriented. In inter-disciplinary contexts approaches once seen as the preserve of social work such as person-centred care planning and in hospitals, discharge planning had been taken-up by other disciplines. In the light of these issues, the importance of social work research, evaluation and practice development in response to changing needs seemed clear. Promotion of the diversity of social work practice was also needed. These imperatives influenced the decision to undertake this research. My interest in the psychosocial and cultural dimensions of trauma provided further motivation. Psychosocial care in the aftermath of trauma was a growing area of practice when this study was initiated and was on the agenda of acute hospitals as part of major emergency planning. It was therefore readily supported as a research topic within the organisation. Above all however I was interested in aligning my work with good practice in the area of trauma and in making a contribution to the development of social work practice in this context. To this end the primary research questions were

What is the nature of the lived experience of trauma?

What are the elements of responsive social work practice in this context?

Summary of the Literature

Chapter 1 addressed the trauma literature, briefly reviewing the history of traumatology (Herman 1992; Van der Kolk 1996; Spiers and Harrington 2001; Figley 2002; Newman 2002) which largely presents a chronological account of cumulative understanding of trauma through time, highlighting major turning points for example Charcot's work on

dissociation; Kardiner's theory of war neuroses and Freud's proposal and retraction of seduction theory, culminating with two separate successful political campaigns in the 1970s leading to the inclusion of PTSD in the DSM III (1980). One of the campaigns was organised in the U.S.A. by Vietnam Veterans and their supporters and the parallel campaign was initiated by the women's' movement, both seeking official recognition of very different forms of trauma. Scott (1990), Young (1995) and Bracken (2001) are critical of the suggestion that trauma of the PTSD type existed but was not officially recognised, and instead argue that it has been constructed in response to political interests (Scott 1990), as part of the expansionism of psychiatry (Young 1995) and as a response to the exigencies of postmodern culture (Bracken 2001).

While trauma and particularly PTSD are contested concepts the trauma literature is in the main, positivistic in nature largely emanating from the disciplines of psychiatry and psychology. The implications of this including the tendency towards conflation of trauma with the categorical diagnosis of the mental health disorder Post Traumatic Stress Disorder were discussed. The relative absence in the literature of work on trauma experiences which fall outside the specifications of PTSD were noted. Of particular concern is the lack of focus on socio-cultural, political and existential dimensions of trauma experience although there are notable exceptions, based on both empirical work and critical analysis from standpoints including critical social work (Davis 1999; Westoby and Ingamells 2010, Marlowe & Adamson 2011) critical psychiatry (Scott 1990; Bracken 2001; 2002; Summerfield 2001) feminisms (Burstow 2003; Fraser 2003; Morley & Macfarlane 2012) and political theory (Lembcke 1998; Pupavac 2002; Seeley 2005). These critical perspectives were reviewed and have influenced the direction of my research. Psychiatry's key text the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), now DSM 5 (5th edition) (2013) and its associated diagnostic technologies and treatments are major topics of trauma research. Aspects extensively researched are prevalence (Breslau et al 1998; Creamer et al 2001; Kessler et al 2005) construct validity (Bodkin et al 2007; Spitzer et al 2007; Rosen & Lilienfeld 2008) and risk factors (Shalev 1996; Brewin et al 2000). The trauma reactions that meet the criteria for diagnosis of PTSD are re-experiencing of the event, avoidance of reminders, hyper arousal and negative alterations in cognitions and mood (DSM 5 2013). These psychological, physiological and neurobiological reactions to trauma and associated diagnostic technologies and specified interventions such as trauma focused cognitive behavioural therapy are accentuated in the trauma literature to the neglect of other dimensions. Yet leading trauma theorists identify psychosocial issues as central to trauma and 'recovery'. Herman asserts

> *"The essential features of psychological trauma are disempowerment and disconnection from others. The recovery process therefore is based upon empowerment of the survivor and restoration of relationships. The recovery process may be conceptualized in three stages: establishing safety, retelling the story of the traumatic event, and reconnecting with others."* (Herman 1998:98)

In addition to Herman's work, five empirically supported principles (Hobfoll et al 2007) have been developed by an international panel of trauma professionals and researchers to guide and inform intervention and preventative work at the early to mid-term stages of mass emergencies and disasters as follows: *1) a sense of safety, 2) calming, 3) a sense of self- and community efficacy, 4) connectedness, and 5) hope* (Hobfoll et al 2007:283). Studies of risk and protective factors (Hobfoll, 1989, 2002; Hobfoll & Lilly, 1993; Bonanno and Mancini 2012) assert the significance of transpersonal resources and loss of resources for example economic and material resources (e.g. employment or loss of employment, income and income loss) and interpersonal resources (e.g. positive and negative interpersonal support, availability of affinity groups). Therefore the need for psychosocial responses to trauma is evident and further research is indicated on the socio-cultural, political and economic aspects of trauma that have been heretofore largely overlooked. I will argue that social work, which is inherently psychosocial in perspective, is well-placed to address the effects of trauma as it intersects with people's lives in private and public spheres.

Chapter two of the literature review focuses on social work. Themes arising from the trauma literature and pertaining to social work are examined and a strengths perspective (Weick, Rapp, Sullivan, & Kisthardt, 1989; Saleebey, 1992, 1994, 1996; Sullivan & Rapp, 1994) is considered an important component of practice as a counter-balance to the focus on pathology in much of the trauma literature. This practitioner research study is then located in the context of wider debates and developments within social work. An overview of social work as an evolving human services discipline is presented and social work's standpoints in working with people in distress are explored. Debates on key issues for practice for example the complex positioning of social work with respect to imperatives of care and control are examined and ways forward are considered. The second part of this chapter discusses the elements of trauma-informed social work, using the work of Herman (1992) and Hobfoll et al (2007) discussed earlier as a guide. Principles in trauma practice developed for organisations by the Canadian Council on Social Work Education (2012) are also integrated. Building

on this synthesis of underpinning principles, social work is conceptualised in terms of the spatio-temporal metaphor of the 'thirdspace' (Winnicott 1971; Bhabha 1994, 2003: Irving & Young 2004; Keenan and Miehls 2008) and is seen to encompass a social constructionist (Parton and Burr 2005; Witkin 2012) understanding of trauma, an emphasis on the social work relationship (Ruch 2005; Wilson et al 2008; Ruch et al 2010), sensitivity to the centrality of meaning and interpretation (Goldstein 1986; England 1986; Howe 1986; Goldstein, Miehls and Ringel 2009) together with a commitment to build on strengths (Saleebey, 1992, 1994, 1996; Sullivan & Rapp, 1994; Weick, Rapp, Sullivan, & Kisthardt, 1989) and abilities towards reconnection for people in relationships and renewed possibilities for membership and participation in society.

Summary of the Research Findings

Research was undertaken within a constructivist - interpretive paradigm (Denzin and Lincoln 2000; 2013) with service users, social workers and non-social work emergency department professionals. In total 26 people participated in the research. Semi-structured interviewing and a mini focus group were selected as the approaches in data gathering and the data was analysed using a constructivist grounded theory approach (Charmaz 2000; Charmaz 2006; Bryant and Charmaz 2007). NVivo qualitative analysis software was used primarily as a data management tool and provided additional benefit in maintaining an audit trail with respect to data analysis.

Three primary research findings emerge from the study which address the original research questions which were

What is the nature of the lived experience of trauma?

What are the elements of responsive social work practice in this context?

The primary research findings are

1. Trauma may be understood as an experience of liminality;
2. Living through trauma is underpinned by a recursive trajectory of feeling, naming and interpreting trauma and oscillation between a sense of coping and not coping in interaction with others in the everyday world;
3. Social work in this context is a relationship-based process which creates a 'thirdspace' at intersections of trauma and lived experience whereby the significance of trauma, grounded in multiple contexts is recognised and ways to respond are [re]viewed and made practicable.

The secondary research findings are

1. A significant number of service users held negative preconceptions of social work before attending the service leading to initial apprehension.
2. Non-social work staff had a very good understanding of the psychosocial needs of people attending the emergency department and of the role of social work.

The three primary research findings are closely linked in so far as all the research participants either lived through these three levels of experience or were witness to these processes in their role as an emergency department worker. I will initially outline the three findings together and then review each of them in the context of the literature. The two secondary findings pertain to and will be discussed in conjunction with finding 3 Co-constructing Social Work. Building on this analysis, I will describe a conceptual framework for trauma-informed social work practice 'Relationship-based Social Work – A Thirdspace in Responding to Trauma', based on and re-combining the primary research findings and the relevant literature and incorporating the secondary research findings. Figures 1, 2, and 3 illustrate different dimensions of the framework and are integrated in the discussion.

The experience of trauma encompasses profound existential feelings of fear, suffering, loss and uncertainty which dis-place the person in relation to their pre-trauma sense of self and situation giving rise to an experience of liminality. Trauma often becomes the dominant lived experience, which is felt, defined, interpreted and incorporated in interaction in the (now changed) everyday world. This recursive trajectory can take people to the extremities of their resources and beyond (Kelly 2008). At this point people may seek or accept professional support. On coming to the social work service, people often feel overwhelmed by intense and painful emotions associated with trauma coupled with an altered sense of themselves and their circumstances. Through working together in the social work process, a safe, contained 'thirdspace' is co-constructed, which I will subsequently discuss in more detail. The eventual aim of social work intervention is to enable people to re-place/re-position themselves in relation to the trauma (as is illustrated in figure1), to lessen their distress and enable re-connection with themselves, other people and other aspects of their life (Herman 1992; Hobfoll et al 2007). Figure 1 illustrates a vertical axis of issue, process and outcome and depicts a process of working with trauma, through social work, in a co-constructed and safe 'thirdspace', through a given period of time.

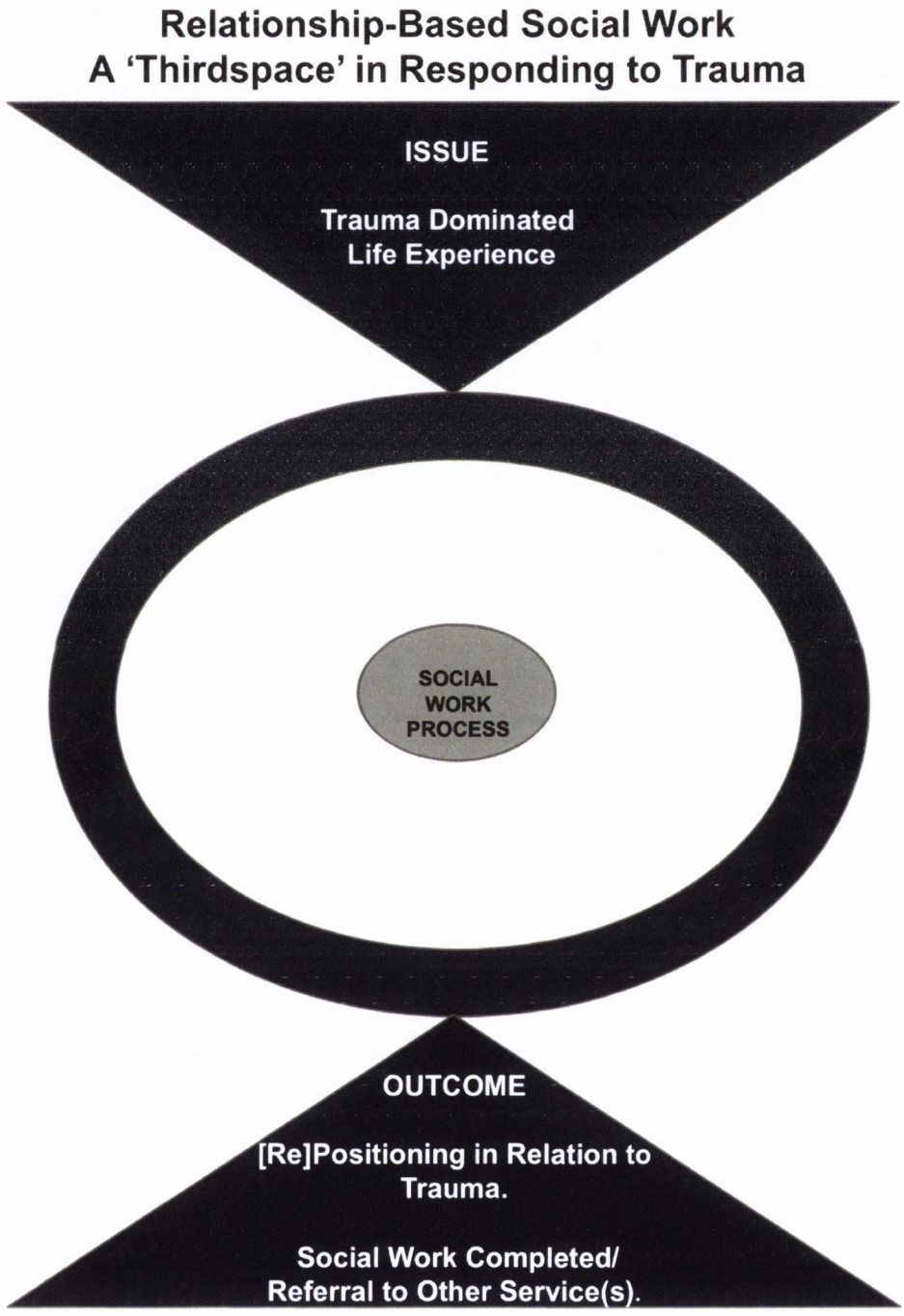

Figure 1: Relationship-based Social Work: Trauma Issues, Process and Outcom

Of the fourteen people, who had availed of the social work service and participated in the study, only one had a diagnosis of PTSD. Five other people had been assessed by a psychiatrist but did not receive this diagnosis. One of the above referrals had been initiated during the process of social work intervention, in a situation of prolonged and intense distress. None of the remaining eight service user participants had been medically referred to or had themselves sought a referral to a psychiatrist for assessment. People's accounts of their trauma experience, shared in the research, however show that they variously met some or all of the diagnostic criteria for PTSD but perhaps not always in the combination specified by the DSM 5 (2013) (see table 2). Ten people met Criterion A in that they experienced, witnessed or learned of the *'death, threatened death, actual or threatened serious injury'* to themselves or someone close to them. For three of the remaining four people the trauma was self-injury, in reaction to a build-up of personal and inter-personal stresses. Self-injury is not addressed by PTSD. The other person had experienced bereavement, felt to be traumatic by her, but would not have met current DSM 5 criteria because it did not occur in traumatic circumstances. However this bereavement would have met DSM IV criteria. Changing DSM criteria has been termed 'criterion creep' in the literature and has attracted critical comment in relation to construct validity (Rosen 2004; Rosen, Spitzer and McHugh, 2008).

PTSD Criterion B*: intrusion symptoms:*

Research participants described many instances of re-living the trauma either being suddenly transported back to thoughts and feelings of the original event by an environmental trigger or being persistently drawn to review the event in their minds to try to make sense of it. As with other reactions documented in the literature including avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity (DSM 5), these reactions were not articulated as discrete phenomena but rather in relation to their meaning in relationships and in orientation to and participation in the everyday social world. Lived experience of trauma, is already meaningful as it impacts and is shown in the analysis, to be embedded in a series of discursive practices. Trauma is therefore understood as both embodied and inter-subjective in nature, arising in the context of relationships and circumstances rather than a discrete, internal emotional state.

Criterion C*: avoidance* was evident and took many forms from avoiding physical environments, distancing from others, self-distraction and use of alcohol in an effort to escape intrusive thoughts and painful memories and feelings. The intrusion/avoidance

dynamic is well documented in the trauma literature (Herman 1992; Dunn 2001; van der Kolk 1994, 1995, 1996) as is seen to be a distinguishing characteristic of PTSD.

Criterion D: *negative alterations in cognitions and mood* was common to all participants and included negative thinking in relation to self-worth, sense of failure, self-blame and justice and safety in the world. Many people described themselves as positive, happy and engaged in life prior to the traumatic event which resulted in mood changes including sadness, anger, depression, despair, fear, numbness and guilt. Criterion D entered the list of PTSD diagnostic criteria with the introduction of the DSM 5 this year. In effect the DSM-IV criterion 'avoidance and numbing' was separated into two criteria: avoidance and negative alterations in cognitions and mood. As discussed in chapter 1, this change was influenced by factor analytic studies for example (Solomon, Mikulincer and Berbenishty 1989; Foa, Riggs and Gershuny 1995) which highlighted the distinctions between 'effortful avoidance' and numbing. Numbing was found to be an identifying feature for PTSD in achieving a differential diagnosis (Foa and Rothbaun 2001).

Criterion E: *alterations in arousal and reactivity* were experienced by many people who reported sleep disturbance, irritability, hyper-vigilance and angry outbursts. In this study heightened arousal and reactivity was more common among people who had experienced a single event trauma such as a road traffic accident while numbing was a more common experience among people experiencing the long term effects of traumatic bereavement. However this was not exclusively the case in this sample and the sample size is too small to generalise; this would however be an important issue for further research.

Criterion F: *symptoms* of *duration of more than one month* was met by all participants.

Criterion G: *functional significance,* which relates to symptom related distress or impairment in functioning was met by all participants who described felt distress and enduring impact of trauma in relationships with others in families, and in work and social situations.

Criterion H: *attribution* out rules causal factors other than trauma. In this study there was an identifiable source of trauma in each case and no one reported an alternative cause of distress. Criterion I which specifies PTSD with dissociative symptoms and Criterion J which relates to delayed onset did not apply in this study.

Although the research found considerable overlap between the experiences of the respondents and the DSM PTSD symptom criteria, reactions were not described by the

research participants as discreet emotions and cognitions as per the DSM, but instead as embodied, lived experiences which impacted on all aspects of their lives.

This finding fits with Heidegger's (1927) elucidation in "Being and Time" of the situated-ness of human beings in the world and his rejection of Cartesian distinctions between the thinking subject and an exterior objective world as interpreted by Bracken (2002) and others and discussed in the literature review. I used Heidegger's concept of Befindlichkeit in analysing these findings as discussed in chapter 5. This illustrated both the reflexive nature and inter-relatedness of three levels (i) feelings of trauma and loss; (ii) changed sense of and experience of self; (iii) changed situation or circumstances that are co-constitutive of trauma experience. In telling the story of their experiences the participants moved readily between these dimensions and the efforts made to cope with their impact in everyday life. Therefore the interpretation of trauma reactions in this study differs from that inherent in the DSM which is cognitively rather than socially oriented. This raises issues addressed by Davis in relation to pathologisation of trauma, specification of professionals to treat it and of cognitively based treatments (Davis 1999). The findings of this research support Davis' concern in relation to lack of interventions to prevent trauma escalating to PTSD. The findings also support the need for psychosocial intervention to reflect and respond to the ways in which trauma is lived, which will be discussed in relation to the two remaining primary research findings. Finally the reflexive nature of trauma experience was very evident in the depth and detail of people's analyses of their experiences of trauma, the essence of which emerged in the research as an experience of liminality. By extension experiencing trauma was akin to entering a liminal space, such was the sense of dis-placement and uncertainty and the profundity of loss, sadness and change. The term liminality was not used by any of the research participants but applied by me, the researcher as a theoretical concept (Charmaz 2006) in the final stages of analysis. The concept of liminality is generally attributed to the anthropologist Turner's (1969, 1974, 1977) development of Van Gennep's work on rites of passage from one cultural state to another involving according to Turner, three phases: separation, transition, and incorporation. He used the metaphor of a tunnel to convey the dark uncertainty of this transitional experience. He saw the liminal phase as

> *'.... the pivotal point of the transformation from phase to phase or state to state.....at one and the same time, the conditional negation of both states or phases of secular social identity, the common ground of both and the power to transform the one into the other.'*
>
> (Turner 1977: 54).

The concept of liminality has been used to convey the subjective experiences of fear, uncertainty and disorientation in various traumatic situations for example following a diagnosis of serious illness such as cancer (Little et al 1998; Navon and Morag 2004); in the context of living loss experienced by carers of persons affected by AIDS dementia (Kelly 2008); to portray the cultural tensions impacting on the mental health of immigrant communities in Canada (Simich et al 2009); to capture the sense of crisis, uncertainty and powerless of parents of very preterm babies in neonatal intensive care units (Watson 2011) and to analyse issues of 'otherness' and risk assessment in mental health social work (Warner & Gabe 2004). The significance of the separation from the past state, the sense of being lost in transition and profound uncertainty regarding the future, implicit in the concept of liminality lends adequacy to its use in representing the nature of the lived experience of trauma.

However completing the transition from the liminal state to a new incorporated state of wellbeing is often not straightforward. The next two sections deal with the research findings that address this psychosocial process. Living through trauma in the everyday world emerged as a process of active social negotiation of life through liminality. People described a recursive trajectory of naming and defining their experience, seeking meaning, coping and not coping in the everyday world and oscillation in connectedness and disconnection in their relationships and dealings with others. Again this was a reflexive lived experience, which led people to question, and re-evaluate aspects of their own lives and of human experiences more generally. This trajectory aligns with Heidegger's idea as discussed by Fieldon that we are at once *'focused inwards on...thoughts and feelings and outwards into 'everydayness'* (Heidegger 1927/1962 cited in Fieldon 2003). It also has parallels with the Dual Process Model of bereavement (Stroebe and Schut 1999, 2001) whereby grief is understood as a process of both confrontation and avoidance of painful emotions and is lived through moving between a focus on grief and engagement in a now changed world.

The recursive trajectory of being absorbed with thoughts and feelings associated with trauma and at the same time engaged in other aspects of life, was reported as being exceedingly difficult by many of the research participants leading to avoidance of certain situations for example being unable to return to work for an extended period or contemplating changing occupation to reduce the risk of further trauma, in the case of a professional driver. Another research participant moved house to avoid memories that were proving too painful. Many *'kept going'* because they felt they had no choice, parents of young children in particular commented on this. Ultimately having responsibilities was considered helpful in coping with trauma by a majority of

participants. Responsibilities mentioned included parenting young children, wanting to be a more available loving parent and partner, financial responsibilities and responsibility in caring for pets. This dual focus on trauma and establishing, maintaining and coping with other aspects of life has also been identified in research with resettled refugee and wider immigrant communities living in Western societies (Simich et al 2009; Westoby and Ingamells 2010; Marlowe and Adamson 2011).

All the service user participants in this study, had sought to or had agreed to attend the emergency department social work service in the aftermath of a traumatic event and social work was generally seen as a resource in managing the mutually influencing emotional and social aspects of trauma experience. Social work as it is understood and experienced by the three participant groups in this research is the subject of the third primary research finding and is discussed next.

Co-constructing Social Work - Creating a 'Thirdspace' in Responding to Trauma

Interviews were held with nine non-social work emergency department staff, from the following professions – medicine, nursing, mental health nursing, occupational therapy and administration. Staff were included in the study on the basis their involvement in inter-disciplinary work and sampled to the point of theoretical saturation. Interviews focused on their understanding of the psychosocial needs of people in the aftermath of trauma, on their perception of the social work role and on how they interface with social work in their day to day work. Perceptions of the position of the social work service within the emergency department were also explored. Their responses constitute one of two secondary findings from the research and will be discussed now.

Perceptions of the Role of Social Work and Referral to the Service.

Four key areas indicating referral were identified namely assessment of need and risk, counselling and psychosocial support, follow up and liaison between the hospital and individual or family and continuity of care between hospital and community (this involved direct work, referral and care planning). Staff clearly identified social and emotional issues as indicating referral to the social work service. They indicated high levels of sensitivity to these aspects of the service users' experience but felt social workers were better placed to address them having the skill set and dedicated time and space (a private office away from the main emergency care area) to do so. However at

times staff applied normative standards in relation to age and gender in judging if a person required a follow-up service which may have militated against potential for preventative work. However all self and family made requests for a social work service were processed not withstanding the staff member's assessment of the need for the service. Staff saw the social work process as underpinned by dialogue, provision of information, containment of anxiety, empowerment, and referral. They saw social work intervention as helping to break cycles of ongoing difficulty in people's lives which contribute to attendance at emergency departments and identified it as having a role in the prevention of re-admissions. Staff therefore showed a very good understanding of the social work role, the service was valued and was seen as an integral part of emergency department care. This is in contrast with negative accounts in the literature on inter-professional practice centring on relative status of professionals, professional identity and specialism and different positions on discretion and accountability (Hudson 2002 cited in Wilson et al 2008). The general assumption is that social workers are more closely managed than some other disciplines resulting in less autonomy (Wilson et al 2008). The opposite was perceived to be the case in this research

> *I see it [social work] .....perceived as a little freer to act because they're not quite stuck in "the system" and there's no Big Brother really dictating down to them....social work practitioners would be perceived as being more autonomous.....a little more outside the system, a little more independent of the system, more in control of what they themselves are doing,.....I think that's a good thing.*
>
> (Doctor- Registrar)

Bronstein identified five elements of effective collaboration between social workers and other professionals which pertained at least to some degree in this context as discussed below. They are

> *".... Interdependence, newly created professional activities, flexibility, collective ownership of goals, and reflection on process."*
>
> (Bronstein 2003:297)

Social workers had a separate management structure which lent autonomy. Bronstein envisaged *'newly created professional activities'* as newly initiated inter-professional projects. While there was a tradition of joint work with certain disciplines for example with the mental health team and the occupational therapist there were no joint projects in place at the time this research was undertaken. Although an extremely busy working environment staff from all professions were flexible in relation to their time and how

they defined their roles with a shared commitment to optimum patient care. There was no structured reflection involving social workers with the team as whole, as nursing and medical shifts changed outside of social work working hours but a referral system through liaison nurses facilitated discussion, feedback and reflection.

Negative Preconceptions of Social Work held by Service Users.

This constituted the second secondary finding of the research. Many service users identified a range of preconceptions about social work that caused them concern when a referral was suggested, although this was not an issue for others. However even those who did not consider it an issue personally, felt it might be an issue for others. Preconceptions centred on the 'control' side of the care versus control debate discussed in chapter 2 of the literature review. Parents were genuinely concerned about a referral to a social worker if they or their child was vulnerable in some way for example a young mother who had self-harmed was frightened she was being referred to social work to have her baby 'taken from' her. These negative preconceptions were corroborated by referring staff. The Consultant identified situations where teenagers may have been admitted to the emergency department having been drinking as instances in which he would be most likely to get a negative reaction to suggestion of a referral to social work

> *"I'd say to the parent that I want you know, routinely, a social worker to follow you up on an outpatient basis, they would be concerned...they might think.... "Oh God, this thing has spiralled out of control, before I know it, they'll take my kids off me..." there might be that kind of fear..."*
>
> (Consultant)

Other people associated social work with *"dysfunctional families"* or with provision of material support and therefore could not easily identify with the suggestion of a referral for themselves. The source of these negative stereotypes seemed to be media representations or a generalised understanding. None of the participants attributed the preconceptions to direct experience. Some of the male participants felt prohibited from attending a social work service or any service where they might be expected to talk about personal or emotional issues and understood this as a 'macho thing'. These findings were worrying as such preconceptions likely prevent many people from accessing support. In addition many people approach a social work service regardless of the setting with fear and apprehension. This was under-recognised by social workers

in this research (including myself as a practitioner researcher), who tended to view the service as a resource. Fortunately people's fears seem to dissipate with additional information and reassurance from referring staff and in initial contact with the social worker. The need to address people's preconceptions in an initial meeting, where possible, is a recommendation of this research.

Creating a 'Thirdspace': Features of Social Work at the Interface of Medical and Psychosocial Realms

Social work itself has been described as a 'liminal profession' because it operates 'in-between' the public and private spheres inhabited by individuals and families (Christie 2001) often mediating between those who are accorded discursive rights and those who are excluded (Warner and Gabe 2004). In the context of this study, despite barriers to initially engaging with the service, social work seemed to have successfully established itself at the interface of medical and psychosocial realms creating an autonomous transitional space or 'thirdspace' encompassing spatio-temporal (dedicated time and protected space), relational (collaborative and relationship-based), dialogical (the service is delivered through talking and interactive discussion), ethical (the social work approach was based on humanistic ethics and principles of social justice) and phenomenological (meaning making) dimensions, in which people could articulate and explore feelings, experiences and responses to trauma. The concept of the 'thirdspace' comes from the writings of the cultural theorist Homi Bhabha (1994, 2003, 2009) as discussed in the literature review and represents his interpretation of liminality (Barlow 2007). Bhabha described the Third Space as a

> *"...a borderline place where cultural differences touch..."*
>
> (Bhabha 1994: 207).

The concept suggests a state of 'in-betweenness' or hybridity where differences and disjunctures including past identities and future possibilities can be held, explored, merged or overcome to form something new. According to Warner and Gabe

> *"Whilst liminality represents a state of being 'in-between' two otherwise distinctive entities, hybrid forms of otherness involve the merging of characteristics from two distinctive entities. They are still 'in-between', but they have created something new."*
>
> (Warner and Gabe 2004: 388)

In developing the concept of the 'thirdspace' Bhabha (2003) acknowledges the influence of Winnicott's work on the transitional space or space between the person and the other/environment. Although linked to liminality, Bhabha's term 'thirdspace' better represents the 'space' provided through social work than the liminal space as Turner (1977) envisaged it. While Turner saw it as a transitional stage preceding the eventual passage to a new state, Bhabha (1994) allows for tension between the old and the new states to be held and negotiated. Barlow suggests Bhabha's 'thirdspace' is a space where

> *"...differences overlap and displace each other and cultural values are negotiated, individuals often emerge transformed; a cultural hybrid emerges that is continually in transition and always incomplete."*
>
> (Barlow 2007: 245)

The findings from this study would suggest that a 'thirdspace' is co-constructed when the social worker and the person(s) affected by trauma come together in an area and interaction which is part of but symbolically separate from the Emergency Department, to explore feelings and experiences, consider possible explanations and interpretations and experiment with new coping mechanisms and resources that hold potential for altering current levels of distress and suffering. The co-construction of the 'thirdspace' is represented in Figure 2 by the horizontal axis of the diagram. The detail of the processes which both constitute and are enabled in this 'thirdspace' will be discussed in the next section.

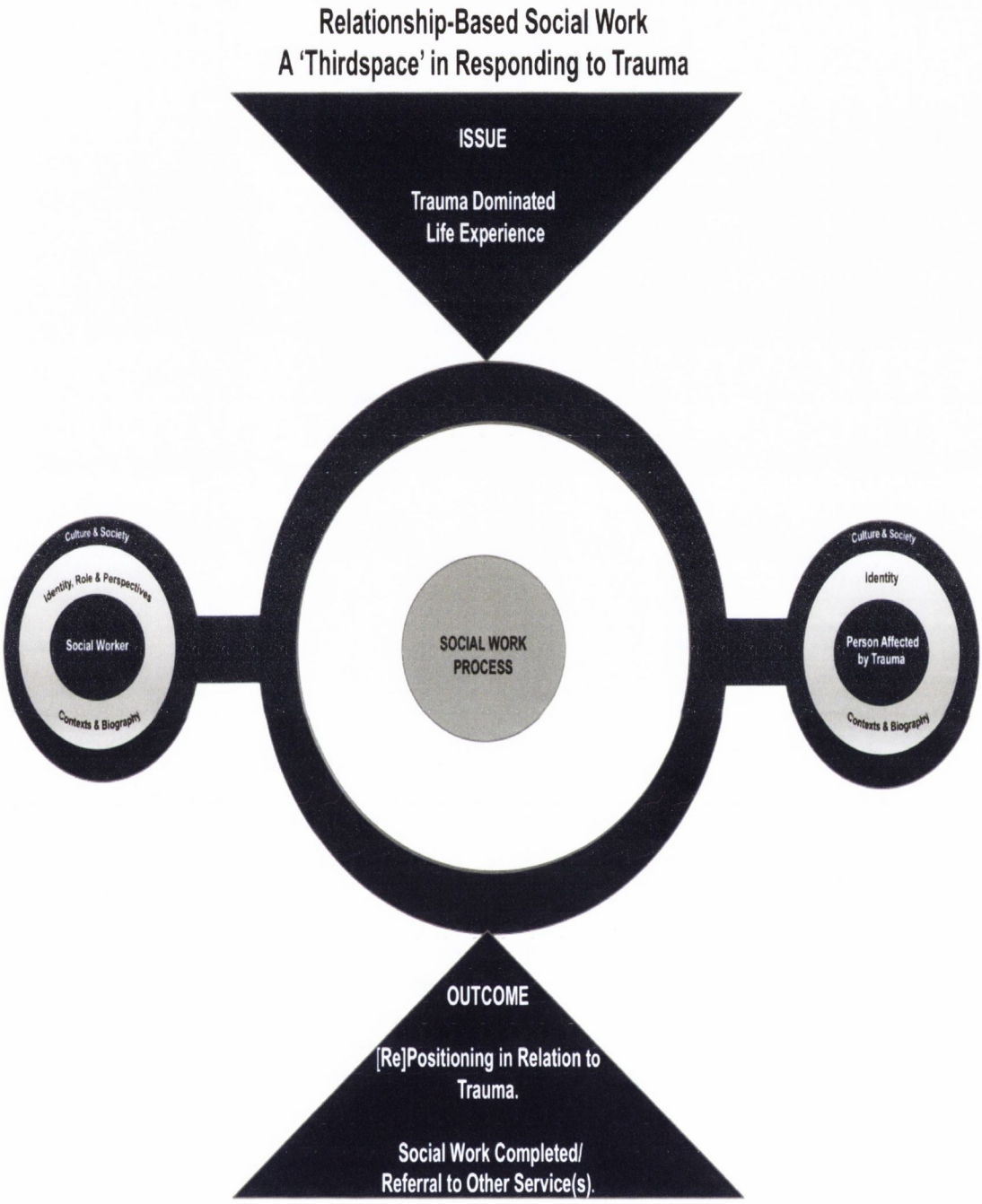

Figure 2: Relationship-based Social Work: Creating a 'Thirdspace'

A strong message from this research is the centrality of the relationship-based nature of social work practice in trauma work. Service users consistently identified the importance of finding a safe and accepting place to talk through their distress. They cited the importance of feeling comfortable with the social worker, finding her easy to communicate with and believing in her commitment and capacity to help. Compatibility and shared understanding reducing the need to continuously explain was valued with one research participant summing up with *'she gets where I'm at'*. For others disclosing issues and feelings to a stranger felt uncomfortable at first and required adjusting to. These findings align with service user research which consistently identifies the quality of the relationship as significant to service-users (Mayer and Timms 1970; Quinton 2004; de Boar and Coady 2007; Beresford, Croft and Adshead 2008; Howe 2008; Buckley, Carr and Whelan 2011). The findings are also consistent with research that shows service users to be concerned with the personal qualities of the social worker (Doel and Best 2008). A majority of the participants spoke at length of feeling a sense of relief and unburdening while talking with the social worker and feeling lighter, uplifted and relieved afterwards. They attributed this variously to the social worker's listening skills and ability to pick up on the important things even though they may not have been identified as important in the conversation. This fits with key elements of relationship-based practice particularly attunement and containment and awareness of transference dynamics (Howe 1998; Sudbery 2002; Trevitchick 2003; Ruch 2005; Wilson, Ruch, Lymbery and Cooper 2008; Ruch, Turney and Ward 2010; Turney 2010; Smith 2010). Conversations that helped people to make sense of experience and find meaning in what they were going through were important. This encompassed provision of information on trauma by the social worker which contextualised people's experience and fits with the concept of normalisation, integral to psychological debriefing (Mitchell 1983; Dyregrov 1997). It also had a more phenomenological or existential dimension where the social worker became attuned to the meaning and significance of current experience in the context of the person's wider life. The social worker's ability to convey this understanding was important to service users. The importance of this component of social work has been addressed by social work theorists (Goldstein 1986; England 1986; Howe 1986; Goldstein, Miehls and Ringel 2009) and lead England to argue

> *".....that social workers will need to know about the meaning of experience is the only constant and the only necessary element of all social work accounts"* (England 1986:117).

The social workers use of a strengths perspective was very evident too and appreciated by service users although they did not use the term. Other professionals identified empowerment as part of the social work role. Barriers to change were explored and challenged, including socio-cultural barriers such as gendered role expectations. Participants reported on this resourcing aspect of the work as making a lasting difference to them in various aspects of their lives. Variously service users reported increased confidence, self-esteem and self-efficacy after social work sessions. Service users commented on finding it helpful to seek a balance between focusing on trauma and focusing forward on possibilities. Saleebey makes this point in relation to the use of a strengths perspective in trauma work.

> *"Practicing from a strengths perspective does not require social workers to ignore the real troubles that dog individuals and groups.....But in the lexicon of strengths, it is as wrong to deny the possible as it is to deny the problem.....[A strengths perspective] does deny the overweening reign of psychopathology as civic, moral, and medical categorical imperative..... It denies that all people who face trauma and pain in their lives inevitably are wounded or incapacitated or become less than they might."*
>
> (Saleebey 1996: 296-297)

The social worker and service user relationship was in itself identified as a key resource for change and many people viewed it as a secure base to return to as they took steps in rebuilding relationships and re-engaging in other aspects of life that were kept to a minimum in the liminal post trauma phase. This re-engagement was encouraged through involvement of family members in sessions and by goal and task setting which people reported to find useful. Finally opportunities for review were seen as important elements of social work, which allowed for on-going consideration, integration and consolidation of changes achieved and a refocus on future goals. This is consistent with the dual emphasis on reflective and relationship-based practice as articulated by Ruch 2005 and Wilson et al 2008. In Figure 3 overleaf these dimensions of social work practice are integrated with the previous elements of the conceptual framework set out in figures 1 and 2. I will go on to discuss the framework further in the next section.

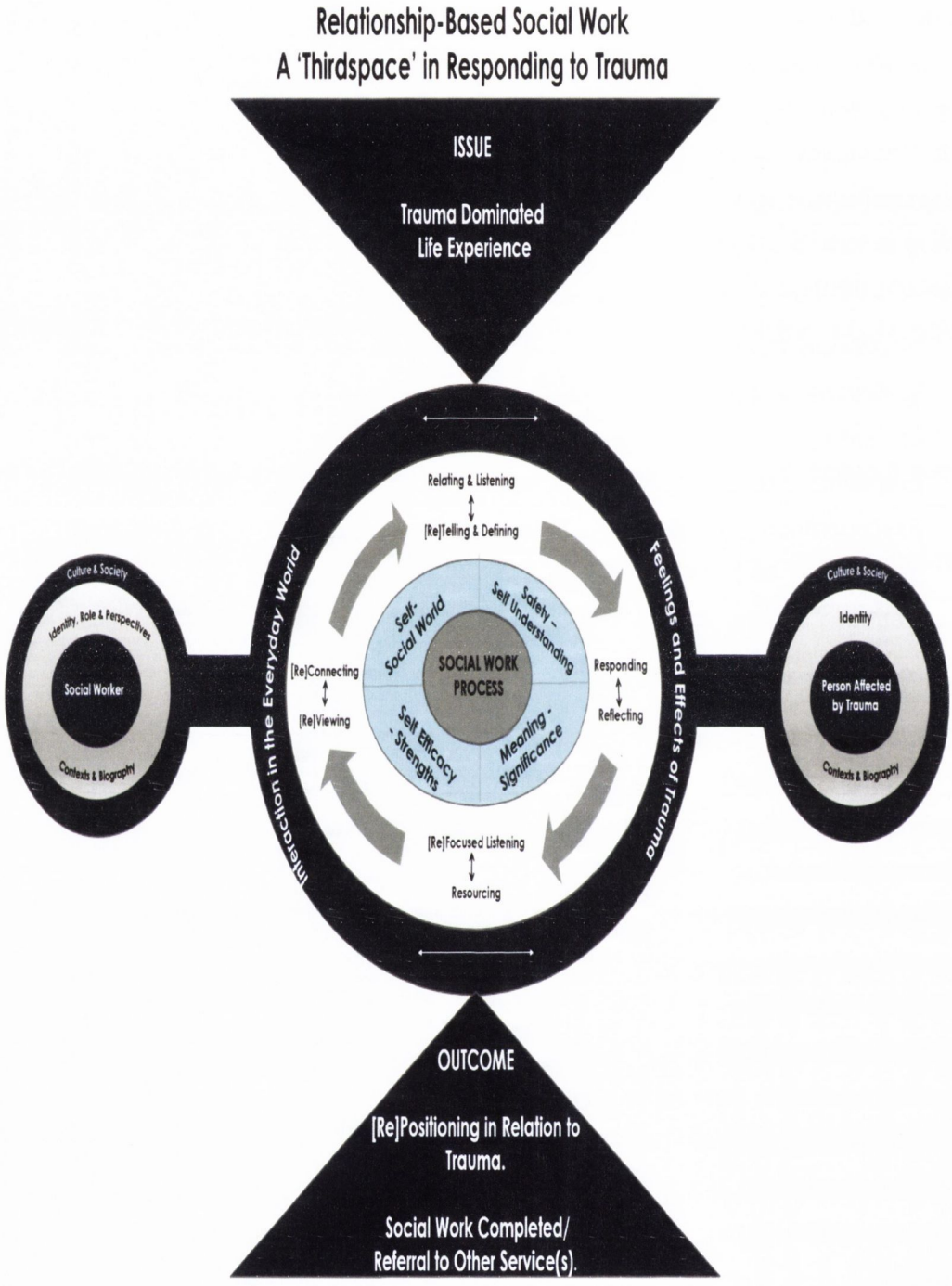

Figure 3: Relationship-based Social Work: A Thirdspace in Responding to Trauma - the Process

Relationship-based Social Work: A Thirdspace in Responding to Trauma

This section seeks to draw together the key elements of the foregoing discussion in combination with other relevant issues addressed in the literature review to further explain the conceptual model for trauma-informed social work practice, which is developed from this research.

Rationale for the Theoretical Base of the Framework

The framework is based on the research findings and the theory and practice of relationship-based social work. The social work relationship emerged from this research as the central element in trauma-informed social work practice in this context and was found to be both facilitative of change and therapeutic in itself in providing safety, understanding, containment of anxiety, opportunity for reflection and meaning making and a secure base to return to discuss on-going issues, successes and difficulties. This dual process is explicated in the relationship-based practice literature (Howe 1998; Sudbery 2002; Trevitchick 2003; Ruch 2005; Wilson, Ruch, Lymbery and Cooper 2008; Ruch, Turney and Ward 2010; Turney 2010; Smith 2010) It also draws on my practice experience as a practitioner researcher and that of former colleagues who participated in the research and have reviewed the framework as part of a member checking process set out in the methodology of this study. The framework is also based on theories of liminality (Turner 1969, 1974; 1977), the transitional space (Winnicott 1971) and the 'thirdspace' (Bhabha 1994, 2003, 2009). Spatial metaphors seemed to suggest themselves throughout the research. From the early research interviews with service users, trauma was described in ways that conveyed dis-placement and a sense of being adrift and lost, often in a void particularly in situations of bereavement or where something that was once meaningful is now viewed negatively because of a traumatic event, for example participants' views of work following an occupational injury and what felt like uncaring or hostile responses from employers. In terms of physical space the social workers' dedicated quiet office space adjacent to the emergency department was perceived by non-social work staff as a resource in creating a safe space to work with people in distress. It was perceived to be autonomous and symbolically different and to the rest of the department thus allowing for a different approach in responding to people's needs. Social work was seen as providing a service 'in-between' emergency health care and discharge home. As the work was further conceptualised other interfaces emerged between past/present,

present/future, inner/outer worlds. The relationship-based 'thirdspace' of social work allowed a safe and resourced space for people to, as Bhabha (1994) envisaged hold the tension of these binaries, to become familiar with the insistences of both and in time negotiate a position in-between that was less distressing and allowed hope back in.

The Vertical Axis – The Process Over Time

The vertical axis represents a process through time, moving from issue, to social work process to outcome. Trauma is non-teleological (Janoff-Bulman 1992, Davis 1999, Kelly 2008). Many people move beyond trauma but on reflection say they have changed, often people identify positive change others don't, at least not in the short to medium term and theirs is an experience of living through trauma. I have therefore based on the research findings, literature and practice experience suggested the outcome as one of re-positioning in relation to trauma rather than as 'recovery' or 'resolution'. As one research participant said '*I didn't want to feel better, I needed to do this [grieving]*' She and others wanted different outcomes from social work such as a place conducive to talk about the extent of her loss and to understand her own feelings better.

The Horizontal Axis – The Social Work Relationship

While the vertical axis represents past, present and future the horizontal axis represents the present time meeting of the social worker and person affected by trauma who in meeting co-create the 'thirdspace' of the social work conversation.

As discussed the social worker and service user relationship is in itself a key resource for change and not merely an assessment, co-ordination or referral service although it may encompass these components. Both people bring their contexts and biographies to the relationship. Shared or similar contexts and biographies may initially allow for a high level of recognition and feel re-assuring but this should not be assumed. Reflective practice and reflexivity are important elements of social work, which allow for on-going consideration and integration of the inter-subjective elements of practice as they become relevant to working together (Morrison 2001, Ruch 2005, Wilson et al 2008). The service user's feelings, reflexive sense of self and sense of their situation, which underpin identity together with the efforts they are making to cope in their changed situation are brought to the social work relationship. This forms the frame or

focus of conversations. The social worker's personal involvement is framed by the social work role and social work perspectives (knowledge, values and skills) which underpin the creation of a sense of safety, respect, recognition and understanding of issues raised by the service user. In the initial meeting the social worker is welcoming, calming and acknowledging of the person's situation. Creating safety is a key element of trauma work (Herman 1992, Hobfoll 2007). Brief introductory information about the social worker, the service, the form an initial meeting usually takes and possibilities for further support, helps the person settle in, get their bearings and restores a sense of control in relation to what they can expect from the service. This is important as trauma produces a profound sense of loss of control (Dunn 2001). This research highlights that the social worker needs to be mindful of preconceptions the service user may have about social work or any aspect of the service and explore this as part of a relationship-building process in beginning work.

The Frame/Focus of the Work

The outside circle represents the frame or focus of social work, which is psycho-socially and culturally oriented, engaging with the naturally occurring trajectory of meaning making, interacting and coping in the everyday world as discussed in chapter 6. The social worker asks open questions about the process of coming to the service (reason for referral) allowing the service user to bring the focus to whatever is most important or to what is easiest to talk about first. The social work approach is ethically lead rather than driven by a particular theory or procedure. This is to allow the service user to define and interpret their experience in their own terms rather than impose definitions and meaning on their realities. In her argument for putting ethics before theory to ensure we don't do injustice to people we work with, in our professional representations of them, Rossiter suggests

> *".....there is no professional story that adequately represents the singularity of person. We then might base social work on sociality: the moment when we hesitate before we know and, instead, leave room for others to be outside what we know, beyond our reach, where we cannot lay hold of their personhood, thereby respecting persons..... [giving] up the fantasy of complete comprehension in favour of an orientation towards the revelation of the Other. It means that we no longer look to any new theory or passing fad as the answer. Instead, we consider new knowledge as second to ethics: a resource for conversation, questions and self-discipline that grounds an ethics of sociality*

and generosity. In this way, social work can situate itself in justice-oriented representations……"

(Rossiter 2011:994)

The conceptual framework developed through this research, although relationship-based in orientation is otherwise epistemologically open. Following Rossiter I believe no one theory is adequate to represent the immensity and complexity of human experience and instead theories should be used as sensitising concepts (Blumer 1986) to help in the recognition of someone's experience, to suggest a direction for further discussion, to generate information that can be shared with the service user, to deepen understanding, resist oppression, expand worldviews and generate possibilities and hope. The social work relationship acts as a 'container' (Bion 1962) for difficult and unmanageable feelings, lessening their overwhelming effects and opening ways to reduce their impact. Trevithick discusses the process of containment in the practice setting

"……..talking to someone who has the ability to listen, to empathise, to ***take in*** *and to* ***bear*** *the worries being expressed, and the ability to come alongside the individual in ways that communicate an understanding and give the sense that the person is not alone. The final stage of this process involves offering back the concerns to the anxious person but in a modified form-where the major anxieties are managed but are altered so that they no longer carry the same 'sting' or sense of turmoil or anguish. This enables 'natural' growth processes to reassert themselves….."*

(Trevithick 2003:171 original emphases)

Reflective and relationship-based skills of listening, responding, reflecting, re-focused listening, resourcing, reviewing and re-connecting are used throughout the conversation to fit with the service user's feelings, issues and needs. This is an interactive, two-way process and is depicted as such in the middle section of Figure 3 with two-way arrows between each skill set. This process is cyclical and flexible, allowing for concentration on any one area according to the current issues and needs of the service user. However it is set out to move from a more cognitive level of storytelling to a more emotional level of feelings and meaning and back to a cognitive level of refocusing on strengths, reviewing and planning in order to continuously create and maintain safety.

Finally the inner circle presented in a pale blue colour, brings a focus to the central elements of trauma-informed work namely creating safety and self-understanding; considering meaning and significance; building self-efficacy and strengths; and facilitating connectedness with self and social world.

Taken together the elements of this framework provide the essential elements of trauma work as set out by Herman

> *".....establishing safety, retelling the story of the traumatic event, and reconnecting with others."*
>
> (Herman 1998:98)

by Hobfoll et al

> *" 1) a sense of safety, 2) calming, 3) a sense of self- and community efficacy, 4) connectedness, and 5) hope."*
>
> (Hobfoll et al 2007:283)

and by the Canadian Council on Social Work Education

> "Incorporation of trauma awareness, safety, rebuilding control and empowerment and a strengths-based approach"
>
> (Canadian Council on Social Work Education 2012)

Limitations of the Study

The study has a number of limitations. It is a small scale study situated in the social work service of a hospital Emergency Department focusing on experiences of fourteen service users and nine non-social work emergency department staff whose perspectives were gathered through semi-structured interviews. The number of research participants was determined by sampling to theoretical saturation. In addition the perspectives of the three social workers who were directly involved in service provision in the Emergency Department and those of the social work manager were gathered through participation in a mini focus group. The methodology allowed for in-

depth understanding of people's experiences of trauma and of a social work service in their respective capacities as service users and service providers within a single, specific context and at a particular point in time. The findings are not representative in a statistical sense. No claims of a quantitative nature are made, either in relation to the sample size or the way in which it was selected. Instead the research sought to explore the subjective experiences, perceptions and practices of the three cohorts of research participants. I am also mindful that meanings and practices emerge in and vary across contexts. However the research generated a number of issues and themes of liminality and 'thirdspace' that may be transferable to similar contexts. These themes have been integrated in a relationship-based social work practice model that may be relevant to social workers engaging in trauma work in other health care contexts.

The study did not seek to research the experiences of partners, children, family members or other significant people in the lives of service users. However the central roles of family members and others in the trajectory of living through trauma clearly emerged from the data, as reported in Chapter 6. Research participants variously described experiencing a changed sense of self, sometimes as a result of trauma reactions such as avoidance and hyper-arousal (DSM 5) and living in a changed situation. The negative impact this had on others was a catalyst for seeking professional support in a number of instances. The findings of this study suggest that the impact of trauma on family members and significant others warrants further research. This study engaged people in the immediate aftermath of concluding their work with a social worker. Research exploring the potential long term impact of social work in the context of trauma is also required.

Finally, there was a significant time lag between data collection and analysis which took place in three phases with three separate participant groups between 2001 and 2003 and subsequent production of this dissertation. This was due to competing demands of undertaking research, working full-time (initially as a social work practitioner and manager and laterally as a social work educator) and balancing personal commitments. Having moved to work in the university, I made a decision in 2005 with the support of my supervisor, to apply to take time off the PhD register to concentrate on my new roles as a lecturer and practice-learning coordinator. My application was approved by the university. During my period 'off register' I continued to work on the study as time allowed, completing data analysis and developing the practice model based on the findings. I was further engaged with the areas of social work theory and practice in trauma contexts, through developing and delivering an assessed teaching module for final year social work students on this topic. I returned to

the PhD register in 2012 and completed the writing of the dissertation in 2013. I addressed the time lag during the writing up phase by returning to the research site and arranging interviews with the three social work respondents who took part in the original study to review the findings and discuss the relevance of the social work model for current practice. The model was well received and was thought to capture key issues and interventions and represented the relationship-based process in the work. No changes were proposed. There was a consensus on applicability of the model in the current practice context. The challenge of balancing commitments to direct practice and research is common for practitioner researchers (Carter Anand and O'Connor 2010) and may be a factor in the relatively low output of practice-based research in social work in Ireland.

Observations and Conclusion

This research set out to understand the nature of the lived experience of trauma and the elements of a responsive social work approach in this context. In reviewing the literature both the extent of the psychiatrisation of trauma (Davis 1999; Bracken 2001) and the reductionism inherent in categorising the immensity of human traumatic experience as a single disorder - Post Traumatic Stress Disorder (DSM 5) (Burstow 2003; Seeley, K. (2005); Marlowe 2010; Westoby and Ingamells 2010) to the neglect of the range of ways trauma is expressed, understood and managed that fall outside the parameters of this narrow diagnosis was striking. It is perhaps easier to be critical of another discipline than of one's own. However given the pervasiveness of traumagenic events in the social and the natural world occurring at international, national, community, family, inter-personal and personal levels (Meiner and Veel 2012; Winkel Holm 2012); I would argue it is a responsibility for all human service disciplines to contribute to the knowledge base in relation to understanding and responding to the needs of people affected by trauma. With its theoretical foundations in the social sciences and its relationship-based practice orientation, social work can make an important contribution in mediating the psychological, social, cultural, existential, political and economic interfaces of trauma experience. Social work has not yet reached its potential in this regard.

This practitioner research study gave me an opportunity to work with service users and social work and non-social work colleagues to articulate social work theory from practice. Practitioner research has many advantages (Padgett 2008; Shaw and Lunt 2011) for example researchers as 'insiders' in their organisations are allowed privileged

access to research sites and can negotiate the involvement of colleagues, service users, carers and wider communities of interest as participants, advisers or co-investigators. However it is important to address potential problem issues such as pre-understanding, role duality and managing organisational politics (Brannick and Coghlan 2007).

Constructivist grounded theory (Charmaz 2000; 2006; Brymant and Charmaz 2007), as a well-structured approach, proved to be a suitable research methodology for a beginning researcher. Its structure also helped maintain a focus on the data which guards against the risk of 'insider bias' in practitioner research. Collaborative research can build mutual understanding across disciplinary, service user-service provider and other divides. Small team research projects would serve to build research capacity and embed research mindedness in social work teams to a greater extent than an individual project such as this can achieve. Research is labour intensive and dedicated research time is needed if practitioner research is to be developed within social work.

This research highlights the benefits of inter-disciplinary work and the inter-dependence of social work and other disciplines in service delivery in the hospital Emergency Department. Good collaboration across disciplines allows for a more comprehensive service to meet the complex needs of service users. It also provides for sharing of responsibility and risk, which one hopes can facilitate fuller engagement and more creativity in practice. Opportunities for disciplines to share skills and knowledge through working together, contribute to the ideals of a learning organisation (Abramson and Mizrahi 1996); Bronstein 2003; Wilson et al 2008). There is also potential for collaborative, interdisciplinary research, informed by social and cultural theories and methods to address the limitations of many of the existing trauma studies (Simich et al 2009).

The extent of negative preconceptions held by service users in relation to social work and social workers was of concern. Preconceptions were based on media representations of social workers, public criticism and a generalised sense of what social work does, centring on child protection and working with people in poverty rather than on research participants' direct experiences. This lead to apprehension and fear for some participants in this study, when referral to social work was recommended. Negative public perceptions of the social work role in relation to the protection of children and vulnerable adults have been addressed in the social work literature (Clarke 1993; Banks 2001; Humphries et al 2004; Lundy 2006; Pritchard 2006; Dominelli 2009; Seden et al 2010). Social workers need to be aware such negative preconceptions may be a barrier in service users engaging with social work in health

and other contexts particularly in initial contacts. This is an issue that needs to be addressed at all levels within the profession.

This research underlines the value of understanding experience from the perspectives of those who live it. People living through trauma articulated a depth and detail of anxiety, pain and loss that an outside perspective could not reach. In talking to people about living through this experience, a trajectory of responding to trauma in private and in public emerged. Social work practice seeks to engage experiences, perceptions and adaptive processes arising from trauma to reduce distress and regain hope and wellbeing. The conceptual framework 'Relationship-Based Social Work A 'Thirdspace' in Responding to Trauma' offers a place to begin.

Epilogue – Reflections on Theory, Research and Practice

This study has its origins in a search for ways to respond to the painful feelings and changed circumstances commonly experienced by people living through trauma. Working as a social worker in a hospital emergency department, I had witnessed the complexities of trauma, grounded in a multiplicity of contexts. My search began with formal theory. I found that the extensive trauma literature is for the most part produced from within the scientific rational idioms of psychiatry and psychology and is underpinned by empirical research. Much of this published research coalesces around the classification of the mental health disorder Post Traumatic Stress Disorder (PTSD), which since 1980, has been enshrined in the authoritative Diagnostic Statistical Manual (DSM) of the American Psychiatric Association. The DSM specifies psychological and physiological trauma reactions, present in particular constellations over a prescribed timeframe as constitutive of PTSD. As a categorical diagnosis PTSD does not allow for variability in trauma reactions. It fails to address socio-cultural contextual issues and has been criticised for its universalism and the resulting de-politicisation of trauma. While it offers a partial explanation of trauma experiences, reliance on the PTSD construct risks pathologisation of what for some, may be adaptive behaviour.

There is markedly less published work on the social, cultural, existential, political and historical dimensions of trauma or on psychosocial processes developed as a response to traumatic experiences. However, I found research based on social constructionism, from philosophical, political, feminist and critical social work traditions valuable in indicating a theoretical frame for my research and a potential focus for practice. Having established a social constructionist epistemology which emphasises the inter-

subjective construction of trauma within language and discursive practices, I then turned to the social work literature, to locate trauma-informed social work with reference to both a chronological account of theoretical developments within the discipline and debates on the role and positioning of social work. Principles of good practice in trauma intervention produced by Herman (1992, 1997, 1998); Hobfoll et al (2007) and the Canadian Council on Social Work Education (2012) were used as a benchmark in the identification of the constituent elements of social work practice in this context. Relationship-based practice, the strengths perspective and the person-in-environment approach were all potentially relevant in addressing the multi-faceted nature of trauma. A theoretical framework was needed to integrate these diverse perspectives as foundations for social work practice. Reflecting the positioning of social work at the interfaces of different realms of lived experience, for example the intersection of people's lives pre and post-trauma and inside and outside the hospital and the need to respond to the sense of liminality or dis-placement inherent in trauma, social work was conceptualised in terms of the spatio-temporal metaphor of the 'thirdspace' which provided opportunities for dialogue across binary divides.

Moving to the empirical phase of the research brought my focus to 'trauma as it is lived' and to 'process knowledge' inherent in practice. In the study, undertaken with service users and service providers from social work and other health related disciplines, the lived experience of trauma emerging from the data analysis was one of liminality, of being cut off from a familiar life, from people who were close and from future possibilities, leaving people feeling lost, lonely and in despair. However feelings were co-articulated with ways in which they were managed in relationships and in social situations, generating responses that were particular to the situation and the people involved. These responses set up recursive cycles of interpretation and action encompassing the (re)actions and interpretations of others (Blumer 1969). This continuous referential relationship between inner and outer worlds constitutes a cycle of meaning-making or 'a hermeneutic circle' and supports the social constructionist worldview already adopted. The data suggests that these interactive, psychosocial processes are often difficult and stressful for people living through trauma. Frequently it is change, tension or conflict at this level that renders distress visible and generates referral to professional support services.

The findings from the second part of the study which explored people's experiences of the social work service pointed to the significance of the relationship with the social worker, in allowing for a safe space to talk through and reflect on often very painful

experiences of trauma and its ongoing impact in their lives. Many of the research participants highlighted the social workers' responsiveness to what they said and felt. They spoke of the social workers' capacity to pick up on what was most important from the range of feelings and issues articulated or left unsaid. People reported feeling lighter and less burdened having talked through their experiences and feelings. Interactive dialogue with the social worker also explored people's personal sense of what is meaningful and the wider frames of reference (cultural, political, religious, gender, family norms) they used to think about their situation. Through discussion and reflection they identified linkages between wider belief systems and troubling personal thoughts and feelings. This was said to have opened up new ways of seeing and generated new choices and possibilities in managing life through trauma. Relationship-based social work practice already conceptualised as opening up a transitional space (Winnicott 1971) or 'thirdspace' (Bhabha 1990, 2009) emerged as a congruent response to people's sense of dis-placement and dis-connection in the context of trauma. This 'thirdspace' of the social work relationship exists among multiple other spaces or intersections where people live their lives, negotiate meaning and take action. It is a space in-between, inextricably connected to the relationships from which it forms but affording opportunity for intra-subjective reflection and inter-subjective dialogue. This is made possible by the containing possibilities of the relationship, attunement to emotional needs and consciousness of the connections between intrapersonal feelings, relationships and lived experience in wider social contexts.

Through the research process it became clear that the relationship between the service user and the social worker and the resultant 'thirdspace' of social work practice as conceptualised in this study, is in itself both a source of knowledge of what may need to be addressed and a resource in responding to ensuing needs. As Flaskas has argued

> *".....creative therapeutic practices emerge in the specificity of the therapeutic environment and not so much in the abstractness of theory".*
>
> (Flaskas 2012:151)

As discussed previously in this chapter, Rossiter makes a related point foregrounding a practice ethic that demands we desist from relying on prescribed theories and classification systems and instead meet the other person as they are. She contends that

> *".....there is no professional story that adequately represents the singularity of*

person. We then might base social work on sociality: the moment when we hesitate before we know and, instead, leave room for others to be outside what we know, beyond our reach, where we cannot lay hold of their personhood..... It means that we no longer look to any new theory or passing fad as the answer. Instead, we consider new knowledge as second to ethics: a resource for conversation ....."

(Rossiter 2011:994, already quoted in this chapter)

Saleebey also advocates that 'coming to know' is a collaborative process between the individual and the social worker based on 'mutual sharing of knowledge, tools, concerns, aspirations and respect'. This affords the person the opportunity to 'name' their own circumstances rather than being labelled or diagnosed by others (Saleebey 1996:303)

In completing this study I have developed in my understanding of the theory-practice relationship. I have moved from privileging formal knowledge to recognising and trusting the embodied process knowledge inherent in all practice situations. However, I would argue that both forms of knowledge are required to respond to the complexities of trauma and subtleties of each person's experience. Realising and utilising process knowledge can be achieved through a reflexive, relationship-based practice approach as has been set out in the practice framework proposed in this dissertation. This approach draws on theoretical knowledge while giving optimum attention to how people define and interpret their own situations, thereby introducing formal knowledge in a focused way that is relevant and sensitive to people's lived experience The proposed practice approach remains epistemologically open to incorporation of plurality of theoretical approaches as best fit for the individual(s) involved and the contexts of their experience. Though the underpinning knowledge domains are diverse with foundations in psychodynamic, critical and social constructionist theories, points of intersection occur in the emphases placed on meaning-making and negotiating the social world whether at intrapersonal (self-reflexivity) or interpersonal levels, in social groups or in wider cultural and political contexts. The approach incorporates established principles of best practice in trauma intervention. Moreover the findings of this research would suggest that a reflexive, relationship-based social work approach provides a 'thirdspace', where people also move beyond meaning-making and social negotiation of trauma experiences to find ways to transcend limitations and distress, *"....to make hope practical...."* (Giroux 2010: 356) and to reconnect with other aspects of their lives.

Finally undertaking practice-based research has revealed the extensive and valuable resource of tacit process knowledge inherent in everyday practice which is often unrealised or under-realised. It is our ongoing challenge as a discipline, to refine our capacity to work collaboratively with service users in practice and in research, to connect with tacit knowledge of what may make a difference in people's lives in the multiplicity of contexts in which social work is practiced.

The study also illustrates the generative potential of practice research in the development of formal knowledge and practice approaches. As people moved from roles as service users and service providers to become collaborators in a critically reflective research process, reflexivity was enabled, the 'fixedity' of professional power structures was challenged and opportunities for the active participation of all interested groups in knowledge building and service development were opened. The data from this study suggests that participation in practice research was viewed positively by all three cohorts of research participants who had a shared commitment to service development. Service users indicated that a desire to share their experiences in order to help others, was a primary motivation in their engaging with the research. I too will continue to take opportunities to share what I have learned through participation in practitioner/ academic research initiatives.

While formal theory is the scaffold of professional practice, it becomes clear from both social work practice and research that people's experiences tend to exceed the parameters of formal theory and prescribed classification systems. However theory that is near and sensitive to lived experience of trauma offers new insights and possibilities and can be both reassuring and liberating.

> "*Theory and practice are not two separate activities, but different phases of the same contextualized activity.*"
>
> (Butt and Parton 2005: 803)

Integrating collaborative, reflexive practice research with the theory-practice dyad forming a *"triad of theory-research-practice"* (Sheppard et al 2000: 481) enables a meaningful dialogue between lived experience and theoretical knowledge. We have a responsibility to people who use social work services to continue to refine the theory/practice interface through engaging in practice-based research, because to return to Proust

> *"....griefs, at the moment when they change into ideas lose some of their power to injure our heart...."*
>
> (Proust, In Search of Lost Time 3: 944)

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Appendix 1 Information Sheet for Research Participants

HOSPITAL

ACCIDENT AND EMERGENCY DEPARTMENT

SOCIAL WORK RESEARCH STUDY

This research study has developed from the experience of providing a follow up social work service in the Accident and Emergency Department of the hospital. The information gathered from the study will be used to identify the needs and experiences of people who use the service in order to continue to develop relevant social work services that could be of some assistance in meeting those needs. The research study is being carried out in conjunction with the Department of Social Studies at Trinity College and is part of my work towards obtaining a higher degree in Social Studies. I am asking you to participate in an initial interview which will take approximately one to one and a half hours to discuss your experience of having gone through a difficult time in your life and of subsequently availing of a social work service from the hospital. With your permission the interviews will be audio-taped. Your responses in the interviews will be kept strictly confidential and individual responses will not be shared with other hospital staff, unless information is disclosed that indicates a risk to you or others. In such situations a referral will be made to appropriate services. The audio tape will be coded so your name does not appear on it and the tape will be stored in a locked filing cabinet. The tapes will be destroyed on completion of the research study. Identifying information (for example name, age, family size) will be deleted or disguised in any subsequent

publication of the research findings. When the study is concluded I will meet with you to discuss the findings and get your feedback, if you would like.

Obviously you have a right to withdraw from the research project at any time. Your decision to participate or not to participate will not affect your relationship with the social work service at .....Hospital or with the hospital more generally in any way.

If you are willing to participate please sign the attached consent form. Thank you very much for your assistance.

Your willingness to share your experience is greatly appreciated and could make an important difference to other people who use our service.

Signed

Erna O'Connor

Social Worker – Researcher

Appendix 2 Consent Form for Research Participants

HOSPITAL

ACCIDENT AND EMERGENCY DEPARTMENT

SOCIAL WORK RESEARCH STUDY

CONSENT FORM

I have read the research participant information sheet and I have received adequate information about this study. I am aware of the policy of confidentiality and the limitations of confidentiality that apply to the research. I understand that I am free to withdraw at any time without in any way affecting relationship with the hospital social work service or my care at the hospital.

I agree to take part in the study

Signed

Research Participant

Date

Signed

Social Work Researcher

Date

Appendix 3 Interview Guide: Social Work Service Users

INTERVIEW GUIDE: SOCIAL WORK SERVICE USERS

Welcome

Acknowledge peoples' efforts in participating and restate the purpose of the research. Sign the consent form.

1. Tell me about how you came to the service.
2. What were things like for you at that time?
3. You worked with me/with X here over a period of time. Can you tell me what that was like for you? (My aim is to check what people remember and what if anything held meaning or value)
4. In the sessions what felt comfortable/good?
5. What were the hard/hardest parts?
6. How did you feel about attending a social work service?
7. If you were to describe how social work sessions work to someone about to come here what might you say?
8. Did you talk to anyone else in your life, about the sessions?
9. Who/what else was important to you over this time?
10. What did you need to do to be able to continue with your life after the trauma of what happened? (Clarify that what they learned may be of help to others)
11. What is it like for you now?
12. What still may need to change?
13. In what ways could this service change and improve?
14. How have you found doing the interview today?
15. Are there other ideas or observations you would like to add?

Check how the participant is feeling now. Review and agree key themes from the interview. Thank them for participating. Outline the next steps in the research process.

Appendix 4 Mini Focus Group: Social Workers –Guide Questions

MINI FOCUS GROUP: SOCIAL WORKERS – GUIDE QUESTIONS

The Focus Group took the form of an open discussion facilitated by me as the researcher and to which I also contributed.

Welcome

Acknowledge peoples' efforts in participating and restate the purpose of the research and the plan for the interview. Discuss and obtain consent.

The themes/guide questions were

1. Explore views of issues and psychosocial needs of people who use the A&E follow up social work service. What informs these views?
2. Share thoughts on the role of social work in this context.
3. Discuss how each participant works, including preferred theories and approaches. Elicit values underpinning practice.
4. What works? Why might that be?
5. Discuss how social work is understood by service users in this setting and what they may think about social work more generally.
6. Discuss perceptions of social work within the A&E service and the expectations of non-social work colleagues.
7. Check if social workers discuss their work with other A&E colleagues. What information might not be shared? Why?
8. Discuss how they feel about their work.
9. Ask if they are out socially and get into a conversation about work how do they describe what they do?

10. What should change in relation to the social work service provided here?
11. Other ideas and observations or questions?
12. How was the experience of participating in the focus group?

Thank people for their involvement in the research. Review and agree key themes from the interview. Thank them for participating. Outline the next steps in the research process.

Appendix 5 Interview Guide: A&E Staff

INTERVIEW GUIDE: A&E STAFF

Welcome

Acknowledge people's efforts in participating and restate the purpose of the research and the plan for the interview. Discuss and obtain consent.

1. What is your role in A&E and do you refer to the social work service?
2. Who might you refer and why?
3. What do you see as the needs of people who use our service?
4. Are there any common issues or patterns that you notice?
5. In what circumstances do you select social work rather than other A&E services for example the mental health service or the O.T?
6. How do people respond when you suggest they see a social worker?
7. Are they surprised that a service like this is attached to A&E?
8. How would you describe what social work does to a service user?
9. How do you think the service works and how could it be more responsive to the needs of service users and the A&E service?
10. Any other observations or ideas or questions?
11. How did you find the research interview?

Thank people for their involvement in the research. Review and agree key themes from the interview. Outline the next steps in the research process.

Appendix 6 Table: Profile of Research Participants-Service Users

No.	Name	Age	Employment	Concurrent Attendance other Service	Duration of involvement with Social Work Service	Gender	Source of Referral	Trauma type
1	Eileen	50-55	Retired	GP & Psychiatrist	12-15 months	Female	Nurse	Bereavement
2	Linda	30-35	Employed	GP	12-15 months	Female	Chaplain	Bereavement
3	Anna	55-60	Employed	GP & Psychiatrist	3-6 months	Female	ER Consultant	Occupational Injury
4	Brigid	35-40	Employed	None	3-6 months	Female	Friend	Bereavement
5	Therese	40-45	Employed	Bereavement Support Group	9-12 months	Female	Social Work Outreach Service	Bereavement
6	John	45-50	Self-Employed	None	0-3 months	Male	ER Consultant	Road Traffic Accident
7	Dave	30-35	Employed	Psychiatrist	12-15 months	Male	ER Consultant	Road Traffic Accident
8	Kathy	30-35	Employed	None	3-6 months	Female	Partner (Dave)	Partner in Road Traffic Accident
9	Alison	30-35	Full-time Parenting	None	6-9 months	Female	ER Psychiatrist	Self-Harm
10	Michael	30-35	Employed	None	0-3 months	Male	Psychiatrist	Wrongful Incarceration
11	Paul	50-55	Unemployed	Psychiatrist	9-12 months	Male	Psychiatrist	Self-Harm
12	Paula	15-20	Employed	None	0-3 months	Female	Family Member	Domestic Violence
13	Richard	50-55	Self-Employed	None	0-3 months	Male	ER Consultant	Road Traffic Accident
14	Sarah	15-20	Student	None	6-9 months	Female	Doctor	Self-Harm

Appendix 7 Table: Work Related Profile of Research Participants- Non Social Work ED Staff

No.	Position	Responsibilities	Post Qualifying Experience
1	Staff Nurse	Clinical	05 years
2	Senior Clinical Nurse	Clinical & Educational	12 years
3	Senior Liaison Nurse	Clinical & Managerial	28 years
4	Senior Liaison Nurse	Clinical & Managerial	09 years
5	Occupational Therapist	Clinical	07 years
6	Mental Health Nurse	Clinical	16 years
7	Administrator	Administrative	21 years
8	Doctor – Registrar	Clinical & Educational	04 years
9	Doctor – Consultant	Clinical, Managerial & Educational	14 years

Appendix 8 Table: Work Related Profile of Research Participants Social Work Staff - Emergency Department

No	Name	Responsibilities	No of Years Post Qualification
1	Social Worker 1	Managerial	21
2	Social Worker 2	Practitioner & Managerial	15
3	Social Worker 3	Practitioner	04
4	Practitioner Researcher	Practitioner & Managerial	15

Abstract

RELATIONSHIP-BASED SOCIAL WORK: A 'THIRDSPACE' IN RESPONDING TO TRAUMA

A THESIS SUBMITTED IN FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF PH.D 2015

ERNA O' CONNOR

Using qualitative research methodologies, this practitioner research study explores participants' lived experience of trauma leading to their engagement with the social work service of a hospital emergency department. The negotiated, situated relationships and the dialogical processes underpinning the co-construction of social work in this setting are explored through in-depth interviews with service users and with professionals who refer to the service. A focus group is used to explore the perspectives of social work service providers.

It is argued that trauma has traditionally been understood within an individualised, psychologised idiom and socio-cultural factors shaping trauma narratives need to be addressed to provide a more comprehensive response. The findings of this research highlight feelings of loss, profound distress, disconnection and disjuncture, a changed sense of self and of life circumstances, giving rise to experiences of liminality. Meaning attributed by research participants to their experiences is shown to arise from and to be modified through inter-personal relationships and wider social interaction in specified socio-cultural contexts.

Trajectories of living with feelings of distress and loss, searching for explanations and meaning, finding ways to incorporate new realities in everyday life and for some moving beyond the effects of trauma become apparent. The elements of a relationship-based social work response, conceptualised in the analysis as creating a 'thirdspace' within the emergency department and within people's lives and its use as a resource to understand and find support to manage feelings, experiences and demands of living in the aftermath of trauma emerge from the data. The integration of social work processes and outcomes in wider relationship networks is explored. This social work approach is further delineated and developed with reference to the literature and a conceptual framework is proposed to underpin relationship-based social work practice in this context. The implications for social work practice, inter-disciplinary practice and for practitioner research in this context are considered.