Supplement to Dissertation

The Role of Reactivity: Experiences in Clinical Decision-Making and Countertransference of Expert Trauma Counselors

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Round One Interview Transcripts

P#= participant

P1 Round One

Researcher: We'll just start and I'll just ask some follow-up questions. If you could describe to me your process when making clinical decisions with trauma survivors. This is your thoughts and feelings that lead to any decisions you have either during the session or after the session, when meeting with a trauma survivor. Just real generally, your process.

P1: I mean it's somebody that I'm not real familiar with, is my initial impression. My major focus would be ego strength and stability, safety. I think that I would want to make sure that my client's external resources, as well as his or her internal resources are well enough intact to proceed with what can be some pretty [inaudible] work.

I'm just sort of thinking extemporaneously.

Researcher: Exactly.

P1: That's I guess, pretty standard, too.

Researcher: Say more about ego strengths, and safety that you mentioned.

P1: If somebody is unskilled in self soothing, and relaxation and grounding skills, then I would be concerned about moving ahead recklessly into exposure work or doing a lot of recall work. I think that even after I've established that there is a safety structure in our sessions, and that we have solid informed consent and agreements, and that a person is able to take care of their own emotional needs in the core of the session, and between sessions, I would still want to kind of tread into the issues of trauma, again depending on the situation. If it's a single incident trauma in adulthood, that's one thing. If we're talking about complex PTSD, I would tread a little bit lighter, and just get headliners, without encouraging a lot of detail that may not be helpful, in initial stages of treatment.

I don't know if this is the sort of thing you're interested in hearing?

Researcher: No, this is exactly ... This is good.

P1: I'd want to know what the person's living situation is, if they're living in relationships that are supportive of their work or if it's a destabilizing type relationship. If there are, I think I would want to do a lot more social skills training, and that sort of thing before going into formal trauma work.

I'd want to know if this person has some supportive relationships at all, even if it's not in their home life, that they can rely on if they should find themselves in need to sort of reach out to somebody.

I'd want to know also that they understand the formal emergency procedures, of calling emergency screeners and emergency workers, and make sure they know how to reach out in that way. How to know when they need a higher level of care.

Researcher: You're teaching them about when they can identify these things within themselves.

P1: Certainly, and also how to understand the system, and what's available to them, which I think has to go hand in hand. If somebody knows that the need a higher level of care, but don't know how to get it, it doesn't help much. Sort of doing some education around that ability to understand their own needs, but also to understand their resources, and how to act on them.

Researcher: Great, so once safety and stabilization are established, how do you decide to proceed?

P1: I think that a lot of the assessment probably would happen without my request. Sometimes people will come in, and they're kind of anxious to get into the meat of things. Sometimes, they're very avoidant of it.

Some of that information certainly would be able to utilize to determine how exactly I want to proceed in treatment. There are folks for example, I wouldn't necessarily consider a great EMDR candidate for example, for one reason or another. Sometimes people, I'm trying to think of a good example, as to why that would be. Some people are close to psychotic, so it's difficult to predict how things might go if I open a lot of doors, processing can be jarring using that particular modality, and others as well. It's sort of a jump in with both feet kind of work.

If somebody ... I guess that kind of goes back to safety, you're just sort of assessing their ego strength, and how their symptoms might suggest stability. I want to kind of keep my eye on that.

I think that if everything's a go, and somebody really seems ready to look directly at some old events that are sticking in their craw, I would want to talk more specifically about what those are. Again, I probably have some of that information, just from doing a family history, and also from people spontaneously wanting to talk about it.

I would want to have a direct, structured conversation about what are the highlighted things that they would like to put behind them, that they haven't been able to. A lot of times, people have either a vague sense of that, or they have a very clear sense of that, depending on how complex the trauma background. If they are unable to really say what they want to work on specifically, we'd probably be looking at, we'd probably go to looking at triggers, to see how the thing manifests right now in their lives, and what are

the moments that it comes up at issue, then to do a float back from there, to see when they remember the first time feeling that way. Take it from that sort of a ... Is that called reverse engineering? I'm not sure what that's called. Start from the present, then go back.

I think that's sort of the next thing. To sort of lay out the road map for what specifics we are going to be trying to desensitize and to process.

Researcher: So that the client knows what they're in store for?

P1: Perhaps, it's hard to know for anybody, how it's going to unfold, but so they know the specific traumatic events that they're interested in working on.

Researcher: How do you ... You mentioned avoidance, which of course is significant in trauma work, I think. How do you manage their, or even assess their avoidance, in doing their work?

P1: I think probably the first thing I do is, it depends on what form it takes. If it's therapy distancing behaviors, like calling in sick or making excuses, or talking about the weather rather than [crosstalk]. It's just something to put on the table, to sort of explore with them, and say "gee, you know, it's occurred to me that maybe there might be something like a defensive sort of thing, what do you think?" Ask them to look in quite a little bit. Hopefully, they're [inaudible] skills are intact well enough to kind of say well "gee, I guess that's what it feels like to me, or what's inside of me when I 'm wanting to run out the door." Whatever the case may be, you know?

It's almost the same thing, as if they were to get angry at me, you know? Just say "well, you know, OK, just as long as you're angry, we're not talking about it, and so I just kind of noticed that, what do you think?" I would just put the thing in the table and see how they respond to that.

Researcher: You're leading [crosstalk]. Hopefully what?

P1: Hopefully open the discussion.

Researcher: You are leading right into countertransference, which is the perfect segue.

P1: You're welcome.

Researcher: Perfect, say just a little bit more about that moment when you're picking up on ... I mean countertransference, of course, there's many different definitions of countertransference, even within the counseling field. There's all sorts of different definitions, and maybe you could just start with sharing how, your understanding of countertransference.

P1: When I have a reaction to my client, a strong reaction of one sort or another, I have to wonder, assuming I'm mindful enough to recognize as a moment. Even

if I'm not, in between sessions it occurs to me that this is what's going on for me, I would want to fold that into my work in one way, shape, or form.

I always have to ask myself the question - is this what other people in my client's life feel like? Does this have to do with social skills, or does that have to do with therapeutic resistance? If there's something defensive happening, I want to be able to bring that into session, in some way, shape, or form.

Researcher: Initially, you're sort of asking yourself these questions, if you're picking up on something?

P1: Yeah, exactly.

Researcher: When you're picking up on something, is it ... You know, what form does that take? Is it a feeling, thoughts, tell me a little bit about that.

P1: It's reactivity, I think. For example, when somebody starts making noises about wanting to harm somebody. That's one of the things that always gets me. Then I get real tense, and I kind of have to have these conversations with a person who is clearly being pretty reactive themselves. This is an example that has happened just only in the last couple of weeks, and so the next time they come in, they are - and between sessions, I'm always asking myself did I meet my obligation to my client, to the community to myself? Is this person a danger, or is this just blowing wind, studying it around a little bit, talking to my supervisor, and my colleagues, trying to get some sense for what I ought to be doing, or if I'd done all I could.

Then, it's in the next session, my client is really well grounded, very calm and very insightful about their own behavior from the session before, I start to react in the opposite way. I feel relief. If I find myself thinking, "oh good, I'm in the clear." Then, I feel like that's as much a countertransference reaction, as my being afraid.

It's sort of confusing relief with results, and so if I find myself in that position, I again, I put it on the table. That's pretty curious that you sit here today, saying these particular things, when you were sitting here last week, saying ... I think I would want to kind of do the dialectic, and draw in those two polars to help my client find balance, and help myself find balance, you know?

Researcher: Yeah.

P1: I think that's where stability exists, and that's where true growth and insight, healing -

Researcher: In understanding that dialectic?

P1: Yeah, in understanding that you have to honor both polar opposites to kind of find within yourself a balance, understand the interpsychic event that can catch

a person from one pendulum swing to the other, and to recognize that both those things serve a purpose. They both have a function, and that sometimes they ... Sometimes the unstated goal could almost be the same thing. To find some way to help my client to explore those opposites. To find some way to come [inaudible] so that there is a balance, rather than the pendulum swing. It's only to recognize that it happened. I think that the - tell me when I'm saying too much.

Researcher: Oh my gosh, this is fantastic. Keep going.

P1: I think that it's easy to be in a quid pro quo admission, to join the client in a kind of denial, because it's not necessarily comfortable to talk about both ends of the pendulum. You just want to live in one, and forget the other. You're doomed to repeat it with your client, unless you encourage your client to find a space and productive way of talking about it.

Researcher: In that doomed to repeat it, or sort of colluding, it sounds like you could end up colluding with your client in the avoidance?

P1: That's correct.

Researcher: How do you decide ... It sounds like you're pretty comfortable bringing up what you're experiencing, regardless of what it is, just bringing up your observations within yourself. Is that accurate?

P1: You mean with my client?

Researcher: Mm-hmm (affirmative).

P1: Yeah, you know, it's - I don't know if that's blanketly true. I think that it's true. Mostly because I think that I have a fairly good relationship with most of my clients. When you've been through it a few times with them, when they've fired you three or four times.

Researcher: You're talking about extreme ends.

P1: You know, there's sort of a kind of a natural thing that happens where they just settle out after a while. They'll say, OK, we've been here before." I had this one client who used to just be real nice and everything else, and he'd have his problems, and he would talk about them, and he'd go on his merry little way, and he'll often say something like "oh, you're just good, you're so helpful. I'm so glad that you're here for me," and dadadadada. Then, I would get this voice mail, that was scathing. It was like, just if he was standing in front of me, I would be afraid.

Researcher: Yep.

P1: It was sort of like an insecure dog, where if you're facing them, they'll sort of like lean up against you, and pant, and look all cute, and as soon as you turn around to walk, they bite your heel.

I, over the course of time, I was able to help this client bring that moment closer and closer into session, so that not only were all the nice things in session, but there was also some of the scathing things were there, as well. They had to be in the same room. He couldn't divide himself that way, because there's nothing I can do. I said that to him. I said "you know, when I get these phone calls, there's nothing I can do."

Researcher: Exactly.

P1: A couple of times I saved the voice mails, and I offered to play them back.

Researcher: That's a fantastic intervention.

P1: He wouldn't let me do it. He completely refused. He said "I don't want to hear it."

Researcher: Oh wow.

P1: I wasn't going to pin him, doing that. It would've been great. I think it would've been helpful to him. He was able to sort of little by little, back it up so that instead of somewhere in the middle of the week he would be yelling in the phone. He was able to feel like, back it up closer and closer to session, until he was able to say something right in the moment.

The day he did, I remember the day he did. He had, what was it now ... I did some inane thing, some innocuous thing, and he was looking at me like I just, you know, punched him in the mouth. I said "are you OK?" He said "no, not really." Then, he started to tell me how I was like, annoying him or something. Which I suppose, there's a kernel of truth to it. I said to him, "you know, I really am so happy that you're saying this to me right now, because this is the sort of thing that you might've started off with on the phone, on a voice mail. Here you are, in the room with me, talking to me. I just have to really value this moment."

Researcher: Wow, that's incredible.

P1: The other part of it too, is that kernel of truth thing, is that a lot of times, people will say things to me, that my instinct is to say "no I'm not." "I'm not a jerk." "No, I'm not ignoring you, I'm not abandoning you." If I look at it closely enough, there's something there.

Researcher: Yeah, well they can certainly pick up on it.

P1: Boy, they can, you know, and so for me to truly - to ignore the affect, and to listen to the message, I think is the other thing that helps them, because then they come to learn that they don't need the affect.

Researcher: Is that something you would - oh, go ahead.

P1: To find that kernel of truth, that direct observation on their part, the accuracy, the message to me, and to talk about that, I think is a thing that can be real helpful.

Researcher: Yeah, so not only well, I mean, not only identifying how you're feeling, and bringing that up, but really acknowledge that kernel to them, not just sort of tucking it away in your own cap for your own knowledge, but bringing that into the room.

P1: Oh yeah.

Researcher: That's impressive.

P1: Otherwise they just have to feel like they're nuts.

Researcher: Right, because that's how they've been treated, for the most part.

P1: Sure.

Researcher: Wow, fascinating.

Since you have acknowledged that countertransference can also be the sort of positive emotion that sort of comes up in you, or reaction or less negative for that matter, can you share any instances of that or what you might do with that information, or that feeling, that reaction you get if it's something more positive?

P1: Sometimes people will kind of find my vanity, and use it to step away from a requirement to talk about themselves. I think that's not happened tons, but you know, on occasion.

There's like this one guy I had, it was actually kind of annoying, and he would say ... I'm thinking about the different situations. One guy, he would always say to me "I'm 57 years old. (Name removed), you look like a young man." You look like you're 30 years old. Of course, there's this little thing in me that said, "oh boy, I like hearing that." It's just such, it's so clumsy, I guess. It's such a blatantly ... What is the term, unartful, is that right?

Researcher: Oh, I don't know.

P1: Yeah, it's just such a distraction away from talking about himself.

Researcher: There's something in you that picked up on that, this compliment was really him avoiding.

P1: It was disingenuous, and it annoyed me. [crosstalk] I want to look 30 years old, but I know it's not true. It's kind of what it was. It was just the way he did it. It wasn't, you know, he wasn't speaking from his heart, in any sense.

Researcher: It wasn't sincere.

P1: It wasn't - even if it was, it's just something you just kind of go "gee thanks," and then move on. I felt annoyed, and so I wanted to put that on the table, I think. There was a reason why I wasn't ... It felt sort of like it was impolite to dis his compliment. I think that he was kind of able to use that to his advantage, because I wouldn't be so direct with him. It was like "well, you know, you've said this before." I said "yeah, yeah, yeah, I've heard it before." I'd say, "tell me how it went with your brother," or whatever the case may be. It wasn't really a direct kind of putting it on the table.

If somebody were angry at me, which almost is easier in a way ... I mean, it's not fun to be in that kind of a tense moment, but it's almost easier to be direct about, than this sort of thing, because then you have the puppy in the rain thing, where you don't want to kick 'em. You know, he's just trying to be nice.

That's that side of countertransference that I've experienced, that I'm maybe not as skillful at doing.

Researcher: Yeah, OK, it definitely sounds like countertransference, and you've touched on this a little bit, but I'm going to delve more about how countertransference, how those experiences with you, impact your clinical decision making with clients. You might decide to bring it up, or not bring it up, or it sounds like you reflect on it between sessions. If you could say more about how it affects you decision making. Especially, in framing this of course, in terms of a trauma survivor, not just somebody who comes in for something else.

P1: Yeah, right, most of the clients I see I think as time goes by, and I think it's probably true of the profession generally, is that we're recognizing traumas as the core an awful lot more than we ever thought.

Researcher: Definitely, I definitely concur.

P1: Fifteen years ago, I might've said "oh well, you know, 15% of my case load is trauma." Now, I don't know that I even know. In some ways, I have to kind of approach my whole case load with a trauma informed perspective.

I'm not saying that there are clients who don't come in with issues that ... Who knows, even the worried well types. You don't know really what's underneath.

Anyway, I lost track of the question.

Researcher: About how countertransference affects your decision making, what you just said leads me to a different question, a different rabbit hole that I would rather go down, which is and it's on the tip of my tongue, we were talking about ... If somebody, you know, a worried well person comes in and you're sort of peeling back the layers, and you know that there's the kernel of it is trauma, and they're not there for that.

We know a lot of people, right? They come in and say "oh, I'm depressed, or I want to do some grief work", or something other than, they'll say trauma. Can you talk a little bit about your decision making around that, like you know that the kernel here is trauma, but they're not - how do you sort of guide that work with, or the decision making?

P1: I think I'm sort of, when people first come in, especially when there's sort of dealt issues going on, not necessarily old issues. Like somebody who's depressed and that don't know why, or somebody has a weight problem, and they're trying to figure out behaviorally what they can do, or introspectively is supporting their weight problem, or whatever the case may be. Even though I had just said, that I kind of approach my whole case load with a trauma informed perspective, I also don't necessarily want to make any assumptions. One can find oneself digging where one ought not be. I think that you kind of have to take things at face value to some degree, unless there's some blatant indication that it's important not to.

When somebody comes in, and says "this is what I want to work on." I just kind of say "OK. That's what we'll work on." If there's something more going on, and if it's something that my client is interested and ready and willing to work on, then we can move on that. I'm certainly not going to push anybody to look deeper or make a lot of assumptions, and ask leading questions in that respect, because that can really tie people in knots.

You have to sort of have an openness, I think, and a willingness to be OK with what they're ready to do, and not ready to do.

Researcher: OK, great, just a little bit on how countertransference affects your decision making. It sounds like bringing it into the room, and like you said you also sort of mull it over between sessions, or reflect on it. If you could say what happens between sessions.

P1: I actually - my greatest insights happen when I'm writing my note.

Researcher: Oh.

P1: I don't know why that is, but I could be sitting there in session, and it could be as clear as day, what's going on to anybody who's a third observer, but it's going

to go right over my head in the moment of the session. After we're all done, and I'm writing my note, it just dawns on me. This is what's happening.

I had a client who was saying ... Oh I can't think, I can't remember, he was saying something. He was doing a reality check with his mother, or something like that. I'm sort of half making it up, because I can't remember exactly the circumstance, but his thinking was a little bit delusional. He was kind of checking it out with her, and she didn't deny that his perception was accurate. She didn't deny that his perception was accurate, and so, he's telling me this. It was only when I was writing my note that it occurred to me that he might have been inviting me to give him feedback on his perception, and his conclusion, really, on his thinking.

I wondered if he walked away thinking, "well, nobody's saying no, so it must be yes." That didn't occur to me as he was talking to me. It occurred to me after the fact. I wanted to sort of ... I wanted to bring that into our session. I wanted say to him, "I wondered if you were asking me this question."

Researcher: Oh fantastic.

P1: Yeah, yeah, and the trouble I had was, in that instance was that for whatever reason, the next session didn't happen. I don't remember if he canceled, or if I was out, or whatever the case was. We had to reschedule, and so two weeks go by, and when he comes in he had a whole host of other things he wanted to talk about. It just didn't seem there was an apt moment, and I didn't necessarily want to steal his session from him, in order to say that. I felt like I lost an opportunity.

Researcher: I'm so impressed. That's impressive.

P1: Thank you.

Researcher: Yeah, holy cow. How do you think - we only have a couple minutes left, and I don't want to take too much of your time. How in looking ... How many years have you been in practice?

P1: Let's see, I was licensed in 1991. I actually started work at the agency in '86. Back in those days, there wasn't a lot of ... There was basically no laws against a non-licensed person doing psychotherapy, and so that's what I did. That was a common practice. Then, of course, the laws changed, and I was kind of corralled into having to get licensed, so I did.

I guess you could say since 1986, but as a licensed person, since 1991.

Researcher: Doing the work, you've obviously been doing real work since '86. Has this brought up any ... Are you aware of how you've changed over time? I think I'm going to get to that in some subsequent interviews, but sort of looking over the course of all of these years, how you work with these clients so differently. I

know that's a big question. I guess I'm not really asking the full question, but just more of reflecting. Has this brought up any - like how you've changed in working with these clients, especially with countertransference, or how you decide what to do? A lot just comes with on the job experience.

P1: Yeah, you know, I think probably like most people who have been around forever, you look back and you think about some of the work you did early on, and you feel kind of embarrassed by it.

It's not just because I've changed. I've been around long enough that the industry has changed. I've been through false memory syndrome stuff, and that whole business. I've been through everybody was panicking about vast organizations of child molesters, who did Satanic rituals - breed babies just to, you know just all these awful things, that just are so ridiculous, but how people just bought into it, in our profession.

Researcher: Yes, yes, the clinicians themselves, you're saying.

P1: Yes, absolutely, and also the attitude about addictions has changed so vastly, and it's relationship to mental illness. How addiction doesn't just mean substances anymore. So much has changed, you can't help but sort of flux with some of those changes, as well.

Researcher: It's not only your own practice, but how the industry and public perception has changed.

P1: Yeah.

Researcher: We're at our time, I'm going to stop recording

P1: OK.

P2 Round One

Researcher: Okay. If you could describe your process when making clinical decisions with trauma survivors.

P2: My process?

Researcher: Mm-hmm (affirmative). How do you approach making clinical decisions with those clients?

P2: Well, I do a careful assessment first, of course. Then I look at the assessment, I look at what their present is, or as their most intrusive or most ... symptomatic symptoms, their life-interfering symptoms. Then we go from there. As they're presenting their issues, and then we're looking at it within the assessment, then I kind of ask them, "Well what direction do you want to go? What is it that you

want to address? Is getting in your way the most?" Then we go into that direction. Before we go into anything like that, we'll talk around it. We won't do any intervention until we've created that stability, the symptoms are all brought down, and the person can easily feel those symptoms, and then make themselves safe. They're able to do that very consistently and predictably. If they get triggered with something through the week, and they're able to bring that symptom back, because I guess I've talked around in a circle more.

I look at the assessment, I look at the symptoms, we prioritize what's getting in their way. Then I make sure that they have learned those emotion regulation skills, to keep that stability, to maintain a level of comfortable stability. Then after that, then we look at the specific traumas or incidents that interests of memories. Then we look at those individually, after they've got a level of firm stability.

Researcher: Okay. You're assessing first, finding out what their primary symptoms are, what they-

P2: Where there are concerns.

Researcher: What their primary concerns are. Addressing stability first before going into any sort of intrusive symptoms, related to the trauma.

P2: Right. Sorry, I talked around in a circle, didn't I?

Researcher: No. You're doing just fine. How are your clinical decision-making processes with trauma survivors different from clients with different treatment issues?

P2: Not a whole lot different, except for those folk that are coming in with a recent suicide, or suicidal thoughts. Then we'll go right into safety planning, and creating that safety net, and making sure, and then we'll back that up with support persons. Then we'll maintain that level of stability, and we'll go into the mood regulation skills there. Then we'll start to look at other things, but I put that safety at the forefront. There's that. With folks that are coming in with depression and anxiety doing a basic assessment, again, and then putting those emotion regulation skills in to settle it, doing medical referrals as needed. I always get a release of information anyway, from their doctor, and see what meds they're on. If that seems ... We do it as a precaution anyway. I say, "Just go get a check-up." Those kind of things.

Then we move forward from there, depending on what needs to be done, and what is kind of the ... What is the origins of that depression and anxiety. As far as all of them, it's pretty much safety, stability, emotion regulation, is the three things I start with. Then I go into the other stuff as it needs be.

Researcher: Are emotional regulation and stability the same?

P2: One feeds into the other.

Researcher: Could you share more about your process around helping clients be more stable than when they came in, and with their emotional regulation?

P2: Looking at what their habits are, their current basic habits. Some folks will come in, and they're not eating. They'll eat ... "Oh, I eat. I snack through the day." They're eating chips or soda and candy bars. We'll look at life changes they can do that would help them gain greater stability, emotional stability, feeding their body, getting rest, drinking water, getting out and meeting someone, getting regular exercise, meds as prescribed, putting the alcohol and drugs away. That's what I mean by look ... Then the emotional regulation is the breathing, mindfulness, the sensory, or the fidgets, if they need a fidget. Something that's going to help them manage their symptoms, where these are pretty much just basic good self care.

Researcher: You mentioned sensory. Could you describe to me what that means?

P2: Like a fidget. My Asperger folk, autism folks, they like to have their fidgets. It helps them to reduce, and calm, so I have them notice when they start feeling the need to pull out their fidget, so that they can recognize that feeling, and then just to notice it. Notice the feeling, pull out your fidget, okay now notice the change. What's helped, what hasn't helped, okay. Then looking for, or even sensory things if they're starting to feel anxious, if it's an anxiety folk, okay. Feel your presence and mindfulness, you're here in this room, feel the couch. All of those things to bring them back to a sense of calm and control. It can be any kind of sensory thing.

Researcher: You have those available for clients?

P2: I help them to find them. If they need me to give them one, then I have silly putty, because it doesn't have a grease, and it doesn't ruin the clothes. It has a container. It changes with the shape, so you're ... I find that one to be really good. Then the texture balls, the stress balls. Then the Altoids or the sharp mints, or that ... What is it? Big Red gum. It has a lot of cinnamon in it.

Researcher: Sharp flavors.

P2: Yeah. Then it grabs their attention, it's a distractor more than anything else. You put it in there, and they immediately stop thinking about, "Okay I'm here." Your sense of presence comes.

Researcher: Nice. Tell me about how you experience countertransference.

P2: Well I've lived a long time. I've seen a lot of things. I've done a lot of things. It's only natural when someone's talking about something, that they're having difficulty with. Then a trigger might come up to me, "Oh, I remember that feeling." I'll sit with that as they're explaining it so that I can get a better

understanding of their feet, their perspective, as they're telling me this story. It's kind of helpful in that respect, to, "Oh yeah. Sitting in school, and the teacher's getting cross at you, and everybody's looking at you. That feeling, where is it in your body, where you feel it, so on. Then I can understand what they're talking about.

Researcher: You said helpful? Say more about that?

P2: It's helpful.

Researcher: What is helpful?

P2: Being able to empathize with that feeling. Whether I've experienced or not, to be able to step into that feeling, and say, "Yeah, that does hurt."

Researcher: For an example like that, when you have the sense of, "Oh yeah, that does hurt," do you express that to them?

P2: Not from my perspective. I might say, "Ouch, that wasn't nice," and they'll say, "No." Then they'll tell me more about how they felt. That's really helpful, when some folks, they kind of shut down and they just don't want to talk about it. If you put in something like that, they'll say, "Yeah." Then they'll go on with what they were feeling. It's almost like a prompt, or a cue.

Researcher: Do you find yourself ... When you're experiencing it, versus empathizing it, empathizing with that feeling, can you say a little bit about that experience, and when it's something that's really coming up for you? Versus empathy, there's just a little bit of a difference.

P2: Yeah, there's a difference. If I get, and it's happened a few times, where they've said something, and I say, "Oh," and I can, immediately that memory comes back of something similar and how I felt. I sit with it for a second as they're talking, and then I move out, and listen to them.

Researcher: You're noticing it in yourself and sitting with it for a bit? Before inviting them to move on.

P2: No, you just notice it.

Researcher: You're noticing it within yourself?

P2: Yeah you notice it. It's not like I'm sitting here stuck in that memory. It's just that you notice the feeling, you remember that memory, and then you move on, and you say, "Oh yeah." Then you recognize what they're doing.

Researcher: Okay. You look like you want to say something else.

P2: No, I'm just trying to see how to describe that differently so it makes more sense. Anyway, [inaudible].

Researcher: I think I understand what you're saying, yeah. How does countertransference, so those experiences, affect your decision-making with clients?

P2: I don't think it affects, it informs, because the decision is really the client's. Wow. How do you want ... What is their impression of what they're feeling, or do they feel like ... What would you have liked to happen different? "Well I wish ..." I said, "Okay, so," then we go on from there. It more informs than it determines what they do, or what I suggest they do.

Researcher: It informs what you do.

P2: It informs ...

Researcher: You're experiencing if you're experiencing countertransference. It informs what you're doing, or how does it ... I guess that's what I'm asking. How does it inform what you do next?

P2: What happens in session.

Researcher: Take your time. These are things that we don't think about everyday, so ...

P2: No, we don't think about.

Researcher: It's not a rush.

P2: I'm trying to think of a client. Okay. Because I don't want to talk about him on there.

Researcher: Of course.

P2: Anything that a client, any sort of identifiable thing would be erased, and not published. Feel free to not ... Take your time to think about it.

Researcher: Let's see. A client brings up an issue. It might have been something similar in my life, so I say, "Oh, I remember that." They go on, because their experience is entirely different, and it has a different scenario. I know that feeling of questioning, or that feeling of hurt, or whatever it is that was similar. I've had ... We'll use a friend. A friend says, "I'm getting older now, and I'm finding that my choices aren't as big as they used to. I'm finding I'm setting my goals differently." That it feels ... she was feeling uncomfortable with it.

I thought to myself, "Oh, I know that feeling, because my goals and what I do has definitely changed due to my age and the length of my career, that I have left in my career. I'm not going to go pursuing some doctor." It's changed my possibilities, and so I could say, I could feel ... As she's saying that, I could feel what she's saying, because I had a similar experience. I could feel what she is saying. Does that mean that I change how I respond to her? No. Does it mean

that I direct her in a different way? No. It means that I can listen to her deeper. That's really what it means. That's how I use that information. Does that help understand it better?

P2: Yes, that's very clear.

Researcher: It doesn't change how I direct the client, or what I aid them into. Whatever kind of discussion we want to do, because that's really led by them. Tell me more about that, tell me about that feeling, how did that impact what you did, would you have done the same thing given another choice, how would it have been different? Those kind of questions are led by their discussion, but my ability to feel what they're feeling is tied to my ability to access that feeling in myself.

P2: Very well said, thank you. Yes. Any experience that stands out to you when you've experienced countertransference with a trauma client? Anything noteworthy? Your own experience of that. Getting away from the clinical decision-making, and those things.

Researcher: Just my personal?

P2: Mm-hmm (affirmative). Personal experience with countertransference. Particularly with a trauma survivor.

Researcher: With trauma survivors. They've had such different experiences, only that feeling of, "Wow, that could have been me. Wow, that could have been my daughter." That sense of a tragedy, or of being victimized. We're never immune from that. That feeling of, "Wow, how can I protect my children, my ... People that ..." Is that what you're asking?

P2: Mm-hmm (affirmative). Well, yeah.

Researcher: Yeah. We all feel ... When one person in a community, within out realm of knowing, is traumatized, victimized, then we all feel vulnerable. That sense of "Eh". There's that.

P2: Okay, great.

Researcher: Anything else about any of this? We'll get back to it later, but is there anything else that came up for you around any of these questions, any of these experiences?

P2: No, that's all right.

Researcher: Okay, thank you

P3 Round One

Researcher: Hello, just to orient you again, we're just focusing on your experiences with clients who have experienced trauma.

P3: That's in the stage of my career, that's most everybody.

Researcher: Unfortunately, probably.

P3: Mm-hmm (affirmative).

Researcher: Maybe it's a good thing they're coming in.

P3: People are more sensitized to it. Also, perhaps, slightly, more hopeful that it'll make a difference.

Researcher: Yeah.

P3: It's still very low level of hope.

Researcher: Feel free to take your time, reflect, no fast answers. I'll probably ask for a lot of follow up.

P3: That's fine.

Researcher: If you could just start by talking about your process when making clinical decisions with trauma survivors.

P3: The first thing that I do is I actually label it that way. They generally aren't coming in saying, "I've had trauma." They're generally coming in and describing an experience. Then, I often will say, "What do you think of when you think of the word 'trauma'? Do you think that's a word you would describe for this?" Then, I pretty quickly go into trauma education. I start with saying ... I usually give some kind of history of my own, saying, "Back in 1980, first time I stepped on the psych unit, none of what I'm going to teach you now was known." The good thing about trauma work is that the science is really pretty strong. We know what to do. Most people react to trauma with growth, not stress disorders. I still see PTSD, they'll go, "Yeah, yeah." I'll say, "but you probably haven't heard of post traumatic growth, PTG." They'll say, "No." I'll say, "Well, that's the norm."

My point in that is to try to raise their hope. That's the norm with time. Most people get stronger as a result of trauma if things go well. Then I usually say if you think about the strongest person you met, odds are they've had trauma in their life. The normal reaction to trauma, or the way the human spirit is built is that we seem to be able to work through stuff. We're never the same, but we work through it. I say for the other third that doesn't, something is going on, often fixable, almost always fixable. The point is to just raise their belief that they can get on the other side of this and have a better life. Then, I usually jump up to that board, and I say, "I'm going to show you the four steps that I go through. The first one is trauma education, which is what we're doing right

now. I'm just teaching you a little bit about the difference between you've had a bad decade, and you've had trauma. There's a difference."

Then, I say trauma has to do with shattering of belief systems. We don't think that that's that big of a deal, but it's a little like an earthquake to your psyche. Do you feel like with what you went through, sometimes this will be an affair in a marriage, or sometimes, it'll be sexual abuse or emotional abuse. Do you feel like what you went through was that your whole world changed? Yes. That's what we mean by shattering of belief systems. It isn't just your ego was bruised or something like that. Then, I say, "If you think about what people are like, and what people go through in earthquakes ... I've only been in tornadoes. I've never been in an earthquake, but when the ground beneath you moves, it's terrifying. People get super anxious, to say the least.

"The second thing you're going to learn how to do, and I will teach you how do to that, is regulate your anxiety. We won't be able to go any farther if everything we do keeps triggering you. In fact, we will use you being triggered as an indicator that we're going too fast. That's why if you can become" ... and I usually say something like it's not that you need to get good at managing anxiety or actually have to get a PhD in managing anxiety. You have to be super good at this. Then, like I said, I think I said four, but it's five. Then, once I know for sure that you know how to do that, then the third step of that, we call "Constructive Self Disclosure", which means talking to somebody.

In this case, it's probably going to be me, who doesn't use your story of what you've went through as an opportunity to say, "I know, man. I've been through that same thing," which well-meaning friends and family will do. Suddenly, they're off thinking about themselves, and you're alone. Constructive self-disclosure means being able to describe what you've been through. Then, I go back, and say, "which can be very anxiety provoking," so that's why we have to watch this. Then, the fourth thing we do is we create a trauma narrative, which is different than the one you have in your head right now. The one you have in your head right now has part of the story. There's more to the story like you've already survived a whole bunch of it.

You might feel like, "I'm all damaged. I'm all broken," but you got here. You're sitting here. You got through the next week right after that. You got back to work. Whatever they tell me. I weave that into that's part of what' going on. There's another part too, which is you probably found parts of yourself you didn't know you had. You might have deepened your spiritual life. You might have become more compassionate towards some other people with particular things going on. We're going to talk about that, and we call that creating a common narrative, which is more complete and it's deeper and it's more complex, and it's more sophisticated than what you have going on now.

Then, out of that, the first step is that you will create a better belief system, one that isn't as shatterable. I don't know what that word is, but that's the word I always use. I say if it got shattered here, what you want is you want here in step five ... and I always use this example. I say for instance, if you say my parents always loved me, that's pretty easy to shatter, but if you said ... I'll turn that off. If you developed ... if you change that to my parents were doing the best they could, probably given who they were and what they were going through, it's not so hard to shatter that kind of belief. That's the first step.

Researcher: It sounds very structured.

P3: Mm-hmm (affirmative).

Researcher: Does it seem that way when you're sitting across from somebody?

P3: Mm-hmm (affirmative), and it's usually standing up there. I'm usually weaving in whatever they've told me in their story.

Researcher: You would lay them out before even ... you would lay that out saying, "This is what's coming."

P3: Yeah.

Researcher: Okay.

P3: I would say that if they may have told me they got in here because their husband isn't even willing to stay with them anymore because they're just shaking all the time, related to a sexual assault, and he doesn't even want to talk about it, and he thinks it happened a long time ago. I'll say that shaking, you're getting triggered. That's the anxiety thing. He doesn't get it. That's what we would call not constructive self-disclosure. He's not a person who can take it. I usually will say something like the first time you heard it, did you think you have to calm him down, because he wanted to get out of the chair and go choke your brother to death? Yes. I say, "Well, that's what makes it not constructive, is he couldn't actually be there for you. All he wants to do is hurt the person who hurt you."

Understandable that you want him to understand, except he's probably not going to be good at this. I do write it up on the board. They usually are sitting here, and I might be standing there illustrating it. I do tell them that's the basic sequence that I go through and that it's ... yeah. I have two goals really, to increase their hope that they can live without the symptomatic part of trauma, increase their belief that they can become not just a victim and survivor, but they can really thrive. They can get on the other side of it completely. I had a suicide in my life when I was 14, so I bring that into it. I say I wouldn't wish that on anybody ever. I also know that suicide ... I can look suicide in the face. It doesn't scare me anymore. That's a good thing for the work I do.

Then, I want them to believe that it's not a ... it feels very messy inside them, so when it gets structured out like that, I think it's like, "Huh, there's a map." There is. It's a sequence. We'll basically follow that. Then, what I always say is I always make fun of academics. I say, "We academics, it has to fit in some kind of an outline. That's how the word processor does it for us." Then, there's you and me and how we actually work through this. It's going to have something to do with those five things up there.

Researcher: For step two, after you get past education, how do you work with them to manage their anxiety and regulate their emotions? How do you decide where to go in that?

P3: Well, I have a lot of structure in that too. I think of PhD in anxiety that you really looking at it like three levels. One level is really tactical in the moment. What do you do with a panic attack? What do you do with can't get through something? I'm going to teach you breathing. I'm going to teach you distraction. Breathing, distraction, I'm forgetting one. Then, there's the mid-level of getting down-regulated on a more regular basis. I go in for on a regular basis just because that's how I go through life, down. That part, I really go through a lot of what being up-regulated like that does to their body long term. Even if ... and I make a point. I have worked with plenty of people, enough people where they got justice, like they caught my ... I think about these are actual situations.

They caught the guy who murdered my sister. He's in prison. Why am I still not sleeping? I talk about that the human ... they get taught a lot about the human psyche. I teach them about the brain so that they understand that that kind of ... that's an automatic response, that they can learn how to down-regulate in general. Then, the third level, the big picture level, changing that world view. Number one is get rid of the idea that it's a just world. It is not a just world. That's not that hard to teach, because I ask people what their religion is, if they have one, or what do they do. Do they have spiritual practices? Then, I usually weave in something about if they've been around kids and noticed how kids ... there's not a parent on the planet that taught a kid things like things are fair, yet every kid believes that. Parents have to teach the opposite. They have to say life isn't fair.

It isn't fair. They have to teach the opposite of that, because it's hardwired into us to believe in fairness. Isn't that a funny thing. Hardwired into us to believe in fairness and plopped in a world where it's not a just world. Then, I talk about trauma that way. I say this idea that people got what they have coming to them aren't really. Then, we talk about all the really good people that they know who deserved whatever that didn't get it for reason of whatever it is. If they have kids or the kid was always passed over for something that they were just as good at, but the other parent pressured the soccer coach or something to start

their kid. That's why my kid got passed. It's not that hard to say, bad things happen to good people.

Then, I talk about that until they get rid of the idea that it's a just world. They're going to have a hard time moving forward. Also, the idea that revenge and justice will get them something that's cruel, but then think about the most bitter person you know. Then, I usually tell some stories about like that gal. She came up to me after I gave a talk, and she said, "What do I do with this?" I looked at her, and I said, "What's your spiritual life like? Can you go in the direction of forgiveness, because that's where your peacefulness is going to come from?" She was staying there for a moment. Her eyes were watering. She just came in, and I held her. She just sobbed, and the people behind her were like, "Oh, my question isn't [inaudible]." Whatever you're ...

I said to her, "You'll have to decide what you're willing to settle for. What you want is your sister back. You won't get her back. Plan B, is there a healthy for you plan B?" That's what she said. To me, these things are obvious. She just said ... when she got done sobbing, she said, "I've never thought about it that I do want her back." I said, "Yeah, of course you do, but you've gotten justice. Justice doesn't do that much for us."

Researcher: Sounds like you do a lot of normalizing, if that's the right term.

P3: I think it is. I believe everything I said, which is that children were set up to have problems in the sense that it is in our DNA. Psychologists that study morality say we're born with eight moral channels. We're born with those. We expect these things. We're born with them. Then, we're in this world. Everybody has to come to terms with that. I think that's a major adult developmental task, to come to terms with the unjust world and apply it to yourself. I almost always, at some point, while we're going through that, I throw in that the process of forgiveness is probably going to be something that we're going to talk about.

Researcher: That you are going to talk about?

P3: Mm-hmm (affirmative). Then, the first time I use the word forgiveness, I say ... I think as a psychologist, and I've been doing this for 36 years, or however many years I had been doing it by then, that I think forgiveness is the hardest thing for a human being to do. The hardest psychological task, and that it goes ... it's healing and trauma and healing. Forgiveness and healing, they go together. There's absolutely no pressure that I feel like it's my job to let them know the research behind forgiveness therapy. They should know about it, because it's not being ... and I usually say, "You might have heard of cognitive behavioral therapy if you did any online research. Certainly, everybody on the

planet has watched tv in the last ten years, knows something about some medication that's supposed to save you from something."

The odds are slim that you've ever heard anything about forgiveness therapy. Forgiveness therapy is more powerful for marriage and depression and anxiety. They know that I'm going to someday weave into a four step process for forgiveness too.

Researcher: Okay. Switching gears to countertransference. Share a little bit about how you experience countertransference with trauma survivors of course.

P3: I am a trauma survivor, multiple trauma survivor, and I'm not by nature very traumatic.

Researcher: I get that, just in the 10 minutes that I've-

P3: Yeah, so I ran emergency services, clinics, and what trauma does to people is it gets them ... they go in one of two directions. One, I got this. Nothing happened. The other one, the extreme version of it is this incredibly unique thing happened to me. Nobody gets that. I need to ramp up everything I'm doing to somehow make you clearly understand what was done to me. I don't have a yearlong tolerance for that. I have some tolerance for it, but at some point, where I get to with that is I'll say, "I know you know this, but just in case you don't know this, you're not the first person on the planet who've been through these terrible things. If you were, I wouldn't know what to do to help you."

Researcher: Can you say more about that point where you get there?

P3: Yeah, it's when I can see that she or he, usually she, is getting entitled about because of what I've been through, I'm entitled to this extra amount of something.

Researcher: You can sense that?

P3: Yeah, and I have ... I intellectually, and I also in my gut, know that that entitlement is ... you might as well be drinking poison. It's the end of all good things. I'm more sophisticated in how I talk to that quality now than I used to be. 20 years ago, I would have said something like, "I have to tell you, in the who's had the worst childhood contest, you're not even in the top 10 contenders for me."

Researcher: That's how you used to do it?

P3: I wouldn't say that in day one, but ... I'll tell you, it stuck, because an awful lot of people came back and said, "I think that was the first day it occurred to me, maybe, I could start thinking about other people have been where I'm at too, and not in a shame on me, shame on them, but the good news is," ... it's like you

don't want to be the first person to have a heart attack. You want to be the 7 millionth person to have a heart attack. Then, they know what to do. Now, I would approach it more like that. More like, do you really think you would feel better if you thought what you had been through was the first time anybody on this planet has been through it. Do you actually think you would feel better, because I would put that in one of those categories of rare disease three out of seven billion people get this.

That should give you a hopeless feeling if it's three, but it's not. Then, I usually say the number of people that if I just Googled this exact scenario, I can Google it, and there's going to be a forum for it. That doesn't mean that what you're going through isn't bad and terrible. I would take it away from you right now if I could, but you did go through it. You're not alone, and you're not going to get more than other people got, because there's not much more to give. Even if you got what you think you deserve, I would tell you it's probably not what you need. There's an awful lot of Hollywood help in this.

You can say things like, "Lindsay Lohan, I don't know what she went through," but really, she could afford to buy anything she wants. It's not-

Researcher: Didn't help.

P3: Then, I say when we talk about priceless, there are things that are priceless. Trauma treatment is priceless. What you're doing right now with the high drama gets you nothing. It certainly doesn't get you extra from me. It wears me down.

Researcher: Energetically when you're sitting across from somebody who's feeling entitled or acting that way?

P3: Mm-hmm (affirmative).

Researcher: It wears you down?

P3: Well, and it also makes ... I also start feeling like I don't have to ... I mean, eventually, I get a reaction like ... I consider myself a really generous person with my clients. They all have my cell number. They can text me. A third of my text messages are from clients. I'll sense something, I'll send them something back. One gal had her credit card stolen. Most banks have a fraudulent blah blah blah. I'll check, thanks for that. You're welcome. I have a PhD in clinical psyche, apparently I know everything. Then, you get updates. "Okay, I met with somebody over there, and they're going to," I'm just like, "Cool. Sorry you went through this." Yeah, it took away from the [inaudible]. "Yeah, hang in there."

They have a lot of access to me when they're in the room with me. I'm not thinking about a grocery list. I give them substantial discounts if they do a prepay, which I always recommend with trauma. Say, "You're going to get tired of this work. There are days that you're going to come in here because you're

going to hate the idea that I got paid for something I didn't do." That's why you should do the prepay, and we'll keep you. Then, I'll say, "It's like tuition. That's a times third quarter nobody wants to go to class. They go because they've already paid."

Researcher: Nice analogy.

P3: Yeah.

Researcher: Other than entitlement, what are some other experiences with countertransference?

P3: Well, if they get suicidal, I don't know if you'd call this countertransference, because I just want to go knock on wood, but nobody on my case load has ever committed suicide. I did have a guy who I worked with for about three years, and then he moved, and I bumped into his father maybe 10 or 12 years after, and he was hit by a truck, and the family wondered if he jumped in front of the truck. He was a heavy drug user, but he was sober for the last year, which is why he felt ... last year of my working with him. Part of what I'm saying about this is I did think about this when I read your study. I wonder if some expert in countertransference would consider this countertransference. I consider it a really skillful approach to acute suicide health maybe, but maybe I'm just mad at people.

I'm perfectly willing to yell at people who are on the phone with me who are actively suicidal. I'm perfectly willing to guilt the hell out of them. I don't have a lot of tolerance for whining when there's a real crisis. I think when there's a real crisis, you have to keep whining and move forward. You get to whine and get back on the bike. You get to whine and call the VA and figure out where that ten grand from your husband’s benefits went. "I don't feel like it. I don't care." Get your phone out, call the VA. "I don't know what the number is. Lucky you, I have a laptop in the other room. It appears the number is ... call them." I don't know what to say. It'll be something like, "I don't know what to say. Here's my situation. Put me through to the right person." You must think I'm the weakest person in the world.

I think you're going through a crisis that needs some clear thinking and substantial action. Call them. I don't get-

Researcher: It sounds like you take those particular instances of countertransference if it's something negative or annoying or exhausting to you, and you really try to turn it into action for the client.

P3: Yeah, I think ... I read what you wrote this morning, and I thought ... this is a theory I have. I think people who struggle the most with disliking their clients

in [inaudible] more generally, are people who look down on them. I would argue that is the bulk of the profession.

Researcher: I could see that.

P3: I got lucky this way when I was 22 and studying with my mentor. This is all he was trying to get across. Personhood is everything. It's the person. It's not the diagnosis. It's the person. It's not the job title. It's the person. It's not the clothing. It's the person. It's not anything. His belief was we're here to understand that people, the persons we're with as persons, which makes it very hard to look down on other persons.

Researcher: Because it equalizes?

P3: Yeah, it eliminates the lesser. Paul Farmer has a thing, right, all the problems on the planet is because some people think some people are more important than some people. If that were translated into nobody thinks anybody is more important than anybody, imagine what kind of world we would have. I think countertransference has something to do with ... I don't want to do anything with you, because you're a lesser human being than I am, you fill in the blank with a negative label. You borderline. You narcissist, you entitled brat. I don't know. It's some label, though.

Researcher: Any instances of positive emotions that come up for you? Positive countertransference?

P3: Oh, like as in wanting to date my clients?

Researcher: No, nothing unethical, but feeling hope or feeling ... it sounds like you turn the negative things into actions, so I'm wondering if when you're experiencing pure joy with a client or-

P3: I don't know exactly why this is, Rebekah, but even when, and my family would affirm this, even when I'm ... I think, not I think, I like all of my clients, and many of them, I love as human beings. It doesn't make me not push them, though. I've never had that, "Well, because I think you're the cat's meow, we're not going to work in therapy." It would just be more fun to add about clothing specials or something. Chocolate ice cream. I don't know. What's it even mean? I don't see. I don't even know what positive countertransference ... I can get an A on the essay, if I were taking the test, but what does it mean in real life?

Researcher: Well, I think it's probably ... if you're asking me, I think it's probably different for every clinician, not just your own negative reactions, but-

P3: I can say this much. I'm not that interested in approval. I wasn't a popular kid at all, and that's not a self-esteem issue. I was asked to do a thing at my 40th class reunion, is that what it is? 1974, so yeah. About 40, yeah. It's a small class, 64 of us graduated but it was an honor that they asked me to do it. I did it, and it

was really well received. There was a happy hour before hand. I brought some of the stuff up, and one of the people who might have considered me a friend, because I'd never use the word friend in high school, she just said ... I said I wouldn't have had anybody that I'd call a friend, and she said, "Yeah, you were intense about so much stuff." I went, "Oh."

At the 40th, it's interesting. You need to, if you haven't been to yours, you should go. So much is gone that people were talking about parties that somebody had and they didn't get invited and what went on at home and why they didn't. One guy that I thought was the most popular guys said, "Yeah, my parents would never let us go to any of that. They thought it was the devil." I'm like, "Your parents?" He said, "They were crazy." One guy who was not really a bully, but just obnoxious, he said, "I never knew. Was it every other day you got a beating from dad? Wasn't there a reason?" Then, I started going, "Yup, everything you did at school fits that profile." People start talking about that. The point of that is that I didn't have approval from anybody. By the time I got to starting my PhD, I realized what a blessing that had been in the sense of I early on started wanting to impress myself. Can I meet my own standards?

I think if I'd had any hope of being popular, I would've cared if what I was doing was going to make me somebody that I would have their approval. With my clients, for instance, if somebody brings up something like, "I just don't think you should be doing it with me in that way," I might say something like, "I suppose if I were doing surgery on you, you might wake up in the middle of surgery and say I think you're holding your scalpel wrong, doc, but I wouldn't, in that situation, listen to you either, because you don't know what you're doing."

Sometimes, I'll say ... this is probably a thing I learned to do over the years, which is to anticipate a reaction that they might have, and to say, "I'm not meaning this as an insult to you. I just know it might be insulting. It's not my intent. My intent is to be really clear. Here's what I really want to be clear about. You don't have a PhD. What were you doing in 1974? That's when I started studying this stuff. Just because you have a relationship doesn't mean you're a specialist in relationships, which I am, any more than getting cancer makes you an oncologist or knowing enough about sex to be able to get pregnant and have a child means you're some kind of parenting expert. I've studied parenting, you haven't. (Personal anecdote removed) After two years, I thought I can help other people raise their kids. Then, I became an expert on parenting. I'm not an expert on your kid, but I'm an expert on kids."

I will do that a fair amount. More often now, somebody will say, "I don't know." I'll say, "I'm just going to pull rank on you here," and these are mostly empty because we know we're doing stuff, and those had to be moved out. Then, sometimes I'll say, "You know those books behind you, I read them.

There are a thousand of them. I've read more since I got my PhD than before, because my field exploded with [inaudible] and [inaudible], brain imaging, that kind of stuff.

That might be ... I don't know if that would be called countertransference or not, but I don't have much tolerance for people claiming an expertise they don't have. I will say, "Look, you're a banker, I'll ask you tons of questions about the finance world, because I know just enough to get in trouble. That's all I know." That's how you are with relationships. You read one book. Then, I will say, "You were audiotaped and videotaped how many times in dialogue with people?" "What?" "No, I mean how many?" "What do you mean?" I say, "That's the kind of torture they put us through in graduate school. Videotaped, audiotaped, and then a whole bunch of people will listen to it and say, 'What did you mean by uh huh?' There's no way you understand relationships the way I do. I just put in time you haven't put in."

Sometimes, they say, "Yeah." I say, "Okay." "How about sequential analysis. How about cross-classification and sequential analysis on marriage conversations. What do you think about those studies?" "What do you mean?" "Right, that's the kind of stuff I read. Not for fun, to be able to help you with your marriage. Your wife isn't listening to you partly because you probably do with her what you're doing with me, which is you're acting like you know stuff you don't know. No humility. How are you going to learn? You're not even going to learn who she is. Has she ever complained that you are in a room with her, and she says something, and you don't hear it?" "That's her main complaint." "Well, you'll have to decide if you want to sleep alone or not. If you don't want to sleep alone, maybe you should try to learn while you're in here."

I feel like that's probably a thing for me, people acting like ... but this is a thing I have in life. I walk around going, "Everybody thinks they're a psychologist."

Researcher: True.

P3: They do.

Researcher: Yeah. We're definitely at our time, so I don't want to take up too much of your time. Is there any ... there will be two more interviews to come, but is there anything that you feel like you wanted to squeeze in since we're face to face. You good?

P3: No, I'll just go with your process.

Researcher: This is great.

P3: Okay.

Researcher: I have lots more questions, but they'll be to come.

P4 Round One

Researcher: Okay so if you could just describe your process in making clinical decisions with clients who have experience trauma overall.

P4: Like overall? So if I had a client who had a lot of trauma? What would be a decision I was making?

Researcher: If you're working with somebody who wants help with their trauma or you know that they're symptomatic in front of you. How do you decide what to do? What are the feelings and thoughts that you have going on in order to decide what to do with the client?

P4: I guess my first one would always be safety. Is making sure that they feel safe with whatever we're working on or if we're making decisions in the community or if we're making decisions on where sessions are going to be going next. Safety ... We practice a lot of trauma informed care here. Really making sure that that's all being addressed. I guess just ... That would be my first thought and process is-

Researcher: Making sure the client's safe [crosstalk]

P4: Making sure their safe. Down to where my office, not having their back towards the door. You know what I mean? When we're addressing things and making sure and being sensitive to maybe experiences they've had in the past. If we're working on curriculum, making sure nothing in there is going to be triggering for them. If we're working on doing something in the community, making sure we're hooking them up with a female psychiatrist if that's something that they prefer. That's all. That's why I would go over first.

Researcher: It's sounds like taking what you know about them into consideration when making decisions.

P4: Absolutely.

Researcher: You mentioned trauma informed care, how does that lends of trauma informed care impact your decisions?

P4: I think it just would, for the most part, it would maybe not impact my decision, it would maybe impact my approach to presenting a decision. Depending on what the decision ... I mean ... Whatever we're going to be talking about next. I guess it would maybe impact my approach more or where I'm taking that next.

Researcher: Can you describe that approach for where you taking it next a little bit more?

P4: Sure. If I was talking to a client about, could you give me a scenario or just an example?

Researcher: Well if somebody in the facility is having a really strong reaction and maybe they can't get through group or they can't ... They become maybe behaviorally inappropriate just because their symptoms are so overwhelming. You don't know how to manage that.

P4: Okay. I guess with the trauma informed care piece, I would probably get them in my office so it's quiet. It's more calming in here. I'd maybe have them sit where they would feel comfortable. I have six chairs in here so every time a client comes in I'm like, "Pick whatever seat you want to go into" and I just kind of follow their lead. They'll always pick where ... Some people won't sit by windows. Some people can't sit by two doors over there. Some people kind of go in the corner. I just take their lead first. I just make it as calming as possible. If know that ... Take for example, if they were in group and acting behaviorally, sometimes I'll go to the group and be like, "What were you working on today?" If they were working on like relationship violence, then I would know okay going back to what their trauma was, is that something that was in their past that's triggering them? I always go back to the safety. What would make you feel safe moving forward? Are you ready to work on this? Is this something that you are ready to work on or can we take different approaches? Maybe you don't sit in this worksheet, maybe you do it individually with the therapist.

Sometimes we have ... We have male staff here because we have maintenance. We have one LSS. Our therapist is male.

Researcher: What's LSS?

P4: Living Support Staff. They just kind of run the houses. Sometimes that can be triggering.

Researcher: Just being around a man.

P4: Yeah. Being around a man. Depending on where they came from or how recent especially their trauma was. I always check in with the men seeing if they come into a house or going onto a floor where they live. Before they go up they have to say, "Man coming on the floor." They'll do different approaches with that and I just check in with them to make sure they're continuing to do that. I think my first thing is always safety or trying to figure out that piece to make them feel-

Researcher: It sounds like trying to put as much control in their hands as possible. If somebody comes in, they sit in a chair, you know they're having a hard time, where do you go next?

P4: I kind of open it up to them. Sometimes I'll even ask them. I always try to help people understand that they won't heal until they feel safe. That process of healing's not going to start until they can feel safe here. Otherwise, they're going to be constantly on guard. That's when a lot of behavior stuff happens or

the insecurity. After they're in here and they sit down and they're ready to start talking about it, a lot of times I'll let them lead the conversation.

Researcher: You let them lead?

P4: Yeah I'll let them lead the conversation. Depending on what we're talking about and if it's behavior then it's trying to figure out a win-win for both sides. Like I said, "Do we need to pull you from this group? Do we need to try something different?" We take a look at what we've been talking about in sessions. Is it something that we're just not ready to talk about yet? New symptoms we always look at. Medications they have. How much sleep they're getting at night?

Researcher: Sounds like it's a lot of problem solving.

P4: Yeah. A lot of our women have come in, some from the streets and in their active addiction they suffer a lot of trauma. They don't ... When they start getting sober sometimes it starts triggering memories of stuff. They can't ... A lot of women don't even recognize what trauma is. To them it's normal life. Until we really start helping them figure it out. It's hard for them. It's detoxing from drugs and then trying to figure out is a [inaudible] symptom, is it a withdrawal symptom, what is it? What's happening and different medications. They're very early stages of recovery coming into this program.

Researcher: How do you go about deciding what area? Medications, mental illness, detoxing, how does that ...?

P4: It's just a lot of eyes on the client. It's very-

Researcher: It definitely sounds like it's definitely a team effort.

P4: Yeah. There's a lot of overlapping between. Post [inaudible] withdrawal can last up to a year. You don't want to throw somebody on tons of medication right away. What's wrong with some drugs is you can have auditory hallucinations. You know what I mean? They might not last as long. It's a balance game that everybody ... That's why we have a lot of staff constantly working with them so they get through it.

Researcher: How do you help ... It sounds like you do some clinical supervision.

P4: I do all of it here.

Researcher: How do you work with your supervisees around helping them make decisions with trauma?

P4: We process pretty much everything. I meet with all of them individually for one hour a week. We'll just review the whole case load. The ones who are recently coming in are the newer clients we spend a little bit more time on or the clients who have been on our radar who might be all of a sudden showing a little bit more symptoms. We spend more time on. We process pretty much just like you

just did with me as far as what did you do? How'd your session go? What did you start with? Going over different ideas from my past experience with them.

Researcher: Does it help you reflect on your own practice in working with supervisees?

P4: Yeah. That's why I actually like it because I feel like I can teach them what I know now.

Researcher: Maybe you could share a little bit about how you experience countertransference.

P4: Have I experience-

Researcher: How you've experienced countertransference.

P4: As far as-

Researcher: Maybe your understanding of countertransference first just to make sure ... There's so many different definitions of countertransference. What your understanding.

P4: My understanding of me feeling countertransference would be if a client was talking about something and it brought up strong emotion in me.

Researcher: Great. I love that.

P4: Then I felt that I maybe did practice the right way because I was going after my stuff out there. It was more about me. Is that right? That's how I learned it.

Researcher: Yeah definitely. Sort of what do you ... Then you have that experience, those strong emotions that come up and then what do you do with that? Maybe you could share some of your experiences with counter-transference.

P4: Like with one I've had? Do you want specific times?

Researcher: When you've experienced it. Yeah you don't have to give client details because it's more about your experience so whether ...

P4: I'm pretty [inaudible] of this. I get more countertransference with people who ... I'm trying to think of like ... the past ... individuals who have lost parents because my Dad recently died like 10 years ago. Throughout my being in this field. Actually it's been closer to 13 years ago now. Sometimes when people are talking a lot about that, sometimes I almost get the rescue. I get it. That's probably the most usually when I get it.

Researcher: That's when it's the strongest?

P4: Yeah when people are talking about death or grief or what not. Sometimes with kid stuff I will. I was a treatment foster parent so I took in the really hard kids. Sometimes that will hit me is when I really start feeling it. If they're talking

about trauma their children have been through and I worked with traumatized children in my home. Sometimes making that connection. I have to put myself in check a little bit. Those are probably the two biggest scenarios that it will happen for me.

Researcher: How do you know when something is coming up for you? Whether it's the grief or something that you hear about. Parent or a child. What happens to you?

P4: I think about it too much when that client leaves my office. I'll know. That's how I'll know.

Researcher: So not necessarily in the moment but after they leave?

P4: Yeah generally a little bit after they leave or I can feel it sometimes in my gut. I can kind of get that feeling where I'm almost ... I want to jump in a little bit more. You know what I mean? I don't know if that makes sense. Kind of not jump in ...

Researcher: Maybe use the word rescue.

P4: Maybe rescue or be almost too much, "It'll be okay." I don't go there but I can feel myself in anticipation. A lot of times I recognize it more after a session ends. Then what I keep thinking about it. I'm pretty good at setting that boundary as far as ... Obviously I think about stuff but to the limit.

Researcher: There's this sort of anticipation in the moment when you're sitting across from somebody. You can feel it internally. It's just this sense of "I want to reach out more or I want to do more." That sort of feeling. Then afterwards thinking about it more [inaudible]. It's just sort of floating up there. If you're feeling some anticipation in the moment, what do you do with that? If you notice it.

P4: I'm really good about keeping my demeanor. I've been doing this for a pretty long time so I'm pretty good about ... I don't think anybody would be able to tell. I don't know. They could but probably not. I'm pretty good at putting myself in check pretty fast and sitting back. Just being myself. Sometimes if, I don't know how to say that right, I probably won't say it. I'm pretty good at putting myself in check. I talk to (name removed) my supervisor. I talk to her about ... I'm a pretty good processor about everything. I'll share that with people.

Researcher: What's the sense that you need to keep it in check? What is going whenever you feel like ...

P4: Probably when I start feeling that rescue mode. Wanting to-

Researcher: What's the decision of keeping it in check versus not or versus like self-disclosure or sharing what you don't want to share.

P4: I've done self-disclosure. I've felt like ... This is what I teach everybody else. Is it going to benefit the client? If it's going to benefit the client by me saying something, then I have experience that my father died when I was 24 ... If it's helping the client in a way but it can't be for my own benefit for me to make the connection. You pick and choose.

Researcher: How do you pick and choose? How do you discern that?

P4: I guess it's the scenario of what the client's talking about and how good ... There's a couple of things. If the client has a different maturity level and different ... Maturity meaning they would be able to see the benefit in disclosing that. Some clients may not and some clients may then take it as I'm trying to be their friend. It has to be will they be able to use it for their benefit rather than I don't want them to get that boundary crossed where all of a sudden they think I'm their best friend. A lot of times when women come in here too they don't know how to create those healthy boundaries at this point. It's very ... It's all dependent on the scenario. With the context of what the conversation is. Where they are in their process of what they're talking about.

Researcher: Probably where they are in their recovery.

P4: Yeah.

Researcher: Their ability to set boundaries. Maybe you can describe an instance where you would self-disclose or would you even just share, "Gee, I'm having a real ..." Not even self-disclose about your own loss but self-disclosing about maybe feeling sad in the moment.

P4: Like to a client? I'm trying to think. If somebody was talking about ... I can give you another example. (Personal family tragedy described). That's another thing where it was a recent loss. She was talking to me about, "I'm never going to be normal again." Going through her normal grief as far as losing a child around that same age. At that time, I self-disclosed saying something along the lines of, (Personal family tragedy described). I kind of reached out to her that way being I can tell you from my family your family is not alone in this. There's other people. That made her feel good just because I think she was a little bit more understood. I didn't really go into my feelings about it but it was more along the lines of it happens. (Personal family tragedy described). You're not abnormal.

Researcher: It was just this normalizing.

P4: You lost a child. You can act however you want to act right now. I think that would be an example of how I self-disclose as far as-

Researcher: Because you could see it benefiting here in that you're normalizing her symptoms. So she doesn't feel like I'm alone or what's happening to me is crazy or I feel crazy.

P4: Or nobody gets it. I was like, "I get it." (Personal family tragedy described). You're okay. You're not okay but you're okay. You're not acting crazy, you're acting like a sad mom. I wouldn't really go into my grief. It wouldn't be like, "I took a week off work." Go into that. It was more about ...

Researcher: What happens because you talked about maybe just a lot of thinking afterwards, after you're done with the clients. Something hit you particularly hard. You're doing a lot of thinking and reflecting afterwards. Can you share more about what that is like? What is going on for you?

P4: I don't really put too much energy into it when I'm done. I'll think about it because you write notes and stuff. You know you write your notes about this is what was discussed and stuff. I don't usually ... I'm pretty good about if it was bothering me a lot then I'd call my supervisor. Then I would call (name removed). I have a lead counselor. Sometimes I'll bounce stuff off of her because I really ... I try to do this big team thing. We often help each other. Then I'll call (name removed) who's my lead counselor and just be like, "Thoughts on this?" They're always honest.

Researcher: Compartmentalizing it sounds like you're pretty good about containing.

P4: I've just done this for a long time. Don't get me wrong. You have your moments.

Researcher: Usually once you get to serve this in the field for so long, then you're not weeping all over the place I guess.

P4: Right. It's not shocking to me anymore. I think 10 years it might've been a different story. Everything you hear is new. Now you just learn to use your colleagues.

Researcher: What do you think ... That brings up a good point about ... I'm studying experts versus novices. How do you think that has changed over time, your reactions to clients? Maybe 10-15 years ago you would've responded differently versus now because you've just seen and heard so much.

P4: I think when you're younger in this field or newer in this field you have ... I don't know if the word dramatize ... I think sometimes-

Researcher: Dramatize? Is that what you-

P4: Dramatize?

Researcher: Dramatize.

P4: I think sometimes like, "Oh my gosh. Guess what I heard?" They energize it a lot more as far as ... This is how I see how it works. When you're younger in the field I feel like when you deal with someone's trauma, it can be bikerish trauma, we all know about that stuff. I think you associate that trauma with that person

more. You're burnt out because you're like, "I have to save them." This is my thing. When you get further down you start realizing this trauma is a piece of who they are but they have this whole world around them and we're working on this one piece. There's also good things that you have to point out too and help them recognize there's life worth living with all this other stuff too. Then I think you don't get as burnt out because you get a bigger picture and longer goals. That's kind of how I see it.

Researcher: It becomes more a holistic view of the client versus maybe early on it's all-

P4: It's all about that the incident.

Researcher: The big scoop. The trauma. The story or the series of traumas that you tend to focus on.

P4: How could this happen to them? This happened this to them. Then you're getting to a point where you're like, "Because they have five beautiful children and they have a good family. This was a horrible incident but ..." I think that's how ... I think that happens to a lot of my counselors here. I can kind of see them go through the process of that first initial burnout where you feel like if you leave, if you take a vacation day, they're going to fall apart because it's all on you. Then you realize they're just going to live their life and they're sad in your office.

Researcher: Do you think that was your process as well?

P4: Probably yeah. I would say that was my process. Especially starting out in this field.

Researcher: What other, as far as getting back to making clinical decisions, how you decide what to do with a trauma survivor. How that has changed over time.

P4: I think I'm more aware as far as just letting them be more comfortable. Not that I wasn't like that when I first started out but I think you just become more aware of the human being. If that makes sense. The person as a whole. The little details that you might not when you're first starting out because you kind of want to dig in right away and sometimes you don't need to dig in right away. Just let them be. I'm just relaxed for a minute.

Researcher: Again definitely with a more holistic approach and being less directive maybe? Do you that's a fair statement?

P4: That would be fair.

Researcher: Is there anything else? This is just sort of the first of what we're going to use. Is there anything else that you think ...? [inaudible] Is there anything else that you think ...?

P4: I'm trying to think. Is there any other questions?

Researcher: I don't think so. I think you've got all of my ... Yeah you've touched on everything.

P4: Good.

Researcher: Great.

P5 Round One

Researcher: Excellent. Good. Again, just feel free to reflect and take time that you need to answer. If you could just start by talking about your process. Thoughts and feelings around making clinical decisions with a trauma survivor. In a clinical setting, how do you go about making decisions about what to do when, how, your experience of all of that? Pretty open-ended.

P5: All of my clinical experience has been through my master's program and after is with the (organization name removed) population, so doing my internship here and working. It's all women who have the trauma plus the addiction issue that they've sought substance abuse treatment for. It's always, always kind of taken both into account. They're at different points though within their substance abuse treatment where some are in active addiction, and some are sober, or have been sober for a period of time and are at a different level where they may be ready to process trauma or understand trauma in a different way. Part of it is looking at where they're at in that recovery from their substance process.

I also always consider what do they actually understand about trauma and how it impacts the way that they experience the world, how they're able to cope with it. If somebody is very, very new to the process, we might be at the point where we're just sort of exploring. Do they view the experiences they had as traumatic, and do they understand what they're going through now that could be related to that? Really a big emphasis on coping skills at that point. I don't do a lot of past-focused work with clients in trauma. I tend to be more present-focused. How's it impacting the way you interact right now and what do we do to help you move forward and heal?

There has been times where I will let clients talk about past-focused, but in my experience generally then people are just diving into details and think that they have to bring up every nitty gritty thing, and there's not always benefit to it. Also when a client is talking about their trauma in any way, I'm sort of watching what they're going through in that moment, so if I'm starting to sense they're overwhelmed because their body language changes, their tone changes, they dissociate. I generally pull it back right

then and help people ground, come back to the moment. One of the things I always use too, is a structured approach using the *Seeking Safety* material to teach clients about trauma and again, big emphasis on the coping skills piece more so. Does that answer the question? That kind of went around there.

Researcher: What happens before ... You said something, and I've went a bit over. Before you get to coping, so you're assessing their level in recovery and then deciding what happens before you get into coping skills, in that period?

P5: Just trying to figure out if they understand what trauma means. For a lot of the women, it's very common here for us to discuss domestic violence, sexual abuse, sexual assaults, whether as a child or as an adult. Not all the clients or even professionals understand the different levels of trauma that people experience too, and that different things are traumatic for different people. One of my most recent issues with the client I currently have, she is involved with the child welfare system, and all her bureau workers happen to be white, throughout her entire experience. One of the foster parents for her children was white, and this woman made some very inappropriate illegal choices, and so all of these things-

Researcher: The client or the foster?

P5: The foster parent.

Researcher: The foster parent, okay.

P5: Well, she had the client's children in her care. That case was closed, and now she unfortunately is reopened again with the bureau. She's got a new set of workers, and her worker happens to be white, 20-something, and blonde. One of the things I had to help the client understand and the team understand is that the client is experienced things with you that are not related to what you have done. It's based on this institutional trauma that she herself was somebody who grew up in the child welfare system and has her own traumas related to that. Her children now have been detained twice. They're currently in your care, and she questions your ability to care for them. When the client is yelling and upset, it's not because she's trying to be mean to you. It's she is scared.

Part of it is the client didn't even necessarily understand all her levels that went into that institutional trauma. Part of it was just sort of us exploring that and her deciding whether or not she was choosing to identify that as a trauma she experienced. I also don't want to say, because you went through this, you are a trauma survivor. That's up to the client to determine. In this

case, she did agree, and it helped become a common language on our whole team too.

Researcher: So you brought it up in a team meeting to understand in the context what's happening with this client?

P5: Mm-hmm (affirmative).

Researcher: Then it sounds like you brought it up with her, the client individually.

P5: Yep, and I brought it up with her first individually and sort of helped her through it. Then I also talked through it with the clinical team. It was right before I took this position on as the program manager and I was still a full-time counselor. It's not common, again, for even professionals to really use institutional trauma and talk about that. I wanted to make sure she really understood it, that we had a common idea of here's where these different things you're experiencing are coming from, and then asked her permission if I could share it with the team, and she gave me permission to do that.

Researcher: Validating her experience and then it sounds like education, maybe that's sort of what happens before you get to coping skills is education with the client about what on earth is going on with them so they understand if they don't.

P5: Yeah, and a little bit, I don't think it's such a linear process. I mean, sometimes too it's, "I want to hurt myself because of this thing," and I can teach you where it's coming from, but we also need to do immediate coping. Anywhere where there's going to be symptoms that cause, "I'm in danger," I'm going to be addressing right away. That doesn't mean you're going to stop feeling anxious. Those will be the long-term kind of things we work on with self-care and things like that, but immediate needs we're going to address right away.

During that time too with this client, I would also be coaching her. "When you go into an interaction with this child welfare team and you start yelling, what they're experiencing is this. They shut down and you're not heard. How can you manage your feelings in a healthy way, still express what you need to?" We're sort of doing, how do we cope, and then how do we understand what this is at the same time?

Researcher: How did it go? Do you think she heeded your advice?

P5: She did at that point.

Researcher: I mean, it's a process. It's not like people change overnight and everything.

P5: Then unfortunately again because we are the substance abuse treatment program, she had some other factors that kind of didn't help.

Researcher: Sounds like you're very practical in your approach.

P5: Mm-hmm (affirmative).

Researcher: How do you think clients respond?

P5: I think pretty well. I try to not oversimplify, but be basic with people. My approach with my clients is, you're a human being and I don't need to be technical. I don't need to explain theory. That's not going to help you. I think with this person in particular, she had been my client in the past so we just had a very good rapport, and I think part of that does come from me just being able to be frank with her, and that my clients can do the same with me.

Researcher: There's definitely some trust that had already been established.

P5: Mm-hmm (affirmative).

Researcher: Did you bring up the institutional trauma that you observed in her? Did you bring that up in your relationship with her?

P5: As far as if she viewed me as part of the institutional?

Researcher: Mm-hmm (affirmative).

P5: Yeah. Actually, there had been a point when we were discussing that where I asked if, "At this point in your treatment do you need to explore some other options, as far as maybe ... " She had also been struggling with treatment engagement at that point due to her substance use, but, "Do you need to go to a different program? Do you need to connect to a different counselor?" She did find a therapist who is her same race, which was helpful, when she was attending. She did not see me as part of that.

There'd be times in the past where she would make comments that weren't directed at me, but they were directed at the larger system. At one point I said, "Every time you say that, you're saying that to me." She was like, "Whoa." She's like, "No. I don't mean you." I said, "But you say it to me, and I'm the only one in the room. Here's how I feel when you say that." She was able to see what it was doing to our relationship, and she was able to differentiate that not all, in this case, white people, are out to get her and harm her, and that our relationship was something she could look at differently than the institutional that she had.

Researcher: Coping skills. Tell me how you work with that with clients. Do you take whatever situation that's coming up for them and work with that or letting them lead with ... That dance of counselor-lead, client-lead.

P5: I don't have a specific approach. It really depends on the client and on whatever their situation is. Most of the clients we have here in treatment

are attending groups at the same time, so they're going to a *Seeking Safety* group, and the way that we run it here in the outpatient program is we have *Seeking Safety* I and *Seeking Safety* II. *Seeking Safety* I is only seven sessions long, and it's coping skills, grounding skills, an art project around skills, and a game around skills. We're trying to hit every type of learning style we could think of. Then we also have started a DBT skills group within the past six months. Most of the clients are hearing skills all the time in all the groups, and we have a common language using *Seeking Safety* and DBT.

When clients come in session, we might be talking about safety planning for the future, and what could you try? I usually, if it's somebody who's newer, I give them a few opportunities to try to think of something, and I'll do a lot more leading and suggesting, like what do you think of this skill? What about this option? Then if it's somebody who's gone through a situation already and it wasn't successful, then I like to do behavior chains. DBT is much more specific with their behavior chains where they go into thoughts, feelings, body sensations, all of that. Where I'll sort of process with a client and try to pinpoint, "So that's what was going on. Could you have done something differently there? What might you have tried?" Again, try to have them do one or two ideas before I jump in. If it's somebody brand new to treatment though who maybe hasn't even had any treatment experience before, hasn't been in our groups, I'll be more direct even so with them.

Researcher: Taking more of a lead in treatment decisions rather than letting them lead because they're so new to it all.

P5: Yeah. If they have no idea where to even start, I don't want to leave them feeling confused, because that can just increase shame and guilt as it is for not feeling like they have an answer, so I'd rather give them more information and see what approach they would like to try and we build off of that.

Researcher: When you get a sense, if a client brings up more past-centered, like let's just say they keep going there. It sounds like you try to redirect, or tell me about your decision-making if someone is just going there.

P5: I think I've gotten a lot better at that over the years. I still have a few experiences I remember in my own head from sessions when clients did come in and gave me detail for detail for detail, and I still carry that, so I can only imagine how they are feeling about that experience. That's why I've started taking a more direct approach when they start going into details, that I'll read body language and say, "Hang on. I want you to stop for a second. I need you to take some deep breaths. I want you to just

remember where you are, that you're safe," and watch their breathing again and their eye contact, making sure that they are calm enough to be going through that. I explain it to them while I'm doing it too, just saying, "I can see that this is taking you to an unsafe place," and just being upfront with that.

Some of it when we're processing patterns, like if it's a client who is in a relationship with an abusive partner, we're going to talk details, but we don't need to go into every moment of a physical altercation. It can be, "We had another argument. He got physical." Okay, so what's the same in the pattern? What was going on before the fight started? What happened during the fight? Do more of an overview to see where we could do different choices, rather than even details in that.

Researcher: You find that maybe some clients get, like you said, caught up in the details and it gets them stuck in there? What do you think is going on for them?

P5: Yeah. I think that ...

Researcher: What is going on for you that you're noticing this is not the direction here?

P5: Definitely just watching them. When I can see that somebody stops making eye contact with me or they're breathing, so they're hyperventilating, or they just can't stop crying. Those to me are all like, we've got to stop this.

Researcher: A lot of body signals.

P5: Mm-hmm (affirmative). I think sometimes too that clients, they have an idea of what they think therapy is supposed to be, and a lot of times the world and professionals even, sort of encourage that you have to do that. I think a lot of clients come in thinking they have to go through every detail in order to heal. Sometimes just slowing them down and teaching them you don't have to relive that experience to move past it. Then unfortunately I think there's some clients too who do that for a way to get attention, because they don't know how else to get people to notice them except to keep amplifying their distress. Sometimes too I try to watch for that. If I see no emotion, I'm also wondering what's going on there? It could just be they're so overwhelmed or it's just become so routine because they've told it to so many people it's not therapy anymore.

Researcher: Do you need to get that?

P5: No, but I'm going to put it on silent. I see everybody at 3:00 today, so it's fine.

Researcher: That brings us to the next set of questions about countertransference, so if you start to get a sense ... Tell me more about that moment where you're

sitting with somebody and something's obviously coming up for you where you're thinking or feeling, "This is getting pretty [inaudible]. This client isn't saying anything or if there's no emotion, or there's way too much." What's going on for you in that moment?

P5: I actually had one of those moments today. My client, we had a team meeting, which means we have (organization name removed) team members, which is me and a parenting person, and then some outside case managers and a bureau worker. The client initially came into the room, she hasn't been coming to treatment. She's just unfortunately engaging in behavior. She was sitting in this chair, and I was sitting slightly behind her, and she wouldn't make eye contact with me for most of the meeting because she's missed our last four or five sessions.

Researcher: That'll do it!

P5: Yeah. Missing a lot of her treatment, and one of the first questions one of the case managers asked her was, "How's treatment going?" She's like, "I haven't really been doing it." I was just thinking, no! You haven't!

Researcher: So you have a lot more emotion about that than she was presenting anyway.

P5: Yeah. I was just sitting there not saying anything. I said, "Well, you've missed all of this treatment, and we need you to commit. Otherwise, we're going to need to discharge plan." Just very, very blunt with her. She said, "Well, I'll decide later," and I said, "No. You need to make a commitment now, because you don't get to be half in treatment. That's not going to help you." She turned away from me at that moment, and I was like, I am so annoyed with you right now! I could feel it in my chest, and I could feel it- Not feel it in my thoughts, but I was thinking, you're just aggravating me!

That's when I knew. I was like, wait. Let me just take a step back. She's not doing well right now. She'll come around. Which she did. I just have to notice in myself that I can always feel it in my chest when I'm starting to get annoyed. I just get a little tight and I become very ... What's the word for it? Just, I don't have patience for people when I'm starting to feel like some of the countertransference a lot of the times, and that's when I know it's a good time for me to just assess where I'm at.

Researcher: So you feel it in your body first.

P5: Yeah.

Researcher: Then how do you go about making decisions based on what you're feeling?

P5: Normally I just have to catch myself and then it's like, wait a second. I need to just slow down. This person is in treatment for a reason, and they

are not doing this to intentionally go after me. There's some moments when I just need to say it out loud to another person, just to be like, "Oh my God! This is so annoying!"

Researcher: Like to a peer or a colleague?

P5: Yes. Not just- No. Definitely a colleague. Generally someone who also knows the client I'm interacting with, that they know that I'm not necessarily trying to bash the client or berate them in any way. It's just I need to say it out loud and then I can be like, okay. I know where she's coming from. I just need to check myself, and I'm allowed to feel annoyed because I'm a human being too and I'm involved in this relationship, but that doesn't mean I take it out on the client. I just need to sometimes talk it out loud to a colleague.

Researcher: It helps. Then when you're experiencing that with the client, it sounds like you're telling yourself or you're reminding yourself, "This isn't about me," and then if you need to get more directive with somebody in that moment, you do.

P5: Yeah. I think that sometimes that has been helpful, like the situation- When I said before, like this client in particular used to make comments. She would make a comment and she would change the tone of her voice to be ... I don't know an appropriate way to say this, but she would sort of mock being a slave to white people. She would change the tone of her voice and she would say, "Whatever you like."

Researcher: Wow. That's hard to hear. Even just sitting here talking to you. That's hard to hear.

P5: Changing the tone of her voice. So I actually used that in our session. I used how I was actually feeling because at that point, I thought it would be beneficial for her to understand that because we have a very long-term relationship at this point from her two different treatment go-rounds, so she could understand that people that care about her, her using that language damages the relationship, which I thought could be good for her in working on relationships and trauma. For some clients who I wouldn't have the rapport with, I wouldn't necessarily call it out right away, but I think that using my relationship with a client is a really good therapeutic tool when I'm doing it for the right reasons.

Researcher: How has that changed over the years of being a counselor? Have you used that differently as a novice counselor versus now?

P5: I don't think I did when I was a new counselor.

Researcher: Just not even aware of it or not using it?

P5: I didn't know how to use it. I would feel it and then I'd have to go to supervision and it was mostly like, this sucks. Why is this happening? Just needing to understand that this is the treatment process. I've just become a lot more comfortable in my role as a counselor and in my view of relationships with clients that I am a lot more intentional about using my feelings and even down to facial expressions. I'm very intentional with clients with that.

Researcher: With your facial expressions?

P5: Yep.

Researcher: Say more about that.

P5: When I was running groups or even in individual sessions, if a client says something and I know they're sort of avoiding the full truth, I'll just be like, and be like, "Come on." Usually the ones ... Again, it's very intentional who I do that with, and they'll be like, "Okay fine."

Researcher: So you'll purposefully use a facial expression, not avoid it or try to- I got it.

P5: I really try to teach my students that they're still at a point where they have unintentional facial expressions, and those can be interpreted as they're meant or misinterpreted, but in both ways not having a good outcome, and to just be more purposeful when they're doing that. I think it's really helpful.

Researcher: Sounds like it's one of those tools that can be used wisely and intentionally really.

P5: Yeah.

Researcher: Is there anything else that you think you ... I'm trying to think of the best way to word this. If you are having an experience and an emotion sitting with a client that isn't negative, or you're not annoyed, or you're not feeling manipulated, but more positive. I mean countertransference in general is neutral, but is there anything like feeling great joy or anything where you would make a decision on based on a positive something that's coming up for you?

P5: I would think so. Now I'm just trying to think of what would be ... I don't try to hide if I'm proud of a client for something they've done. I'm very open with giving validation, and I try to make it general validation. "That's so awesome you did this!" I try not to bring those compliments back to me in any way, like, "That's such good work that you learned from therapy I gave you." It's more like, "Oh my God! You put in all this work! That is just amazing!" I try to keep it very genuine too. I don't give vague

compliments to clients. I guess I wouldn't say, "It's amazing." I would say, "This is amazing you accomplished whatever it is."

I use sarcasm a lot with clients and when we're having a positive interaction too, I'll be more sarcastic with them, but it's again with certain clients who I have a good rapport with and who get it. When we're in a good place in treatment, I notice that in sessions I'll be teasing more than just kind of keeping it very formal, clinical. I don't know if that answers the question.

Researcher: We're getting there. There'll be more. There'll be more interviews. I'm trying to think of what other experiences have you had picking up on ... What other emotions come up for you with clients or that you're picking up on? Is there anything that particularly comes out as stronger over another emotion?

P5: I guess just because it happened today that I'm just thinking irritation as one that comes up, but again, that irritation is always based in something where I need to pay attention to this because of what's going on in this situation. I know I've experienced very intense sadness with clients. We lost a client a few months ago, like two months ago now. She passed away unfortunately from an overdose, and we, the entire agency for a day had to process that all together, and just sitting with the women was very, very sad, and sitting with the staff was very sad.

I'm not generally one to cry in front of clients. I don't hug generally. I mean, there's always a few people who are always like, "Ahhh!" I'm like, "Oh, God!" That day, I again decided it's okay to cry in front of clients, to reflect their emotions, because part of that is just letting them know that because I feel this way, because you're feeling this way. It's okay to express sadness and to grieve and allowing myself to go through that process but also using it as a teaching tool.

Researcher: Sounds like it was very ... It was intentional. I mean, you're also human of course. Making the decision that it's in the best interest of ... Whenever that self-disclosure that comes up, it sounds like you're very intentional on who's this serving? If it's not serving the client, I'm not going there.

P5: Yeah, for sure.

Researcher: Good. Is there anything else that you think ... Can you think about your clinical decision-making? Clinical decision-making starts when they first call, first enter your office to ending treatment. Can you talk a little bit about that other half or the last portion of clinical decision-making?

P5: Mm-hmm (affirmative). In terms of their trauma?

Researcher: With the trauma survivors. Well, not necessarily in terms of trauma, but I mean obviously if they're a client who's experienced trauma, what's the ... Obviously with addictions we want some sense of recovery towards the end, but how do your decisions ... What kind of decisions are you making towards the end as they're getting ready to transition on to the next thing, whether it's a lower level of care or they've completed treatment?

P5: Not everybody here takes the same approach, but one thing that when we're getting somebody towards the end of treatment-

Researcher: You're just dealing with outpatients?

P5: Yes. I always looked at (organization name removed) as this is a substance abuse treatment program that is aware of other issues. When somebody has addressed their substance abuse, we need to move them on. Trauma is not something that you quickly recover from. Substance abuse, generally, we keep people in this program much longer than many other programs, but there's still that point when I think people need to ... They can get so much from treatment here, but they need long-term therapy to deal with some of their trauma issues. My focus here is really coping skills, and then as we're wrapping up here, let's find you a therapist so that our sessions are very skill-based and substance abuse skill-based with some of this other stuff coming in.

When you're going into therapy, that's something long-term where we won't have to get you so far and then sever that connection and you start over. That's always something I'm considering. Some people want a long-term therapist. Some people want a short-term program, like there's the (organization name removed). I don't know if you're familiar

Researcher: I don't know about it.

P5: It's for survivors of sexual abuse. They have different groups that they offer and all the clients need to come in for one or two initial sessions so the staff gets a feel for them and that they understand skills, and then they're moved into groups. They have an art group. They have a survivors of abuse as a children group. I can't remember what one of the other ones is called, but you actually do share your whole story in that. That's when I'm coaching people too on there's different groups you can do there. You pick your own approach to this. If the client asks, I'll give them my opinion too, and generally when I'm offering a resource, I'll say, "This is why I think this is a good fit for you." I'm also sort of helping them figure out do they want long-term? Do they want a program? Do they think they're good? Which they could be.

Researcher: That decision, how much of it do you think or do you feel is you getting a sense versus them seeing what they need?

P5: Ideally, it'd be 50/50. Unfortunately, it's not always that way, and ultimately it's the client's choice, so we have to respect that, and I can always give my recommendation. If they have legal involvement, sometimes those parties step in, but ultimately it's really up to that person what they want to do.

Researcher: What are some things that you're picking up on that they might not be saying directly that would lead you to recommend one thing or another as a transition?

P5: If they're aware and they're openly talking about it, that makes it much easier. If they have addressed maybe one aspect of trauma, but not another issue, like if they were a survivor of child sexual abuse, but they're in a current DV relationship, they may want to talk about one and not the other, and not necessarily understand how they're connected. I might try to get into a little education around that and encourage in which direction to go. Sometimes if we haven't addressed it at all and I'm still seeing behavior patterns, like, "The whole time we've been working together, you have continued to find partners who did A, B, and C," or, "You've continued this behavior in these different ways that this isn't something that just goes away. We need to work on it."

Researcher: Are you thinking at that ... Is this an example of, "I know that these behavior patterns are trauma or originated." Is that what you're thinking in your mind, and so, "Yeah, you can see this boyfriend after boyfriend," or something of the same type of individual.

P5: Mm-hmm (affirmative).

Researcher: The client might not be aware.

P5: Yeah. They might just be continue-

Researcher: Or more likely just not aware.

P5: Then I always too, whenever I'm talking to people about any additional issue, whether it's domestic violence, trauma-related, or any other kind of addiction, I always bring it back to their addiction they're in treatment for too, just that I really think you have to have a dual recovery approach with substance abuse and mental health. You can't work on one and think the other's going to get better. Seeking Safety does a really good job of explaining the connection between the two and just reminding clients that if you heal here, but you stuff this, it's going to come back, and I don't want to see you here again. I'll try to explain it to them that way.

Researcher: Do you do groups?

P5: Not anymore.

Researcher: Not anymore.

P5: I used to.

Researcher: Just individual.

P5: Mm-hmm (affirmative).

Researcher: Just individual, okay. Interesting.

P5: It's just because the new ... I'm in a management position now, and so this client I kept on was because of some of the child welfare issues she has going. It just would have been traumatic to cut her off at the point, and her case has extended longer than expected. Her and I have a rapport. It's just easy.

Researcher: Oh, yeah. It absolutely happens.

P5: It's nice to still have that client interaction too.

Researcher: Is there anything else that you think ... I know this is just general. This is just the first one. Do you feel like you said at least what you needed to say?

P5: I hope so!

Researcher: Excellent. Thank you, thank you.

P6 Round One

Researcher: If you could describe your process when making clinical decisions with trauma survivors.

P6: First, I assume that everyone's a trauma survivor. My first thing is, I assume generalities, I mean ... What's that term when they say everyone should wash their hands? There's a term for it.

Researcher: I don't know.

P6: It's the first, the best defense, but it's the ... Okay. I'm not even going to go there, because it's ... There's a term for it, basically, it means, just assume. As soon as I come up with the term, you will recognize it. Basically, I assume everyone is a trauma survivor, but I let people lead. Usually, in this setting, there's an intake. A lot of times at intake, we ask questions that can seem kind of invasive, but they do help us assess if someone has, as far as they're willing to talk about at that time, has had some kind of trauma, experience that we

identify as trauma. Like I said, even if they don't say anything, I kind of assume they're trauma survivors. I kind of use a trauma informed approach. I'm thinking as I'm talking.

Researcher: Pausing is just fine.

P6: If someone shares a trauma of some kind, the thing that would change my decision making would be about ... The only thing that would change, it wouldn't change my orientation. I would still, first, work to make a connection, a therapeutic connection. It might change, depending on a couple of things. First, if the trauma is very, very recent, and that's their presenting issue, I'm going to still, of course, work at the relationship, but really, my focus is on: Are you safe? The first thing would always be: Are you safe? It doesn't matter if they really are or not. It's more about: Do you feel safe? In that case, I might ... My first thing would be to work with them on a safety plan. What would it take for them to feel safe? If it's a recent trauma, and it has to do with something that (group name removed) could be involved, I guess I would involve resources, if need be. That's all for recent trauma.

The vast majority of people I work with, it's not as recent. Some, it still feels recent to them, and so, it is. If they're experiencing active symptoms because of it, it's recent. My first thing would be, assume everyone's experienced trauma. Use a trauma informed-lens which is more letting them lead, letting them, using their language, giving them options, not direction.

Researcher: Not giving them options?

P6: Giving them options, instead of directions.

Researcher: Oh, giving them options. I see.

P6: That's one. Then, if they identify that it's a recent trauma, something that they haven't ... Then, I would deal with safety issues and possible resources, or at least tell them what their resources are. If it's longer term, if it's like trauma symptoms, based on a traumatic event, but they're safe, and they're not actively in the midst of the aftermath of it, I think my first thing would be to say ... We just talked about this today at my (group name removed) meeting, because I still struggle with this. I might think it's their main issue, but they might not. First, I have to decide. If they bring it up casually, but they're not identifying it as their main issue, even if I think it is, then I have to decide how I can bring, because ... Another piece I always try to do is trauma education. How I can bring it? Maybe use different language.

A lot of times, people who have had a trauma that involves interpersonal violence of some kind, don't like to name it rape. They would rather call it an assault. Try to use their language, and maybe, kind of go around it, by doing education, just on whatever wording. It could be unpleasant experiences or ...

Without focusing on a specific incident. I have to decide if the client is open to ... Some people come in, they want to deal with this issue. They're like, that's it. They want to dive in. Some people, I think it's definitely a contributing factor, whether it's developmental trauma or a specific one incident, but they're not really ready, but I think that it's kind of an issue. It would change. One, I would have to decide how to go around it, using their language, maybe using some education. I even realize some of the education I use, today I was thinking about it. I was thinking, if someone is not ready to acknowledge ... If they talk about it in a way that you can tell they're kind of ... Part of them knows it's a big, but they're ... Using some of my education, even, would not be, necessarily ... I think it would be too much. I just realized that today, as I was processing a case. It's all about ... The word trauma is throughout it all. It's almost like I need to step back.

Safety. Stabilization. Then, the 3rd thing would be normalizing and educating, but that's where I would have to decide whether I go beat around the bush, almost, kind of use different words, or if someone's ... That would be something I would decide.

Researcher: If the client isn't ready to use that word, rape, you would align with them, and not use that.

P6: Maybe they come in for depression, and they're like, this is one of many things. I see throughout their history, that they have a complex trauma history. I might even say that to them, but I won't press it. I might say ... I might kind of say that one time, but then ...

Researcher: See where they ... How they react to that.

P6: Yeah. I would let them lead. That would be a decision I make. Then, I have to decide, I think the last thing would be, if they're ready to actively address trauma. I might only, and always, just address symptoms, and that's okay. I might think it's a trauma related depression, but I'll deal with the depression. That would be a decision to make. Then, the last decision would be, if some one should be really wanting to work on their trauma, then I kind of talk to them about: What are some ways we can work on it? I do EMDR and some emotional freedom technique, and stuff. That might not be something they want. I just kind of tell them their options. CBT is still considered one of the ... I don't necessarily think so, but I do think it's a good tool. Sometimes people are more okay with staying there, and don't really want to do something that is actively reprocessing trauma. That last step, when they're open to do it, I might let them. I might decide with them, what direction we're going to go.

Researcher: When you figure out that they're ready, do they ... You work with a young population, so do they have a sense of how they want to work on it? If you

weren't even giving them options, and you say, "Okay. You're ready." You ask them, "How would you like to?"

P6: I don't think a lot of people do. I don't think they know. I think they just know they don't want to ... They just know that it's really impacting them. I do have clients who have known for their whole life that stuff happened, and it's only now affecting them. I think it's affected them before now, but this is ... I have a client, for instance, who was taking some psychology courses. Just talking about family stuff has really triggered a lot of her own serious developmental trauma, that actually didn't occur at the hands of her family, but it happened when she was younger. She thought that she had already dealt with all that. They know that. They know that it's affecting them, that it's impacting them, that they want to feel better, but they don't necessarily know.

Once in a while, I'll have someone come in. I had someone come in who asked for EMDR. It was a lesson for me, too, because I did one time EMDR, and she decided she wasn't ready for that, partly because she felt like she was so not in touch with her ... I think she would have benefited, still. I really think it scared her. She also ...

Researcher: What came up for her, frightened her?

P6: Yeah, or, I think what scared her more, is that she's so disconnected, probably one of the most disconnected. She intellectually knows and wants healing, and actually works actively ... Issues around sexual abuse of children, and stuff, in a way that I almost think is really triggering. She's really disconnected from her feelings. I think what scared her even more is that she didn't see any immediate ... She has a performance, so she didn't feel like she was doing it right, that she wasn't feeling something that ... Even though I reassured her that there's no right or wrong. I think it scares her, that, what if she tries this and it doesn't work. Maybe there's no hope. For her, I think it was more, that. Of course, I'm not going to push EMDR on her if that wasn't ... In that case, instead of backing completely off of somatic or sensory motor stuff, more body stuff, we've been doing things that aren't EMDR, but might be some tapping or just different alternative things that she could try, that might not work. She's willing to give them a try.

Researcher: It sounds like you have lots of tools. It sounds like you have lots of go-to things.

P6: I want even more.

Researcher: You want more. Okay.

P6: Yeah.

Researcher: Sounds like you have more all the time. You're engaging the senses. You're familiar with EMDR, some cognitive behavioral, having things laid out for people to do while they're sharing. Can you talk a little bit about how you acquired that over your career? How, or what, you're particularly drawn to, or is it just a little bit of everything? Based on your clients needs, or trainings that were available?

P6: I think that for me, I acquired it more ... This is what's hard, I acquired it more by ... I still have a real sense of, I don't even like my title. I think I told you this. I don't know. Trauma specialist. I don't feel like a specialist, and I'm the only one with that title. It makes it seem like I'm kind of the expert. Luckily, now (name removed) here, and she's having to take that mantle more than I. Still, I feel that I still am developing my ... I wish I just had it more in mind ... When this comes up, I'm going to do this. I'm still not sure. All I know is, my theoretical orientation is humanistic, and that I'm willing to try anything that is considered evidence based. Quite frankly, things that ... Evidence based is still, also, very political at times. Things that, if I read enough about, and have training on, and it seems like people who have been in the field a long time, are somewhat endorsing. I'm not going to just do it, but I am going to look into it, and try to get some training on it.

I started out with working with [inaudible], serious and persistent mentally ill. It was CMI when I was young. [Inaudible]. Then, I worked in addiction, and trauma wasn't even a thing. The word trauma, nowadays is ...

Researcher: Everywhere.

P6: Mm-hmm (affirmative). Trauma-informed was nothing. Boundaries were nothing. It was so different. It's only been in the last ... Everyone I worked with has, I always have the sense that it wasn't just chemical in their brain. It was life events and just the ACES study, and all that. It probably wasn't until I was ... in 2016, I started working for community corrections, doing a very cognitive behavioral program that's called Moral Reconation Therapy. It's designed for ... It was created in prison, so it's designed for corrections population. It was very structured, but I still was able to put my own ... Make it a little bit processing. Then, I worked with drug court, and I started to realize that in addictions, some of the ... Oh, my gosh. Everyone. I would say 99%, there was such trauma. Then, their addiction created even more trauma. What they needed to do to get their ... It was just this cycle.

Luckily, around this same time, trauma did start to become more of an issue. I would just take some trainings, and I would say I was trauma informed, but I didn't really know what that meant. I still sometimes am not ... If I had to write it down, what would that mean. I kind of know it. It's like that Supreme Court Justice who said, "I don't know. I can't define pornography.", or whatever, but I

know it when I see it. That's almost how I still feel, sometimes, about it. I started doing more training. Then, I worked in a prison. I worked at (organization name removed) before I came here. I became even more interested in trauma. Still, if you need any amount of help, they don't offer a lot of ... You don't get professional development. I mean, you do, but it's like the funds [inaudible].

I would just do any trainings I could and read. Then, I got hired here as a trauma specialist, feeling almost embarrassed at that title. Now, I don't feel embarrassed. I just don't like it, because I don't think I'm an expert. Feeling almost embarrassed because, they maybe think I know more than I do.

Researcher: They, meaning your clients?

P6: The people that hired me. All of a sudden, I'm at this place of respect and, that I never got in Community Men- ... Just this, so I took on this mantle. This has only been a year now, of having a lot of bits and pieces. Reading a lot, reading Bessel Van Der Kolk, Janina Fisher, Peter Levine, all of those. Quite frankly, once I got the interviews, but some beforehand, what I realized is, I really do have the experience, because a lot of the stuff I had been doing, I'd always been interested. I realized that some of it was just, because I'd been in the field for 30 year, some of it, in spite of myself, I had developed skills of empathy, and support, and letting a client lead. What I needed to do this year, and it's really been this year, is get some more practical trainings. I have the theoretical underpinnings. I felt like I had the counseling skills. I got trained in EMDR. I've been learning more about somatic and sensorial motor. I'm going to be doing a training next week on self-compassion, with Kristin Neff. She's wonderful if you ever ... Her website's self-compassion. Dr. Kristin Neff and she has this great self-compassion website that's really practical, but there's a self-assessment that's a really useful tool that I have a lot of clients take.

Researcher: I was thinking her work was about counselors' self-compassion, but it's teaching clients self-compassion. Is that what you're saying?

P6: Yes. I still think it's good for ... I mean, I look at it for myself, too.

Researcher: Not like a counselor couldn't benefit from it, or anything, but okay.

P6: I've done some trainings on trauma stewardship. I love Dr. Laura van Dernoot. She wrote *Trauma Stewardship*. She came to (location removed) a few weeks ago, free, and I went to see her, so, just working with my fellow staff people on taking better care of ourselves, and being better stewards of trauma, so that we don't burn out and drop the ball. That's a long answer. It's not easy.

Researcher: It's helpful.

P6: It's not easy to answer, because it's all been so hit and miss.

Researcher: I think that's how it goes. Share a little bit about how you experience countertransference.

P6: How I experience it?

Researcher: Yeah.

P6: Very rarely. The way I experience it is ...

Researcher: Did you say very rarely?

P6: I was about to say, very rarely. I'll just say what I was going to say. Very rarely, do I experience countertransference of a negative ... It's negative, like anger or frustration with a client. I've experienced that. Mostly, the kind of countertransference I experience is more like, for instance, a client who recently talked about what I consider an assault, and she very much minimized it, then showed me pictures of her bruised neck, from him pushing himself on her and she kept trying to get him off. He gave her all these, hickeys, basically. At a party, where there were a lot of people, and she kept trying to push him off, and no one helped her. I'm still, even as I'm talking to you, I'm so angry.

It was a fraternity, off cam- ... It's such a common story. How I experience it is, I really want her to acknowledge that it was an assault. She's mostly upset because she thought of him as a friend, and she was a Freshman. It happened her first day of being here on campus. She had met him when she had come up to visit before. She had thought of him as a friend, and now she's in the classroom with him, where all she can do is sit. She said, "I can't help it. I just keep staring at him." I said, "What are you feeling?" I'm not scared or anxious. I'm just sad. I'm just like: Why won't be talk to me now

My countertransference is almost like, partly, I want to, not literally shake her, but I want to say, "This isn't okay." I do say that, but I say it. I have all this feeling about it. I want to, but I'd overwhelm her. I would totally overwhelm her, and she probably wouldn't come back.

Researcher: You'd overwhelm her if you had all of that stuff spill out of you.

P6: Mm-hmm (affirmative). Even with what little I did respond, because this was just a triage, and I put her on my caseload. The little I did respond, I worry that I might have been too ... I feel like I really ... I just told her I do think that it was assault, but we don't have to go there. That's what I said. We don't have to go there. We can just talk about how you're affected. We don't even have to talk about that right now, because she actually didn't come in for that reason, but it was one of those doorknob statements. Then, she showed me a picture, so you know that there's a part of her.

The countertransference I feel is wanting to fight. I get really anxious and I want to fight for, take on a client's battle. Basically, it's that old, the other term,

codependency, whatever it is. I want to fix it for them and see justice done. How I deal with it, how it feels is, I feel anxious, and I find myself, if I'm not careful, I can actually put pressure on clients. I really work hard not to do that. What I do with that is, I talk to other staff. I'm really open about my feelings. I didn't realize how much it affected me, until I talked about it today in that SASS consult. I actually got tearful. I didn't even realize how much if affected me. I do try to talk about it. I try to acknowledge it. I try to be really open, at least with myself. Usually, people here tend to think of me as the confessor. I confess everything. I try to be open, at least, with myself about my feelings about a client. Sometimes I find that in itself can change.

I had a client who had Aspergers, and he is kind of odd, just by nature of what he struggles with. When I first met him, I remember thinking, I don't' really want to work with him, because he's not my typical client. He doesn't have social skills and he is not going to give me ... I didn't think all this at the time. He wasn't giving me those cues that I realized I expected from him, which is about me. I don't want it to be about me. I had to do a lot of work. I found myself almost ... I would go up to the front desk, because they had known him from before he's come. I'd be like, oh, my favorite client's there. He's one of my favorite clients today, because I've learned so much from him about acceptance, about my stuff, about what I was bringing into it, and maybe trying to get my needs met unconsciously. I just think he's wonderful. Still, if I talk too loud, he'll start to go ... If I'm too excited, too friendly, it's uncomfortable for him.

It's just different. That's what I do with countertransference. It took me months and months of processing, figuring that out.

Researcher: Particularly, with him.

P6: With him. That's what I try to do. I try to be ... There's a term for it that I can't remember, something like, the shadow counselor, or whatever. I try to have that shadow counselor, the one that is evaluating me. Try not to have it nonjudgmental, though I do sometimes. Just watching what I'm doing and why am I doing it, and how's it affecting our therapeutic relationship?

Researcher: You said you realized that you rely on cues, so, maybe, body language, or emotional cues. You didn't know how much you relied on that?

P6: What I rely on, I realize, this is going to sound really shallow. I'm usually good about making a connection right away. I rely on them liking me, giving me something. He's really taught me that's probably not okay. I've always known. I haven't tried to intentionally do it. He taught me that if I'm not getting something from the client, I need to ask myself: What do I need and how can I get that? Not from a client, but in my own life. He wasn't giving me anything. It was about him when he was here, not me, or our re- ... Of course, I know people don't come for me, but he wasn't going to give me that. That was

definitely countertransference. I had to do that, self. It took a long time. Now, I'm very [crosstalk]

Researcher: It sounds like you do a lot of reflection out of session time? What is going on here? It sounds like it paid off.

P6: Yeah. I think, in this case, it did. I can't say I'm always aware, but I try. I'm probably more open to talking about my concerns. That can be hard, though. Sometimes, if that's all you do. I'm not good about blowing my own horn. Tooting my own horn, whatever that phrase is. I tend to present my weakness, sometimes. I don't necessarily consider it weakness. I consider it just, this is what I'm dealing with. Later on, I'll have interactions and realize that people believe my press. They don't realize that I'm pretty capable and I do a pretty good job. What they hear is my talking, so I'm trying to get better about who I talk to about that. I'm not really good at that, still, though. I'm just trying to get better. It has its downside.

Researcher: Did you find yourself doing some reflection outside of work? At least, outside of the office, your office. In addition to talking to others about it?

P6: I think I do reflection outside of work by myself. I think, if I do reflection outside of work with other people, it's often more just stuff about ... It's kind of vague, like, gosh, I've had some really hard cases and stuff. I think I do reflection outside of work, in general. I really try hard to not bring stuff home, but I know I do. Sometimes I don't realize it until I get sick or something. I'm really working on that. It's more specifically ... We have so many clients that, a lot of times, my reflection is almost while I'm, for 2 minutes after or during, and then I have to move on to the next one.

I think that's why it took so long with my one client, who I was telling you about, who has Asperger's. I didn't have the time to just really sit and process it, so it's almost like, oh, I've seen him today. Think about it. 2 minutes after, and then the next client's in.

Researcher: It sounds like he's so different from anybody that you'd worked with before, that you just put more thought into it, in general, because it was so unusual, for a lot of reasons.

P6: Yeah.

Researcher: Your countertransference, how you experience it is, maybe, the sense of urgency to help advocate, wanting the other person to ... In your sadness, because you mentioned you were processing this with some coworkers. Back to the case of the woman with the assault. Was the sadness, and the tears coming up about your helplessness, or about the fact that she didn't have the awareness,

or the willingness to go there and say, be as mad as you are. What was the sadness coming up for you about?

P6: I don't know. That you ask that, I'm thinking, I don't know. I'm thinking part of it was, just a real empathy. It's almost like I was holding her feelings for her. It's like that she couldn't feel, so I was feeling, maybe, more about it. It really was the sadness, partly was just what she'd experienced and feeling, almost, for her, because she couldn't in the moment. I think part of the sadness might have been that I ... The system. The whole Greek system, and the whole rape culture. Not just Greek system, but the rape culture.

I think, even when we're talking now, what I'm thinking is, (personal story removed). On a level of the same age as my child, and experiencing stuff. I think, partly that. I also think sadness of, I hope she comes back. I made an appointment with her. I think she will. Maybe I pressed her too much.

Researcher: Some self-doubt.

P6: Yeah. I think that's just the nature of the beast, too. What works for someone doesn't work for others. I'm not exactly sure all the reasons.

Researcher: It's still fresh.

P6: Yeah.

Researcher: If you could talk a little bit about how, and you've touched on this some, but, how, when you experience something like this, how it affects your decision making.

P6: I think if I don't deal with it, if affects it in a way where I try to overcompensate. For instance, if I felt like I was too pushy with someone, or whatever, then I might, way back away. It becomes more about me, in that moment. It becomes more about me. I start to have more self-doubt, so I start to, maybe, back away from anything I was doing. Throw the baby out with the bath water, type thing. Sometimes, this hasn't happened in a long time, but there's been times in my years of doing this, where I've resented the client, which doesn't help. The clinical decisions, then, are based on assumption of negative intent. I might look at someone's behavior and struggles with a lot of empathy. If I resent them, then I start to think they're personality disordered. Even that, I have empathy for, but in a negative way.

I might diagnose them differently, and I might diagnose them as, just being an awful person, instead of ... I really try not to do that. I know that I've probably done that in the past. Usually, I catch myself, but I'm sure I have. I can't think of any right now, but I know I've had resentments. I think diagnosis can even be affected by that. If you feel bad for someone, and you're having ... Nothing's wrong with feeling bad for someone if you have empathy for that person, but if

you have some countertransference, if I have some countertransference, I might even diagnose them as, maybe they do have borderline personality, which I still think is a political diagnosis, too. I have empathy for them, and so, I don't want to diagnose them with something that, just for purposes of record keeping, that's what they fit. I maybe diagnose them with something, with PTSD. Usually, I think people with borderline often have PTSD. Still, I might keep them from getting something they need, because I am trying to be kind, if I have a lot of empathy. I might diagnose them, pathologize something, or diagnose them, maybe with anti-social personality, because I don't, because there's something in countertransference.

Diagnosis. I might also, like I said, self doubt, so back away from stuff that might actually work if I just modify it. I think those are big ones, if I don't deal with that kind of transference. I'm sure it's happened many times.

Researcher: Even just listening to you, I imagined it happened in corrections. [crosstak] Holy cow.

P6: Everything was about behavior. I'd be like, and this is where my countertransference was, I wanted to protect them. I don't even know if it was countertransference. It was more like, at the system. Everything was about, these were adult women, and I was like, seriously, some of the behaviors that were seen, are negative, are stuff we do all the time in the back, in our offices, the way communi-

Researcher: Countertransference with the system.

P6: Exactly.

Researcher: Anything else? That's all the questions I have.

P6: Really? Did I answer them okay?

Researcher: You did just fine.

P6: I feel like I answered them okay. Did I answer what you wanted, because I do talk a lot sometimes, and not ...

Researcher: It's helpful, though. Yeah. Yes.

P7 Round One

Researcher: If you could just describe your process when making clinical decisions with trauma survivors.

P7: When you say clinical decisions, you mean interventions? You mean the-

Researcher: Anywhere you want to start. You can start with assessment, if there's things you do before an assessment, how you make those ... Any kind of decisions, interventions ...

P7: What happens.

Researcher: ... where to go in session.

P7: Sure. Given that I am now in a private practice setting, that changes clinical decision-making. When I'm in an institutional setting such as a counseling center or a mental health center or a treatment center or I worked in a student health center, if it's a medical setting, those settings impact clinical decision-making very significantly, mostly because of the short-term treatment model and the time that you have available with someone, so that determines goal-setting. It doesn't influence conceptualization, per se, of the overall client picture, but it influences conceptualization in terms of what can you do and what is appropriate given the amount of time or the frequency that you're going to see someone.

Private practice has some similar limitations, depending on the client's situation in terms of their goals or their financial resources, if they use insurance, or their overall stability. Those things influence, again, not necessarily the conceptualization diagnostically or in terms of what the client is bringing into the therapy experience but what we're going to do together. Since I'm now back in private practice as of this week full-time ...

Researcher: Oh, so this is newer. I mean back to-

P7: It's a return.

Researcher: It's a return.

P7: It's a return.

Researcher: But this is new?

P7: This is brand new.

Researcher: This setting is new?

P7: That's why there's tape and light bulbs on my desk, yes.

Researcher: Okay. You kind of have your foot in both worlds, also?

P7: I have. Now, I've just landed both feet here, so yes.

Researcher: Oh, okay.

P7/Researcher: (Location information removed)

Researcher: Yes.

P7: (Personal story describing place of work removed)

Researcher: None of that would be in here at all.

P7: That's fine. Just so you have context, though.

Researcher: Yes, the context is ... It won't even-

P7: That's fine. In private practice, it's more often the case that folks are interested in longer term therapy. It's a little complicated. Folks can have more complex, ie. chronic, long-term, entrenched sort of patterns that they're dealing with or they can, in a way, have more severe symptoms than a short-term treatment setting can handle. One of the reasons that I have ended up, over the years, working with trauma and complex trauma is because I spent the majority of my career in private practice, and you see a lot of trauma, and you see a lot of chronic, long-term trauma.

At this point in my career, folks who I work with or who I am in contact with know that I do that work, and so I get a lot more referrals for that work. Folks are calling me already identifying as having some sort of trauma history and wanting to do that work. I consider myself a generalist, but I have that area of ... I have a lot of experience there. When someone calls, they will often identify that way. I just had someone call, and they identified as having grief and trauma, and they were having a hard time finding another therapist to work with. There aren't other folks, apparently, who do trauma work who have openings, and so another therapist referred them to me. In that situation, that lens is there already.

When I'm doing a phone consultation, when someone calls to schedule ... If they email to schedule, we end up having to talk on the phone, because I'm not going to schedule somebody that I haven't screened, because that's not appropriate in private practice. Well, it's not appropriate anywhere, but especially in private practice. I'm working solo, so the safety issues are really important. I'll do a safety screen. If they're in an actively unsafe situation, if they're actively at risk of seriously hurting themselves, those are two of the screening questions that I would ask.

Researcher: So their safety?

P7: Mm-hmm (affirmative).

Researcher: Which impacts yours, of course.

P7: Well, it's more are they in any kind of really imminent risk situation where they would need to be in connection with a hospital or some kind of more intensive level of care? Those are the two questions that I would start off

with. Then, that doesn't mean that they can't have active self-harming. That doesn't mean that they can't have active suicidal ideation. It's just if there's imminent risk of severe physical harm to someone. I ask those questions on the phone. Usually, the way it's discussed, if a client says yes in any way if they're in a domestic violence situation or if they are, again, really at risk of hurting themselves. It doesn't happen very often. Most folks don't call if they're in that kind of situation, but I do screen.

Usually, on the phone I will ask just briefly what it is that they're calling me for and get a general sense of that. I try not to make people do their entire story, because they're going to have to come in and tell me their entire story the first session, and a lot of people have had prior therapy by the time they end up calling me. I try and help that. Then, during assessment, I have some pretty specific questions that I ask about trauma. Over the years, I've developed a much more open-ended way of asking that, because people will rule something out in their mind before they'll talk about it to you. I'll start out really open-ended, but then I will also follow up with really specific questions. Have you ever lost your home? Have you ever lost your job? It's not that those things in particular, just because those things happened doesn't make them traumatic, but I just want to get a sense of what somebody's been through. Oftentimes, people don't identify something as related to the trauma that they're working on, but it's contributed somehow. If somebody's been through five traumatic events or overwhelming events or adverse life events and then they come with the sixth, that's going to influence.

Researcher: You developed that over the years just through experience?

P7: Right. I mean, I've also read a lot. I've read research, so all of that's sort of in there, but yes, it's more of a clinical focus than some sort of instrument. I don't use an instrument, per se. I can, but I don't typically. The way that I tend to do assessment is rather than asking specific questions related to a diagnosis, I just go through areas of functioning. My intake assessment is tell me about your sleep. Tell me about your mood. Tell me about your energy. Tell me about your concentration and attention. Tell me about your relationships. I mean, I've got a whole set of questions. The training that I've had as a psychologist is that diagnosis needs to be based on functioning, and it needs to be based on a constellation of symptoms that hold together. Rather than nowadays, there are a lot of intake assessment forms that have ADHD and they have all of the symptoms, anxiety and all of the symptoms ...

Researcher: Exactly, yes.

P7: ... and you just check the boxes, which kind of freaks me out. If you ask somebody about sleep, they'll really tell you about sleep. Then you can find out, well, how long has that been happening? What other times in your life

have you had those kinds of patterns, and what are the times when it works, when you're not having those problems? You just get so much more information than sleep disturbance. That just means nothing to me. So you can tell I have some judgment on that. I just think we lose information, that's all. If you ask someone if they have an elevated mood, that's leading them down that path, whereas if you just say, "Tell me what your general mood is like. When is it different? How often is it different? What happens before it changes? What problems are associated with that, if any?" Oh, so when your mood gets better, you also can't sleep? Tell me about that. That could be anxiety, not just elevated mood. I try to be really careful with that sort of thing.

Then, I also diagnostically try and keep things very simple. I am very careful, I hardly ever give more than two diagnoses at a time, because I think we can over-diagnose, as well, especially with trauma. Trauma can look like bipolar disorder. Trauma can look like a generalized anxiety or a panic disorder. Trauma can look like an attention issue. Trauma can look like all kinds of things. An eating disorder. What I've found over the years, and this is just because this is what I do, but if you resolve the trauma, the other stuff sort of resolves itself.

Researcher: Yes.

P7: I'd rather somebody didn't walk around with five diagnoses in their record if they're going to resolve themselves. That's assessment. What was the original question?

Researcher: No, this is great. This is perfect. This is about clinical decisions, so how you go about making these decisions, and you're explaining why. Is that usually done first couple sessions?

P7: First few session, yeah. Then the other piece of it is the longer that I'm in practice, the less diagnosis really means to me in the end. It's sort of a counterbalance to I take it very seriously, and I'm very thorough, and I try to base it on functioning. At the same time, in terms of long-term psychotherapy, the point is what is the client actually doing in their lives, and how are they functioning in their lives, and how are they making meaning of their experiences, and what's getting in the way of that? Diagnosis really is ... After a while, it doesn't really impact the clinical judgment, in a way, for me.

In terms of treatment goals, it's what does the client want? A question that I will ask is, "If we're successful, if we do good work together, what will be different?" They'll say, "Well, I'll be able to sleep," or, "I'll get along with people," or, "I'll have friends," or, "I'll like myself." I can put a lot of clinical language around that that makes it sound really fancy and cool, but

ultimately, what is it that the client wants? That's what I really try to stay with.

That said, things seem to sort of hang together around certain areas. A lot of trauma work has to do with boundaries and identifying what is me and not me, and where do I want to hold that line, and where is that limit, and how permeable are my boundaries with people, and do I have a sense of what my needs are versus the other person's needs? There's a lot of work around boundaries. There's a lot of work around emotion regulation and just being able to recognize what emotions are happening and then be able to make choices around it rather than the emotions driving behavior, instead of having those strong reactions to things. Marsha Linehan's work, it's very, very well done. You have awareness, i.e. mindfulness. You have emotion regulation. You have distress tolerance.

Researcher: Distress tolerance.

P7: Then, you have interpersonal effectiveness. That's it. If people have that, they're okay. If people have that, they are pretty satisfied in their lives. In trauma work, it's this interesting balance between a pretty high level of structure and also a great deal of fluidity and flexibility. For example, early on in my work with folks, I will often do quite a bit of psychoeducation. I have some handouts that I've developed over time that I think are useful and that fit for me and so then the client. If they fit for me, then the client, I'm able to teach it. It's also just basic information like the trauma activation process, what actually is happening in the brain and the body, what is the trigger response cycle light, the fight, flight, freeze, or fawn response. How can we begin to understand how that's what's happening for you? It's not you, it's this process. This identification can begin, also, through that psychoeducation.

The early part of therapy is about the rapport building, about creating the safety for someone. I don't like safety. Security is a better word maybe. The stability of the space for the person to be able to let down a little bit to do the work. Then, it's about giving a lot of information. Just a lot of information about that trauma activation process, about grounding, about boundaries and assertiveness, about being able to recognize what's happening internally and how that translates into needs and wishes and desires.

Beyond that, I would say it becomes more of an interpersonal process. It's based on the relationship between the client and the therapist and using that as the container to practice. If you were my client and you showed up and I didn't know we were scheduled, that could piss you off, or that could hurt your feelings, or that could scare you. Whoa, therapist doesn't know what they're doing. Okay, I'm counting on you to be stable. My life is chaos. You

need to be stable. I've had clients, and I'm very okay with that. I screwed up. Absolutely, you have every right to be pissed at me, totally, or I'm so sorry I hurt your feelings. That is absolutely the last thing I want to do, and I totally understand how that could have felt that way. We're getting into interventions now.

One of the things that I feel like I've learned over the years, especially with folks who have experienced trauma at a development level so that they end up having personality disorder, traits or symptoms ... That's what I think of as complex trauma. Complex trauma is development, and any of the personality disorders can be boiled down to some form of trauma, in a way. Folks with that level of impact of the trauma really need genuine, stable interpersonal stance from the therapist, so if I screw up, I screw up, and I need to be able to own that. I do screw up. There's nothing I can do about it, because I'm a person. That's one of the stances that I've gotten feedback from other professionals about when I've worked with them in settings with folks with complex trauma and also from clients when they've gotten further into recovery, that that's something that makes me safe. Anyway, that's another aside. Yeah, go ahead.

Researcher: No, keep going.

P7: Psychoeducation, skill building.

Researcher: It sounds like that's been more structured, because you were talking about structured versus flexibility. As you lead more into the interpersonal-

P7: That's when-

Researcher: That's when things get-

P7: Right. That's when, in my view, if I haven't done my own work, then I'm not going to be able to help the person. The idea that the therapist can only help somebody as far as they've gone. Then, in terms of interventions, my view is that a good number of interventions that are promoted in the larger field of psychology have to be modified for trauma work. Meditation and mindfulness is a really good example of that. In order to use meditation, very simple example, you're encouraged to close your eyes. For a lot of trauma survivors, that is extremely overwhelming, emotionally flooding, memories, all of that stuff. I've just had so many survivors say, "No, there's no way I'm going to meditate. I tried that, and I had a flashback right there in the yoga studio, and I'm not doing that again."

Assertiveness, also. The classic formula, the way of approaching assertiveness needs to be modified for a trauma survivor. Guess what? No one feels safe, and there may not be any safe people in their lives. How are you going to work with that? Modifying interventions is also something. It

feels like it happens more naturally for me now, but I had to really learn about that early on. That's all I got right now. That's all I have. That's my first answer.

Researcher: That's great. The difference between your decision-making with trauma survivors versus non-trauma survivors, it sounds like a little more ... It sounds like you're, well, I don't want to say treading more carefully-

P7: Yeah.

Researcher: Okay.

P7: I was just working with a trainee this year, and they were being hard on themselves because they felt like they were walking on eggshells during the first few sessions with someone. Of course, walking on eggshells, that's pretty strong. That's not useful as a therapist. To be careful is smart. Yeah you need to be careful, because you don't know what the triggers are for that person. You don't have that rapport and that stability of the therapeutic alliance in place yet, so you don't know where you're going to cross a boundary for the client. Yeah, you need to be careful.

Researcher: Talk about the interpersonal, it's leading towards countertransference. Tell me about what your understanding of countertransference is. There's so many different definitions out there from Freud on and all different iterations of what-

P7: Projective identification.

Researcher: Yes, all of that. I think it would help if you talked a little bit about how you view it.

P7: My frame.

Researcher: Not how you experience it yet, but more just what is it to you?

P7: I would describe it as a couple of things. I would describe it as partly unresolved issues on the part of the therapist that get triggered by behaviors or the interaction with the client. The other way that I would conceptualize it is in terms of a projective identification. What I mean by that is, at this point in my career, that the therapist is tuning into an experience of the client and mirroring it within themselves. In a way, a parallel process. That's how I would describe that.

Researcher: Share a little bit about how you experience it.

P7: Well, my most recent example, I experience it more often when I'm not resourced, when I'm not well resourced, if I'm not well rested, if I'm not taking care of myself, if I'm not feeling stable in my own life. You can tell space is important to me maybe. Having what I consider a beautiful space is

very calming and soothing to me. If I have a little space and I've got my little tea and everything's all settled, then I can focus. Now, again, over the years, thank God, I'm maturing a little bit, so it's not as important. I've been seeing clients, and it was a mess, according to my standards, and it was okay. I could still do the work. So meditation and yoga pay off.

When I'm not rested, when I'm not centered myself, I know that I'm more at risk, so I have to be more careful then. What I mean by more careful is I have to make sure I have my consultation people in place. I have to make sure that I have a way to journal or reflect on it. I have to get back on track with my yoga or make sure that I have snacks throughout the day, whatever it is. Whatever it is that I'm going to need to take care of myself.

Researcher: What's telling you that you need those things?

P7: Usually, I feel a sense of agitation or reactivity to a client. I'll get bored, or I'll get impatient, or I will get overly concerned. Just any sort of magnification. Something somebody will do, I'll find myself getting annoyed with a client, which is not typical for me. I could also end up getting overly warm like I love this client. This is my favorite client. That kind of thing. Attachment or aversion, one of the two.

Researcher: Anything particular that's used different for you around trauma survivors when experiencing countertransference?

P7: That's interesting. What I find myself thinking is I have less of it. Huh, that's interesting. Two clients popped into my mind. I've done a lot of trauma work, and I've started it early in my career. My first work was in a rape crisis, rape education program. I understand it really well, I guess, and it just makes a lot of sense to me. The things that people struggle with when they're working through a recovery, it just makes sense to me. Whereas, autism spectrum, for example, really challenging for me. Really challenging for me. All the perks of the interpersonal process are missing for me.

Researcher: Perks is a good word.

P7: That's really challenging for me. It takes a lot more patience for me. It takes a lot more groundedness and a lot more compassion. I've talked with other colleagues, and it's the reverse. Actually, (name removed) does a lot of work. He does neurofeedback, so he works with a lot of neuroatypical individuals. It's his favorite. He loves it. Loves it. Then, someone with a trauma history is much more challenging for him. It's just interesting to think about it that way.

What I notice at this stage in my career, I don't have as much negative transference. I would have more positive transference. What I have to watch for is someone who has the resources and has agreed to pay for services and just has not for a while. I just let it go. I just don't ask. That's an example of

how I would get caught in countertransference. I had a client that I saw for probably two, two and a half years, just made tremendous progress. Happened to be dealing with issues of gender identity as well as trauma. I was just gunning for this person. I was just really so proud. I had a little bit more of a maternal, I think, response to this person. They didn't need that necessarily. I mean, it was good work, but I think about them and I get a warm feeling sort of thing.

Researcher: When you're in session experiencing either that aversion or attachment, what happens in session? What do you do with it?

P7: It's much more of an internal process. Sometimes I'll talk about it. There's one person I saw across settings. I had seen him in one setting, and then they ended up contacting me again. This person was just very overt with their transference, just very, very clear with it. I walked on water, so the therapist as the ideal. We would laugh about it. Each time they said that, wow, my ego just was floating on air. That felt so good to hear. I'm concerned about how that might influence my work with you, so I think I'm going to have to acknowledge that out loud, that every time you say that, that feels really, really good. The person, "Well, I want you to feel good." "I know, but you know what? You don't actually have to say it that strongly for me to feel that connection with you. I feel connected with you, even when you don't tell me I'm the best therapist that ever walked the Earth." To process it out loud helps me unhook, and then, if it's used well, it can help the client.

Researcher: The client can see what they're doing, hopefully.

P7: Yeah. Well, they can experience the connection without the idealization and devaluation. Counterexample, a client literally interpreted something that I said really very, very extremely the other direction and was really angry. In that moment, I had a fear response, because it could damage the alliance, this person could get triggered into a suicidal episode, a lot could happen. I, in that moment, said, "I'm feeling some fear as you're saying those things. I'm concerned that I'm not going to be able to help us figure out the miscommunication there, and that that's really going to hurt you, and that there's not going to be anything that I can do about it." Luckily, this is somebody that, again, wasn't the first time that had happened in therapy, so we had made an agreement to be able to do some grounding if there was a miscommunication, because that just was going to happen. The miscommunication was going to happen.

We practiced some grounding in the moment, and they actually decided to leave session early, which I was okay with because they had practiced the grounding. That was kind of our deal. Then they contacted me a few days later and said that once they'd calmed down, they'd realized how they had

been triggered. Again, the psychoeducation early on helps us provide the frame for what's happening in the work. Of course, I'm thinking of examples where it worked, and nothing's coming up where it was really ... I mean, if that had happened to me in my 20s, I would have been devastated and very, very concerned.

Researcher: For?

P7: For the client.

Researcher: For the client, okay.

P7: And there would have been some ego stuff around me failing as a therapist or something like that. Now, I guess because I've done it long enough, I feel this pretty strong faith in the process with the client. I have a lot of faith in people and in their process. When people choose to come into therapy, most of the time, they're choosing to get into their recovery at whatever stage they're at. It's their work, not mine. I think of myself as a Sherpa.

Researcher: You're carrying the loads.

P7: Right. We're going up the mountain together. I'm going to carry a lot more at the beginning until you get stronger, and then we'll share more. That kind of thing.

Researcher: That's a nice analogy. You said most of this process happens internally.

P7: Right.

Researcher: Would you say it happens outside of session internally or when you're sitting across from a client internally?

P7: It's more in the moment now ...

Researcher: In the moment, okay.

P7: ... than it used to be. It used to be that I needed to process something out loud with a colleague and make sense of it. I would just have strong reactions and I wouldn't know what they were about or this is the person I keep thinking about and worrying about, so what's that? If I'm doing heavy clinical work and I have a more intensive caseload, Thursday nights are usually I'm pretty wiped and I've got a lot to process, so that's when I'll usually have some extra need to talk to somebody, another therapist, who gets it kind of a thing so that I can just release it and figure out what it is and then move on.

Researcher: Excellent. I think we're good for now. Do you have anything else to add?

P7: No, this is fascinating. It's fun to think about it and talk about it.

Researcher: Yeah, that seems to be what I've-

P8 Round One

Researcher: Start by describing your process when making clinical decisions with trauma survivors, and you can start anywhere in that process.

P8: Okay. Wow. I would say probably part of my ... Well, obviously my process begins with an assessment, and I usually have to determine if I am going to be doing supportive treatment with the person or if I'm going to actually do active treatment with the person. That's probably one of my first distinguishing decision-making processes, because if they do not have enough social support or they're actively in the midst of something very traumatic or dramatic that is not resolved and that is going to in some way send them all over the map as far as being some days feeling pretty good and then other days just feeling like they just were re-traumatized in some way or another, then I will tend to provide what I would consider supportive therapy. In other words, help them get through the critical time so that then they can achieve a level of stability in order to actually receive treatment for the trauma.

There are some people who on assessment are otherwise very stable and they have good support systems. Everything else is in place other than their basic symptomatology that's related to their trauma. That's probably my first decision-making process. Then there are times when even from session to session I will ... I actually, I practice, I'm EMDR trained.

Researcher: I am, too.

P8: Oh cool. Yeah, and it's my primary. I'm also trained in PE. My [inaudible] CBT. I worked for the military. So I have a lot of other options, but I do tend to, if a person is ... If it looks like they're in a very acute exacerbation or something else has come up, I may provide some stabilizing, a session that might be more about ... It much more looks to me like supportive therapy as opposed to actual active treatment moving their trauma into a different direction, only because maybe they're ... Like I had one person recently who's basically wife left. At that point in time to have worked on the trauma would have felt very disrespectful, actually, but more than anything not timely. The thing that was in the front of their face at that point in time was adjusting to this very recent issue.

Researcher: Mm-hmm (affirmative).

P8: So that's what needed to be addressed, and then the trauma, once things settled down, then, yes, the trauma becomes the thing in the forefront.

Researcher: So are you assessing, it sounds like a lot of external resources, but I imagine there's some ... Like at the forefront are you assessing how strong they are in their internal and external resources?

P8: Yes, yes, and that's for me because I'm EMDR, I'm going through the protocol, obviously, but I also have, because I work ... I have a somewhat, I suppose, although I'm sure there's many of us across the United States, my primary patients are law enforcement.

Researcher: Oh, okay.

P8: So I have to know where they're at in that process of ... Like let's say the reason they come to me is after an officer-involved shooting, I would need to know where they're at in that before I necessarily start treatment, because that is a very intensive process with a lot of interviews and a lot of pressure and a lot of involvement, and depending on how big it is, you know, it might be on the news and so the person is dealing with that. So generally speaking, I like to see things stable as far as the outcome of something like that. Stable enough so that treatment can begin, because sometimes what will happen is, if I started treatment too early and then all of a sudden something comes down like now somebody's suing them. That ends up completely interrupting the entire process. You end up having to stop and then deal with that. Usually I'm just assessing where is the process, and certainly I'm going to end up hearing pieces and parts of the story, and that's going to end up making me determine whether a person is in a position at this point to start actual, really active EMDR.

Now, that being said, there are a lot of times when I will go between ... I will use EMDR for one session, two sessions, three sessions in a row, and all of a sudden I stop and I'm doing two or three sessions of supportive therapy. Sometimes things will end up happening in their life where I'll just make the determination that we need to slow down a little bit or ... It just really depends. Some of these situations are very long in the past. I'll tell you another one of my decision-making processes, too. I don't look up their case.

Researcher: Ah, okay.

P8: I don't ... All of my cases are public record, almost all of them. Many of the cases I've been involved in have made the news, some of them the national news. I don't look at it. As soon as I ... I just don't. From a decision-making standpoint, for me to approach it with an open mind and to have them provide me with the narrative instead of having the narrative supplied to me by the news or some other process that may or may not be distorted.

I've actually been ... I'm a critical incident first responder too for psychology. This is my area. I responded to several, and I was there on site watching things unfold and the news is so grossly incorrect, that I just made a decision that I

really can't watch it. I can't watch things that I might eventually get involved in because the distortions are so remarkable that it makes ... Talk about countertransference, it makes it very difficult to be easily present for people, because you have all of this information that is thrown at you from the media that is, in my experience, probably didn't happen. It just ends up making it very difficult to, I guess, have ... It's sort of like a metacognition, where you're listening to the person and then you're playing back the audio of the news report you heard, and then you're trying to either blend the two of them together or you are ... So it's just not useful, and so I stopped.

Researcher: Sounds like a very smart decision.

P8: I hope so. People are talking, "Didn't you see it on the news?" It's like, "Ah, yeah, no I didn't."

Researcher: Yeah. I bet you get a lot of good ... I can imagine your clients, some of them anyway, would appreciate that.

P8: I think so. A lot of them ... I'm pretty transparent. They'll say, "You don't watch the news?" I say, "No, I've found from my experience it is very difficult to do my job and have all of those distortions in my head." It's interesting, because law enforcement tends to not watch it a lot either.

Researcher: Oh, interesting.

P8: Because of the same thing. Once you've been involved in a few things and you hear the news reported and how distorted it is, you just get to the point where you think, I don't want to work that hard, and so I don't.

Researcher: Yeah. So when you're either switching gears to do some supportive therapy from doing active therapy, how much is it the client is sort of dictating or you're making the decision. What's the sort of lead, co-lead on that? Either when you're starting or midstream.

P8: Right. I would say that it's probably ... It's an incredible range, because I have some of my clients that I feel have very good self-insight or very high self-insight, and others that are really functioning at a less ... I probably will ... I will usually say I really think it wouldn't be a bad idea to talk. I have some of my clients that will come in and sit down and say, "(Name removed), we just need to talk to day, because I can't process today." I will usually make that call. In the beginning of a session, I'm usually going to ask ... I always ask, "Did you have any thoughts between our last session and now?" Then usually people will give me a reference point from that thought process, and if I hear it was way too hard. "I'm really, really struggling with how much has come up for me," and we'll talk about that for a little bit. Then I'll usually ... It's interesting you asked that, because I do have this sort of ... It must be a decision tree of some sort in

my head, where I'm looking at the current emotional status of the person, how fragile they seem or how far they've moved ahead.

Certainly, if I hear a story when they come in, and they're staying, "Boy, I had so many insights. I was feeling so much better this week. I'm starting to sleep a little bit better. I didn't have any nightmares this week," we're launching, because I feel like okay, good, we are moving forward in a really good way. Other people certainly are gong to just tell me, "I can't process today. I just can't do it." Then sometimes I'm making that decision, and I will often say, "It seems to me that you're in a really emotional place. I think it would be good if we just talked this week instead of doing any processing," and they say, "That sounds good." If someone said, "Hey, no I think I really need to power through," I would probably tend to honor that, but I would tend to go a little slower and watch how that ends up working. Most of my clients, I mean, it's been an interesting process working.

I've been working exclusively with law enforcement and fire fighters, I do have a couple nurses, things like that, and their families, it's been about almost two years now. They are the most motivated group other than ... It's very similar to my military folks that I worked with. It's like, "Fix me. Do whatever you've got to do to get me fixed." If I told them to stand in the corner on their head for 15 minutes a day, they'd do it, because they just are ... They want to get better. Many of them, when you can tell that they're very emotionally dysregulated and they're trying to deal with something, I am going to slow down and I'm going to at least ask enough questions about what's going on with that.

For some of my clients, if they have had a severe sleep disturbance over the last couple of days, it's not unusual for me under those circumstances, because I know from my own experience, but also all the research on sleep, so that's a big one for me. It's much more difficult for us to regulate our own emotions when we're exhausted. So I feel like if I'm doing EMDR with someone who's sleep deprived, I'm not so sure that ... I mean more so than normal, let's say. I feel like I may be putting them in a really dangerous situation, and so I will tend to do some other things. We might talk about coping and we will certainly do some work on the sleep, and maybe I'll switch to some cognitive behavioral therapy about sleep and sleep hygiene, and the mental processes around sleep and the structures around sleep, just so that we have something so that they can get that taken care of. That's a piece of my process that I ask, is I always ask about sleep pretty much every week because if they have severe sleep disturbance, and it's not unusual, certainly because I work with people who work graveyard from time to time, and they often will have terrible sleep.

I have to gauge that because I don't want to put them in a position of ... On some level I'm going to end up potentially creating an exacerbation, even if I use a really protracted safe place at the end, it may not be that I can shut it

down. I just have that sense of it. I look at all of those things. I think a lot of it, honestly, is very intuitive at this point, because I've been doing this for 20 something years now, 23 years now. Especially with law enforcement, they're very stoic, and so you're doing a lot of reading between the lines, and because I work with so many men, they're much more likely to share somatic complaints as opposed to emotional complaints, so when I'm hearing lots of headaches, lots of stomach upset, diarrhea, I'm going, "Ah, okay. So we need to slow down."

Researcher: What else do you do to get a client ready to sort of move from supportive to active? It sounds like accessing sleep and some of those external things. Especially for people who don't articulate their emotions well, you know, if you're working with a lot of men.

P8: Right. Right. Usually I will perhaps do some work on increasing their support system, letting a couple people that they're very close to know what they're about to do so that they will be able to tap into that support. I do extensively work on sleep. There's a couple apps for that that I'll work with them. Sometimes I will have them practice basically diaphragmatic breathing, but along ... Getting them prepared for a safe place, and that is sometimes based on again some EQ issues, as far as I'm concerned. Some people are far more skeptical, so when I get that person who they know they need help, but I can tell I am every week on trial. They are watching me and making sure that I'm not a weirdo. I will sometimes do things that are far more traditional, and we will talk about coping skills. I do quite a bit of psychoeducation, especially in the beginning, about PTSD, about how it forms in the brain, about some of the ways that people cope with it that are useful and some that are not useful. We talk a lot about avoidance, and I will hear about some of their avoidant strategies. I'm getting a lot of that though the assessment process, hearing about the actual critical incident that led to them having post-traumatic stress, and then also looking at the behaviors they constructed in order to deal with their experience.

Depending on how long ago it was, there are times when I get things very soon after an event. I had a series of four people who came in just very recently who were all present for a very horrendous critical incident, and so I get to hear the story from four different perspectives, which is interesting.

Researcher: Oh, wow.

P8: Each of them were in different places, and each of them have reacted differently.

Researcher: Do you mean physical places?

P8: Yeah, each of them were in different mental places going into the critical incident.

Researcher: I see, I see.

P8: And each of them have reacted differently, I believe as a direct result of that.

Researcher: Wow.

P8: Yeah. It's been interesting.

Researcher: Yeah, it sounds like it. My gosh. Let's switch gears a bit to talk a little bit about countertransference and, of course, there's lots of different definitions of countertransference out there. If you could just talk a little bit about how you understand it and how you experience it.

P8: Okay. I see countertransference as, I guess, simply put, related to issues of my own that I have either ... Well, I think if it's true or pure countertransference it's often disenfranchised issues of my own that I then act out with a client. That would be like, for example, if I'm a ... I don't know, I guess a good example would be if I were a woman who never had children and I desperately wanted children and was unable to have them and a series of events, whatever, didn't adopt, if I had a younger person come in my office I might baby them or be very gentle with them somehow or another as a direct result of my own desire to parent or something. To me I think, and I have a super ... Part of my consulting work I do, I have a supervision group with some other counselors. They're all drug and alcohol counselors, but I bring up countertransference with them often. It is, to me, my understand is, and I shared this with the group just within the last month, I said, "Any time you have a strong response to someone, you need to check in with yourself and ask yourself why might that be. What just got hit in you that your response to that person is so much stronger than you would imagine it would need to be." Those to me are often connected to some kind of countertransference.

I've been doing that for years. When I have a really strong response, I will check in with myself, and I will say, "Okay, what might that be related to, and have you worked through that." I think we are all going to have countertransference, but I think the big difference is if you know it already and you're very, very aware of it and you are able to work within that area of countertransference and allow yourself the [inaudible] and recognize, "Okay, this is not what you want to do and this is not how you want to respond as a direct result of that thing that happened to you in the past." Some of them are easier because I work in them so frequently, and others are not as readily available. I think you can also have [crosstalk].

Researcher: Your reactions?

P8: Yes.

Researcher: Okay.

P8: Yes, absolutely. I think, too, you can have positive countertransference and you can have negative countertransference. It's even on some level when we sometimes see a client as a good client versus this is a bad client.

Researcher: Oh, yes.

P8: Or this is a resistant ... That's just another form. I'm having a strong liking response or I'm having a strong like yuck response. Both of those are types of countertransference, and to be aware of that and to make a decision how to counter it in a way that would be therapeutic for the client, not for yourself, but for the client.

Researcher: Mm-hmm (affirmative).

P8: Sometimes that means you have to get out of the way and allow them to work with someone else, because if you have not done any active work in a particular area that just might blindside you countertransference-wise, then it would be very ethical to refer to that person out. You wouldn't tell them why, but you would just make sure ... Or you'd get some supervision for yourself while you're working yourself through that. I really find ... I think I'm in my own little lane. I'm pretty aware of my countertransference. It does come up less and less and less and less frequently. I think that's because of work, work, work, work, work on myself.

Researcher: Ah. How are you experiencing a strong response? Like what happens to you? Whether it's positive or negative.

P8: I would say probably simplistically speaking, when I will have that thought at the end of a session, "I'm so glad that's over." If I have that thought, it's like, "Oops. Ask yourself (name removed) what was going on, why did you have ...?" I don't have that response, so when I do, or if I dread seeing someone, which I don't have that experience right now, but I've had that experience where I've had people that I found fairly dreadful to work with.

Researcher: Mm-hmm (affirmative).

P8: They loved coming to see me, but I found it dreadful. Those are countertransference. Probably most recently, as far as telling on myself as far as that goes, for me clients who really just want to come in and bitch and moan and don't really want to change. There is no amount of motivation you can come up with. That's why my work right now is so delightful. I don't have any of that. But I did. I worked with adolescents, and that's excruciating, in the past. I've worked with people with depression, and that can be very excruciating as well.

Researcher: Yes, I couldn't agree more.

P8: It's just painful.

Researcher: Yes.

P8: For me, action is such a big part of my own sense of self, that I think when people are inactive, like refuse to move, I will have a countertransference response to that inaction, and that becomes what ... I feel like I'm being judgmental as opposed to ... And then I end up having to say, "Okay, so where are they now and have they made any movement at all?" If the answer is yes, then I recognize my need to slow down and allow them their own speed, because my speed has a tendency to be fairly rapid.

Researcher: Yes.

P8: And some people, they're still moving and I have to learn to be very mindful that they are probably just ecstatic about the movement that they're making, because who knows the last five years they may have not moved at all, and so what do they say? That old things ... Something like one person's junk is another person's treasure, or something like that. It's the same sort of thing. It's like one person's speed is not going to be another person's speed, and that person who is moving very slowly could be just absolutely thrilled by it. Just having that recognition helps me. Right now I'm not experiencing that very much, although I am, decision-making wise, I have a few cases that I think, oh, they're sort of my in-between cases, if you will. They're not as interesting to me. They're not as intriguing to me. I do have a response to those cases that is interesting to me, because ... I think it's because I just made this decision to couples ... That's why I'm doing what I'm doing, is I really want to just leverage what brings me the most joy for these last let's say 15 years I can work. I don't want to be doing things that are not ... I get other people find it useful, but I want to make sure that I'm doing more of what really, really speaks to my soul instead of just doing things to make money.

Researcher: Is this the work, or are you switching gears?

P8: No. Just the work. Just the work.

Researcher: I see.

P8: Even in my consulting work. Some of my consulting work is really not ... And yet there's some ... That's a different part, and I get some usefulness out of that, but countertransference is interesting because I think as we get older, or I would say older/more experience in the field, I think our awareness increases, but I also think that there is this counteractive issue, which is we sometimes will become so focused on knowing that we don't allow ourselves to not know. So not paying attention to that ... This work is dynamic and we are dynamic, and there is certainly the possibility that we have had a blind spot or that we have never had a case that triggers something in us, a case anything like that, and that

we're going to have a response to it, and then that's going to come out of the blue, so I think when you say I know them all, I think for most of us that would be incredibly naïve. I think I know most of them, but I would not be surprised if tomorrow ... Actually [inaudible], but Tuesday someone could come in my office and I could have a reaction and I will be searching within myself for perhaps days trying to figure out what is that, what is that, what is that, what was that reaction about. Because I believe that could happen.

Researcher: So it sounds like you do a lot of self-reflection internally when these feelings come up.

P8: Oh, absolutely. Absolutely. Sometimes I write. Sometimes I will talk to a friend or two who are also in the field, but most of the time I'm just looking for patterns in the responses, like where would I do that anywhere else? Do I do that in my private life? Have I ever done something like that before? Is it possible it's related? I don't know. So I will do that. I will do that.

Researcher: How do you find that when you're experiencing countertransference how it affects your decision making?

P8: I would say when I'm experiencing countertransference, I tend to purposely slow myself down, because I know that countertransference and the issues surrounding it, it's much easier to defer to a default process because it's my experience that it tends to hit old stuff, and along with that old stuff are some old habits or old patterns or old ways of being, and it's very easy to, if I'm not slowing down, if I do my normal pace, then it's much more easy to me that I will end up in the default, the old default. As opposed to if I slow down, I ask myself, even in the moment of working, I will be asking myself, "Okay, what's your motivation for saying what you're about to say?" Or "Is this something that you can figure out right now? Do you already know what it's related to, and do you have an alternative?" Because a lot of my countertransference things that I've worked through over the years, I've come up with an alternative path, so when it comes up I know what to do. If it's a relatively unknown countertransference, it's a relatively unknown process I'm going through, I won't have come up with something new to do, so I know that I will tend to revert to the default. That's when I'll stop and I'll just slow down and start asking myself questions to make sure that I'm not screwing up.

Researcher: Yeah. Are you doing that in session with a client? Like in your head when they're in front of you?

P8: Yep. Yep.

Researcher: Okay.

P8: Yep.

Researcher: Do you ever share it directly with the client?

P8: That I'm having a strong response?

Researcher: Mm-hmm (affirmative). Or after you've even worked it out through your head, whatever sort of conclusion you've come to, do you ever share it? Or use it, I guess. Use it externally?

P8: I believe I've used it, but I don't know that I've ever shared it.

Researcher: Okay.

P8: I've shared probably with clients just ... I might share something like they're a joy to work with, because I'm impressed by ... Especially when I have a very strong response of like I feel very proud of them, or I feel very privileged that I've got to be the one to take the journey with them. This little tiny part of their journey. I will sometimes share that with them, because I don't think that sharing would harm them. Probably when it comes to sharing my own process, if it's more on the negative side, like I have a strong negative response, the only time I've ever done that.

Now I'm recalling I have when it has been anger. Not [inaudible], but someone else's anger. I do definitely have some countertransference about people's anger. So when they share when they're very angry and I'm having that response when people are coming at me in anger, even though they're not coming at me in anger, they're just showing me their anger and how big it is, I will sometimes say ... I will let them know, like, "I just want you to know," ... I'll just, you know, sort of a person, not a therapist sort of thing, and I will let them know like, "I just want to let you know I'm on the receiving end. I'm seeing this anger, and I have to admit it's pretty intimidating," and I will let them know. I don't know what it's like for the other people in your life, but I'm just sitting here and I'm letting you know I'm feeling a sense of intimidation." They can have that recognition, like what they're doing right now, if anyone else were to experience, and sometimes I'll tell them, "I'm pretty good at taking care of myself, so I'm good with you being angry, but I'm not sure about the other people in your life, how they might be feeling. If your anger is this big when you're here, I just can't imagine how big your anger must be when you're out there."

That's something I will do. That anger I'm very comfortable giving people that, like, "This is what it feels like to receive that from you." I know that's actually deeply connected to my own countertransference about anger.

Researcher: You know that because of all the work that you've done and all the experience you have, or how do you know that?

P8: Yes. Yes. I think a couple things. I worked inpatient psych early in my carrier. So I was working GICU, which is psychiatric intensive care. We would get people who would come in who were filled ... Who were floridly psychotic in a manic state or just recently attempted suicide kind of thing. You would end up with people who ... And also I worked with adolescents at that level of care, and they are what would really amount to out of control. I have to admit when you're getting that kind of out of control anger, where not only is there no neocortex engaged whatsoever, it really makes ... You get used to dealing with your own countertransference about people's anger. You can't go in your office and hide underneath your desk. You can't do that. You might have been able to do that as a little kid, but you can't run and hide in your room. You end up having to stay present, and then you have to work through your own emotional reaction to that kind of anger.

I got good at just standing still and dealing with it, and then I got, as the years went by and I learned to interact with people who were very, very angry, and I actually did a group in a jail for about a year and a half that was for batterers. They would come to my [inaudible]. You're talking about a whole group of angry folks. I did those batterers groups for three years, something like that. It was an interesting process to recognize that sometimes that feedback given thoughtfully could really make a difference, because I am able to describe it because of the countertransference. It's probably one of the things that I feel most ... One of my areas of countertransference that I'm most proud because I've actually had people you can ... I almost feel like they are having an epiphany right in front of me where I'm able to describe what it feels like to have that come at me. Other people in their life are running and hiding, and I stood still and I let them know what it feels like to have that come at me. That's then useful. But I had to stand still myself in order to understand that and then to be able to translate to describe my experience to them. I had to [inaudible] first, and then observe my own self, and then describe it as best I could. It's been useful.

Researcher: What else helps you stay present? It seems like that's really critical. I mean it sounds like physically ... You may be just physically, your body language, but it sounds like really you have this mental stability in the face of all of this.

P8: That's interesting. Yeah. I work really hard on that. It's something that ... I actually am CBT trained too.

Researcher: Oh, geez.

P8: I had to do some training with martial [inaudible], and I'm not one of those people. I really appreciate the process of mindfulness, and it's something that I've thought years before actually before I even became a therapist. It's been a curiosity of mine for a long time. I'll tell you how I got here.

Early in my career, super, super long story. I'm sure it's probably boring to anyone else but me, but anyways, before I went to graduate school the first time to become a therapist, (personal family tragedy described). I was pregnant at the time and I couldn't help care for him, and I'm one of the family caretakers, and so this is a very, very painful time for me. It was painful losing my brother, painful not being able to do something with all of that pain, to do something good out of all that pain. As a result of that experience, I sought out and worked for Hospice for about a year. I did it on purpose. I always say it was part of my undoing. In other words, it was kind of more Freudian. I wanted to do for others what I wasn't able to do for my brother. Because I wanted to know that was who I was. I wanted to know that I am that person, that had I been able to, I would have. So I did, and I did it for a year. I did it until I felt like I had accomplished what I needed to accomplish. I actually volunteered, so this was for free.

What I ended up learning from that, and this is where I got with this is, I ended up learning from that experience, because I'd already had my very ... It was about 1994 when I went down and did that. (Personal family tragedy described). I had these people tell me over and over and over again ... I would go and see them every month after the person that died, I was the person who followed them in their grieving for a year, and it was fascinating to me how many people would tell me, "You're the only person who will sit with me and let me talk about it." Their big thing is, "You're the only person who doesn't tell me I'm doing it wrong. You're the only person who ... " I would hear this over and over and over again, and they would say, basically telling me it was ... It was like I was the only person, apparently, according to these people who would tell me, that would allow them to be present in their own grief. I realized it was because I was present in my own. That was the only reason I could be present with them, because I knew how valuable it was. I knew that going through that process is so painful and so difficult, but doing it alone makes it hideous. It makes it impossible.

I used that and I felt like it was such a blessing in the very beginning of my career to have that experience, because I realized that it is sort of a shame that we really have a hard time being present in a room with people with strong emotion. We have a really hard time. Most people, regular people, have a hard time being with people when they're in pain, and just allowing them to be in pain, period. I don't need a change from being in pain. You get to be in pain as long as you need to be in pain, and then if you need to shift that, I'll be there and watch that shift with you. It's interesting how I had never realized that was what was missing in my own life, and so kind of oddly was providing it to other people and then ended up finding some people in my own life who were providing that for me. I think knowing I'm present, and actually it's one of the questions I ask myself on a very regular basis, and it's pretty much daily,

honestly, were you present today. One of the things I do to prepare myself for my day is I get present. I make sure that I do some things in the morning in my own morning routine to make sure I'm really present.

I want people to be able to actually feel that I'm feeling what they're going through, and that they can feel my presence in the room. That they're not alone in that room while they're going through what they're going through with their trauma, that I have enough strength myself that I can help them contain that. For me working that through ... And there are times when I've gone through my own little walls and my own little struggles, and I've found the path back to present. Now I find, for the most part, I'm there. I'm there and I notice when there's even ... If you were to say on a scale of 0 to 10 on the SAD scale or something, most of the time I'm a 9 or a 10. If I'm bouncing down to like a 5, I'm asking myself, "Whoa, Trudy, what's going on? What's making it so that you're distracted today or you're attending to other things?" I think it's one of the biggest things we provide for our clients or patients, and if I'm not present, if I'm a ... In a sense it's like instead of being a distracted driver, it's like you're a distracted therapist.

Researcher: That's a great analogy.

P8: I think it's just as bad. It's like I'm not even attending to what's in front of me, and there's going to be accidents much more likely if I'm not present. People have asked me when my phone goes off in sessions, they go, "Aren't you going to answer that?" It's like, "No."

Researcher: Mm-hmm (affirmative). Right, right.

P8: I never look at my texts. I never answer the phone. This is their time. I am present with them. I'm not even in my own life at that point in time, truly.

Researcher: This is fantastic. Thank you. That's all I have and we're at our time. Is there anything else that you wanted to add at this time? We'll have a couple more conversations, but ... ?

P8: No. Hopefully, I tend to go down rabbit holes, so if you need to really make ... Put my feet to the fire and make me stay on task, I give you permission to do that.

Researcher: Oh, no. This is fantastic. Part of this is going down rabbit holes, that's part of this kind of research anyway, but this is fantastic. I really, really appreciate your time. Oh my gosh, this is great. It makes me want to ... There's a couple other people on the East Coast that I haven't been able to visit, but I'm so close that it makes me want to take a trip down to (location removed) to see if I can do one of these in person.

P8: Yes, if you do, just let me know. I would love that. That would be great.

Researcher: Yeah. I'm going to send you a follow-up email just with a quick demographic survey, and then you probably will not hear from me for a few months because this is such a long process to sort of go through all of this coding of the interviews and everything. I'll send you an email fairly soon, and then after that you just won't hear from me for a while.

P8: Okay. No worries.

Researcher: Okay? Great. Well, I appreciate it again. Thank you so much (name removed). I will be in touch.

P8: All right, thanks.

Researcher: Mm-hmm (affirmative). Bye-bye.

P8: Bye-bye.

P9 Round One

Combined with Round Three interview

P10 Round One

Researcher: The first question is very general and very open, is if you could just describe your process making clinical decisions with your trauma clients. You can start maybe from assessment or even before assessment or when you're sitting down with the person ... Anything really.

P10: Yeah. So I would start with how I advertise my services. I post myself out in the world as a therapist who specializes in helping people who had a history of trauma heal. And then I specify in there that my clinical belief is that everybody has everything inside of them that they need to heal, it's just a matter of helping them access those resources.

P10: And so I, from a resourcing perspective, is kind of how I start that process, and then in the phone interview. I do a phone interview with all clients before, generally placing them on my wait list. It's usually not... I'll talk to somebody and then they can be scheduled. It's a talking and then a wait list experience.

P10: And so, I do that is I first share with them that I have a wait list, and then say, "Do you want to talk to me further? You know, knowing that I have a wait list, knowing that it could be a little while 'til you see me, do you want to see if I might be a good fit?" And so I just again, control. So the decision-making here is around the person having as much control in a situation as possible. So do you

want to be on the wait list first before we go into any story or kind of *Cliff Notes* version of why they might want to be on the wait list?

P10: And then if they say yes, I do make them say, "Would you like to first tell me a little bit about why you're seeking counseling, or would you like me to share with you how I provide services generally? You know, it can be different for each person." And so again, they're deciding.

P10: So there's just a lot of the person deciding already in the interview, and control's in their hands, and that way. Then completing the phone call, they're on the waiting list and I call everyone back. So I think that just a really trauma informed way. It's like every phone call I get I will return that call and so ...

Researcher: Nice.

P10: ...even if I don't have an opening, even if they never call me back, this sort of thing I'll just say, "I have an opening and if you want that give me a call back within 24 hours or 48 hours" depending on how many people I have kind of waiting, give me a call back by five o'clock tomorrow or this sort of situation and usually what I find is that most people don't after waiting a period of time. They're like, "Well, I've found another therapist or it wasn't that urgent," but the ones that who do want to come in and see me call me back right away and there's this, "Okay, I know what you provide. I know you know a little bit about my story I want to see you."

P10: Then other clinical decision making would be pursue assessment. So, I have an assessment form just like a standard biopsychosocial, but with it I always share with people that the first session they won't have to share with me every detail of their life. It's their choice how much they choose to share, and as we get to know each other as we're working together more things might come up. They might feel more comfortable sharing things. They can share what they want too, but they don't have too. So again, the control point and then at the end of the session and during the session if somebody is really sharing a lot, a lot, a lot of sharing and it seems as if they're really stabilizing in that, I would ask them ... I would say, "You're really sharing a lot right now. I really value that and you've had a lot of experience and a lot of things in your life."

P10: So, you would say something about containment. Say something about how containment can also be helpful in therapy and sometimes people feel they have the experience of wanting to share more. That all parts of them want to share. Somebody where there's a part of them that really wants to get into the room and another part that really wants to hold it back and I just want to honor all of them and so just throwing out this idea that there might be a conflict and that they

might not want to share all that, because I think that often times people have significant trauma there's this sort of shutting down and maybe depression that sets in, but then there's also this sense of almost, for some people, there's this intense like I have to get everything out right now in this moment within 60 minutes. For others there's this detached sort of, not depression, but just this detachment from the trauma and they're telling the story as if happened to someone else. So it just really depends on how the person's presenting how I would approach that.

P10: And then treatment planning. A lot of people I see have posttraumatic stress disorder or major depressive disorder or generalized anxiety disorder and the posttraumatic stress disorder clearly is traumatic through, but major depressive disorder isn't as clear; however often times, the people who I treat that have the disorder have significant traumatic events scale, experience. So, in working with them I would treat the trauma as well as the depression. So yeah, I think it just depends on how a person is receptive.

Researcher: Fantastic. Great. Thank you. Can you share how you experience counter transference?

P10: So my experience of countertransference is noticing ... I know what I experience when I'm in the room with someone. So, if somebody comes in, and they are really, really activated and kind of maybe yelling or upset or this sort of thing. Like it's whatever my body is experiencing at that moment. Maybe thoughts that I'm having but for me it's more of a body experience of like oh my body is experienced and wanting to pull back from this person, and my body is experiencing this or that and then my mind I think I might say, "Oh, okay do I want to use this in that situation?" Likely not. I would likely guide them through some sort of containment, grounding, connecting.

P10: Another experience would be when I see people having positive change or kind of accessing those resources, so working with a teen who is having some positive change right now and their experience of that positive change. Is this change? Now for me I like change. I can't really think what ... I'll go with that counter transference of like yeah, you're able to do more schoolwork than you used to be able too or having less nightmares, taking care of yourself and really kind of experiencing that and making it bigger for them to see. Like oh, this is kind of actually a kind of cool thing.

Researcher: So, once somebody is ... Well, it sounds like your process is ... I mean immediately it's the body first and then the mind follows. It sounds like that's what happens and then what sort of goes through your mind when you notice something happening?

P10: So, when I notice something happening my mind, I think, I wonder if it would be useful for the client to know what I am experiencing or I wonder if I said this like, "Oh I'm curious right now." I mean as you sit there and you have your head down and you're crying, I really feel this ... I'm curious because I'm having this experience of wanting to go to you and also feeling like maybe want to stance.

Researcher: And maybe what?

P10: Maybe want to stance and I don't really know what you want. It's curious to me that I'm having this experience. I'm just kind of throwing that out.

Researcher: Do you other times choose not to share?

P10: Yeah, yeah, so like I would say with a client who is really escalated, like I would choose not to share in that moment. Like, "Oh I'm feeling like as you raise your voice." I would choose not too. I would help them deescalate and then maybe later, depending on our rapport, and if this is a relationship problem in other relationships in their lives and in some way we've been able to work through it, I might bring that up like in a past tense. Sort of-

Researcher: Like after reflecting on.

P10: Yeah, like after reflecting on month's later it's so interesting that we have this ... We really seem to have this connection and you really seem to be making these positive changes in your life. You're still struggling with these different relationships where this anger tends to bubble up. It's so interesting because when we first started to meet you were quite angry in session, and now you're almost like a different person. I think that's what I would do but I wouldn't share it in the moment.

Researcher: Okay. Okay. So what sounds like you do ... You air on the side of immediacy it sounds like using what's in the moment right there and acting on it unless there's something telling you that maybe it's not safe or in some ways making it more about you and less about them and then that's not the road you're going to go down in just trying to decide who is this going to benefit really.

P10: Yeah, exactly. So a lot of trauma therapy is about those interpersonal resolutions.

Researcher: Absolutely.

P10: Complex trauma is attachment wounding and so really the attachment I'm trying to heal the most is the clients' relationship with themselves. Sometimes my relationship with them can also be a mirror for that or even a substitute until they get to the place of where they can have that relationship with themselves.

Researcher: How do you think your clients respond?

P10: I would say-

Researcher: Do you get like a wide range of responses?

P10: Totally. For the most part, there're some outliers and there's almost ... All of my clients respond really well to that approach. There's like two clients that I have currently that are questioning, "Is that a good fit?" I don't know. I don't know what's a good fit and so in trauma therapy again that decision making around ... Gosh it's a really important that it be a good fit.

Researcher: Do you adjust your approach accordingly?

P10: Yes.

Researcher: Do you think?

P10: Yeah. So an example would be EMDR. A part of that is identify the peaceful place and there's a lot of people ... Well' there's a few people I work with who are like, Absolutely not. No peaceful place."

Researcher: Right. Can't think of one at all. Doesn't exist. Can't do it.

P10: Yep and so okay, I clearly know we're not going to do EMDR for a while. We're going to do other kind of more body based therapies and maybe you might like to start meditating or doing yoga or something that sort of experiential, running, outside of session as well. So building and more of that integrative.

P10: And I also have a consult group that I'm a part of that I find really helpful.

Researcher: Ah, yes. That leads to later questions because that's super important definitely. Are there any other ways that you can think when you're having these experiences how it affects your clinical decision making? Are there ... Is there anything, any instances you can think of how it impacts either you or the clinical relationship?

P10: Well I guess I think of suicidal thoughts. That's another one that I really worked too ... So there's a part of me that's like red alarm, fire alarm and suicidal thoughts are this sort of thing and so when someone expresses this, I really worked with that sort of aspect of myself to be like- And really so that I can work with the person in whatever it is that their experiencing and that's been very, very beneficial.

P10: When I first started I was like fire alarm and I think I would get more activated with that and potentially escalate the situation whereas you know now with more experience and time and just lots of training around the area, I'm able to really keep that part of myself in check so that I can help them with whatever they need. That's been really validating for a lot of people. In the past they can't even really talk about this and people just freak out. I don't feel like there's a safe place to talk about this, so it's been helpful with just trying to get out what purposes are those dots concerning what role are they playing in your life?

Researcher: Okay, great. Can you think of how your clinical decision-making might be different with trauma survivors versus treating other issues even though I know primarily you're working with trauma survivors? Is there anything that you can think of how ... Even if somebody ... Right? We know a lot of people will come in and they'll say, "I'm here for depression," and then digging, digging, digging and then you know there's some trauma behind there. Is there any ... Or maybe thinking back maybe before this was solely your clientele how you were to approach things differently with the trauma survivor versus another clinical issue like OCD or depression or anxiety?

P10: See I have a really hard time with that question. I think because I have a really hard time with thinking of sort of a diagnosis without seeing how the person is embodying that lived experience, so it's like-

Researcher: So say more about that.

P10: Like I ... Like the DSM was kind of a suggestion. It's like a suggestion that never have been used to bill insurance, the original copy. Right? So, there's this piece where I have a really hard saying, without meeting the person and hearing their experience, because for some people ... I'm trying to think of anyone that I can think of. Well, I have this one person actually that I work with that trauma does not really seem to be at the root of their experience, but they've got a really intense experience of life. The way that I approach them is just based on their kind of experience and what they need from therapy and so I use internal family systems. I use illness management, recovery with them. Illness management recovery. It's an evidence-based program for people who have like psychosis or something like that, whatever. This sort of thing and so I use that as well and I use internal family systems and sematic awareness. The reason I work with -

Researcher: They're presenting?

P10: They're presenting and it's not like I use ASF. Also, with folks that have an extensive history of trauma, but it's just different depending on the person.

Researcher: So, it's more person to person than diagnosis?

P10: Yeah.

Researcher: Do you notice your body feel differently or your thoughts? Is there a consistency, I guess, of how your body reacts or maybe what kind of thoughts you have client to client or is even that wildly different?

P10: I think depending on how they present with their history, how resourced they are when they come into my office, really depends on how quickly we move through therapy and how sort of suggestive I am. It's like Oh we could do EMDR in two weeks after we've been working together for maybe a month or so like doing the resourcing, I'd go like oh we could move into EMDR, but I think how resourced they are when they come into session. How they manage their affect. How upset they become over ... How many kinds of red alarms they have in their life, if they're able to manage difficult emotions in a healthy way. They have a support system. Whether it's a real kind of living external support system that's robust or partially it's an internal imagine support system with some also external supports that's robust. So it needs to be ... Depending on how resourced a person comes in. This is a big decision maker.

Researcher: How ... Do you assess that out formally, informally or are there certain things that you do to assess that out?

P10: I would say both. So if we're going to do EDMR, I always have them administer dissociative experience scale.

Researcher: I just gave that to somebody the other day.

P10: Oh yeah. A clinician or a client?

Researcher: To a client. I gave it to a client.

P10: Oh, yeah.

Researcher: I like that scale.

P10: That's such a helpful tool and it really helps identify in how resourced a person is I think too because often times people will say, "Well I used to have these experiences but I don't anymore or I'm right here on them." This is sort of kind of where there at and I say this isn't for your whole life. Do this for the past 30 days, so I think that's helpful. So, that's formal.

P10: Then also in the assessment I ask questions like tell me about things, people who are supports to you or things that you have to do. Tell me what your strengths are.

That sort of things and so that sort of picks up on kind of where a person is at. Tell me about your family. Tell me about kids or work or holistic approach.

Researcher: What ... Switching gears a bit. What does your, since it seems like you have a really good connection with your body, what ... Can you tell me a little bit about what happens when somebody is on the other end of the spectrum and their pretty disassociated or their talking ... It's like their talking about somebody else or when their describing something or their telling you something and it's like they're talking about the weather? So instead of maybe your body feeling ... Like how does it differ? How does your body differ from somebody whose like overly emoted versus somebody whose really detached, which seems to be what happens often times with trauma clients?

P10: Yes, those two are really-

Researcher: Prominent.

P10: Yeah. There's like a numbness almost or like just absence of feeling what I experienced, and then I would ... Often times I would call out and I'd say, "Hi, you know as we talk about this. There's almost like there's an absence of feeling." So, I might call it out as my experience but that's the experience I'm tune in with that they are possibly having over there and so I might call it out and we can talk about what it means to have absence of feeling around trauma and do some education around that.

Researcher: Do you ... You mentioned maybe encourage people to engage in some sort of activity like physical activity in between sessions. Are you to give other homework or are you the type of counselor to ...

P10: I always give homework.

Researcher: Okay. Okay. All right. So no more about that. Okay. You do.

P10: I always have people at the end of the session tell me what they want to take from today's session. That's how I always ... Well, some sessions I don't end that way but I usually say, "You know we talked about a lot today, we were here, we were there. I wonder what's going to be most helpful for you to take with you from today's session and maybe there's some things that you would like to contain before you go." So I do a containment and I do what do you want to take with you, and sometimes taking with them, "Oh I really want to practice peaceful place meditation we did or I really want to start my own sort of routine in the morning and write, do the self-care." Whatever it might be. But it's not like ... You know I tease them. I go, "This isn't a graded assignment. It's really you want it and it's

okay. You may do it, you may not do it. Either way we'll talk about it." You made a face about homework.

Researcher: It seems to be a thing where it seems like some people ... some clinicians really do it a lot with everybody and think it's really critical for the continuity of the work and some see it as school and triggering and they don't do it, so it really seems to come out on either side. I was just like hum where you fall in terms of homework?

P10: Well I also do clinical hypnosis. So with that, you can do the session in therapy, which effective and I measure how effective it is with the person by having them think about the experience before and then after if they want too and I experience change in them.

P10: So my youth, for instance, wants to be able to focus and do homework and get it done, but their feeling really distracted and all over the place so we did hypnosis on focusing.

Researcher: Oh wow.

P10: Before the youth was like, "I'm not going to be able to sit down. At 6 o'clock tonight I cannot sit down and do my homework." Then I said afterwards, "Well, how confident do you feel now." "I feel halfway, halfway. I might be able to sit down and do my homework."

Researcher: Oh, my gosh.

P10: And so I said, "Well I'm going to email this to you right now so you have it so let me know about hypnosis if it's effective. This one was effective for you because we did this measurement, now you can take it with you and all you do is listen to it just once a day, that's all." Well, it was only 10 minutes of focus. I said, "It's only 10 minutes a day."

Researcher: Is it guided? It's prerecorded or-

P10: I record it so-

Researcher: Oh, you're recording it in session.

P10: In session.

Researcher: Oh, and then they can take it with them.

P10: And then they take it with them.

Researcher: Oh, okay. Okay.

P10: Yeah, so I guess that's the homework.

Researcher: Absolutely.

P10: You know listen to this and see what happens. You know when you come back next week tell me how your homework went.

Researcher: Wow.

P10: Yeah, so I really like that and I think clients really like that too because then they have this continuity between sessions ...

Researcher: Absolutely.

P10: ... and it's effective.

Researcher: Oh, my gosh. That's fantastic. I haven't talked to anybody who does hypnosis so-

P10: I love hypnosis.

Researcher: Fantastic.

P10: I do. I'm trained in Ericksonian hypnosis. It's very permissive.

Researcher: Okay. Okay. You must have great ... It sounds like you do sort of maybe an objective and subjective assessment of its effectiveness I guess. It sounds like they get to read themselves and wow.

P10: They get to read themselves and when they come back in next week they can say, "Did I do this? Did I not do this? Do I want to do more work around that?" I have somebody who has really chronic posttraumatic stress disorder and came to me just hanging off the ceiling and we've been doing hypnosis because she wants to go to work and she can't get herself to go to work and stay at work, but she doesn't want to reprocess, do any reprocessing or even the exercises that we do to calm are really, really very triggering for her, so hypnosis is almost like a double benefit because it's calming. Your calm, your relaxed in hypnosis and she's hearing the suggestions that she can go to work. I tell her stories about going to work and remembering things and getting up on time, and she's been able to work for three weeks. She's missed one day.

Researcher: Oh my gosh.

P10: So this makes it three days a week. So I think it's working for her.

Researcher: How did you ... So that's a perfect example of did she come in knowing that I have all of this trauma and I am not going down the road of reprocessing, maybe what else can you do for me?

P10: No, she came in. She had been reprocessing. She had been doing EMDR with another therapist and she couldn't afford the sessions because they were out-of-network. So, she came in. I took her insurance and she was just flashbacks, night terrors and flooding and no peaceful place. "I can't find a peaceful place." She was like, "I lied to that other therapist about finding a peaceful place." And I just was like, "Really?" She also has a seizure disorder and so what I've been doing with her is saying, "Well, let's work on getting your feet underneath you before we do any of that reprocessing work. You know, we can do that in the future. If that's part of the therapy, we can come back to that, but I want you to first to be cleared by your doctor." So, she went to her neurologist appointment and they actually didn't sign off on it. They said, "Well I don't know exactly what's causing these seizures. I'm not comfortable signing off on EMDR." I said, "That's fine."

P10: So, in the interim what about some hypnosis? She just was like, "I wanted to do hypnosis from the start and I'm so happy that you're doing that and so."

Researcher: Oh, fantastic.

P10: So we've been focusing on kind of almost somewhat surfacy things like she wanted to eat healthier. She wanted to get to work and stay at work, so these are activities of daily living is how what we've been focusing on with the hypnosis, but in there she gets to feel calm, a peaceful experience. Cleaning her house was also another one we worked on. So, it's just really building her up until she gets to a place ... If she gets to a place where she does want to do some processing, we can. More potentially she could do that through hypnosis.

Researcher: Yeah. Sign me up. I would love all of those things. To eat better, focus, get to work, stay at work, get along, clean up the house. These all sound like really fantastic goals. Wow, nice.

P10: But for her, her trauma was getting in the way of her doing that and so it's just another angle that doesn't say we have to go. Is this helping ...

Researcher: Right.

P10: ...for somebody?

Researcher: And it's so stabilizing. It makes a lot of sense.

P10: Yeah, so that's where we're starting and I expect that as long as she'll come see me, she'll probably be coming to see me.

Researcher: Yeah, nice.

P10: And she's making progress, but yeah.

Researcher: Wow, very nice. It's nice that you have-

Round Two Interview Transcripts
P1 Round Two

Researcher: Okay, so the first question is really open and it's about how your personal and/or professional experiences influenced your current approach with trauma survivors, so sort of how you've developed over the years. This could be like, CEUs, supervision, things like that, so anything you want to say.

P1: Well, I don't know.

Researcher: Sort of your early influences.

P1: Yeah, yeah. Yeah, early in my career, I was just completely afraid of trauma because it was right around the whole self-memory era.

Researcher: Oh, yes.

P1: You know, where people were all suggesting things that caused families turmoil. There were lawsuits and everything. I thought, "You know, I'm just going to avoid the whole thing." What I did instead, I think, was I made it a point to understand the structure of treatment and to take the admonishment of those days seriously to be very aware of [inaudible] kinds of problems that can arise from this sort of, actually treatment of any kind. Let's see. Who was it now who generally hammered out the whole structure of stability first?

Researcher: Oh.

P1: Yeah.

Researcher: It could have been like Judith Herman?

P1: That's who it is. It was Judith Herman. I went to some workshop trainings with Judith Herman. I mean, it's like anything, I guess. You feel like you're not winging it. You have some kind of an idea as to what the roadmap looks like. I started to feel more comfortable with doing the work and more grounded.

Researcher: Yes.

P1: I mean and just things developed through experience after that. I think that probably it was my work with EMDR that really kind of filled it together for me.

Researcher: Mm-hmm (affirmative).

P1: You know, it helped me understand how bringing together different angles of treatment into one place can be very helpful and sort of coming from the bottom up sorts of treatment, I think, really spoke loudly to me. Peter Levine, I became interested in a lot of the concepts of Peter Levine, and of course Bessel van der Kolk.

Researcher: Oh yes.

P1: Yeah, I mean, it sort of led me into curiosity about the physiology of trauma and anxiety, and how that might inform the kind of work I do. Really, I think what it actually has done was it had formed my clients' understanding of themselves, because often coming to treatment regardless of what the problem is they'll feel like they're moral failures. You know?

Researcher: Mm-hmm (affirmative).

P1: If something's broken, and I mean, I suppose in a sense that's true, but I think that it allowed me to kind of approach this thing technically.

Researcher: Ah, yeah.

P1: To understand a little bit about neurology and [inaudible], and the trauma effect and how anxiety affects, and how we just get along from day to day or whatever our physiology basically drives a lot of that [inaudible], and so people start to feel like they have a little bit more emotional latitude to approach the problem if they think of it as a technical problem rather than a moral failure.

Researcher: Yeah.

P1: Reduce a lot of the fears. You know?

Researcher: Great.

P1: Anyway, as usual and so you just sort of go on rambling.

Researcher: Oh, no, no, no. The rambling is really good for this kind of research so this is just fine.

P1: Yeah.

Researcher: Okay. The next question is about leading a session. How do you determine when to let a client lead the session versus when you might take the lead and what factors contribute to that decision?

P1: Yeah. You know that's the question I misunderstood the first ...

Researcher: Yeah.

P1: I thought you said leave the session and I thought, "Oh, all right. That's fine."

Researcher: You know, I have spelled that out to everybody since that I've interviewed just in case there was another misunderstanding.

P1: Yeah. It sort of depends on the client. I have people who come in and just sort of like know what they want. You know what I mean? In situations like that, I

feel a little uninvolved because sometimes people will come in and it doesn't matter who's sitting in front of them. You know?

Researcher: Oh, yeah.

P1: They know what they want to talk about. They know what they want to do and they do it, and they leave. Sometimes I feel a little bit like ... Well, I don't know. I don't want to put it in harsh terms, but I feel a little like a prostitute in a way. It's like I'm not really doing anything here, but I kind of take the approach that people who do that it's not clear that they're just avoiding in some way, shape or form. If it really seems like it's helpful for them to do that, I'll let them do it.

Researcher: Okay.

P1: In those cases, they leave the session and a lot of times with folks like that if I get the idea that I want to be more the leader of the session and I start it off that way, I usually start off each session kind of summarizing what we had done the last time so if they're going to kind of jump in and start saying, "Well, this is what I wanted to talk about today," and they start out [inaudible] then I kind of let them do that. I might at some point along the way kind of put that on the table and say, "You know, it's interesting to me that we make a plan," and I come in and put it on the table and we're talking about something else. You know?

Researcher: Mm-hmm (affirmative).

P1: Yeah and so if there's some kind of defensiveness going on there, then it usually becomes apparent in those kinds of conversations, but then there's a lot of folks who really come in and want to just put themselves in my hands and they want to understand themselves better. I can give them a plausible way of doing that. I can give them information, and psychoeducation, and for some people they really respond well to that. I suppose it's sort of a non-answer, but that's the answer is I kind of follow my clients what they either explicitly or passively are asking. You know?

Researcher: Yeah.

P1: If they want more guidance, I can typically provide it pretty well and if they're really just wanting to use me ...

Researcher: Right.

P1: ... Then they can do that as long as it seems to be helpful, as long as it's moving towards a goal.

Researcher: Great. If a client is going off in a different direction than originally intended, that would be a queue that maybe you would coral them?

P1: Yeah. I mean, in the very beginning. I suppose I am a little bit more assertive in the beginning in terms of both goal, articulation, and so forth. I want to try and establish the direction of our work and if they're moving off of that, it's either for a good reason or a bad reason. You know?

Researcher: Right.

P1: We have to try and figure that out, but it's up to me to ... That's leadership, too, is that it's up to me to recognize that we've gone in a different direction or apparently in a different direction. I had this woman who came in who had a car accident in 1978. It was in December during the winter and the car actually went airborne in front of a tractor-trailer, and over a guardrail, and down a hill.

Researcher: Oh, my gosh.

P1: Yeah. Her husband was in the car at the time. Nobody was hurt, but the car was totaled, and the thing that was ... This was an EMDR person. The reason that she's telling me now is because she has been finding it ... Actually, had right along found it difficult to drive in the wintertime or on the Interstate. She does what she has to do and she'll drive if she absolutely has to, but most of the time she let's her husband or to her adult children or something of that sort, but they took on some foster kids so now she needs to be able to drive them places to resolve this. She didn't want to be uncomfortable.

Researcher: Right.

P1: So she came in and she targeted the 1978 accident and the thing that was the most at issue for her that the moment that at first wasn't going airborne, but going down the hillside, but with a tractor-trailer oncoming or anything else. It was the fact that her husband grabbed the wheel and she felt anger.

Researcher: Wow, yeah.

P1: It turns out that lifelong in practicing she started to go back into childhood and issues of control, and then the lack thereof, and having her needs come second to her father converted to kind of a position. He become a minister and he and his family had to be the upstanding example in the community so all of her needs always kind of got to the backseat and that extended right into her marriage, which is a 41-year-old marriage now, but right from the start she had career aspirations that she put on the backseat so her husband can go to engineering school and it's just one thing after another that she never no matter what she wanted to do. She'd take second fiddle. Her husband's family absorbed a lot of his attention, but he didn't seem to pay a lot of attention to her. This is the issue that really kind of came up and it almost didn't have to do with the accident at all.

Researcher: Right. Right. Oh, that's what I love about EMDR.

P1: Yeah. That's the thing. Our work shifted pretty clearly and cleanly. I mean, it became apparent that even though the original goal was quite clear it went in a different direction and so we follow that.

Researcher: Oh, great.

P1: We're still talking about leadership, right?

Researcher: Yeah.

P1: Yeah. Okay. So she even questioned herself in those moments when she went off into other areas in her life and how it always came down to belonging and lack of control and frustration and being put behind other's needs and so forth. She wondered if she was just distracting away from bringing up this moment that we targeted originally and so even she was wondering if she was just being defensive about anxiety or if this was really an issue, but I think that it became clear that this is kind of long term work. This isn't just about an accident.

Researcher: Yeah.

P1: Yeah. I think in that instance leadership is really kind of honoring her questioning of herself but, also, kind of trying to actively keep the issue on the table that this may be about something more than just the accident, and so I suppose in some sense it's more of a partnership in situations like that, which is certainly to me an ideal.

Researcher: Okay. The next question is: If you could reflect on an experience in which your clinical decision making proved unbeneficial, and how did you respond and adjust your approach?

P1: When my clinical decision making was ...

Researcher: Off the mark or however you want to say it.

P1: That's never happened.

Researcher: Yeah. I'm sure. Just dig deep. I'm sure that maybe, perhaps, you can find one little thing.

P1: I think probably I could if I try hard. It's funny because I jokingly say it's never happened and then when I try and think of something like an apt example, I can't think of one right now.

Researcher: Well, if you want to let that linger.

P1: It's twice a day, probably. Twice a day I probably could come up with an example, but at this moment I ...

Researcher: Oh, that's funny.

P1: Yeah.

Researcher: If you want to let that linger in the back of your mind, we can.

P1: Yeah.

Researcher: That's totally fine. We can go onto next one and maybe something will jar your memory.

P1: Yeah.

Researcher: The next one is focused on counter transference and how you determine if your personal issues have been triggered by the client or if it's more of a client-driven narrative being played out in the session, if that makes sense.

P1: Mm-hmm (affirmative).

Researcher: Okay.

P1: Yeah. Well, I'm not sure. Sometimes maybe it's both. If I am having a reaction to my client, there's two possibilities and maybe both are true that something in me is being triggered that has absolutely nothing to do with my client or something in me is being triggered that maybe my client triggers in other people, too.

Researcher: Right.

P1: You know? If I'm going to do something in that moment, if I'm going to put it on the table, it depends on how long I've been seeing this person and if I understand how they might accept my feedback because of my own reaction. I mean, sometimes other people will ask me, though. They'll say, "Oh, I have a client who said to me I feel like you're disappointed in me." I wasn't completely certain she wasn't right. My first instinct is to say, "Oh, well. I'm not at all disappointed in you. I think you're doing a fine job toward your goals and everything is wonderful and all that kind of stuff. She needs approval, right?

Researcher: Right.

P1: Then looking at it a little bit closer I wonder if maybe she isn't right about that. I mean, what is she picking up on that suggests that to her? I might ask, "What is it that you're seeing that makes you say that?" Because I'm not so very objective about myself and so maybe other times maybe my clients are objective about me. If she's getting the sense that there's something there, maybe there is. I think that if it's not something that I have to consider the possibility that my client is right, however that might come about. I guess I would have to bring it up in supervision and try and hammer it out outside of the context of a session, but yeah. Probably more than not, I will find a way to

hammer it out in session. I mean, if there is something there, it's probably worth looking at.

The fact of the matter is with this particular client she has been making lots of progress and she sort of got to a certain place where she plateaued. She was doing really well and maintaining her gains, but the lack of movement became just a little bit dull and I think maybe what she was picking up on was that and that really is about me. Isn't it? If she's plateauing, she's plateauing. I mean, maybe she needs to find a way to move forward from there or maybe she's right where she needs to be for the time being, but that I should start to look disappointed to her maybe says something about me. You know?

Researcher: Right.

P1: Maybe that's your countertransference in that sense. I don't know. It's funny because as I'm talking you, I'm sort of working it out in my head now. I don't know. Yeah. I don't know that if there's a really generic way of answering that question.

Researcher: You're answering it just fine, yeah. I'm not looking for generic. This is good.

P1: Yeah.

Researcher: Well, and it sounds like you're pretty open to letting or asking, digging more if you've already established a relationship and you think that they can sort of handle that line of questioning from you.

P1: I know for people who get very angry in session, I am reactive to that and kind of regularly reactant to that. I've said to people that the message that they're delivering is being obscured by the energy to which they're delivering it and that I really need them to find a way to ground themselves and then give me the message in a calmer way. I say to them I feel it in my body when they start to get angry and really that energetic kind of anger. I don't feel like in danger or anything, but I feel my body just getting tense and my breath go funny, and everything else ...

Researcher: Yes.

P1: ... But I say to them, "This isn't helping because I can't really listen well."

Researcher: Yeah.

P1: More than not, people will say ... I mean, they'll kind of calm down and they really do want to be heard so there's some incentive to wanting to ground themselves, but I'm happy to offer instruction to help them bring their physiology down to earth.

Researcher: Yes. Go on.

P1: I mean, I don't know if that's a kind of counter transference.

Researcher: Oh, definitely. Yeah.

P1: Yeah.

Researcher: What's your understanding of clinical intuition and how does it guide your professional judgment?

P1: I have to say that over the years. See? I'm sort of thinking about that in contrast with just kind of structure and so I think about in the early years and when I see people who are thoroughly in the business coming in and kind of talking about their work or if we're sharing a client for one reason or another, how they're handling their situation. It always seems like there's something almost mechanistic about it and I remember that in myself. I remembered just glomming onto an orientation or technique or something and over years I think even imperceptibly I've found myself a little bit more when it comes to structure. I mean, I value structure and I think my clients do. I think that there's comfort in that and I think that that's important for both of us.

It's not a religion. I think that I've been more willing to follow my clients' needs and strengths rather than just a certain way. Yeah.

Researcher: Do you think that's a, I don't know, residual effect of being a new just coming out of grad school and like needing something to hold onto or not trusting yourself that you think you see that more in newer counselors?

P1: I do. I think that the kind of work that that produces is just as good, I think. People gain from that approach. Having somebody kind of early on manualized in their work, and for some people who are quite seasoned I see how. Like we have the director of our DBT program she's like ... No. I mean, that's not so true. She's a perfect blend of manualized work and intuition. She's really quite that way, but she has like a team of people who are learning DBT treatment and some who have been doing it for a while, but really adhere to certain protocol and they do phenomenal work. These folks will often refer people to me for EMDR treatment and then that really works. These people they learn the skills. They know how to kind of understand themselves well and if there are things that they want to ...

If there are anchors they want to pull up from the past, they're really ready to do that. They have the grounding skills to do it safely. I can see. I'm not a DBT therapist. Like all of us, I suppose on DBT more.

Researcher: Yeah, exactly. Well, said.

P1: I'm not nearly as protocol driven. I don't know. I suppose with the EMDR I am.

Researcher: Yeah?

P1: Yeah

Researcher: I mean, some people can get pretty loose with the structure, but I think that it's flexible, the EMDR structure.

P1: It is. Yeah and studying all the different protocols or different problems with the EMDR it's sort of like you should flex a little bit, but what I've found is just ... Maybe this doesn't apply. I forgot the question, but is that with EMDR sometimes I will find that I am becoming less effective, generally, and when that happens I say to myself because early on that happened to me. Back in '94 is when I got originally trained in EMDR and it was just like wonderful. Everything's working great

Researcher: Oh, yeah.

P1: After a while, I started to notice that it wasn't quite ... I didn't quite have the traction I used to have and I wondered what was going on and I recognize that I started to drift as we often do in these things from the protocol. I started, I wouldn't call them shortcuts, but I wasn't necessarily as adherent to the protocol and so I thought, "Well, all right. Let's just put on the student mind and just refresh the protocol. Just start from scratch. Just do it because it was working then," and sure enough I started to get traction again.

Researcher: Oh.

P1: Yeah. Over the years, there's something to that protocol.

Researcher: Yeah.

P1: There's just something to it, and so I think it really pulled together all of those different aspects of treatment in a need little package.

Researcher: Yes.

P1: Over the years when I find that happening time and again, losing traction, it's a standard for me. I'll go back to the protocol and kind of get my grounding again in the protocol.

Researcher: Yeah. Yeah, absolutely.

P1: Yeah. So in that sense, I suppose I'm manualized, but there's some intuition in there, too, I suppose. I don't know.

Researcher: Well, there's something telling you to that something isn't working.

P1: Yeah. Excuse me. Yeah. Right. The problem I had was that when I was trained initially in EMDR there were no EMDR therapists in (State name removed). I think there were like about three.

Researcher: Oh, wow.

P1: We actually kind of found each other and started doing peer subversion groups because we didn't have anybody to guide it. No supervision.

Researcher: Nice.

P1: I've always felt and in my agency we employ over 600 people and I'm the only ... No. That's not true, actually. I was going to say I'm the only EMDR therapist in the agency.

Researcher: How many people did you say?

P1: Over 600 people are employed by (organization name removed).

Researcher: Holy cow!

P1: Not all of them are licensed therapists.

Researcher: Right.

P1: We have a lot and for years I've been saying, "Oh, they're getting trained." People are referring their clients to me because I do EMDR, but for some reason we can't let go of the money for people to go get trained, right?

Researcher: Oh, yep. Yep.

P1: So recently Roy Kiessling, I don't know if you know him or not.

Researcher: Oh, I went to one of his trainings. Oh, yes. I even have his autograph.

P1: Oh, no kidding. Really?

Researcher: Yeah.

P1: He came to (State name removed) and he was going to do a training. He learned that I was around and he invited me to come and sit in on his training.

Researcher: Oh, my gosh.

P1: Yeah and so not only was that a lot of [inaudible] for me, but it was good to get that refresher.

Researcher: Yes.

P1: I didn't actually. It's funny because there were other people. Robert Paige and what's her name? That's funny. Hawking, Hawk?

Researcher: Hmm. I don't know. It doesn't sound familiar.

P1: Anyway, so it's just people that he basically trained and they became trainers and so that was the training that was going on, but he wanted me to do this training, go through the training, and then go onto become a consultant in his

organization and so he was kind of creating this structure where it wouldn't cost me any money, but it would cost me work to get there. So why did I bring this up? Roy Kiessling. Oh, yeah. He came. Oh, yeah and he also wanted me to host one of his trainings in the agency and I thought, "What a great idea," because that was his whole thing was to bring the training into agencies, into community mental health. He wanted me to go through this training and I did this sort of last year so I did the two part training and then kind of like presented to the agency this option of having him come in, and then he would give a special right to people who wanted to train.

So we had a grand total of one person who took him up on it.

Researcher: What? That's horrible.

P1: Yes.

Researcher: Oh, my gosh.

P1: Now we have two EMDR commissions, me and this other person who just got trained and has yet to actually do the work in the agency. I kind of imagined he'd have like 20 people or something.

Researcher: Right. Oh, that is surprising.

P1: He was offering both trainings and 10 hours of consulting between the trainings for a total of $1,000.

Researcher: Oh, that is a bargain.

P1: Oh, my gosh. It is. So I don't know if we're going to see that again, but yeah. What are you going to do?

Researcher: Wow. Well, and hopefully the person who got trained will be able to use it soon. I understand that feeling of, "Right." It's a little scary to start to use it the first time.

P1: Well, and she taps me for my thoughts on things now and again, and I'm always happy to be available to her for that.

Researcher: Wow. Well, in the meantime, it's-

P1: I'm anxious to do it.

Researcher: Yeah? In the meantime, it's job security for you if you're like one of two people.

P1: Yeah. I suppose it is. Yeah. Maybe I shouldn't encourage people to get trained. I don't know.

Researcher: It's interesting. Yeah.

P1: It is. Yeah.

Researcher: All right. Well, I'm going to cycle back around to see if you've thought of any experience in which your clinical decision making went awry and how you've responded and adjusted.

P1: Yeah. I mean, just thinking about EMDR and early on when I was using this treatment back in the '90s I had this one client who has a history of psychosis and she had wanted me to do EMDR with her and hers was kind of the trauma of neglect in her early years and so with those it's sometimes hard to find that first initial target and so that's what we were working toward and she was relatively unskilled in terms of self soothing, self care, grounding, and safety, but she was anxious to move forward on it and I allowed myself to be anxious with her to move forward on it, and so we both chose a plausible, initial target and we did the EMDR session and she had the worst week of her life.

Researcher: Oh, boy.

P1: This is so rare, really, because I tell people, "Well, it's nice to have somebody you can call and talk to if you're having unusual thoughts or feelings or you're feeling just strapped. I try to make myself available as well, and that sort of thing, but rarely have I found people have that much trouble between sessions, but this person did and she ended up hospitalized.

Researcher: Oh, my gosh.

P1: Yeah, exactly. That was a huge, huge lesson for me. I was just horrified. I suppose that was sort of a nonclinical decision, in a way. I needed to be grounded for her because she wasn't grounded and she was anxious and so I needed to be patient for her, but I wasn't. So even though if anybody seems to be really chomping at the bit to do this and I don't think they're ready, I'm not going to do it, and so I suppose that was a moment of learning. I mean, that's how I adjusted myself generally in my work was that I am not going to move ahead if I don't think they're ready. That's that. They can fire me if they like, but I'm not going to do it.

Researcher: Right. If they fire you, that's-

P1: [crosstalk]

Researcher: Go ahead.

P1: What I've found is that learning grounding skills and learning how to comfort one's self and learning safety skills and so forth actually the anticipation of the EMDR treatment becomes kind of a carrot for them to do that; whereas, if I'm telling people to breathe deep and pay attention to [inaudible] thing and so forth, there's a lot of eye rolling and saying, "Come on. Let's get on with it."

Researcher: Right.

P1: But if they understand that what they want to do is at the end of establishing these skills solidly, I've found that to be a kind of carrot for them. You know?

Researcher: Interesting.

P1: Yeah, but I don't know if that's really an example of just allow the decision, I suppose, was what it was.

Researcher: That works.

P1: Yeah.

Researcher: It sounds like, obviously, it's something that's been longstanding. You still practice that way today, right? It's like if they're not ready, forget it.

P1: Well, when I do training in the agency, periodically people want to know about EMDR and they'll ask me to come and do a one-day training and so I always manage to bring that up whenever I do these trainings because I really need for that to be clear to people that you want to be ... It's safety first, essentially, is the thing.

Researcher: Yeah. Well, this is great and I am done with my questions.

P1: Okay.

Researcher: So hopefully this took ... This time I have a little bit of a different setup and I really, really appreciate it.

P2 Round Two

Researcher: Okay. First question, very open ended. How have you personal and professional experiences influenced your approach with trauma survivors that you see currently? This could be things ranging from certain CEUs that you did, supervision, a particular client that helped you figure out the best way to navigate with subsequent clients. What are those maybe highlighted personal or professional experiences that guide with how you work with them now?

P2: Well, it's all of the above. I've been doing a lot of training. Thank you very much. I've been doing-

Researcher: CEUs.

P2: CEUs, yes. CEUs and I've been doing a lot of reading. I've been looking at dissociation differently because I'm finding, especially with the developmental trauma, the complex trauma stuff, that we tend to look at dissociation from a this or a that. I'm seeing and I'm learning that it's more shades of dissociation.

When I'm talking to a client and they're telling me about something, then I'll say, "Oooh." Then, we'll look at that in a different way. This is especially true with a veteran that I was seeing. I'm not seeing him any more. He would kind of get that ... Just kind blank look. He'd be engaged, then all of a sudden it'd go kind of blank. We'd be getting into a topic, and and it was just kind of like I'd thought well, I misread it, but then over time I could see that's what we're looking at.

It got too close. He's closing it down. It's not a true dissociation, but it's definitely a change. He's interacting in a different way to accommodate where he can go and can't go. I've been looking at that. You do take your personal things and you see how when a client is talking to you about something, how it's easier to empathize or understand that perspective because you've seen it.

Researcher: In other clients?

P2: In other clients. I've seen in kids at school. A lot of different, ooh, I've seen this one before. I can understand that because this child told me about this. Gaining a better understanding of why it's harder to change and because that normal or this feeling of normal has gone this long, so for me to change to a new kind of normal, there's a lot of resistance to that change. I've adapted to trauma for this way and this long, so for me to relax into this relationship that is much healthier is hard for me because it doesn't feel normal. Looking at that, that's experience from another client looking at this client, and also flavored by my own experiences. Say, ooh yeah, that's how come they're having trouble with that. Is that what you want?

Researcher: There is no right or wrong. Yeah, I mean, is sounds like your clients have been maybe not primary, but maybe primary motivator for how you maybe look at things differently. Put pieces together, and maybe see patterns and apply it to ...

P2: Yeah, it definitely is a puzzle.

Researcher: Yeah, yeah.

P2: A puzzle, and just trying to see. First of all, trying to see from their perspective. Why does it make sense?

Researcher: Their behavior [crosstalk].

P2: Yeah, and their approach to how they're interacting with their problems. How does that make sense? Then, how does that function for them? Then, turning around and saying, okay, if this is functioning, is it truly functioning? How is it functioning, and do they like that or not? I want to come in here, I want to rid of these outbursts I'm having and conflict. Okay, well, let's look at it. Now, this is what's happening, dah-dah-dah, and this is where you end up. Do you like that? Is it working for you? No, it's not working for me. That motivational

interviewing thing, is this working for you? Then, they said, "No, it's not." I said, "Okay." Then, we look back at, and we're doing a behavioral chaining. Look back at, where do you think you can change that? Where do you think it could be different? I've been doing some of that.

Researcher: Has it just been a sort of a slow cumulative affect over a period of time?

P2: Mm-hmm (affirmative). Of all of this. Yeah, I'm starting to put different things together, where they make sense, because none of these things that we learn in these little packages, in these little CEU things work. You have to put them together. You have to integrate it, and then mesh it within the client.

Researcher: You mean like a training in isolation?

P2: Yeah.

Researcher: Does it work that way?

P2: Mm-hmm (negative).

Researcher: Yeah. Oh my gosh. I bet I'll see you at a training one day.

P2: More than likely.

Researcher: Okay.

P2: Okay, so that felt little rambly.

Researcher: No. No, this is exactly ... Like I said, that sort of free association of ... No, this is exactly. This is great. Okay. A little more concrete now. How do you determine in a session when to let a client lead versus when you take the lead in a session?

P2: Well, I tend to really let the client lead. I'll take this client this morning. I'll let them lead. They're going to tell me all their stuff, and dah-dah-dah, and how they felt. Then, we'll get to a point where ... We got to a point where she said, "And then I did this." I said, "Okay, let's back up." We go into, how did you feel? What was the urge, feeling or whatever that made this behavior happen? There I'll take the lead, and I will slow them down and redirect them to paying attention to those precursors things. Then, once we look at that, I said, "When it happened, it goes really fast." She said, "Yeah." I said, "We're not doing it now. You're not in that position now, so we can slow it down."

Then, when they need a greater understanding for why they did something, or how they got into that mess, then we can back it up and slow it down. Then, if they're not understanding like not understanding why a child reacted to them in that way, then we can do some psycho ed, and we do the window of tolerance and say, the kid's here, you're here. How does that inform? Then, we take it

back, so there's that educational piece to add to the chaining thing we were doing. What adds to the scenario that she's playing out.

Researcher: It sounds like there's a turning point where maybe the ... Either after the client narrative or something after they go on, you see this point at which you can insert either ... We've got to slow this down so you can learn something from what you're talking about.

P2: Yeah. Otherwise, you're just telling me a story.

Researcher: Yeah.

P2: Yeah. Then, those points of where things don't make sense, so we back it up and say, what part doesn't make sense?

Researcher: To you or the client?

P2: To me or the client. When they get off into illogical thinking. Then we say, "Okay. Let's stop here." I'll redirect there. Also, when it's something that needs to be pointed out. Wow, look at that. Did you use your skill? What skills did you use? Then, congratulate. Identify what skills are you using, and are you using them on a regular basis? Within a story, it's nice for them to know and feel that success of, I'm doing it, and I manage it, and how did you manage it. Let's back it up.

Researcher: There's some encouragement in the ...

P2: Validation of their ...

Researcher: Validation, yeah. I'll do that. If you could reflect on an experience in which your clinical decision making proves unbeneficial. How did you adjust your approach after that?

P2: This is within the framework of trauma?

Researcher: Well, with a trauma survivor. Yeah.

P2: A young man, a veteran. Terrible, terrible developmental trauma history. Really, I mean, bad. Not so much a wartime trauma, but still difficult. Lost a buddy, some grief. I promised I'd bring him back. I promised the wife I'd bring him back. There's that grief, that sense of responsibility. The reading I was doing at the time and trainings I had been to said that you really can't make much headway with the wartime until you kind of resolve some of the developmental stuff, so I took that away. I said, "Okay." We started working back here, and then it was really hard and we hadn't made much ... Made some headway, but not much. Then, I went to another training.

Researcher: Uh-oh.

P2: I know. Specifically on veterans. They were going on and on about the family of the company, of the vets. The unit is a family and so on and so on, and I had an epiphany. There's his family, there's his resourcing that I've been struggling to find over here, to anchor anything to. There is his resourcing. Taking that family to help him heal, this family became much more logical because we solidify this and bring it back here. Would they have allowed that? What would they think about you being thrown against the wall 15 times, so on and so on. That was my epiphany. I'd gone in circles for a while trying to follow the best practice protocol that didn't fit with that particular client.

Researcher: Nice. Those trainings, you hear one thing. Go to another training ...

P2: You hear something else.

Researcher: Love it.

P2: Yeah. You really have to be careful with them.

Researcher: Yeah. I think you're right. That didn't work with that client.

P2: Right.

Researcher: Maybe it would have worked with a different client.

P2: Right.

Researcher: That's where that good clinical judgment comes in.

P2: Yeah.

Researcher: Nice, nice. Okay. This is getting into countertransference. How do you determine if your personal issues have been triggered by a client, or if it's more of a client driven narrative being played out in session? For example, if you're getting a sense maybe of ... Bless you.

P2: Excuse me.

Researcher: If you're getting a sense that maybe you're being manipulated in a session. This is just an example. How do you determine? Is it you or is this client is, this is how their relationships are, and this is how they react outside of the office, and this is how they interact in their other relationships and that is what's playing out here. Versus, this is really about my Aunt Sue or my little grandson who is pretty good at manipulating me. Does that make sense? Just determining what kind of decision making or things, factors, help you parse that out.

P2: Well, I'm thinking about a particular client who had some personality disorder traits. I don't think I could fully diagnose her, but definitely had some patterns she was playing with. What I found her trying to do is getting me to do the work, me to excuse her behavior, for me to align with her and being the victim.

Her husband didn't have any sense. Her playing on her intelligence and so on and so on. What I found was if you listen and you're quiet inside, you can hear the burrs, you can hear the bristles. Then, you can say, "Is this about me or is this about her?"

Then, you start asking those questions inside and balancing them and say, "Okay." If it bristles and you feel it, a little bit of poke. Is this about me? Is this about her? Then, it's a little bit easier to identify it because you take you out of the picture, and then it's easier to see the pattern because you see it with the relationship she's described with her husband, dah-dah-dah. It's very similar. The relationship she described with her mother, dah-dah-dah. Then, her playing with me about appointments, about not being here. Can you help me with this? Feel sorry for me. Those kind of things.

Researcher: How are you taking yourself out of the picture? When you get the sense of that bristle, is that when you take a more objective ...

P2: I look at it. I use a different eye. Just use a different eye.

Researcher: Okay. Got it. A different lens. Okay. Great. What influences your decision to disclose any countertransference reactions, or not to?

P2: Well, if it doesn't add to the therapeutic thing, then no. You don't. I say, what is this? I do say it to myself. This is very similar to something I've done or I've experienced. What is the value of me saying, "Oh, yeah, I've done that too." I say, does it matter? No. I usually don't. Sometimes more when it's just causal talking and greeting, and they're telling me about their weekend and what they've done and I'll say, "Oh, [inaudible] we did that too. We were putting things in the yard, and you know, things aren't coming up." More neutral stuff. I very rarely share anything about my personal life or personal experiences because I feel they're just not beneficial. Sometimes I'll do that at school, but it's more about kids knowing ... I went to 20 different schools. Letting them know that it happens. They're moving around to a lot of different schools, and they're lamenting that. I say, "It happens, but you know, we too go forward." Helping them, but that's an educational setting. Where there, I'm being more of a role model than in this therapeutic setting so different hats.

Researcher: Yeah. It sounds like you do a lot of internal checking and internal reflections and internal asking yourself questions. Does that happen primarily with the client or between sessions, outside of session, reflecting or is it this sort of thought process you're talking about.

P2: It's mostly in the session. The thought processes outside of the session is anticipating a client coming in and looking over the notes. We did this, we did this, we did this. I wonder about ... Then, I look at strategy more of where we need to go. What have they shared so far? How does it align with our plan?

Have we covered everything in the plan, so on. In the session, I'm very much introspective, and I'm constantly asking myself these questions. I'm also wondering, I wonder if, and checking into how I'm feeling. If I'm getting bristles, then I'm paying attention to how come I'm getting a bristle here. Is it because I don't believe this, or how much of this is true? I'm questioning that.

Researcher: Got it. Okay. Last question. What's your questions? What's your understanding or clinical intuition? How would you describe that?

P2: Clinical intuition?

Researcher: Mm-hmm (affirmative).

P2: I think it comes with time and practice. Comes with experience. We're not always ... Don't always have good intuition, and we make errors, dah-dah-dah. Such as it is, and God willing they're not critical errors. I also find that clients can be very forgiving. If I try something out on them, they're going to tell me whether I'm going in the right direction, or they're going to redirect me. If I allow that, then we'll go in the direction that they need to go. If I am too forceful with my thoughts or my direction, of course we're going to stalemate or it's going to crash and burn. Intuition is as much about listening and being open as it is to having a thought or a premonition of where we're going to go. Anticipation of whatever we're doing, focus it on it [inaudible 00:22:35] for which is the right one.

Researcher: It can be something ... I'm not using right words. More passive or active. I don't know if that's the right words, but maybe more internal or external.

P2: You have to be willing to let it show, to let it come, because as you're talking to someone, and then all of a sudden you see a change in their behavior or their stance, then you can say, "Hmm, interesting." Then, you go forward and then it connects to something else. It's not an intuition so much as it is just being observant, patient, and waiting because it will. Knowing, having an idea, having enough background and continuing that training to see what you're looking at. I remember and not really realizing, oh, that's what I was seeing. Then, over time-

Researcher: [crosstalk].

P2: Now I recognize when I see that I know the client is either uncomfortable or whatever. I need to pay attention to that.

Researcher: There's a rational or educational, analytical reason part that also feeds that you would learn in a CEU course to guide that intuition, is what it sounds like. I mean, it's ...

P2: Like me understanding dissociation better. I know that now. A few years ago, did I realize what I was ... No. Not so much.

Researcher: Now you can pick up on it using that clinical intuition because of all of the ...

P2: Yeah.

Researcher: Yeah. Okay. Great. Great, great, great. I know you've got a client coming in. Anything else that comes to surface? Okay.

P2: No.

Researcher: Thank you, thank you.

P3 Round Two

Researcher: Refresh your memory because it was so long ago. Again, just looking at ...

P3: Trauma, trauma, trauma.

Researcher: Trauma, trauma, trauma. Looking at countertransference reactions and clinical decision making around that so just in terms of thinking about your trauma clients. So the first question is very open and just getting a little bit more information about how your personal and/or professional experiences influence your current approach with trauma survivors. So this could be CEUs, or really good supervision, or particular client experience and I understand it's cumulative, but if anything stands out for you ...

P3: Okay.

Researcher: Feel free to take some time to think.

P3: Oh, you know what? I didn't hear the actual question in there.

Researcher: That's okay.

P3: I thought you were building up to the question.

Researcher: It's just that [crosstalk] it's just that it's so general. So, how have your personal and professional experiences influenced your current approach with trauma survivors?

P3: Okay. So I can start with professional first. The work by Bessel has had a big impact on me, you know, the body remembers.

Researcher: Oh, yes.

P3: It's one thing to have a hunch and notice a thing or two and try something, clinically, and it works, and it's a whole other thing to go to a workshop or a

training thing where you're getting some CEU. Bessel was here a year and a half ago or so and one of my clients who had trauma, who also was a counselor back in the day, got one of his flyers and I said, I wanna go to this. What do you think about you going to it? She went, "Hmm." I said, well think about it and I'm gonna go. If you go and wanna hang out, you wanna have lunch. You wanna do whatever so you don't be there alone, I can do that. That was a very powerful experience for her because it normalized an awful lot of what she was going through body wise.

Also I think ... She was having the same experience, I would say, that I was in the sense that I'm the clinician doing the work and going, this will work, and she's on the receiving end of it going, "I think this will work. It seems like it will. I get the idea." Now the two of you are in a room and there's a researcher who's been studying. He's got a really powerful methodology, been doing it for a while. Basically, affirming what you're doing. That accelerated ... This started a, I don't know how you would exactly label that, but that was a deliberate decision on my part to say, "Hey, counselor, as a professional, who also has trauma that you would like to get rid of. You want to stand one foot on one side and one foot on the other side of that and come to this training thing and just see ..."

So part of what that did for her on her end was it was just I guess deepened her trust through the process, look at it that way. For me, it's just validating. Okay, good. Okay, good. All right. Okay. That is why that thing works. Okay. Ooh, that's why that thing is working. There's certainly, I think, training, a trauma informed training. Training about how to do trauma informed treatment. It's confidence building. I don't think just for me. You're out here not exactly alone in the wilderness, but in some ways when you're in an office, the door is shut, it's you and the client. There's a lot of creativity going on there. There's a bit of guessing going on. There's a lot of art, enough so that when there's some science behind the artistic thing, the creative thing you might be doing at the moment, that makes a difference. Psychology has that scientist, practitioner model. It has since the Boulder conference in 1949.

I know that's a really hard model for people to live out. I think it's the best model. I still think we should, if we can't be scientist practitioners, we certainly need to be stolid practitioners. For the professional development and the work that the scientists are doing with their publishing is pivotal for me and my work. Because besides getting ideas, it gets your community to learning. You're sitting there kind of on your own on the one hand, and on the other hand you're going, no, I'm not really on my own. I'm in the little outpost. I'm tethered to things that these people over here with some nice grants and university support, which I'm very happy for. We need that. More grants, more grants. Please help them do more and more research. Pay them more. I'm all for that.

My personal experiences, not only am I a trauma survivor, I read a thing the other day where they're talking now about not just surviving, the usual sequence was that I can get survivor-thrivers. That's the thing I've been teaching my clients for years. I saw something the other day. Somebody's researching super survivors or super-thrivers. And I thought, what I like about that is, again, validation because I believe that about myself. I believe that through my own recovery, my own journey that on the other side of that what I have is tremendous hope, tremendous confidence, tremendous depths, tremendous capacity to have patience, to stay put, to mean I have my own proof from the inside out that what I'm saying is possible, is possible. So then I'm not sitting there going I've got my fingers crossed, I hope this works. I'm not doing that.

It gives me a lot of confidence to say stuff like, I'm quoting myself, something like this, I say, probably two, three times a month, not to the same person, but something will come up with some client. It might not be every week, but it's frequent. It might be 3.5 times a month, it's pretty frequent. Where the person will say something like, I don't even know if it's possible and I will say, "Oh, I know it's possible." That doesn't mean you have to do this. You don't have to. This is very hard work and what are the big promises at the end here? There are a lot of big promises that are absolutely possible, absolutely doable. But this is not like a two-month journey, a three-month journey. It's probably a journey that's years in the making and you don't have to be in therapy the whole time.

You just should be in therapy when you get stuck. You shouldn't be out there, out stuck, all by yourself. You should come in here, get unstuck, and then go back out there and then when you get stuck come back in here. But I say that you know, we're talking a number of years if what you want is complete healing and if you want to, what would I have been like if I hadn't had these events happen to me? Well, let's see if we can find out. Then what would you be like as a completely healed person who has the advantage of all of that wisdom and all of that knowledge and understanding. That's maybe a long way to say that my professional involvement gives me confidence from the outside in. My personal involvement gives me confidence from the inside out. Maybe that's the way to think about it.

Researcher: Nice. Great. Next question about client leading the session versus you leading the session. What factors determine who leads and when? Lead it's L-E-A-D, some people heard leave. Just to clarify.

P3: Yeah, I get what you mean. I think urgency, probably. I think the ... Probably I almost always start a meeting with some version of what's on your mind, what's your agenda for today, what did you bring in, what are you facing. Then I almost always will say some version of, I have five agenda items, or I have only one agenda item or, I don't have any agendas today, but I've got one that popped into my head as soon as you start talking about what you're facing. The

form that a particular meeting takes is there's a lot of, let's call it mutuality and the construction of that. I don't know if I told you a thing that I do in the mornings, Rebekah, but I do a thing they call it meditating on my client's [inaudible].

It's not unlike an old generally about how much I love people. Its not that. In the old days I opened up my calendar. Now I turn my phone on. My calendar's there. And like today, besides you I have four clients. So I meditated on you today. Okay, Rebekah, Ph.D. Dissertation stuff. Man, that shit sucks, and just sort of like that. The meditating on it is just thinking about the person, trying to get everything else out of my head. This stuff can go on for hours. This is like a minute or two per appointment basically, I might go longer. I just try to quiet myself and then I see what rises to the surface. That's what I mean by just kind of meditating on them.

Sometimes I have a super strong reaction. I've learned over the years to pay attention to that, like my psyche is trying to say, "Hey, you missed something," or, "Hey, there's a dangerous thing going on," or, "Hey, here's something you hadn't anticipated, you weren't thinking about that's probably in the picture, you should check that out." Some version of that and if I get a strong one of those that's gonna be one of those days where I walk in and think, "Hey, I'm not sure what's on your mind, but I have about four things." They'll be connected to, I'll give you an example from a meeting yesterday.

There's trauma in the picture. There's a new relationship. There's a decision about a lease that's coming up. Should I give up my lease and move closer to where she lives, and trying to keep it at a super, uber, uber practical level and, of course, what I'm saying is, I think the community you're thinking about going to is awesome. I think that community, and then I went on, I would say yesterday, and that particular person [inaudible] because there was a really bad, terrible, traumatic, almost abusive break up of a very, very long marriage, like 40, 45 years I think it would have been, that's a lot, long one. I'm seeing a couple of patterns recur, and so that they became crystal clear to me yesterday morning in my meditating.

That became a strong example item and when she came in I need to figure out if I should do this move or not, and I came in with like, "Oh, I'm glad we're talking about that because here's what I think." If you get really serious about why, besides the fact that it's a 45-year marriage that ended, that what parts exactly about that. You have absolutely no community, she didn't have this, she didn't have that, blah, blah, blah, blah, blah. All that stuff. And then warning sign, warning sign, danger Will Rogers. There's how is what you're doing now going to protect you from some of those things because you need some protection. Yeah, I'm glad you're in love, but I like this guy and I think, good.

I'm for the relationship but there's some structural stuff here that didn't make [inaudible].

So I did that and that dovetailed very nicely, enforced her idea about should I move out there and I'm trying to figure out the metrics to make that decision. So I considered that my job failed and that's what I meditated on this morning. Guess what popped up for me about you? So I think most of my meetings are like that, where there is the kind of mutuality in the co-construction of the way the ... I would call it meeting, but I would say that I am this way and I expect it of ... I accept the context, I require that the person who's coming in is leaning forward and engaged with what we're doing. My rule is I don't ever want to invest more than the person in the room is investing because I'm gonna be investing quite a bit, they're going to have to, too. So I don't know if that helps.

Researcher: Oh, yeah. Definitely. It sounds-

P3: It's not really who's leading, but it is about a requirement for, there will be mutual engagement here or else because I'm not them. I'm not the ox pulling the load here. That's not what I'm going to be doing.

Researcher: How do you address that when you feel like you're the ox pulling the load?

P3: I say, sometimes, the context is usually, it's usually not trauma. The context is usually some youngster whose parents have decided he, by youngster I mean a 20-something year old, often living in their basement, and they're a threat that you're gonna go to counseling or we're kicking you out. [crosstalk] At some point I make some kind of statement like, you know, I've already been paid. I'm gonna be paid. I don't know if you care if I'm just paid to do no work. Maybe we could play cards. I'm good at cards. Do you want to play cards? Or we could, I happen to have a few skills.

This is a little ... This is true. I normally wouldn't bring this up in the normal course of any conversation, but in this particular conversation I would likely say something like, (Location information removed) Then [inaudible] he wasn't even born. So I started studying what I have to offer you in 1974. I have three degrees in it. Also, my last degree I could have gotten away with 120 credits, but I have 207 so in a way I almost have six, seven Ph.D.'s, so you can decide. I have expertise galore if you want to tap into it.

I'm paid to help you, but I'm not really paid to strap you to a surgery table and cut you apart, whether you want me to or not. It really is a collaborative thing. I could tell you what I think you need to know, but I would rather address what you think you need to know. I would rather address what you're facing and whether there's, where did you think you're ... Why do you think you're still in your parents' basement. I have my theory, but what's your theory? How do you plan to ... Do you want to just play cards or do you tap into ... But some people

would say it's a fair amount of expertise. If you have a toe that hurts and you're with somebody who knows how to fix hurt toes, do you want to tell me you have a hurt toe or not? I don't know. It's really your call.

I will do something like that. I don't have, except in that circumstance there's no real reason in life, really, to beat your chest. But there is a group of 20-something young men who are living in their parents' basements that seems to make a difference. Somewhere in there I often will say something like, "Hey I'd like to tell you where I'm going to be in a year. "Then I'm gonna predict where I think you're going to be in a year." It will be like, "My life is not only going to be where it's at, but better. I already know that because of the amount of effort I will put into assuring that. Unless there's an act of God my life is going to be actually an upkick a little bit. Two, three, four, five, seven, 15% approved, I don't know. But it's not going to be going down. Yours? You're going to flat line and go down."

"I know that because it's the same thing as if I know I'm going to work out three days a week for the next year, I know that I'm going to maintain or probably improve my health a little bit. If you're on the couch watching TV your health is gonna go down. That's what we're facing here. I don't know. You don't have to do this now. You might not be ready. One, some day in your life you will have to make a decision to get actively involved. That might be this year, it might be next year. Might be with somebody else. Might be in a different city, different country. I don't care."

"I don't really care because how your life turns out isn't actually gonna affect me. I can help you make your life turn out better, but you'll have to make that decision about whether you actually are here to prove your parents wrong or if you actually want to tap into some of my expertise. Your call." I will do that. I'll do some version of, "If you're not ready, you're not ready. No big deal. But you have to sit with me anyway. Do you want to sit here meaninglessly or meaningfully?"

Researcher: Yeah. It sounds like you do a lot of, well maybe not a lot, but at least consistently reflecting on your work with clients outside of session. Does that feel accurate to you?

P3: Let's see. I don't split my caseload off from other people who are important to me. I don't talk about my caseload, but I also don't talk that much about other people who are important to me either. I'm not a big gossip, but I think it's more than I'm not a big gossip. I'm not somebody who ... I'd rather talk with the person I'm with about them than about me, about anybody else. I'm not reflecting about my clients outside of the session any more than you might generally be thinking about family and friends. Except I don't really separate it into family, friends and clients.

The opposite of I have one pile of people that I care about and that means for some clients I will be thinking about them a lot for reasons that maybe their struggle [inaudible] right now or there's something extra complicated and I'm just noodling on their situation, trying to move it forward in my own head. When things are not very stuck and things are rolling along I probably only do that morning meditation on them and only on the day that they're coming in, if that makes sense.

Researcher: Yeah, definitely. Definitely. Next question is about reflecting on an experience in which your clinical decision making proved unbeneficial, and how did you respond and adjust your approach.

P3: Right after the Trump election, which was an emotional blow for me, because I'm an American, a joke, but also ...

Researcher: I can appreciate that.

P3: (Personal family tragedy described) He [inaudible] in July of last summer and health care, which I'm pretty healthy and I'm personally not affected by a lot of these policies, but vulnerable people very much are. For me that was an election that fed an awful lot of ... I mean even if we take the Russian collusion, all of that, out of the picture, there is still a lot of people in the country who appear to be perfectly willing to vote for the purpose of, it appeared to be, green stupidity and I know there was some desperation in there, but I also think there was really ugly humanity stuff going on.

It was hard to see real hard fast numbers on that. Cool that the popular vote went in the other direction, but it wasn't a landslide and I thought summer it would be a landslide. So the fact that it wasn't a landslide, (Personal family tragedy described) So this is an actual life and death thing for somebody who generally I love a lot.

If my mother's health insurance would have negatively impacted, that would bother me, too though differently, because she's ... Let's see, she will be 88 in September. So I have a different reaction to the trends happen with some of her health care. It still ticks me off, but not terrify me. One of my clients, this is not overly trauma related. I was teaching a class on that Wednesday. Next day I canceled it. I rescheduled clients. I had a number of clients who, they were shell shocked. They came in and ...

Researcher: Yes. Oh yes.

P3: Whatever they were going through, "Oh fuck, what the fuck is going on with our country, and what does it mean and how many people ..." So the election was traumatic for me in the sense that it really did shatter some fundamental beliefs that I had. It's nice to have some trauma theory behind me to know what was going on. But I will say 10 days later, somewhere in there, one of my

clients came in and ... So this is going to be a plus/minus for your answer because I'll tell you what he said to me yesterday so you can decide if it was a mistake or not. I'll give you a visual on his guy. Tall, white, white hair, 60 plus, maybe 65 or '6, six figure incomes for a long time. Mostly flies first class when he flies. Can bicycle well and brag and run, I don't know, two, three miles at a time when he runs on his treadmill. So you get the picture, right?

Researcher: Oh, yes.

P3: White privileged.

Researcher: Yep.

P3: Male, white, privileged. Why am I saying? Because he got caught in an affair. He lost his job. He came in and did some sort of, "Yes, I want to save my marriage," and we worked for a little while on that. All the while he was continuing the affair unbeknownst to anybody. Eventually he reached out. The affair's discovered. He gets fired. He and his wife engage in a three-year long program, like let's get this marriage fixed. Within six months of that he has decided he's going to forget his wife and go back to the other woman, who he then spends on. She gets into rehab. At any rate, it's not been a fun journey and, to his credit, he's growing, he's moving along.

But after that election there was kind of a slug thing that was happening and I was saying something about, "Yeah, but what about this? This had to do with election stuff," but it did have to do with his thinking, like how was he arriving at some of this stuff? It connected to an oblivion that has been, you can just say white privilege and enough oblivion right there, but if you add in white male and you add in has always been in the executive suite, it's just layer on top of layer on top of layer. I can't see and everything that I got I earned all by myself and all that stuff. Anyway, I'm a few days into this and the realistic freak out that's going on with my sister, the mother of my nephew, and with his sister.

Anybody who knows this, I mean there's a shell shock and an anger and a sobbing thing. It was almost like a redo of the day that the calls came in that he (identifying information removed). I'm a little raw. That's the whole point of that. Here's Mr. Slug and I asked him, "Where are you getting this information?" And it became a pretty heated debate and at some point I said, "I don't know, I didn't read that," and then I said some version of something like, "Then shut the fuck up about shit you know nothing about, (name removed)." Then I went into, "This will be the impact this has on my (name removed). This will be this. This will be that. Who are you that you just sit around without the blah, blah, blah, you sit in judgment of people, and you sit ..."

So that was November, and about two, three weeks ago, it's not like we haven't revisited that, but we revisited it again and he said something about like you

just keep saying it. I'm not giving them and I'm oblivious and then the word oblivion is a real insult to him. So I said, "Well, what would you call this? What's the right word? You give me a better vocabulary word and I will use that. Tell me the right word for it. What about this and what about that?" Last night he was in here and he said, I'm finally beginning to get that oblivion thing. And I said, "Do you think you're up for being a little less oblivious about how that's damaging other people?"

Beside the other thing that happened when he got fired the guy who took over after him fired I'm not sure how many people. The whole mission, it was a big nonprofit, the whole mission of that place changed. The whole tenure changed. The place imploded, and that's not an egotistic thing that he was saying, that's reports from all around. People who were on the board, and watching it. That's a realistic assessment of this when he left. It's a little like Trump when he gets impeached. I think Nixon took 48 people down when he went down. 48 people were convicted. I think 73 were charged. Anyway, what then will happen with Trump when he is impeached, he'll take a bunch of people down with him. There are already how many firings already, but there will be. I'll have my fingers crossed for who I hope gets taken down.

The point of it is, is that he really said that, "Oh, that company will land on its feet. I got the reassurance of the next board member who's kind of a wise elder." Then people that he considered friends, people that he recruited, were fired without conversation about it. (Identifying information removed) That was the dismissal conversation. So a bunch of trauma [crosstalk] firing. This is a Christian organization. So let's throw that into the picture. So there's all the hypocrisy related to that.

The other day, he said, we were talking. So last night he said we were talking the other day about mentoring and about I didn't have any of that. Then he said, but it's so arrogant. Who is better than me? [inaudible] I go to. They should be coming to me. He's getting like he actually gets that about himself. I don't think if it had been videotaped and uploaded to the internet that anybody would have called that first session a good session. But in the context of ... By then I had been working with him, their three-year contract will be up at the end of December. I guess I'd been working with him for two years by then. In that context maybe it doesn't sound as bad, but I think at that particular session, a slice of that, the upside is the vulnerability and the rawness that I was feeling and that came through, with some version of maybe the right kind of kick in the ass that he needed. I'll just put it that way for [crosstalk] clinical terminology there.

He said to me the other night, "You're the closest to a mentor that I've ever had," and, wow, yeah. So I don't know, you decide if that's a ... So what I did was I just, he said something to me. Let's talk about this last few months and

then I don't know how this will go, whether you deciding how to code it, but poor thing. Somewhere in there I felt very distant from him and angry. If you want to talk about countertransference and something else. About maybe six, eight weeks ago he came in and he was ... Maybe it's probably five, six weeks ago. "I might not come back in here. I come in here and I leave sort of upset and shaking. I do think it has to do with that this is just politics for you." I said it has nothing to do with politics. He said, "No, it is. You think we're on opposite sides of that."

I said, "It's not politics. You're going to turn it into politics and you're going to demean it and I don't appreciate that." He went into something else and I looked at him. He said, you know, "I hurt." I looked at him and I said, "You broke my heart. I'm trying to heal it over here, all by myself. It's my job to heal it. Its also professional and a personal value of mine to heal and to stay." And I said, "This is what's really going on with you." He's engaged now to the woman he was having an affair with. "This is what's really going on. You've never had to stay with somebody whose heart you broke. I'm not holding this against you. I just can't heal as quickly and as expediently as you would like me to. I want to be healed, too. I'm going to heal myself as fast I can. And this is about as fast as I can."

He said something else, I don't remember what it was. I said, "I don't really care for me, what you do with this. But you're here, in this new relationship." She's 31 years younger than him. "The first time in your life that you say you've actually had love. I believe that and I am thrilled for you that you have that, but do you want to know who you're going to do this to? You're going to do this to her. That's what's going to happen. You think you're never going to do it because, whoop-to-do, you found the right woman. No, this is a thing that happens when people love each other. This is what things that happen. You're giving yourself permission to leave. I'm gonna be here throughout the end of your contract. You decide whether you walk in the door or not. You can abandon these classes if you want. I'm not going to."

"I'm not firing you despite the fact that I have often felt like firing you. This is what actual commitment looks like. When you decide if you're up for real commitment or not, that's your call. But I'm not leaving despite that fact that you took your smugness and me knowing that that's a representation of something that goes on with an awful lot of people and that is why I have a nephew who might die sooner than he would have to. That makes you somebody that I look at and I go, 'I can't believe I'm sitting in a room with somebody who has that kind of sensibility.'" So he started crying. He said, "You're right, I'm sorry." I said, "I know you're sorry. I know you don't mean to do that. I get that. If I thought you meant to do it we'd be having a different

conversation. But that flagged me about that oblivion. Mental oblivion. You give me a new word for it, but that's what I call oblivion."

So he came in. He's been here twice a week, that's his contract. He came in the next time and he said, "I'm back." I said, "I see that." He said, "You made a lot of good points." I said its kind of my job, and I said, "Why are you back?" And he said, "You're right, that's what I do. I put my head in the sand. Yeah, my company's gonna be okay when I'm gone. Truth is, all of those people got fired." I said, "Yeah, and they all reassure you when you take them out to lunch, we'll be okay, we'll be okay. But you don't even want to pay attention to the fact of what that conversation with your wife was like that night, and the kind of getting sleep for [inaudible] many weeks until they could land on their feet and hoping they could get work or whatever happened to their mortgage for the first couple of months before they did. Yet you don't want to pay attention to that part. I would call that oblivion. What do you want to call it?"

So I don't know. That was the election and combined with my nephew's vulnerability and just trying in the midst of all that to ramp up, as a family, our own capacity to care for him. In the midst of this I moved out of the building that I worked on and I lived in that we owned. (Personal family circumstances described). So that sort of stuff going on in your life that is demanding and powerful. Not the usual, "Geez I hate doing laundry, could somebody please fucking vacuum. I don't want to vacuum this week."

Or embrace again the family vacation, and warts that need to be removed, and in-laws that are jerky, and all of that. But that one was extra big, I'll put it that way. An extra big personal low. I don't know if that's a good or a bad outcome. Long term, good outcome. Did I have to do something in such a way that he had a terrible few months? Maybe. Honestly, I don't have any regrets. I just know if I were being watched by other clinicians some of them would be going, "You know what, you're fucking nuts." He did yell a bunch of stuff at me that day. About you're crazy, you're fucking this, you're a [inaudible]. Then when he came back he said, I don't remember what he said.

I said, "(Name removed), these are things you've said to me and I know you didn't [inaudible]." I said, well, "(Name removed), you yelled all those things to me and I know, then and now, that you didn't mean them. I don't think you're actually are in here taking advice from somebody that surely believes that's absolutely talking crazy. I just think your feelings were hurt. You felt threatened. You're doing what human beings do. Welcome to the human race. A place you don't like to live, but a lot of us are just down here on planet earth living. You had a human moment there and not going to kill me. I want to thank you on that." He said, "Really, I don't need to be thanked." That's normal

relating between people who are trying to keep a connection. One that gets hard. Anyway, I don't know how you want to code that, but ...

Researcher: Well, excellent. Oh my gosh. I wish I could talk to you for hours, or I wish you could mentor me. You really just answered the next question. So I'm going to skip to the last one because I know we only have about 10 minutes left. But the question that I think you just did just gives such a solid example answer to was about how you determine if it's your personal issues that are being triggered by the client, or if it's that client-driven narrative being played out in session. And what influences your decision to disclose. It's such a good example because really it was a combination of all of that that happened. You were obviously personally triggered. You had all this other stuff going on, and then he just provided you all this information about his pattern and you brought that in and was upfront with him about that. It's just incredible. So, you've answered that.

P3: Back in the day when therapy ... It isn't today, and I don't know how long you've been in this field, Rebekah, but once upon a time what I just described wouldn't have been an unusual kind of session for people to have. But then, it's okay that things changed, too. But then there was this worry that the ... Let's see, that the clinicians were too involved, or something like that, with the clients. So that's why we should be putting together behavior treatment plans and staying away, doing something behind a lab coat, behind a [crosstalk] mirror, to get them to change.

There was a lot of that that happened and there was a time in the history of this where people, where the theorists really believed if you didn't have that kind of engagement, that kind of emotional connectivity to your patients, your patients at the time you basically were doing therapy. Now this would be considered by some like, wow, I think you crossed like 700 boundaries there. I would say that, yeah, it depends on how you define the boundaries. Why don't we look at outcomes and we'll see. Is there a better way to get there? I don't know. Show me a better way to get there. We got there.

Researcher: Right. Exactly.

P3: We got there. Well, I don't know.

Researcher: Exactly. Exactly. Okay, to wrap up. What is your understanding of clinical intuition, and how does your intuition guide your professional judgment with clients?

P3: I would have to roll in my spiritual practices and beliefs. I feel I can tell the difference between a thought I have and whatever you want to call it, divine inspiration. I feel like that's a physically different sensation for me. There are enough times during the week where I'm sitting there trying to think of what I would like to do next and then I don't think, but an idea is placed in my head

from outside my head. I have learned to trust that so I form that thought and I say something. I just expect that I do something with it, and it generally turns into something powerful. So I don't exactly believe in the idea of intuition, like stuff actually floats around in the universe energy-wise and then we bump into it or something.

My more personal beliefs or however we want to put that, about how awareness works, is that there's stuff that is going on, but if we actually were looking in the right places and thinking about stuff in the right places, or watching it, we would know how we arrived at that thought. But because we actually don't have the awareness, we don't really know how we arrived at it. It looks and feels a lot like I was being intuitive there. Also, you were paying attention to something that you don't know you were paying attention to, which is okay, you don't have to. I wouldn't necessarily call that intuition, but I do call this other thing that I get something that is not inside me that's not a thought. I call it divine inspiration, but I don't think too much about it. I don't say I'm channeling my (name removed) and she's helping me from the other side.

I just go, well, I'm open. I'm open, open and I just pay attention. I just pay attention to what's floating around in the universe and what floats in an idea then it gets some kind of an assessment and then I use it. I think clinicians are much better off if they have great sensitivity to their interior world and they know they can put language to what's going on. Which is why I think I am a better clinician than I would be if I couldn't tap into my inner life, let's just put it that way, a simple way.

I don't think being totally connected to science and having absolutely no connection to your interior world is a good way to be a clinician. I think you have to have worked with solidly in the ... I can't explain it world [crosstalk] solidly in this for sure has been explained. We got some solid science that we can take to the bank and we should trust that other stuff once we learned how to trust it, I guess. I don't trust everything. Sometimes they go, something floats in and I went, "That's not from my guardian angel. That came from some fricking prankster in the planet who wants to mess up my head."

I don't know what it all is. I don't care. I'm not somebody who needs to go find out where the energy, I don't know. I'm not like that. I just don't need to turn away from it, but I don't have to pursue it either. I think clinicians ... Well, you know what, I'll back up. I'll make a really strong statement here about this one thing, which is I do find clinicians who are like, "I have to stop it. I channeled it, it came in with the energy. I could [inaudible]." I just wish, I want them to all go live in Southern California. They can feel each other, love each other, do what they really want.

Despite the fact that I will tell you that I have a good friend who that's kind of what he does. He does tapping and he does ... I don't even know what he does. I go to his events and I can tell you my knee feels better when I get done. That's, I'm never gonna lie about that. I don't get the connection. I don't see it on the drive back from Houston when my knee should start hurting. I know that it's not hurting. Pretty sure it's about whatever energy is stuck in me because it's moving. I don't know. I don't spend a lot of time in that world. I'm not particularly attracted to it, but I am repulsed by clinicians or healers who I think are just too lazy, frankly, to look at the research, and because they just want everybody to trust them because they love people. I just don't have that much time for that group of people. I don't.

You all go find each other and go heal each other. Good. Good. Good. Run along now, that's sort of how I feel. I think there's a fair amount of scamminess in that group, I'll put it that way. I don't know. I think there's plenty of incompetence in the science trained only clinician group, too. My wish would be that clinicians would read a lot of science, really lean into that, study it, and know it, and then pay close attention to, from their interior life and check whatever help they can get from wherever the ideas are coming from.

Researcher: That's a beautiful summary to end with. That is fantastic.

P3: Okay.

P4 Round Two

P4: ... Going, but it's nonstop.

Researcher: Yeah. Well, it's job security.

P4: Right, exactly.

Researcher: Unfortunately.

P4: Right.

Researcher: I just have about five questions and some follow up questions. I know it's taken awhile. Thank you for sticking with me.

P4: Yeah, no problem.

Researcher: I've got about five questions. If you'll remember, we're talking about countertransference and clinical decision-making. My first question is just really open, and specifically focused on trauma survivors. How have your personal, and professional, experiences influenced your approach with trauma survivors? This could be anything from really excellent supervision, or CEUs

that you've taken. Somehow, you've developed a way to work with trauma survivors. How did that come to be?

P4: I've done a ton of training. I think that's one thing. I've worked here for 14 years and we really put trauma informed care as part of our philosophy. It's really stressed amongst the staff. Now, I'm in a management position, so I do a lot of trainings with my staff. I talk to them a lot about it. I would say, just a lot of training. A lot of training that I had, which is great.

Researcher: Do you find that the trainings are ... Sometimes, it's really impactful when ... It sounds like you're also doing the training. Do you find any impact difference if you're receiving the training versus doing the training, and training other people?

P4: I think both. Receiving the training is definitely a different impact. I think when you give a training, then it reminds you. Do you know what I mean? It reminds you of the correct way to do things, or talk to people. I would say both on that, yeah.

Researcher: Okay, great. Speaking of correct ways to do things, one of my questions is about ... If you could just reflect on an experience in which your clinical decision-making proved beneficial? How did you respond and adjust your approach?

P4: Let's say it one more time. When my clinical decision-making did not work?

Researcher: Yeah. It took a wrong turn, or some clinical decision that you made with a client didn't go well.

P4: I'll have to think about that. [crosstalk]

Researcher: Please feel free to take time and reflect. This isn't a race.

P4: I know it happens.

Researcher: You'd be surprised. A lot of the people I've talked have joked about, "Oh, that never happens."

P4: Do you want a single incident, or maybe generally what would be an issue?

Researcher: If you can think of a single incident, great. If you need to start off general, and then maybe it'll lead to something specific, that's fine too.

P4: A couple weeks ago, we had a bunch of positive urine analysis for clients. Generally, what we do .... I'm in a residential setting, so that's a big deal. What I ended up doing, and we do this sometimes if something happens, we have an all client meeting. We have the clients and I kind of come down as more like the

principle, where you are really [stressed] and stuff. I was really talking about no use on our property, about just kind of going into it.

Then, a couple days later, I found out that the lab made a mistake.

Researcher: Oh, you're kidding.

P4: No, and it was bad because I really laid into people. Not unprofessionally, but I was really ...

Researcher: Firm and stern.

P4: People called bureau workers, zero tolerance, going on and on. I don't know if that was my judgment call. I guess I could've been like, let's get confirmatory tests for all these. You know what I mean?

Researcher: I'm curious how you found out, that all the tests were wrong.

P4: We actually ended up doing confirmatory. In the lab, since then have gotten splash guard, but one of the samples splashed into ... No, it wasn't splashed. One of the samples ... I guess, when they test it, they test 50 at one time.

P4: One of the samples had such a high cocaine level, that when the condensation raised up on top of the sink, it dropped down into the other sink.

Researcher: Oh, my gosh.

P4: Since then, now we have major issues with ... Now, we're just constantly asking for confirmatory, but yeah.

Researcher: Oh, wow.

P4: They took care of it on their side.

Researcher: How did you tell the clients?

P4: The counselor's sat down with them. I sat down with a couple, just apologized, explained to them what happened, what they're doing differently, and what we're doing differently. We owned up to it.

Researcher: I bet that was ... That could be a very therapeutic moment, if you're this agency owning up to, "Wow, there was this big mistake," and admitting things. Even though, technically, it wasn't your fault, but just to be able to admit and have an open honest conversation with clients.

P4: Yeah, absolutely. Actually, they took it a lot better than I thought they would, so that was ...

Researcher: Nice, nice, nice. Is there anything in the course of a conversation, that you've had with a client over the years, that maybe you said something, or inadvertently made an intervention, that wasn't helpful?

P4: I can't think of a specific example. I know I've done this before, where I've been working with a client and sometimes maybe I'll make a joke or be sarcastic. I tried to changed the mood, and it only made it worse. I use a lot of humor in my counseling, so I try to pull them out of something, but they take it the wrong way. Not even take it the wrong way, they don't find it funny. That would be probably my oops, sometimes.

Researcher: That's a good point because I tend to use a fair amount of humor with clients. Can you think about, what is it in you that wants to shift the mood or make a joke?

P4: I think, for me, it's probably because I'm ... I don't want to say I'm not. I'm really good with confrontation, but it's harder for me to work when the energy is really intense. I've totally reflected on this before. Sometimes I might do it more for myself. I bring them down, so I can communicate better.

If it's something like they're upset up a situation in their life, but more I do that if they're upset about a rule or something like that, where I have to try to explain it to them.

Hold on one second, okay?

Researcher: Okay.

P4: Can you hold on one second?

Researcher: No problem.

P4: [inaudible]

Researcher: You're at work?

P4: Yeah. That's okay, I was just showing someone how to destroy meds. What question were we on?

Researcher: It's fine. We're switching gears. Well, we were talking about humor, how that can go awry, and soothing yourself, maybe, if you're feeling like the energy is low.

P4: Yeah.

Researcher: My next question is about leading sessions. How do you determine when you let a client lead versus when you take the lead, in a session?

P4: I actually always, pretty much, let clients lead. Unless, I have something on the agenda to address. Even if I do that, I'll address something, then I let them take the lead from there.

Researcher: About clients who sort of ... If you get the sense that they're avoid something or just going off on bunny trails for some reason or another, what's your sense of how long you let that go? Do you just let it go?

P4: I guess it all depends on the specifics?

Researcher: Yeah, of course.

P4: I usually feel like they'll talk about it when they're ready. If it's not imminent, like I have to talk about it right that second or they have to, then I just wait for them. Unless, there's an appropriate time when I can bring it up. Do you know what I mean?

Researcher: Do you have a sense of when that would be? What factors make it an appropriate time?

P4: Sometimes, I feel if they're dancing around it or they just haven't said it, I'll ask a question. I do a lot of motivational interviewing to try to get them to talk about it.

Researcher: How do you determine if ... This is about countertransference and if your personal issues are being triggered by the client, or if it's more of a client-driven narrative playing out. For example, if a client is particularly manipulative, or you're picking up on that sense, how do you decide if it's, "Oh, this client is ... Oh, there's something in me that's being stirred up, that isn't resolved."? Or, "Oh, this client must do this behavior in all of her relationships, and so I'm just part of that." It's the client narrative, if that makes sense.

P4: I think, I just reflect on ... Pretty much, when I do sessions, after every single session, I reflect on it.

Researcher: After session?

P4: Yeah. I can go back and think about all that stuff. That's kind of where ...

Researcher: Can you tell me more about your reflecting, after a session?

P4: After a client leaves, I always take time in between. I'll sit there and think about what we talked about, do the group note, and then if I have any that [inaudible], I think about that too. I'm usually pretty good at knowing if it's my stuff or their stuff. I know what kind of personalities are hard for me to deal with. A lot of times, I prepare myself before a client comes in here.

Researcher: A good example is, if there's a certain personality in the room, that you know that you have difficulty with, you can parse out, "This is my issue with this personality."

P4: Right.

Researcher: Do you have an example?

P4: I can say, anytime I have really aggressive clients. Sometimes, I have to center myself before they come it.

Researcher: To prepare yourself.

P4: I have people piling into my office right now. Can I call you back? Are there a lot more questions left?

Researcher: I have one and a half more questions. I can certainly ...

P4: Let's finish then.

Researcher: Sorry, so sorry.

P4: No, that's okay. I just have a pile.

Researcher: We'll make it quick, for sure. What's your understanding of clinical intuition?

P4: I think, it's going with your gut, being able to trust yourself to make decisions, and trust yourself that you're doing the best interest of the client. Also, being okay if it wasn't right.

Researcher: I'm sorry, I didn't catch that last part.

P4: Also, being able to be okay with yourself, if it wasn't right.

Researcher: Is your clinical intuition sort of ... It sounds like it's always right? I don't know if that's too extreme of a statement.

P4: No, I think it can't always be right because we're not God. That's what I would tell my counselors. Knowing, trusting yourself enough, to know that if it's not right, that you felt something needed to be addressed.

Researcher: Great. I will end there because I know that you have to get back to work. I appreciate you taking the time.

P4: That's okay. Did you have anymore? I have another minute.

Researcher: What influences your decision to disclose any countertransference reactions that you have with a client?

P4: What is what? I'm sorry, say it one more time.

Researcher: What influences your decision to disclose, or not to disclose, any countertransference reactions that you're having with a client?

P4: To my supervisor?

Researcher: No, to the client.

P4: To the client?

Researcher: Yep.

P4: I've never had to disclose that. I think if it got to a point where it was affecting their therapy, or affecting my ability to do therapy with them, then I would disclose it.

Researcher: Do you know what that would be? Do you have an example? What would be affecting their ... ?

P4: If they weren't making progress because of something I was feeling, if it was affecting the relationship, or if I knew I wasn't being my best around them. That's what I would say.

Researcher: Great. Thank you so much. I will let you get back to work.

P4: No problem.

Researcher: Bye.

P4: Bye.

P5 Round Two

Combined with Round Three interview

P6 Round Two

Researcher: Okay. First question is if you could share your personal and professional experiences, briefly, however you want to share that, that have influenced the way that you treat trauma survivors in your present work? In your approach? Which is a really big, broad question.

P6: Experiences or education? Experiences, right?

Researcher: Well, personal and professional experiences.

P6: Okay.

Researcher: So it could be education. It could be CEUs. It could be something that was really impactful.

P6: Okay. Well, I would say personal, you know, I have my own trauma history, so that definitely has impacted. But I don't think that ... So I think that's impacted my ... You know, I think we tend to want to work with issues sometimes that maybe we're familiar with or maybe have worked through. So I think a personal history ... But then I'm thinking about that personal history even and what has impacted how I work with ... So I think that that has impacted how I work with trauma survivors because I try to put myself more in their shoes more in a way.

Researcher: Mm-hmm (affirmative).

P6: So it's like, and just ... Or a lot of times, it's, I can connect.

Researcher: Mm-hmm (affirmative).

P6: Because I kind of get what they're saying ... Even though it feels they're at a much different place than I am, I can still ... I think a negative way, not negative, but not a great experience was my working in the prison.

Researcher: Oh, that's right.

P6: Yeah.

Researcher: Yes.

P6: Because at the time, I thought we were doing pretty good work, even though I always had this sense of ... Just really struggled with the way the women were treated and some of the ... I felt like I was doing okay work, but I felt like the system was just really not ... They didn't really care that much if someone got healing. And towards the end, I started to realize I personally was not a good fit there. And the people who were telling me what I was doing wasn't okay, now I look back and realize they were not trauma informed at all.

Researcher: Aww.

P6: And I, but I was buying into it too. So even though I was trying to be what I thought was trauma informed, we didn't really know what that was. And at the same time, I was using programs ... There's this one called moral reclamation therapy, which is used even with, I think (name removed) County Corrections, that is I think so un-trauma informed, you know?

Researcher: Ooh.

P6: But there's some positive stuff in it, but it's very ... You have to pass steps and you have to share things in front of people and all sorts of stuff. And I did those groups well, you know. And so I feel like I kind of took on some ... Even though I thought I did not want to abuse power and I really, I still feel like almost in spite of yourself when you have that much power.

Researcher: Mm-hmm (affirmative).

P6: So how that informed me is not so much then, but when I came to (organization name removed) and a little before when I started to study trauma more, it just, it was a time when I was not very trauma informed and I used that lens to almost like, never again.

Researcher: Mmm.

P6: If I start to do anything that's similar, I ask myself why. And so that informed me. Also, I really liked MRT, the therapy I was telling you about, Moral Reconation Therapy. I really liked that. And it's used in corrections. And it also reminded me just because something is used in a lot of places, really evaluate. Is it really trauma informed? Why is it used? Just because it's evidence based, who's ... what's the evidence?

Researcher: Ah, yes.

P6: So, and then here at (organization name removed), it's really been trainings, trainings, trainings. Reading, reading, reading. Meeting with people like (name removed) and consulting in ... we have the interpersonal violence services, just group, some of us are on the smaller group. The team.

Researcher: Mm-hmm (affirmative).

P6: Consulting. I think going to the trauma conference last June in Boston was kind of a big thing for me. Taking EMDR, because the first part of that training was all about trauma in a different way than I had experienced it before. So, yeah. I think those are the ones that ...

Researcher: Did your initial work, your initial professional work was in the prisons, or in the ...

P6: The initial was in community mental health.

Researcher: Ah. Okay.

P6: So I worked in primarily with, it was then CMI, not it's SPMI.

Researcher: Oh, okay. I was just wondering if your first get go. And that's hard enough working with the SPMI population. I'm thinking, oh my gosh. I know people who sort of first professional experience was in the research fields and, boy, does that.

P6: Yeah. And my first in corrections was community corrections. That almost ... and drug court.

Researcher: Oh.

P6: So those were structured, but almost a little harder because in the prison where I worked in the treatment program, they wanted to succeed because it cut so much time off their sentence.

Researcher: Oh, in prisons?

P6: Yeah.

Researcher: Oh.

P6: And it was in the women's prison which tends to have still plenty of violence, but less than in the men's prison. So it was actually harder when I went to corrections then when I went to the prison.

Researcher: Oh, interesting.

P6: Because, yeah, corrections, yeah. It was just, yeah.

Researcher: Okay. Thank you.

P6: Mm-hmm (affirmative).

Researcher: How do you determine when to let a client lead the session versus when you lead and how ... what kind of factors go into that kind of decision making?

P6: I love that question because I am so not intentional. I'm not very ... So I would say most of the time ...

Researcher: Well, when you say you're not intentional, does that mean you just don't think about it and it's sort of an automatic, whatever happens.

P6: Yes. But most of the time, well to be really honest, because we'll have the ... When we write stuff like our next treatment plan and stuff, mine's so vague normally. Because, and I'm working on it because we are technically a brief therapy model. But I do have the leeway because if someone's an IVS, we can

have longer. I would say I tend to let the client lead with content up to a point. But, while I point out themes, patterns, and maybe give some skill building. So I guess I would say I would let the client lead as far as mostly content, but I slow people down a lot so it's pacing. So it's more about pacing.

Researcher: Okay.

P6: Where they lead with content for the most part, but I might stop them and point out patterns and themes and use something they brought up to maybe teach a self-soothing skill. But very rarely am I the one that brings up the content, unless there's a specific thing, like if we're doing EMDR or something.

Researcher: Mm-hmm (affirmative).

P6: And then might bring up something just like what we talked about, check in with something we talked about last week. But really, and part of it is I really want to give them a choice and the sense of not being another place where someone's telling them they need to do this, this, this.

Researcher: I see.

P6: But I really treat most people the same way in session whether ... Because I really do assume that most people have had some trauma in their life. And it's just my style anyway to have kind of that Rogerian, humanist or whatever. Actually, they could still be directive too. But I can be directive, but mostly I let the person lead. Unless there's just too much information or almost word vomit, you know?

Researcher: Mm-hmm (affirmative). Yes.

P6: Or something like that. I might even challenge a little bit. But I very rarely come up with ... I'm much more reactive in a way to what they're saying rather than directive.

Researcher: Can you say more about pacing?

P6: Well pacing is one of those ... It's about ... Just like, say they're telling their story. Sometimes just kind of slowing down, asking some questions. Asking them to breathe for a moment. So I do try to watch and see if people are breathing and if they're shallow breathing and so, and it's a think with the word vomit when they're telling me all this stuff's going on. And sometimes it's hard because I have clients who are so, just to even kind of say, can you just take a ... Just for a moment, you've told me a lot of information. I just, I just want to figure out where you want to go with it right now. What's the most important information for me to know right now?

Researcher: Mm-hmm (affirmative).

P6: Or even I might just say something like, you know, you're clearly, I don't say that, but ... I just noticed that you're not really breathing right now and I, you know, it seems like you have a lot of stuff going on. So can you just sit for just one minute and take some breaths. And then you can start up again, or whatever. So pacing for me is ... And a lot of times, it's for me.

Researcher: Well I just wanted ... And that's exactly what I was going to ask next ...

P6: Yeah.

Researcher: ... is what's ... So you're seeing some reaction in a client and then is it to ... Yeah, what is it for.

P6: Right.

Researcher: Is it for you to absorb it all? Or to ...

P6: Some of it's to help them start practicing self-soothing. And even if it's just by breathing or ... A lot of times, it's about, okay, you tell me that. That sounds really hard. Where are you ... What are you feeling and where are you feeling it?

Researcher: Mm-hmm (affirmative).

P6: So pacing would be getting them more in touch with not just the frontal lobe, but actually the limbic system and central nervous system and their body and ... Because a lot of trauma work today, most trauma specialists sort of think it's bottom up processes instead of ... That's why CBT, while it's okay, it's not considered a best practice for trauma. At least not early trauma. You know.

Researcher: Mm-hmm (affirmative).

P6: So. I try to do stuff like that. And I want to get better at that all the time of the pacing and where are you feeling it? Can you tell me what you're feeling?

Researcher: Is there any instance where you feel like you would need to accelerate versus decelerate the client from sort of ...

P6: I'm sure there is. Let me think of one. I'm sure there is. Maybe when someone's stuck on one ... I don't want to say stuck on one aspect. Much more likely to slow down rather than speed up.

Researcher: I was just curious.

P6: But maybe if someone is ... Yeah, I can't think of anything right now. But I bet you I will come to you before you leave. I think sometimes if someone's stuck on one specific part, but then I realize, it's okay if they're stuck on one part. That means that's probably a piece we need to work on. So that might not be it. It's usually not ... The hardest for me is sometimes I want to accelerate someone, usually if I want to accelerate someone, it's my own stuff. Because, and it's usually not trauma. It's more sometimes they may have trauma, but it's more just being a honest personality disorder sometimes ...

Researcher: Yeah.

P6: ... where it's ruminating on something that, yeah.

Researcher: Got it.

P6: So.

Researcher: Okay. Next question. Can you reflect on a time when your clinical decision making was un-beneficial, and what you did and how you adjusted your approach?

P6: I have many times where it's un-beneficial by the way. Many times. I had ... A lot of times I encourage clients to ... And I'm very aware this could be tricky. But I encourage people using mindful self-compassion, so to do compassionate touch. And it usually is just something like this.

Researcher: Mm-hmm (affirmative).

P6: And then, or for some people, I'll do this whole thing, where if this isn't comfortable. Maybe your belly is ... And just as you're doing compassionate touch, you know and I go through the ways ... Maybe you say something compassionate to yourself. And I always acknowledge that it's really hard that actually saying something compassionate to themselves is actually harder for them most times than touch. But both can be. But a couple times I had clients who even with me putting all these caveats in place and acknowledging that this ... Because I'm always saying, you're the expert. If you don't want to use something, that's fine. But a couple times I've had clients who, one in particular who was just so disgusted by the idea, because of her own trauma history, of the compassionate touch.

Researcher: Hmmm.

P6: That she couldn't really get past it in that session. She was just ... And so what I try to do is use that. And just kind of, you know, what feelings did that bring up and is that ... I like ... One question I like to use a lot is, is that familiar?

Researcher: Mm-hmm (affirmative).

P6: You know, and so is that a familiar feeling and ... But it, she still felt, left frustrated, and so it wasn't ... I don't think it was beneficial. And I'm thinking at the time I was probably even more invested in some of these things because I have continued to change and really not be invested. And whatever works is all I'm invested in.

Researcher: Mm-hmm (affirmative).

P6: You know. And do no harm. But I think that what I would do differently is even more remind people these things that I suggest for you, you may want to try them someday but not today. Or you may never want to try them and these are just suggestions. And as soon as I start telling you, feel free to say, no, no thank you. And we can move on. Because I think I tried probably a little too hard if I remember right to make it okay. Or to explain why it might be a good idea instead of listening to her. So.

Researcher: Mm-hmm (affirmative).

P6: Yeah, that was one. And EMDR. I'm not as ... I know EMDR is everyone in trauma therapy talks about EMDR now. And I do EMDR. But, I've seen some success and a lot of nothing, and then a few people where it actually made them ... I think it in the moment made it definitely activated them too much.

Researcher: Yeah.

P6: And I didn't stop it in the way I would now. You know.

Researcher: Yeah.

P6: I let it go on a little. And I also let them decide. And today I wouldn't, if I saw that they were getting, breathing heavier and really emotional and just shaking, I wouldn't ... I would stop it. You know.

Researcher: Rather than having them ...

P6: Yeah. Because I would check in with them and they'd be like, no, I want to continue. And I'd be like, we can. Just not today.

Researcher: Yeah, yeah.

P6: Let's do some other stuff.

Researcher: Nice. Okay. How do you determine if your personal issues have been triggered by the client or if it's more of a client driven narrative being played out in session? So, does that make sense?

P6: So if my personal issues or if I'm just kind of responding to a hard story?

Researcher: Well, or if ...

P6: Or is it countertransference you're talking about?

Researcher: Yeah, countertransference. So if you're being triggered by your own countertransference, or just ...

P6: Or just my own story, kind of.

Researcher: Right. Right. Your own story. Or if it's, this client evokes this in many conversations and you're being pulled into that natural dynamic because it's more about their role.

P6: Yeah.

Researcher: So if it's that client or the narrative, or is it when you have a reaction.

P6: Yeah.

Researcher: How do you determine is it you, is it them?

P6: I think I just ask myself a lot of questions.

Researcher: Internally? In session?

P6: Internally and in session. Okay. First, internally in session, I always try to have that shadow therapist kind of and that's kind of watching and ... But a lot of times it comes after. I wish it came more in session, and I constantly try to be aware of what I'm feeling and responding to, but sometimes I don't have the time or energy in session to figure out ... the best I can do usually is, oh, I'm having some kind of reaction. You know. And just kind of note it and then afterwards ask myself what that was. But I also consult a lot. And use clinical supervision for ...

P6: And I haven't here as much in all honesty. Because I don't have regular supervision. So in here it's more I think consulting with a couple of people I trust. But I ask myself a lot of questions. And most of the time it's after. In session it's more just like, okay, note this is going on. And if I saw something that is kind of out of the norm or surprises me, I really note that. Like, where did that come from? And so then afterwards I ask those questions. So and consult. And I still don't always know, you know. Sometimes I just make the best guess I can make, you know?

Researcher: Yeah, yeah. What influences your decision to self-disclose ... Self-disclose any countertransference?

P6: With clients?

Researcher: Mm-hmm (affirmative).

P6: I don't do that enough and I actually think that could be very therapeutic.

Researcher: Ah.

P6: What I ... I self disclose a lot and I will do stuff like ... I self disclose more than most people here, but that doesn't mean a lot.

Researcher: Mm-hmm (affirmative).

P6: But I have a couple of other people, we all have different styles. I haven't sat in with everybody, but when we talk, a couple other people maybe disclose a little more. But to me, I'm pretty much the same way I am here everywhere. And the difference is I really work hard to ask myself why are you doing this to make sure it's for them and not me. And sometimes it's simply to make a connection. If they have a son, I can talk about, well I have a son too. Or sometimes I use people in my life as the fall guy for a learning moment, you know. Like, well, my son ... I don't know, some story or whatever. But, and then there are times in sessions where I'll disclose how I'm feeling, but it's usually not countertransference.

Researcher: Because you're usually not in the ...

P6: I mean, yeah, it's more like ... It's more like, when you tell me that story, I feel really frustrated for you.

Researcher: Mm-hmm (affirmative).

P6: You know, I feel ... Or, I feel angry that you had to go through that. Or, stuff like that. So, that's a good ... I don't think I disclose very often in a

countertransference, because my countertransference, most of the time ... Every once in a while it's more maternal.

Researcher: Mm-hmm (affirmative).

P6: And that's usually a male, because my son's 21.

Researcher: Mm-hmm (affirmative).

P6: And he has struggles with some stuff, so I'm like, you know. And I don't share that, but I usually, later on I'm like, oh, that's what that was. Most of the time, I my countertransference if I have it is usually not so nice. It's not so maternal. It's more like irritation. And it's usually a really, I'm just going to say this, really maybe people with dependent personality disorder.

Researcher: Mmm.

P6: Because I feel ... It's my own stuff. But I don't want to be the only person in someone's life or totally responsible for someone because ...

Researcher: Yeah.

P6: ... you know, especially when I first started out I was a case manager and it was a different model. We had to. And it was horrible. And then the second is probably just the norm, if someone's like telling me about me. And I don't even know if that's countertransference. It could be just no one likes to be told about them, you know, but.

Researcher: Mm-hmm (affirmative).

P6: Kind of someone who's just complaining a lot. And so what I ... I don't disclose that, because I ... but I do ... I do try to acknowledge it myself and then really work ways to find a connection with them. A therapeutic kind of an alliance. And I usually can. But I don't think I disclose that very often. No, I don't. I know I want to more. You know. I'll have to explore that one.

Researcher: What is telling you, you want to disclose more?

P6: Because I want to use all the stuff. And so if using countertransference would be helpful to the client, that, that's just an area I haven't really explored until you asked just now. But I think it could be probably really therapeutic for certain clients. Like, especially if something they've elicited in other people too.

Researcher: Mm-hmm (affirmative). Right.

P6: Yeah. Yeah.

Researcher: All right. Last couple of questions. What's your understanding of clinical intuition?

P6: Intuitively, I believe clinical intuition is ... It's something I rely on way too much. I mean, I'm really ...

Researcher: Really?

P6: Yeah, I'm really working hard at being more intention. I've told you that.

Researcher: Uh-huh.

P6: I mean, I'm not disconnected. I think I have some counseling skills.

Researcher: I'm sure you do.

P6: Yes. But I really rely on ... I rely on two things more than I'd like and others that take away from intentionality. But that I appreciate that I have them. One is my personality.

Researcher: Okay.

P6: I ... I like people. I'm friendly. I'm warm. I rely on that instead of too much ... So, which makes it ... That's probably one. The other person ... It's hard when someone's really flat and depressed. Because I'm used to like, dah. So, the other thing is my intuition, and I ... So, and I could be talking about something different than you're talking about. But clinical intuition, just ... If someone were to ask me why did you do something, I wouldn't always know how to say it.

Researcher: Mm-hmm (affirmative).

P6: In words. Because it's just something I just sensed. And I don't know if that's based on experience or just this intuition. And so I don't know if that's what you're talking about, but ...

Researcher: Well, everybody has their own sort of different sort of definition of how they use it ...

P6: Yeah.

Researcher: ... and what it looks like. And how it manifests, so.

P6: So I just feel like there's a lot of things that's not said that I assume. And I'm often correct, you know? But not always. That's why I say I don't want to rely on just my clinical intuition, because I think that could be a little bit arrogant and it could keep me from checking in with the client to see if they agree with my clinical intuition or they're ...

Researcher: Mm-hmm (affirmative).

P6: But I do think it's what ... That intuition is kind of the backbone of what I do also.

Researcher: It sounds like it guides your ...

P6: Yeah.

Researcher: ... clinical judgment if that's the word.

P6: And it's hard to know how much is intuition or stuff I'm observing without even realizing I'm observing it. Because if I'm ... If had to go ... But it could be a facial expression that was sleeping and I caught it, but didn't like consciously ...

Researcher: On an unconscious level, yeah.

P6: Yeah. So it's hard to know. Yeah.

Researcher: Okay. Okay. That's it. Any other questions?

P6: No. No. I'm excited for you, though, because you ... Are you ... You're getting there.

Researcher: I know. It's so hard to find people.

P7 Round Two

Researcher: Okay. First question is just very broad about your personal and professional experiences and maybe you could talk a little bit about how they impacted your work with trauma survivors?

P7: Oh, wow, that's a huge question.

Researcher: Feel free to take your time. Think, pause. I'm an introvert. I need to do a lot of pausing before I-

P7: Mm-hmm (affirmative). Lots of things come to mind as you say that. Personally and professionally. Surely-

Researcher: It could be anything from personal or like CEUs that you've taken. Feel free to just-

P7: On a personal level, I have had trauma exposure both in my own life and through family and friends. One of the lessons that I took from different stages of my life that I really, really fully realized the importance of at this stage, was that if treatment had been available to especially people in my grandmother's generation, that the whole course of my family history would have been altered. And, of course, that individual or those individuals' lives would have been dramatically improved.

So I wouldn't say it's a calling, per se, or habits or spiritual layer to it. But it's made my work feel really important and gratifying on a personal level. You know, that perhaps even one person that I've worked with in my career is the equivalent of that person in my own family history. So that's really gratifying for me and probably adds to motivation.

Researcher: Does that creep up in session?

P7: I don't think so.

Researcher: Okay.

P7: I've never had someone that I feel like, "Oh, wow, that's the equivalent of that person in my family." But just more general issues around especially depression and trauma and anxiety. And the impact of cultural oppression and social justice issues, and how those really interfere with ... I mean, you name it. You know, career opportunities for women in my family and access to resources and loss of cultural identity, especially as white people. So, yeah, I think it's definitely, my personal experiences definitely shape my investment and affinity for trauma work. It just feels natural to me. I mean, at this point it's just infused in the way that I see me in the world.

On a professional level, tons of things have influenced. My initial ... Gosh, yeah. So as an undergrad I was interested in child development and so started taking classes which then led me to families. Which then led me to the community. You know, just the understanding of the individual in various contexts. I don't remember if we talked about this last time, my career developments or stuff. But I started out in early childhood and then I wanted to do school counseling or teach. And then I decided, no, I'd really ... all right, I was going to teach. And then I was like, oh, I'd really rather do more intervention with individual people and help that trajectory, so then I was going to do school counseling. Then it turned out it wasn't really going to be what I thought it was going to be. You know, it wasn't the depth in terms of what I wanted.

So then I looked at psychology. And so as I was prepping to go further, because I'd realized very early an undergrad degree in psychology was going to do nothing. It wasn't going to be able to do what I wanted to do.

Researcher: It's so disappointing, isn't it?

P7: Well, I guess it's reality.

Researcher: Yes.

P7: So then I started planning undergraduate training and, as part of that, also ... I can't even remember how that happened, but I got involved in peer education in a women's center doing [inaudible] education. That changed me in terms of how I saw the world.

Researcher: I did similar work in college in one road I went down.

P7: Yeah, it's supposed to be mind-blowing, and it is. So I did that and that really then connected me to this women's center for many years. I was connected to them throughout all of my training. In fact, the director of the women's center, who was my first mentor in the field of women's issues, wrote a letter of recommendation for me to come to (State name removed). Anyway, so did that and then did a ... Gosh, I mean, women's issues were really a big ... You know, the issue of women and then gender study sort of things ended up being really strong throughout my training. And really influenced. I mean, you do women's issues, you're doing trauma work. You do social justice work, you're doing trauma work. Again, it just felt like, "What else am I going to do?" That's just what I do.

Some of my very early clients, like my first practicum client, my very first practicum client, had subclinical dissociative identity.

Researcher: Wow. Throw you into the frying pan.

P7: I mean, very serious, very serious. One of my other clients in that first practicum semester was in a domestic violence situation. You know, again it was like, well, okay, this is what I'm going to do and this is what I'm going to have to learn to, you know, explain. And then had some amazing supervisory experiences with very powerful trauma specialists. That had an important effect. And then, after having done this work in the women's center and this training experience in my Master's degree, my first job was in a battered women shelter. A family violence shelter. So, you know, dunk. Slam dunk.

So very intense experience there. It had a huge effect on me. I was in my early 20s, I was fresh out of my Master's program, you know? So. And then I would say my next sort of full-time position was in a substance abuse treatment center for women. So, you know, I developed a class, a psychoeducational experience for them that looked at the parallels between substance abuse as a form of

addiction and abusive relationships as a form of addiction. It was so easy to teach. I mean, the parallels are very, very clear and very easy, and it seemed to be really useful for them. And I hadn't been exposed – so this is my ego talking – I hadn't been exposed to the idea that relationships could be addictive.

That hadn't been talked about. I hadn't read about that, nobody had taught me that, and so it felt like this really important sort of discovery for myself. That was so logical and obvious, and then the teaching of the class really seemed beneficial. You know, there are these moments in the class where very simple exercises happened. Brainstorm, generate, all this stuff, characteristics of addiction, and then have them do the same for characteristics of an abusive relationship. And their [inaudible] lists, you know? And then we could talk about how each one perpetuated the other. I wish I'd known what I know about the brain because that would have been the next sort of ... We could have worked it really in some concrete ways that that affected them.

So I don't know if I'm answering your question anymore. Where are we at?

Researcher: Well, it sounds like a very linear this led to this led to this, led to this, and here you are. I mean, all of these experiences impact your sitting across from a client now.

P7: Right. I mean, how could they not? Yeah, [inaudible] to want that then. So, yeah, did the substance treatment and then I went back in for my doctoral degree at that point. This was 99. At that point, that's the first time I labeled myself as focusing on trauma. Trauma and social classes were my two ... Trauma, social classes and social justice. Those were the three labels that I gave myself at that point in terms of areas of focus. And it all interweaves for me.

Actually, I just did a talk recently for the interns at the counseling center and found myself laying out this continuum of trauma. Not a new idea, but for me it was really interesting to see how I categorized so many experiences as a form of trauma. And if you use the term very loosely, it's any injury, right? It's any injury and that can be, depending on the person and the context and their stage of development and their resources and their genetics and temperament and all of that, it can be almost anything. So you look at now they're categorizing adjustment disorders as trauma-related stress disorders, right?

Researcher: Right, right. It makes sense.

P7: Which, yeah, it makes so much sense. So for me, it's all trauma work at this point. You know, I'd be interested in talking with other professionals at the same sort of stage of development that I'm at to see if they have their one overarching conceptualization of human suffering and what generates psychopathology per se. Because you have to have an organizing principle at some point, right? So apparently that's one organizing principle. And it fits with

some of the exposure that I've had to Eastern philosophy and religion in terms of human suffering and what the causes are of that, and what may then be ways through it, happen to be.

It's no coincidence that Marsha Linehan's work for a form of severe complex trauma treatment is mindfulness, emotional regulation, distrust and, you know, it's all connected. And, of course, we can see how much use that has even if somebody does not identify themselves as being traumatized. It's just good for everybody. So I would say, in terms of the things that most ... So then I'm in private practice, right? I get my degree and then I go into private practice, and during my degree I'd done work with division of family services and I'd down work in the women's center again. I did work in the student health center and I developed groups and blah, blah, blah.

And then go into private practice and there's the sort of pragmatic world and then the clinical world. And what you're good at and then what needs to be done. So I started doing work with foster parents and doing educational support groups for them. And I did psychological evaluations for a public school district and so learned a lot about more formalized assessment as well as more systemic evaluation of what was affecting the identified patient sort of thing. That's when I started to get frustrated with my training because the training doesn't translate in many ways into real world, especially real world where there's significant forms of oppression or resource access or promised resources.

I think I told you this. I was working with – she was an LPC, right, she wasn't a social worker – an LPC who was using EMDR with her child patients and getting really, really good results. And I was like, whoa, I want some of that, whatever that is. Am I talking too long?

Researcher: No, not at all. I get paranoid that perhaps it turned itself off.

P7: Oh, my God. I have to show you this thing before you go. I just saw this artist who does these cartoons of the effects of anxiety. I laughed so hard I cried this morning. They were so funny. Because it's something like that, like "is it on, is it on, is it on? I'm listening to you. Really. Is it on?" You know. And she just makes it really comical, you know?

Researcher: Oh, funny.

P7: I just laughed because it was like, "Oh, my God, get out of my head." I mean it's really more neurosis than anxiety, you know? It's what she's depicting but it was good. So EMDR. EMDR has been, for me, the most effective training, the most useful training, the most applicable to trauma work. That, again, was sort of the next really solid piece and when I first started using it I was a mess. You know, it's really complicated to do it right and I was kind of on my own in a lot

of ways and then I had the consultation stuff and all of that. But I've seen a lot of very, very impaired folks with very few resources.

And so that training also actually didn't fully translate, in my opinion, in the real world. So I learned a lot working with people. They taught me a lot and we learned a lot together. You know, I probably do, at this point, half of my practice is probably EMDR based and people will contact me specifically for that. Which is wonderful because, you know, then they're invested already. And the question, how could all of my personal and professional experiences not influence my work right now? So do you feel like that answered your question?

Researcher: Mm-hmm (affirmative).

P7: Are you sure?

Researcher: Yes.

P7: Okay, okay.

Researcher: Thank you.

P7: Sure. Would you tell me if it didn't?

Researcher: Oh, yeah. Oh, yes, yes if I need it, and with a lot of this I'm not looking for anything specific. It really is more of like and then if you say something, that sound intriguing or I need clarification, I will.

P7: Okay, okay, cool.

Researcher: Oh yeah, if you were way out in left field then I would really ... Okay, so when you're sitting with a client.

P7: Yes.

Researcher: How do you determine when to let a client lead the session and when you take the lead, and what kind of factors lead to those decisions?

P7: So since you do EMDR, one way of describing it would be when the processing stuck.

Researcher: Mm-hmm (affirmative).

P7: So if the processing isn't stalled, then what do I need to do? You know, partly at this point if there be in a way is holding the space properly so that the person can do their work. And so if that's happened, whether I'm doing it or they're doing it or we're doing it or it's just happening, then I'm a witness to it. And, you know, I joke that I need to get a set of pompoms because there are so many times I just want to cheer for someone as they're getting to whatever it is they

need to get to, whatever that looks like for them. So, yeah, if the processing stalled ...

Researcher: And outside of EMDR?

P7: Well, I'd say that applies generally.

Researcher: Okay.

P7: I just think it's a good way of describing it, right? So-

Researcher: And it's pretty apparent when you're across from somebody if the processing is stuck. The other modalities would be ... yeah.

P7: It is, it is. Exactly, exactly. You know, they're struggling, they're not exploring or pulling pieces together or emoting or aware, you know? I mean it sort of feels different for every person. So if I were to think of an example, somebody that I'm not doing EMDR with ... So there's someone who has really severe chronic pain. I mean, it's debilitating and they're at a point where, you know, part of what I've been wondering about and they're been wondering. I just talked with them about this recently but they've been wondering about it separately and we hadn't talked about it. Whether they should apply for disability. And to even consider that is a breakthrough for them.

And in this session they were processing about how painful it is for them emotionally to not feel productive, to not feel useful, to not contribute. And that there's a great deal of shame associated with that. And so they were processing that and what pops up for me is, you know, it's disabling. Of course you're distressed. It's disabling. You're doing everything you can and it's not enough. You're still in so much pain you can't function. At that point, it just felt important to say that. You know, it makes sense that you're struggling this way because it's disabling.

And at that moment, the person then began more strongly emoting and acknowledged out loud to themselves and to me that that's something that they're considering but they thought that it was giving up or being lazy or taking advantage or all of those things that people think. And so then I got back out of the way. So I think that's what I mean. But as we're talking, I guess part of what happens is I have an internal sense and I decide if I'm going to follow it. I don't know. That's really hard to say.

Researcher: Oh, I think you've said it eloquently.

P7: Okay.

Researcher: And the internal sense. Clinical intuition is sort of the next area that I want to talk about and your understanding of clinical intuition and how it guides your judgment in session. What is it and how do you use it?

P7: It's interesting since we've been talking about the experiences that contributed to me. I got a brain map this morning so I've got goop in my hair. So I feel like I'm covered in-

Researcher: I would have never know from this angle.

P7: I'm just explaining why I'm scratching my head like ... So it's interesting. I'm sort of reflecting back on my early work as a therapist and I qualify that two ways. One is post Master's and then the other is post doctorate because they were starting over. It was really such an opportunity. So when I think about clinical intuition or clinical judgment or clinical wisdom, I compare to those times. And in those times, what I thought was intuition was actually just anxiety and over-analysis and vigilance, right? So the person is doing that. Okay, what does that mean? I'm going to compare it to ... you know, it was more of an analytical process, whereas-

Researcher: Which is almost the opposite with intuition.

P7: Yeah. All the potential necessary in order to develop. I don't know. But, yeah, it was more of a watching rather than a sensing sort of process. And so now it's interesting. I check my intuition with the client. So let's take that example that I just gave with the client with the chronic pain. I had this sense that there was a piece that wasn't being acknowledged. And that was a felt sense. It comes from kind of my core. It's a sense. It's not even a feeling. It's not a thought. It's a sense.

And then connecting with the thought about it, which is, "This is a disability. This person is experiencing a disability but that's not being acknowledged." So then I check it with the client. God, what did I actually say to her? I said it seems like this is just disabling. That this chronic pain keeps you from doing the things you want to be able to do and how you could be capable of if you didn't have this burden. But I ask it in a way that's like checking with the person rather than telling or rather than labeling or rather than sort of owning that myself. Because I also don't know. I could be wrong. And I'll say that to clients frequently. Like I could be off but this is what I'm seeing. You know, this is what I'm noticing.

And again that's partly, potentially, huh, that's so interesting. It might be part of the feminist training but also part of the EMDR training. Because in EMDR you try really hard not to make assumptions about what somebody's thinking or feeling, right? If they are distant, you try to get the therapist out of the way. So that's interesting to think about. I bet that's had an impact, which I like. What do you notice now, you know? What do you get from that, you know? It's just this sort of testing, checking. But clinical intuition for me is a felt sense. I would describe it as a synthesis of what I'm observing, of the history that I've had with

that client, what I know about their life experiences and history, and the interpersonal experience of sitting with them.

And in order to really, fully utilize my clinical instinct or clinical sense, there needs to be a strong therapeutic alliance because oftentimes the sense is something that's unspoken. It's something that might not be acknowledged. It's something that is outside of awareness in some way. I mean, otherwise what do you need the therapist for?

Researcher: Right.

P7: And my clinical intuition, I think – and this is just my own sense – is much more refined and my timing is much better, and I can hold something not in a way of controlling or directing but just in terms of knowing when it's going to be useful.

Researcher: To intervene or say something or verbalize it? Okay.

P7: To offer to the client, yeah. I mean, with more advanced clients you have more experience with their own development. I don't like advanced but they're more experienced with their own development and they've had more resources to do that. We can talk about that. You know, so the person isn't at a stage of idealizing the therapist and so we can talk about therapist as tool and how that can be really useful to them. I really like that when we can get to that point, and so on. It's less personal. You don't have to be identified with what's happening, you know?

Researcher: You're leading right into the ... You mentioned being wrong and if you could reflect on that experience where your clinical decision-making was unbeneficial to the client and how did you sort of respond and adjust?

P7: Well, I've had a client recently who presented with anxiety, social anxiety, and really was very clearly, I thought, asking for skills training, asking for more of a problem-solving, social-focused approach. And it just felt strange. Like four sessions in, I was like this is so uncomfortable. It just does not feel right. Something's funny. It feels pushed. It feels like I'm telling her what to do and I don't like that. And so I was struggling with the thinking of, okay, is this my own personal style, that I'm resisting being more directive? Because I can do that. It's challenging for me if it doesn't feel like a collaboration sort of thing.

And the symptoms weren't shifting. It was kinda like feeling worse. You know, somebody who had dealt with anxiety at one point in her life and really did all of the yoga and change their diet and did all these alternative lifestyle interventions. And had read about behavioral therapy and thought that was the thing that they needed. So it seemed really clear. And yet just was, you know, not getting better at all. Even any little slight improvements. So they were starting to feel discouraged, I was starting to feel discouraged. And there was

one session where, you know, where I used a checklist or how do we do it or what do we need to do differently? You know, did all that stuff and nothing was really ... You know, it wasn't adversarial but it was starting to get this oppositional sort of stance. I don't know, it was very strange because that just doesn't happen anymore in my work.

And so the session where everything shifted, he said something about ... How did he put it? Something about wanting to understand himself better. You know, wanting to really know himself and accept himself. And I was like, "Well, that's not what we're doing here." I said that, like, "That's not what we've been doing." He's like, "It isn't?" Like, "I don't think so. We've been trying to fix your symptoms." He's like, "Oh, no, I need to get to what's deeper." I was like, "Well, that sounds great. You want to try that?" He's like, "Yeah." And part of what it involved was doing some interpersonal work because it was really confusing how he got there. Like how did he get there and does this happen in other relationships? And what did I do that contributed? You know, like what actually happened? And so it was such a relief, such a relief.

But I would say, more generally, I think oftentimes they just don't know when they're fucking up. Clients either stop coming or they don't tell you or they think it.

Researcher: Yep.

P7: So, you know, I'd love to say that I'm that aware that I know. I mean, I think there have definitely been some times when he went to trauma where I've gone too fast. I have pushed too hard. One of the reasons I was being more cautious and following this client so closely without pushing what I thought needed to happen is because I've done that. And it's been hurtful, you know? I don't know if I'm different than other therapists but I've gotten a feedback that I go very deep very quickly. You know, people can drop into deeper states really easily and that can be really threatening to their psyche when you're dealing with trauma. You know, it can be really overwhelming. People can get [inaudible] really easily.

And so I would say that's probably been my biggest growth edge is pacing and being more in tune with that drop. I think earlier in my career I thought that's what you were supposed to do. I thought that's what's therapeutic.

Researcher: Going deep quickly?

P7: Yeah. Like what are you here for? Let's go.

Researcher: Yeah, let's get in there.

P7: And of course we know with trauma that can be counter-productive, to say the least. There's one client I really worried about that issue with. I worked with

him for almost three years. Severe religious abuse as a gay man. He'd had a really horrific form of conversion therapy kind of bullshit experiences. You know, like medical castration and, I mean, just really horrific. Not to mention an abusive family. I mean, we did very deep work, very deep work. It was one of my early MIR cases and so he just really ... And he was that type of person that wanted that. For years I actually felt like that had potentially been harmful. You know, re-traumatizing.

And then, luckily for me, which of course is why I'm telling you this story, I saw this person at an event many years later. It was just a few years ago. And they were in a completely different place. They were off all medications completely. No meds at all and, you know, expressed a lot of gratitude for the work that we'd done. So partly it's like even sometimes what seems like unproductive or potentially even harmful work, you can also misinterpret that. So I don't know in the end how to answer that question. And I'm going to be watching that, thank you.

I do watch it but it's like I don't really think of it that way. It's interesting. And reviewing and doing ... do you know Andrew Leeds' work?

Researcher: Oh, yes. He did my EMDR training. Ah, Andrew Leeds.

P7: He's so sharp.

Researcher: His own personal bedside manner but, man, he's got a brain to beat all brains.

P7: I mean, he's designed to be a trainer.

Researcher: Yeah.

P7: Yeah. So I'm doing his CEU thing for a book, right, and so I'm going back more to the peer protocol.

Researcher: Yes, yes. Some trainers will make you do that or CE ... you know.

P7: And I'm really liking it because I feel like it's protective for the client. I really do.

Researcher: It's so easy over the years to get ...

P7: Sloppy.

Researcher: Yes. Yeah, yeah.

P7: Yeah, there is an expectation in the field that you do a self-study 10 years in.

Researcher: Oh, interesting. Oh boy, I'd be due.

P7: I actually thought when you invited me to do this research, I thought, oh, this can be a tool for me in terms of my own analysis.

Researcher: Interesting, interesting. Okay, I want to be respectful of your time. You touched on this a little bit. You're just going right in one thing and the other. How do you determine if your personal issues have been triggered by a client or if it's more of a client-driven narrative being played out? And, yeah, I mean we'll just start with that.

P7: I just set up my first consultation group here and we were deciding how we were going to set it up. And I found myself saying the primary reason that I seek consultation is to check my own countertransference. That's something I really pay a lot of attention to. Well, it feels like it anyway. I think it's important and pretty much it's you telling them how to have a reaction to somebody. A fairly neurotic and emotional person and so it's a lot.

Researcher: And so you would couch that as all countertransference?

P7: Not necessarily.

Researcher: Okay.

P7: And that's why I check it, right? And so I'd say partly I check it, that process of checking with the client. You know, like, oh, this is what I'm noticing but what do you see and how does that resonate or not for you? And partly if I'm having ... I would say if you're going to give a rating, right, if I'm above a four out of 10 I need to consult. I have a case right now with a couple who are seeking asylum in this country for religious persecution and, as you know, the current political climate is creating additional barriers for people who are doing that. This is their fourth year in the process. They've done everything right and now, all of a sudden, there are these barriers up. I am just infuriated. I'm infuriated and I'm terrified for them. There's every chance they could get sent back and killed.

Researcher: Yes.

P7: And so I'm definitely having strong reactions to it. It's not because these people are evoking that intentionally. There's not some sort of interpersonal dysfunction for them. And it's not necessarily a countertransference per se of like they are reminding me of a family of origin issue that I need to then acknowledge and work through separately. It's I am freaked out at their situation, right? You know, different stages of my career that's happened like the first time I worked in a battered women's shelter, the first time I worked with somebody who had just tried to OD. You know, all those kinds of things. You know, the first time I worked with somebody with complex trauma. Holy God, you know? I really knew I was working with complex trauma.

Anyway, so yeah, that strong reaction or no reaction, right? So extremes, intensity. I look for intensity. And then I check. I get the [inaudible] input. The past several years I've had two consultation groups that I meet with, so I have

consultation once a week and I'm pretty dependent on that. I really like it because otherwise I would just have too much to process. And I benefit from hearing other people consult and process. And it just, you know ... man, this is research so you're not going to want to go around telling people this is how I think.

Researcher: Oh, no, I-

P7: Part of it is like an energetic sense. You know, like is it clean? Is the energy clean with this person, you know? Or do I have this funny agenda thing happening or am I having a strong response or do I have a sense of this person needs to do this. Or am I resisting or do I get kind of annoyed when I realize I have to meet with this person or, you know, what's going on?

Researcher: So you could still have that same reaction if the client is sort of driving that this is my narrative?

P7: Right, sorry.

Researcher: No, no, no, no. This is-

P7: Yeah, so the other part of that. I don't seem to have reactions to that as much anymore.

Researcher: So you notice it?

P7: Sure, oh yeah.

Researcher: And it's just not a reaction?

P7: I mean, we've all got our own projection, you know, and some form of reaction in some point in time. Yeah, so for clients who are looking for the expert, I will just label that. So you're looking for therapy that's really focused on giving you clinical expertise so that you can benefit from my training and my knowledge. And it also seems from your family and cultural background that it's really important that I do my job. That I'm (name removed) and that's what you're here for. And they go, "Yeah, why do you have to say that stupid shit out loud?"

So again that checking and labeling it is helpful for me because then we've made an agreement of what ... And then when that changes, when the person starts to feel a lot more comfortable and so they can allow me to not be perfect. And maybe I do kind of slip some things in, actually. You know, like I'll make a mistake and point out that I made a mistake. So that would be one example.

The guy that I was talking about with the anxiety, you know, we talked about, wow, okay, so how did we end up here? You came and it seemed like you

wanted solutions like looking at your goals list, you know. So what happened? And he's like, "Well, I don't know. This is what I do with people."

Researcher: Ah, ding, ding, ding.

P7: Right. Like, "Oh, okay." Right? So that might be a good example where I was concerned it could have been a countertransference issue, but it wasn't.

Researcher: This is his pattern.

P7: Right. I had a supervisor once who, we were talking about a difficult case and I was lamenting the fact that I couldn't find a way to match with the client. You know, I wasn't able to sort of match my style to the needs of the client and my supervisor was like, "Okay, you need to get rid of that idea that you can find a way to match with every client. That's not realistic." And to this day I disagree. I mean, I wouldn't say every client but I see it as part of my job to match. You know, that's why we talk about meeting the client where they're at. That's a version of it.

Researcher: Yeah, yeah. Better than them conforming to you?

P7: Right, right, so how do I tell about your question, how I do I tell the difference? If it's me, I'm having a really strong reaction. Then I know it's me. If it's the client, then it's like a low level, maybe interpersonal sort of response that I'm having. And I just don't seem to get pushed by it anymore, I don't think.

Researcher: Great. It sounds like you do a lot of-

P8 Round Two

Researcher : So, the first question is pretty general and it's about how your personal and professional experiences has influenced your approach with trauma survivors. So this can be anything from a specific, maybe you had a specific supervision experience, or a really telling experience with a client, or some CEUs that you took that really changed things, just anything personal or professional that influenced your current approach. Which I know is really general.

P8: Huh, huh, huh. Interesting. I'd probably say, there are probably a few different things that kind of feed into that. One is, and I had my own experience with, and I think based on some of my experiences as a direct result of trying to get some of that results for myself, I think I had some insight as kind of a consumer that some things that work and some things that didn't work so well. And so I think that informed me. I think probably because there was so much, like when I was young, and the type of therapy they used, there really wasn't a lot of I guess what I would call hope,

secondary to treatment. There really wasn't any strong types of therapies other than you just talked, and talked, and talked about it. But there really wasn't, in the beginning of my career, there really wasn't that much hope, and so.

Researcher : That sounds grim.

P8: Yeah, and so I think for me, that's why I was so attracted to the EMDR, and that sort of thing, like I said, I was trained in PE, and I'm trained in CBT, and things like that, and I think they all have certain things that they do that are very common to one another that are overall pretty useful, but I found for myself that the EMDR was a faster process and it seemed to target it really just very specifically, and that's why I was so attracted to it. It was less about, I guess I would say less about all of sort of like the peripherals, like you have to get the person tons and tons of details because I think, especially early on in my career, I worked a lot with domestically battered women, and I worked a lot with child survivors.

Is that feedback from my phone or yours, I'm wondering?

Researcher : Oh, I'm not hearing anything on my end.

P8: Oh, okay. Okay, good, then it must be, it doesn't matter.

So, for me, I think that really contributed quite a bit, which was the whole idea that there really wasn't a lot of specific types of treatments that were really going to just gently allow the person to process what was going on with them, as opposed to having like all of the details, cause early in my career when I was working a lot with battered women and with, there was women who were sexually abused as children, when they had any kind of dissociation involved in their trauma, or if they had some big gaps in the memory system, it was almost like people go, well I guess you're not ready to process, or I guess you're not ready to get any help, it was almost like they wouldn't get that response, and there was kind of an un, I don't know, I would say probably more or less unspoken sort of focus in my, if a person was blocking part of it that there were very important reasons why and there's like nothing you can do about that, and that it would end up that when the person's brain was, or when the person was able to or had got to that point that, now we can move forward kind of thing.

And the EMDR doesn't really require that, it doesn't require a full narrative, so I really like that it doesn't, like even with PE you're supposed to continue to, so in the narrative, so on the narrative. Well, it's with the EMDR it's more about the sensory experience of the whole thing, and so it's very different, and I like that because it just seems to me it's much more gentle and it also doesn't have that higher sense of, oh, I guess you're not

gonna get anywhere because you don't have full memory, so the estimate kind of thing. So, I like that. It makes me feel as a collection, it makes me feel a lot more, I think it makes me able to present the treatments with a lot more hope because the people, cause people will even still ask me, well what if I don't remember parts of it, or what if I, you know like especially, too, with little kids, is they know it happened, for example, but they don't even have a really full narrative of it, so it's nice to know that that isn't the necessary component, so I hope that fully answers the question, to kind of sum up.

Researcher : Oh, definitely, definitely. I've personally found the same thing with EMDR, that it's pretty forgiving and flexible, but yet provides this great structure at the same time, so I can resonate a lot with what you're saying. Yeah, I've talked to a few other people who, once they've taken that, and not everybody I'm interviewing is doing EMDR, but it seems like that seems to be sort of a linchpin for just sort of a change of, or just a big influence, just a change of focus.

P8: Yeah, and I think because they do have some type of somatic in it, for some people, quite frankly, I think for them to kind of move through the treatment, for one, some people actually hold so much of it in their body that they almost think like, I don't know why other people think this is a big deal because I don't think about it all the time, I don't whatever, but they have all this, almost like this physical energy within their own bodies that it's actually delaying their argument. And like their lack of sleep, like they're always, their mind is going, going, going, going, they have this big knot in their stomach, that kind of thing. So you're able to really target that in a very different way with sort of the idea in mind that some people stuckness doesn't have to do with just some of the obvious pieces like avoidance and everything else that goes with PTSD, but it could actually be that their bodies got somehow or another, they're just more comfortable, perhaps, or their bodies are more comfortable manifesting their symptoms via body stuckness, if you will, as opposed to some kind of narrative thing that, or some kind of even cognitive belief system, any of that kind of stuff.

So, and that's the other thing I like about EMDR sort of flexibility is that I can target thoughts, I can target feelings, I can target physical sensations, I have so much, I can target symbols, and then people can end up just kind of letting themselves go from there. And I also do like the fact that you can do interweaves, as well. So if someone really is stuck you can gently introduce sort of an I wonder and then see where their brain goes with it, cause if it isn't, it isn't, and if it is, it is. So, it's nice that way. So you have that much more stability, I like it.

Researcher : Yes. Do you, on a sort of side note, do you do, cause you do a lot of first responder work, if I remember, yes.

P8: Yes, yes. Almost primarily.

Researcher : Yeah, the first responder protocol, have you done those trainings or do any of that?

P8: I have done, I have not cause actually none of them, and that was one of the ones I was gonna pursue this year, but most of the time I do use the protocol, which we see more or less the protocol for immediately after a critical incident. So the one that you would do, like basically an early intervention protocol, I've used those, but for the most part a lot of the people I get are far enough along after the CI that they wouldn't end up, and I have used it a few times, as a matter of fact I probably, it wouldn't surprise me if I end up doing it this week because I have one coming in this week that is a right after the fact, maybe two or three days after the CI, so I will probably end up doing some work with that, that's not unusual.

Researcher : Yeah, I was just curious. I know a few clinicians who are going to those trainings out here in sort of preparation for when we have our big earthquake, which we know is coming at some point.

Okay, my next question is about leading the session. And lead, L E A D, I got a couple of people mishear that word so I'll spell it for you, leading. How do you determine when to let a client lead the session and when you take the lead, and what factors kind of lead to those decisions?

P8: Oh, that's interesting. I don't know that I think about that really very consciously. I think, to be honest with you, it probably has everything to do with their level of confidence, and I think some people just come in, and I think either because their own maybe seeking, or maybe perhaps from prior treatments that they are much more clear about what they need and what they're looking for, and then other people are so, basically lacking in confidence, they're just so tentative and they're so, that I feel like it behooves me to help them see that I have confidence. I have confidence in the process, I have confidence in them, and that sometimes my confidence carries them until they end up having enough of their own. Because I think this kind of thing, especially for me, working with first responders, it actually has a different element because they're so use to being in control, it's just part of their training, it's part of their mindset, and also being what I would call powerful.

So they're use to being in a position of power, in a position of I know what to do, that level of confidence, and when they come to me, very often part of the difficulty and part of sometimes what ends up amounting to a barrier

in treatment is that they don't have that confidence and they don't feel that confidence. And so usually when I'm doing the initial evaluation and everything, I am, I would say more unconsciously than consciously, but I'm very clearly looking for sort of their degree of confidence in all of this and how sort of skeptical they are, I guess would be a good way of putting it.

And so, I think with those people who have high levels of skepticism about treatment, and it's actually the first responders, cause again, part of why they go into the field, they go into it, it's why they're successful in their careers, is that confidence that they end up learning or that they've already have partly developed and that's become, becomes very whatever. So for them to come in and kind of say, I don't know what to do about this, I'm stuck and I don't know what to do about it. So if I really get the sense that they are super skeptical and that they are sort of, I would say, looking for someone else to say, yeah, we can do this, this is really manageable.

And so I will have the tendency to be more direct in the beginning of those kinds of situations and I try to normalize their experience and sort of put it from the standpoint of how could you have known, it isn't anything about somehow you're flawed as a person that would not know how to handle this or would not know that this has had this, has been happening, and that it was your family member who basically called you out on it, that kind of thing. And so I usually will start out, but then what I notice is as time goes by I will shift back. I'm always hoping to get to the place where I'm being directed rather than me being directive.

Researcher : Can you give an example?

P8: So, let's see. Oh, well I can tell you one that was recently. So recently I had somebody who came in to see me who was in a very excessively powerful position. And was encouraged to come in, and I could tell even the first session had one foot out the door. Absolutely had a foot out the door, so I knew that if I didn't make a good pitch that first session and come across as very confident like, yes, we can tackle this, this is not, I mean this is very manageable kind of thing, and to normalize the experience of, to start out with that sort of level of confidence so that, like, okay, yeah, let's not worry about this, this is absolutely we can do this. And then to give the education about why it was so baffling to him.

So why all of this was like something that of course he would not have necessarily noticed, and sort of explaining basically some of the neurobiological pieces and parts to trauma and how your brain ends up doing its best with what it has. So, sort of in a sense what I do with those people, I probably go very clientsy on them because, for whatever reason, when they know that, oh this is just my body doing this, this is nothing

wrong with me, this is not about my character, this is not about me as a human being being incapable of handling difficult things, this is my own biology because I've been hit with trauma, hit with trauma, hit with trauma, again and again, and at some point the brain just says, screw you, I'm not doing this anymore. And then they end up with all of the psychological manifestations of PTSD.

So I try, I usually will, sort of, not that I'm blaming it on the brain, but basically I'm blaming it on the brain. Because a lot of things I find with my first responders is one of the things, I think, that makes them very resistant, so that's why when I come out really sort of as the expert, if you will, with those folks is because they really feel a lot of this stuff is character, that just, somehow or another I have flawed character and that's why I, and now I don't see that with some other types of trauma, but with in particular with first responders because of their levels of competence that I see that quite often.

So it depends. When I can already tell, they're usually very frank with me, first responders are. They just absolutely shoot from the hip, that is also another reason they're so delightful to work with, they will tell me right in the first five minutes, I don't think this is gonna work. So true to the fact, and I get that message like, I don't know why I'm here, I don't think this is gonna work, I don't really know.

As soon as I get that, then I go into I'm gonna lead at that point. And then I'm gonna be giving them a lot of information, I'm gonna help them normalize this, and usually when I already know, my family sanction is, what they're gonna tell me, my family thinks that they're [inaudible], and I'm gonna start going down the diagnostic criteria, and they will often almost get kind of like, how did you know that, how did you know that, and I kind of look like I'm like a psychic or something, and then I go into explaining what's going on, like this is why you're experiencing these symptoms, this has nothing to do, really, with character, this has to do with your brain just being exhausted and finally at that point in exhaustion it is unable to do the switch that it would normally do when it goes back to everything's good. I mean, you just didn't have the space and time and then the brain just does this.

And so, and I explain that we're gonna try to get it to go back to being able to shut itself off and recognize that your environment is safe now and it's not gonna have to be on that high alert status. And so, that seems to help, and then like I said, as the weeks go by usually when I'm in treatment with them it will shift and I say, okay so what do you want to do today. And I'm

not gonna tell them what we're doing today, I'm gonna have them choose what we're doing today.

Researcher : Nice. Great. Okay, next question, if you could reflect on an experience in which your clinical decision making proved unbeneficial and how did you respond and adjust your approach?

P8: Probably most recently a good example of that would be I had someone who came in who was clearly without a doubt at all in my mind was in a complete exacerbation of PTSD, very, very, very radically difficult case, but the problem was they were unable to process via EMDR because of having top secret clearance. So they, I mean even I explained two, three times that I don't have to know anything, they can just tell me, okay, I can see it but I can't talk about it, okay go with that. So as I explained and explained, but the amount of, I think the person has excessively high integrity, very, very bright, but was unable to find a path to allow himself even in the presence of another person to be thinking about those things who doesn't have clearance, if that makes sense.

Researcher : Wow, yes, wow.

P8: So, I really got very clearly, and so I tried I think twice, and got it all set up, and then we went into one, and I could tell, it's like, okay, this isn't gonna work. And so what I'm doing right now is I'm actually using parts of the protocol without BLS, if you will, so we're talking about things like, I ask along the lines of, if we were processing the positive cognition, when we're getting to when you're installing the positive cognition, in other words, sort of ways to look at himself as resilient, and so I just shifted to that because although he will speak about the general situation, once he hits any of the stuff that has been, it's still not cleared, he won't, he just shuts down, and it's just like you can watch it shut down. He goes into this like completely within his own mind, even within the narrative, and it's like, okay so this is different, and so I don't know how far I'm gonna get and if it's gonna just end up being that we process, I just shore him up for a time until he's to a point probably discuss that he was involved in won't be cleared for unfortunately probably another six to ten years won't be.

P8: Yeah, it's that high. I know of the situation, it's just that the details I think he feels are secondary to him getting forward, so it's not gonna clear. This stuff is simply not gonna clear. So it won't be un whatever, however that process that goes through when somebody can actually fully talk about something that happened, it's a while out. So I think that that's just been my most recent experience. And then once I get that I just sort of, and then I think probably the only other one is that when somebody is decompensating, and I think that goes without saying, when somebody is

in a decompensation, because let's say we've been working on stuff and all of a sudden another critical incident comes up in their, like let's say they, well I would say critical incident from the standpoint of trauma, but let's say all of a sudden their parent gets ill or a family member dies, or I will very frequently just stop wherever we're at and we will go right to coping with that particular situation until it stabilizes. And that's happened most recently, too, where somebody ended up, their husband lost his job, but that was so incredibly out of the blue, very, very stressful, there was no way we were gonna be able to continue to process.

Researcher : So you would go and just switch gears to whatever the other crisis is and manage that before getting back to the.

P8: Yes.

Researcher : Yeah, okay, yeah. Yeah, cause it really does sort of get in the way of any further processing if there's just this overarching issue that has popped up.

P8: Yes.

Researcher : Yeah.

P8: Yeah, exactly.

Researcher : Okay, next question is about focusing on countertransference and how do you determine if it's your personal issues that are being triggered by a client or if it's more of the client driven narrative being played out in a session, if that makes sense. So if somebody, for example, oh, somebody maybe seems particularly manipulative in a session and you're having some kind of reaction, how do you sort of parse out, oh this is my stuff that's being triggered, or, oh this client is playing this out and this his how they play out all of their relationships by sort of doing these behaviors.

P8: And that's in particular with trauma cases?

Researcher : Yes.

P8: Okay, I try to think. You know, I don't, that's really interesting. So, I would say, huh. I think for me, probably how I ferried out those two is like whether it's countertransference based on, like it's countertransference versus it's just something I'm reacting to in the session that's pretty horrific that the person is talking about, I would probably say it has to do with where I hold it in my own body.

So I tend to, when it's something just really awful about what they're processing, like something particularly gruesome part of the processing or let's even say, yeah, I would just say if it has to do with that then I have a tendency to, and I know this is gonna sound interesting probably, but I

always feel like I experience those from the neck up. I just experience most of that, just it's a neck up kind of thing, like I am feeling like sort of, I guess I would say cognitive feelings, I guess for a lack of a better way of putting it. So I can feel my feelings, but they are very cognitively fed, like I know why I feel that way, I'm feeling sad for the person or I'm feeling overwhelmed for the person. Sort of like I'm almost like a [inaudible], I guess I would say from a mirror neuron standpoint I'm feeling feelings that are being triggered like to my head.

But I have countertransference, countertransference absolutely I feel it in my gut, and I feel it in my stomach more than any other thing, and so when I have kind of a stomach reaction to somebody it's more likely to do with me, and so usually those are gonna have to do where, I just usually, sometimes I will think about those in the moment and they will be so familiar I'll know them and I'll just label it and go, okay let it go. But other times I just note them and I note the sort of almost like the spot in the tape, and then I'll go back to it mentally later on and say, okay what was going on with you.

And so sometimes it's judgment, like I'm sort of judging their fear or judging their hesitation or whatever it ends up being, but that kind of thing. So I'll notice those, those are, cause I can actually feel myself for the most part when your neuron system is activated, you know if you figure eight hours a day or whatever for the most part when you're working with people, that's really familiar to me, like I am noting things for informational purposes, so I always see that as definitely [inaudible] system, but it's more cognitive than it is emotional.

Researcher : Yeah, yeah that makes sense.

P8: Yeah, and then the rest of it is gut kind of, gut responses, like okay something just happened here, like I just had that. And sometimes it comes up somewhat out of the blue and I'll note it, and then other times I will be able to within a split second, now I know what this is, and then I slow down and I let it go.

Researcher : What influences your decision to disclose any countertransference you might be experiencing with a client?

P8: You know, to be honest with you, probably the only time I have ever done that, ever, in my entire career has been in groups, the only time. I don't know that I've ever done it in individual sessions. I mean, I will tell someone, you know I feel so sad for you, it's a tragic story and I feel very sad that you went through that. I will do that, but that's more to me along the lines of a feedback and normalizing their experience that it is a sad story, it's sad. Versus like my own personal countertransference, I have

done that in a group setting, not necessarily with trauma survivors, usually with addicts and alcoholics, I've done that frequently.

Like so if I'm having that sort of reaction of annoyance with someone and I also know that other group members are annoyed I will own that and I will say, you know I just want you to know when that's going on I'm just feeling this real surge of annoyance that this comes up again and again, and maybe I might share how I'm kind of taking care of that with myself or whatever. So actually it was more or less though like, would you like my feedback, and I'll just say, when you're doing this, whatever I'll label the behavior, I'll say, my initial response is annoyance, it's definitely annoyance, and so I'm wondering if you know this about other people that are having that experience that when you do this do you notice other people's annoyance. And I'll go, no I can cope with my annoyance, I'm not gonna take it out on you, I'm not going to whatever, but do you notice other people being annoyed with you? So that's probably the only time, it's interesting that that is when I did the practicum way back in the day, we were trained along those lines and I never ever have honestly thought about sharing countertransference in an individual session. It's like we got taught how to utilize our own countertransference, like if we're really feeling that odds are really good that other people have had that same experience with the person. And so it's useful.

Researcher : Right. Great. Okay, last question, what is your understanding of clinical intuition and how does your intuition guide your professional judgment?

P8: What's my understanding of intuition?

Researcher : Yep. In a clinical setting, of course.

P8: Okay, in a clinical setting. Okay. So, I guess how I describe my own intuition is when I'm working with people I'm forming templates, that's how I see it, I'm forming templates based on how they react, what we talk about, things they seem to have difficulty with, things they seem to be at ease with. And so I'm sort of forming this sort of collective fund of knowledge along with my own responses based on every other experience I've ever had with any other person. And so it's sort of almost like I have these two pools of inner knowledge on comparing. The current one with only this person's information and then the collective, almost like the collective knowledge about life, and about people, and about trauma, and about everything, and then I'm doing some kind of inner comparison between the two when something makes sense to me versus this is an anomaly, something isn't making sense. It's like incongruent and it's almost like bashing it's head against my general sort of intuitive pile, if you will.

And when I'm having that happen, and that to me is also, actually that was an interesting one cause I actually do feel that one a little bit more in my body, too. That one isn't countertransference, it's almost like a knowing, like something's missing, I'm missing something, or they're missing something. And it's almost like it's an opportunity to sort of sit with that blank and usually those are the things these days that will occupy my thinking between sessions.

That will be something that will come up even in a drive home or whatever, like okay I'm missing something, and I'll run like a piece through my intuition database, and it was like, yeah that doesn't match, and then I'll be chewing on it for a while and then I will come up with some questions to ask to see if there is something I'm missing, if there is a piece I don't know about, and sometimes they will have to do a family origin stuff, and it's like, oh that was it.

Because it'll almost like go into the bigger intuitive database and say, this isn't making sense in the context of this trauma, it doesn't make sense to me, and it doesn't fit, and then I will try to find all different ways to fit it in, and some of them it's a puzzle piece that doesn't work for that puzzle, and then I will end up maybe come in and ask a few questions, and what's weird is that I will usually I'll ask something and people will kind of get this look on their face, like how did you know that, or, and it's almost like I almost feel like I didn't know, but I just, it's like my brain knew that this piece of the puzzle does not fit this trauma or does not fit this scenario, that it's from a different puzzle somehow, and then I'll end up asking a question about, let's say family of origin, I'll ask a question about like a first marriage for whatever reason, and maybe because knew where it fit or I'm guessing where it might fit. And sure enough, it will be, and what's interesting about that for me is that often times people in their first sessions where we're asking stuff about like family of origin things and such, some people will not answer those accurately.

And then as they're in treatment for a while and they feel safe, all of a sudden then later on down the line you'll ask and they'll go, and now they're answering the question. So then it makes sense to me because I was missing a piece. And then other times you just have to deal with that sort of intuitive ambiguity, like something my brain is telling me, there's something I don't understand but right now I've asked the questions I can think of and maybe just as time goes by all of a sudden something else will happen and then that'll be face in between the face and then I'll be able to fill it in.

Researcher : I love that phrase, intuitive ambiguity.

P8: Yeah, that happens a lot.

Researcher : Yeah.

P8: That happens, it seems to happen a lot because I think it's because these cases are so complex. It isn't like they are, it's not like I can do a checkbox kind of thing for depression and just have that sort of understanding of these are the symptoms of depression and are they less or are they more, because so much of what a person shares, it's not like, especially with my first responders, it's not like it has a beginning and a middle and an end for them, it's for some people the narrative began at the beginning of their career and now I'm seeing them 15 years into their career about a very recent CI, but what's missing is that there was something really big that happened early on they thought they had put to bed and it isn't. And then it all of a sudden comes up and things makes sense, but other times it doesn't and sometimes I just have to concede that, okay right now either the brain is not ready or for whatever reason they don't have access to it, and sometimes it's actually early childhood stuff, which is I think for some people that is very, especially for men, I know that it's much more so for women.

Men have a harder time talking about that and acknowledging it and being at peace with it than women do, they usually tend to discount it in the narrative, like it wasn't that big of a deal, and they will often say that it wasn't that big of a deal, it was a long time ago. Versus women who recognize it was a big deal no matter how long ago it was, they don't discount it that way as much.

Researcher : Yeah, I agree. You know, you seem to, I don't know if it's just because of these questions or because it's skewed or if it's actually the case, but you seem to do a lot of reflecting between sessions or chewing on things between sessions, is that?

P8: Yeah, I do

Researcher : You do, okay.

P8: I do, and I do it, like I said, I do it most of the time, I try really hard to compartmentalize it, I have kind of in a way my thinking time, and then if I'm doing other things I'm really good at compartmentalizing so that I can have the rest, if you will, between things, but I will have some things I will be sometimes thinking and I do have a peer supervision group and we will bring in things that we talk through and the things that we feel stuck about somehow.

Researcher : Great. Okay, that is it for this round. Thank you so much.

P8: Okay. Oh, you are very, very welcome.

P9 Round Two

Researcher: Take time to reflect and think and pause. You don't have to answer quickly. Do you have any questions from many, many months ago that we talked?

P9: No, I'm fine.

Researcher: Okay, great. Well, the first one is pretty open. If you could just share a little bit of how your personal and professional experiences, either or both, influenced your approach with trauma survivors? So this could be some CEUs that you took or a really powerful supervisor that you had in your career, or maybe a series of client sessions or a particular client. Anything that really influenced your approach today with trauma survivors.

P9: Major influences on my approach to treatment, trauma, and especially conflicts trauma are client experiences. And my experience with clients when conventional methods are not effective coupled with a trauma conference with Bessel van der Kolk back east that he does annually where he really affirmed how important addressing the body was, as well as shock therapy.

He wasn't the first one to do it, of course. There've been people saying that for a long, long time and he gives them credit. He did so in a very effective and scientifically supported way. I had done Hakomi training before then, so that's an influence as well, which is definitely a body, or in a client-centered, respectful therapy approach. Sensory motor before that. I haven't done full training. I've just done some reading.

I would say somewhere in the mix as well is my graduate school training, which is more psychodynamic in nature. And I chose that graduate program, so there's also something in me there. I do not find it helpful to me, my direct experience, to try to talk myself out of something. I do much better in the relational aspects of healing and the past-to-present orientation that acknowledges the impact of early learning.

Researcher: Great. Okay. Anything to add, or did I cut you off?

P9: That's all that comes to mind immediately. I'm sure there are other important things, but those are the major streams of influence.

Researcher: Great, great. Perfect. The next question is a little more specific. How do you determine when to let a client to lead the session and ... Versus when you would take the lead and what factors sort of lead to those decisions? And lead is L-E-A-D. I've had a few people mishear that word, so lead- leading the session.

How do you determine when it's you, when it's the client and what sort of goes into that?

P9: My default is that the client leads and to corroborate that, I have read in some of the attachments here ... Research and writing. I can't remember if this was in a mentalizing book where it ... Professional theory kind of book. Backing people is kind of- it included ... If I, as a therapist, take the lead, because somebody kind of ... My client wants me to or expects me to or waits for me to, then I'm reinforcing the idea that the answer is outside of them rather than inside of them. An increasing part of my job is to help them trust their own sense, their own wisdom, their own experience of what they need in the moment. And that depends on context.

So if I have a new client, I'll do some teaching about how to be a good client- about what's effective, what works. With young folks, I'll start with them more non-directive. But a big part of it is guiding them and learning something about what they can do. If somebody's overwhelmed, emotionally flooded, then I'll take some initiative to help them recalibrate, get grounded again.

Researcher: Okay. The Hakomi training is very intriguing. I know just very, very little about it. But do you do that a lot with clients?

P9: I would say, no. I would say it informs my way of working and my perspective. I think it would have had a bigger influence had they done it a little earlier in my work, because it's ... In terms of inclusion of bodily experience, it's a different orientation from talk therapy and so, it takes really challenging those patterns as how I work. And while I believe it can be effective, I still find it difficult to switch. And the parts of it that are ... Depending, of course, like anything that gets practiced a little bit differently, but some people do it in a way that involves more touching the client. And that's an area where I believe face touch is a really human element like a lot of work and it's a delicate and nuanced interaction. Actually with trauma survivors, I think it's really important to approach carefully.

Researcher: Yeah, it just got me- when you had said that early on, it got me thinking about leading and how that works, as far as when you're doing something so physical but that's ... Yeah, that's helpful. Thank you. Could you just reflect on a time when your clinical approach, your clinical decision-making, actually, and it can be small- you know, something minor or something more significant- when that was proved unbeneficial and how did you respond and adjust your approach?

P9: I'm reflecting.

Researcher: Oh, please, please. Yes, yes.

P9: So yeah, certainly I've had those experiences. I'm trying to pull at the specific one. So I had somebody react ... It's countertransference related.

Researcher: It's what related?

P9: Transference and countertransference related. So somebody who's particularly sensitive might be vulnerable in that department. It's always there that some people are more attuned and more likely to misinterpret, so likely to project things. So I'm having trouble make it-

Researcher: Oh no, that's okay. That's okay.

P9: So I tried to reason with someone who is highly activated and ungrounded, flooded, and sort of gotten stuck in really trying to communicate something as softly and as carefully as I can. And it's just impossible for the person sitting across from you to take it in and so, then I've had to adjust what I'm doing to often basic soothing, grounding practices instead of trying to talk somebody down into a more grounded place.

Researcher: It's such a common go-to to be able to just try to reason with somebody. Oh my gosh, I feel like we've ... Yeah, we've all been there.

P9: But yes, I think so.

Researcher: Oh my, you're just not even talking to the right part of the brain. I mean, you're just ... But yeah, it's just- it's so apparent to you and you just ... Yeah, yeah. That's interesting. Okay, great. I'm trying to think about if there's a time also when- if you get any direct feedback from your clients, as far as you know what you're doing isn't working or anything-

P9: I think it is direct feedback when somebody ... Is this a separate question or is this a-

Researcher: No, I'm just reflecting kind of out loud, so I don't really have anything. Yeah, giving you direct feedback about this isn't working or confusion on their part or anything like that, and how you've managed that.

P9: Yeah, no, I certainly have had that and I think it is direct feedback also when somebody's flattered and agitated and not able to take something in.

Researcher: Well, good point. Very good point, yes.

P9: But it is also direct feedback. But yes, sometimes I'll have somebody complain, "This isn't working," or "This isn't helping," or just circling around in the same theme of despair or hopelessness or being stuck in some often self-criticism.

Researcher: Okay. The next question is a little bit longer. How do you determine if it's your personal issues that have been triggered by a client or if it's more of a client-driven narrative being played out in session? So for example, if somebody- if

there's a client who's being manipulative ... This is just an example, of course, and you have a reaction to that. How do you sort of parse out, "Is this my own countertransference coming up or something that I just haven't worked out yet." It's fully me versus, "Oh, this is what the client does in all of their relationships. And here it is, now in the room, and I can bring that into the room because here it is. And I can address that," if that makes sense.

P9: Yes, it makes sense. What I call that is the distinction between different types of countertransference. It's not meaning to me that's something of them. So there's countertransference that is generalizable where a client has a pattern of relationships and evokes a similar kind of response in different people. And there's a kind of countertransference that is more what specific associations I have, what specific history I have, what specific relationship, even, I have to that client and how vested I am in him or her responding a particular way. And I would add to that a kind of third type where it's specific to the therapeutic or to a course relationship projection and project interaction that evokes an often retraumatizing kind of relational interaction.

Researcher: How do you notice when it's happening? Any of those examples.

P9: I notice the client and their body. And we're looking for physical signs of distress. I notice a client is often getting more agitated, escalating more. I notice that what I want to convey is not getting across. I notice I might be doing something out of my normal way of being, in general or in my role as a therapist. I sometimes don't notice until afterwards that I'm reflecting not consulting.

Researcher: And what influences your decision to disclose any of those countertransference reactions or ... Yeah, how do you- what influences your decision to disclose or not disclose?

P9: Whether it's helpful to the client or not. Whether I think it is generalizable and something we need to be aware of in how they interact with others. Or whether I think it's something that's more unique to our relationship. And that third category I gave about it being sort of specific relational pattern that happens in therapy or with someone close, I might choose there, also.

Researcher: You might choose where?

P9: I might choose there to talk about it with the client, because it's helpful for them to know what their pattern is and the particular kind of relationship. Relationship's where they get really scared about their vulnerability or scared of being abandoned, whatever the particular pattern is.

Researcher: Great. Last question: What is your ... Well, I shouldn't say the last question. It won't be the last question. What's your understanding of clinical intuition?

P9: What's my understanding of it? That's an interesting way of looking at it. That it is knowledge that a clinician accesses more through a felt sense, rather than a thought-through logical sense. But it is well informed, usually, by-

Researcher: Yeah, we would hope.

P9: Right. Also, it's going to be colored by countertransference, as well. So what can seem like clinical intuition may be a reenactment with a powerful transference, countertransference. But it will usually hold up upon reflection, an insight that is based on a kind of knowing that's not about the left brain linear thinking. And that can come from life experience and clinical experience.

Researcher: How does your intuition guide your professional judgment?

P9: It's part of it. It's part of ... My professional judgment is based on intuition and linear thinking. I think, each time ... This isn't directly an answer to that. But we're always, as clinicians, trying to be in the conversation relating to the client with what they are kind of- what they bring in in the moment and we're trying to think about on what process meta-level ... What's going on on those other levels of pattern and nonverbals and relational and expectation. So I think that second level, the process level, a lot of that comes from intuition but it also comes from a thinking analysis, as well. So all of those elements are part of what style that summarizes clinical judgment.

Researcher: Okay, great. Anything else that's been triggered by any of these questions or anything come to mind?

P9: I'm interested in my emotional response today in our questions. That does not seem difficult. It doesn't seem how it was the last time we talked. And I am trying to sort through that, so I apologize any part that may be coming out in our conversation. I think, in reflective, I was recalling it dissatisfying, somewhat distressing. A question I had with one of my clients really looks more countertransference than me. And along with curious, I also get irritated by reckoning with this ... The interactions with this particular client, long-term complex trauma. So I'm looking at the sort of parallel process or isomorphosis-isomorphism of that like you and I talked today.

Researcher: Did you meet with this person recently?

P9: Yesterday. [inaudible], so yeah, I'm just aware of that. And I, acknowledging that, am able to let go of a few layers, I think.

Researcher: Yes. There are those clients that do that. Yeah, yeah.

P9: I think that often is a part of our clinical work, that parallel processing, noticing things happening on different levels. And I expect for self and for family

members or interns or supervisors, often a feat of our experience that the client can be very similar or allowed to ... What goes on in those other levels.

Researcher: Do you find yourself reflecting between outside of session, reflecting on your work with clients or thinking about different approaches?

P9: Of course. I think that would be unethical if I weren't thinking about it.

Researcher: Well, some people are really compartmentalized and just shut things down when they leave the office. So I guess some more sort of deliberate reflection on your work or practice, I guess. It sounds like you do, so ...

P9: Yes, yes. Okay, I view that very heavily and I also ... I'm not talking about my own cases with my interns, but I'm doing that with interns and I'm thinking about my own work as I'm doing that and then, I consult with colleagues twice a month ritually and that's pretty much it.

Researcher: Do you do more reflecting with others with these groups and with these supervisees, or by yourself or both?

P9: Both, yes. Both. They're both important.

Researcher: Do you think that-

P9: Just writing a note is part of the request or pass.

Researcher: Oh, right. Right, absolutely. Do you get insight and then, use it in session? Do you think?

P9: Yes.

Researcher: Nice. Well, okay. I think that's all I have for this round.

P9: Okay. And remind me what's next with anything.

Researcher: Yes, I will definitely remind you of what's next.

P10 Round Two

Researcher: All right. Okay. Question one, real open.

P10: Okay.

Researcher: So if you remember, we're talking about decision-making with trauma survivors and counter transference experiences, so if you could just share a little bit of however much of personal and professional experiences have influenced how you approach trauma survivors today. So it could be CEUs, it could be supervision,

some experience with a client. What are sort of the defining personal or professional experiences that shaped how you treat them today?

P10: I think coming from a place of respect and compassion is really key for me, so I think graduate school was actually a really powerful time where a lot of people were ... as social workers, you go through, you do your own genealogy, family ... not genealogy, you do your own Genogram at the end of the day-

Researcher: I did it. I did it.

P10: ... You know that personal sort of searching, and then present it to your classmates was the method. And so one of the things that really came out of that for me was there were so many different stories that brought people to the work, and a lot of those stories did include trauma-

Researcher: Oh-

P10: ... you know, so one kind or another, and sort of a healing journey for the fellow people, classmates and that experience. So that was really impactful, and that piece around compassion, kindness, respect, and what's the most healing thing that you can offer anyone. It was just that kind of presence of being. And so that was just really a powerful thing that I gained from that experience.

P10: And then in my internships, working initially in drug and alcohol treatment was just immediate trauma, trauma, trauma. Immediately self-judgment and other judgment and all those ... just noticing how judgment wasn't as helpful as being able to be less ... having less judgment, more distance, more compassion ... just more like, "Huh, I wonder what that's like." If we could just give some compassion to that party or just listen to that.

P10: Then I found, just in my clinical experience and continuing on with CU's learning, that it's just more effective treatment. People do better with compassion than they do with reinforcing an inner critic. That's my stance.

Researcher: Uh-huh, uh-huh.

P10: And I think working at [inaudible] County was actually helpful for that as well because I saw some of the systems that I didn't feel were as compassionate as they could be, and sometimes I think really re-traumatize individuals as far as when somebody was in a psychosis episode or ... And generally the people who I worked with who had psychosis had underlying trauma. It was rooted in trauma, usually attachment trauma, early childhood trauma or pedo-trauma, and then trying to get something like a stabilization at a psychiatric hospital and just the

four point restraints, protections and all this stuff that is posturing different stuff, and the stuff that's really not helpful.

P10: What was most helpful in those situations was just calm, compassionate care. It helps.

Researcher: Do you think because you ... and probably many clinicians go from working at an agency to private practice, that the level of severity that you're seeing helps you to go that way rather than thinking about going in reverse, like maybe working with a maybe more stable population to then ... like do you think going in that direction helped you be more compassionate for the work that you're doing, because you saw such severity early on?

P10: Maybe-

Researcher: Or maybe not-

P10: Yeah, maybe that's been helpful. Yeah, I think it's definitely been helpful in developing that empathy, that compassion, which is carried over. Yeah.

Researcher: Mm-hmm (affirmative).

P10: I do think some people that I see in private practice though would benefit from having a team of support, so that's interesting to move from ... I was part of the assertive community treatment team, so we moved from really this treatment team model to more of an individual, where sometimes I'll talk with another provider, but it's not really what I do.

Researcher: Yeah.

P10: And so it's much more an individual basis, and it's more of, "Here, you go do this." It's rare that I'll say, "Hey, you want to sign a release, like I think this would be a benefit for me to talk to your [inaudible]."

Researcher: Mm-hmm (affirmative).

P10: So that's different, but I don't know. I think it might be different good in some ways, 'cause the person is really doing that or accessing this other resource-

Researcher: Yeah, it's really on them-

P10: Yeah, it's on them, and they're capable.

Researcher: Yeah. Definitely. Nice. Okay. How do you determine when you let a client lead a session versus when you lead, and what sort of factors go into making that determination?

P10: I say it's kind of like a dance. So there are certain things that are helpful as far as different interventions that can be really helpful for people to experience. Like there's EMDR is one of those interventions. It can be helpful for somebody to experience the reprocessing of the traumatic material, and in those sessions, it's a really co-led situation.

P10: So we're going into it, we do building up of resources. I will sometimes do a protocol called resetting the affect circuits, which is also using the alternating bilateral and helping the person access calm and then access emotion and then calm, kind of a pendulation. And so part of it is if a person comes in and they really just need to get something off their chest, and it's so clear that that's what most of the session needs to be, and there'll be some sort of resolution or whatever that is. But if that's every session, then no therapy is being done.

P10: I just had this conversation with kind of a longer term client, who had gotten back into that pattern of just repeating the trauma. In the session I said, "You know, this really isn't helpful. This is making those brain pathways stronger-"

Researcher: Stronger, yeah.

P10: ... to the trauma. Like, it's not helpful.

Researcher: So the person would be coming in and sort of re-telling or just-

P10: Yeah.

Researcher: ... there again repeating?

P10: Repeating ... and was in a place where they didn't want to do the EMDR yet because it doesn't make sense to do it yet because they've got too much going on, so that's fine, but then also the other stuff like clinical hypnosis ... "No, I don't want to get too much better too quick."

P10: Just like this really holding on to the trauma, and actually what I said to them was, "Maybe we should start meeting every other week to do harm reduction, because I don't think it's helping you to repeat this."

Researcher: Oh, yeah.

P10: And they were like, "What?" And they came in this week and were like, "I restarted yoga..."

Researcher: Oh, nice.

P10: So that was a really hard conversation-

Researcher: That's such a great example.

P10: Yeah, but it's just like, when there's value in all of it, but it's a dance because I don't want them to ... you know, it's our habit to vent. It's what we're taught how to do, but if venting helped, then you could just talk to your friends.

Researcher: Right, you could just go to a coffee shop and-

P10: Yeah, and be better.

Researcher: Yeah.

P10: So that's the dance. So, creating space for people to feel heard and be heard and have that experience, but also space where the therapy can happen.

Researcher: Mm-hmm (affirmative).

P10: And I feel like I have to be indirect so that the client knows what we're doing. That helps.

Researcher: Yeah, definitely. So it does vary both within the session and then from session to session?

P10: Yeah.

Researcher: And it sounds like especially with this client, that's such a good example of setting some parameters and telling a client something that they don't want to hear, and then you see some engagement happen after-

P10: Yeah, it's really one of those situations where I wasn't sure that they were going to come back. I had gotten a phone call, I noticed it on my cell, and I don't pick up when I leave the office. I just noticed the cell phone, and then when I checked it this morning, it was actually the person's partner was calling just to say, "Hey, I think they need to work on this, and we both really appreciate you."

P10: And then today the person came in and was like, "I think my partner called you. I've actually had this really balanced week. I got back in my routine and I was able to get..." and I was like, "Oh, thank goodness. How wonderful for you."

P10: But before, when I was really trying to ... I don't know what I was doing, but I was just trying to create space where she could feel comfortable and build trust I think, was the piece, and then trying to just gently nudge her into, hey, acupressure points or hey, different grounding that you can do, until you can build up to this point where we're gonna do the reprocessing work when it's ready, you know, when you're ready for that. I don't want to go too quick, but ... Yeah, it was definitely getting more into a re-telling of the story, and it was good.

Researcher: And there's a point at which it just goes on too much to the point where you see that this isn't benefiting you at all.

P10: Yeah, it's not benefiting. And they actually had an experience of calling me because they were in such a state of panic trying to drive here, and had to cancel an appointment. Said, "I can't leave my house. I'm afraid. I just have so much fear." And I was just like, this is not helpful.

Researcher: We're not going in the right direction here.

P10: No. But then today to see the person come in, you know, that was a real decision point, just kind of saying, "Gosh, maybe I should have said this a little bit sooner." But it's really a dance-

Researcher: Well, you've gotta build up that trust and have that firm foundation of compassion.

P10: Right.

Researcher: Otherwise, that directive may have just ticked her off and-

P10: She wouldn't have come back.

Researcher: Right.

P10: Yeah, and then there's some people I work with, and there's just so much chaos in their world, like real chaos. Stuff is just chaotic and happening, and I really just have hold that, you know, "Well we can't work on so-and-so, what do you want to do about that?" Or like, "Gosh, that's really hard. That's really outside your control. What about this?" And that's been really helpful for that too, so again, containment.

Researcher: Yes.

P10: And so it's both, but I really try to direct and help contain it, so I feel like that's healthy modeling and it's helping them move in the direction they want to move.

Researcher: Mm-hmm (affirmative). Nice, nice. Okay, great.

Researcher: If you could reflect on an experience where you made a decision that was un-beneficial for the client, and how did you respond to that and adjust your approach?

P10: Well I have one person that I'm working with that really was struggling with identifying a peaceful place, was struggling with identifying resources, was really saying this imaginal stuff is just crap ... was just like, I can't get all that peace, but I just want to get down to the nitty gritty and I want to reprocess. I'm ready.

P10: And so they were able to access a peaceful place, but the resourcing was really just not working for this person. And so I went ahead and said, "Okay, well let's start with the very first experience," and it was not a healthy decision for the person to start the reprocessing of that time. There was this sense that they were kind of ready to have that experience, and they had their supports in their life, but at the same time, I think that it was diagnostic that they weren't able to process the resourcing, and in retrospect, I would have waited on that. I would have said, "Well, let's do a different therapy or let's wait on this."

P10: And how I've worked through that has been really saying, "Okay, this is concerning. Now that you had this experience-"

Researcher: After you started the sort of reprocessing and it didn't go well?

P10: ... Yeah, it didn't go well.

Researcher: Okay. And then so reflecting back to them, "Look, this didn't go well."

P10: Yeah, and they were like, "Yeah, it didn't go well. That is concerning." And I was able to work with them and say, "Let's actually build up your resources first. I don't want you to get stuck. That's not the goal. The goal is to help you move through this stuff."

P10: And so we're still working on building up their resources, as well as medication management, and accessing a prescriber that they feel like they can talk to and trust. So that's kind of where we're at, and that's the one person who I've taken on ... I haven't signed a release, actually, and was like, if you want ... 'cause they've just had such a hard time connecting with providers.

Researcher: Oh yes.

P10: I'm like, I don't mind helping you navigate this. So that's kind of how I've been working with them. I said, "Let's contain this, and let's work. Let's take a few steps back and work on the resourcing."

P10: And they were more open to doing that-

Researcher: That's exactly what I was thinking is that if you would have put the brakes on ... It's like they got to see for themselves that, "Oh, it really was too early."

P10: Yeah, like I'm not ready for it. Not just yet.

Researcher: Yeah.

P10: So that was a hard one, but I think it's working out.

Researcher: Another person who has stayed.

P10: Mm-hmm (affirmative), another person who has stayed, yeah. I've actually, because they struggle so much and at times have been like, "Well I stay because it's so hard to find another therapist," so I actually found them another therapist who does Hakomi therapy-

Researcher: Oh, fantastic.

P10: ... yeah, and I said, "You know, it's a different kind of therapy. Maybe it would work better for you. I'm not trained in this. They have an appointment in the middle of the day, same time you see me. All you have to do is call them-"

Researcher: Oh my gosh.

P10: And the person still stayed.

Researcher: You're kidding?

P10: And I just made it really clear the next time they came in, I said, "Oh, you decided not to call. You're making a choice to stay." 'Cause a lot of this is around indecision. There's a lot of conflict around lack of movement, and so I think highlighting that they're making a choice to come back each time. There's something about this relationship that's healthy, that's connecting, that is helping them work through whatever ... and they can still call that other person anytime. They still have their card, so they have options.

Researcher: You're capturing it in terms of that in that particular instance, where maybe it was a healthy or empowering decision for them to stay?

P10: Yeah, they actually chose to stay.

Researcher: Which is great if that's true, which it sounds like it's true, 'cause I'm guessing you wouldn't lie to people. Is there an instance where you could see it being unhealthy to stay?

P10: Right, like if it really wasn't-

Researcher: Or maybe another-

P10: ... like if it was an abusive sort of ... Not in like a therapeutic relationship, or-

Researcher: Yeah, the therapeutic relationship I guess more so, if they were ... I guess even in that specific example, I was thinking broadly, but if the indecision was unhealthy, you know, instead of empowering them to understand that they're making a choice, which is great ... If they're making the choice out of either fear or laziness or some other sort of unhealthy driver for staying.

Researcher: I mean, I'm wondering if you would-

P10: Kind of see that differently, yeah.

Researcher: Yeah. It just made me think like, man, if it really wasn't healthy for them to stay-

P10: But they stayed-

Researcher: ... but they stayed anyway.

P10: Yeah, hm.

Researcher: Interesting.

P10: That is interesting. That's something to think about.

Researcher: I mean, and you would know, I think, if it was a real-

P10: Like really not healthy, not working.

Researcher: Yeah, well like had an unhealthy attachment to you versus-

P10: No, I don't think they-

Researcher: Yeah. I'm just thinking-

P10: ... No, that's definitely not that piece. It's more of I can't commit, like if I don't commit to anything, then I won't ... I guess I won't have to heal, or I won't have to make this movement that's kind of scary, because this inaction protects me from ... and a connection protects me from the world, and so if I'm just passive, if I'm just over here, then I won't have to do anything.

P10: And so I feel like highlighting that she did make a choice in that was helpful because it was like, "Well, you made a choice. You choose to come back each week. You choose to go to church on Sunday. You choose to do this stuff that you're doing." Definitely, yeah. But some of those choices aren't healthy for them, so it is a hard balance to know.

Researcher: Well, sometimes it's very clear. And I wasn't implying, I was just thinking about in the reverse, what would happen if somebody was really unhealthy. But I like that-

P10: And I feel like it is kind of hard to know, especially when somebody's kind of baseline functioning is not ... they're not doing very well when they walk through the door, and then they continue to not show significant improvement. My inclination was like, yeah, I think it would be healthier, a better decision for you to go to a different therapist-

Researcher: Specifically wondering about the hypnosis?

P10: Yeah, and the hypnosis, I've used it some, but it's tricky. I used it recently, and it was interesting because the person came back and they were like, "You know, I was really triggered by that."

Researcher: Oh.

P10: And so there was just something about it that was triggering. She's like, "When I went into..." She called it, "When I went under," it just triggered other things for her. I was like, "Oh, that's interesting because you don't go under. There's no going under. It's going into a focused state of attention."

P10: She said, "Well, if we do it again, maybe I could go into a state of attention," or you know, just that interactive piece.

Researcher: Mm-hmm (affirmative), interesting. Is that common with hypnosis that someone would be triggered?

P10: No.

Researcher: No, it's not common, okay.

P10: No, but it's common with some people's experience.

Researcher: Absolutely.

P10: Yeah, they have a history of ... This person's very sensitive, and has a significant history of sexual abuse in early childhood, and is triggered by most things. And so I wasn't surprised that they were triggered, but the method I used was one that tried to use the most amount of control for them so that they were in the most amount of control.

P10: And then today I actually taught them a self-hypnosis technique and they're gonna use that for a while and then decide if they want to do hypnosis again.

Researcher: Oh nice.

P10: Yeah.

Researcher: Okay. Thank you.

P10: Yeah.

Researcher: Okay, refocusing, refocusing. Oh, how do you determine if ... This is a countertransference-related question ... if your personal issues have been triggered by the client or in the session, or if it's more of a client-driven narrative being played out?

Researcher: So you're having some reaction as the clinician, and how do you determine if this must be a pattern ... Example, this must be a pattern ... Other people probably feel like this when they're meeting with this client, or this is kind of my own unresolved stuff that's coming up. How do you kind of tease out what's your piece, what's their common pattern in interpersonal ... I mean, it probably isn't that concrete in your head of this is this, and this, but if you can kind of describe that.

P10: I think part of what I do is I ... Schwartz again, IFS is helpful in that I try to be in center, kind of compassionate, kind self when I'm meeting with people, and I feel that dread or that anxiety or whatever it is that's coming up, or that wanting to step back, if there's a lot of anger coming into the room or whatever that is ... is I check in with myself, and I'm like, "All right, if you want to step back just for a moment, sit on the bleachers..." and I do my own [inaudible] work.

P10: I'm just like, sit back, sit on the bleachers, and I'll check in with you after session. And then I can refocus, I can be curious, 'cause that's been the most effective for

me is when I can be curious about what a person's experiencing. So that tells me if it's theirs or if it's mine, is kind of what happens when I'm curious.

Researcher: Ah, okay.

P10: And then after session, I can check in with myself, center, and figure out what I want to do with that.

Researcher: Mm-hmm (affirmative). So there's this self-reflective piece-

P10: Yeah-

Researcher: ... more so than in the session-

P10: Sometimes in the session, especially ... I like to see a pattern, like if there's a pattern, and then if I'm curious enough, I'm checking in with myself, and I'm really like ... There I might say to them something around ... I generally will say something related to my physical experience, like, "Oh, my stomach feels kind of sick right now. I wonder if you're noticing anything in your body?" Or, "What's your experience?" Or, "Have you ever had this experience before with somebody else?"

P10: You know, just kind of something general that would draw them out. But I really do try to feel it out and see-

Researcher: And then so after this sort of reflective piece, do you then, based on what comes of that, then you'll disclose that or not to the client?

P10: Yeah, well usually what I'm disclosing is kind of a body sensation, or like, "Oh, we should talk about that. I really get the sense of wanting to go back," or just something, and I'll do a physical movement, or, "I feel my legs tingling right now."

P10: But I just try to tune in with what I'm physically, 'cause I feel like that helps 'cause trauma takes you out of the body, it helps to get them back in their bodies, in an in body experience.

P10: And that's how I've found most efficient to work through that.

Researcher: And is that after, so would you point out a body sensation after, in your own mind, you had a sense of what was going on?

P10: Generally, generally. But sometimes I think maybe it's quicker than that-

Researcher: Yeah.

P10: ... maybe it's just like, I don't know what this is, but-

Researcher: More spontaneous-

P10: ... Yeah, more spontaneous and more just connected in the moment.

Researcher: Mm-hmm (affirmative).

P10: But if it's something where I feel I see a pattern arising, where I'm like, "Oh, I'm having this reaction often to this particular experience. I wonder what that's about?"

P10: I've actually, in consultation, I've talked about this. I was having this sort of ... When anger would show up in the room, I was having a hard time staying with anger. I was like, "What is this?" It was with a couple different clients, and I was like, this is not helpful. I need to stay with anger and learn from it.

P10: In consultation, I actually got the advice, my friend and colleague said, "When that happens to me, I'm always just curious." And I was like, "Ah, that is so helpful."

P10: So I've just been using that and practicing it. It's been really helpful.

Researcher: And that's the ... Especially whatever was going on with anger with you, that was your pattern-

P10: It seemed like it, yeah. That was my pattern. It was with a couple different clients, when anger would show up, and it wasn't any sort of ... And it wasn't consistent either, 'cause sometimes anger would show up and I'd be there with the anger and with the person and present, but for some reason, sometimes it would show up and I would have a hard time. So it was just my work to do.

Researcher: Mm-hmm (affirmative). And then when you realize it's your work, do you bring that into the room at all?

P10: Sometimes. I talk about in general that I've done work-

Researcher: Oh, I see, I see-

P10: ... or in general that, "Yeah, emotions can be hard. I know for me sometimes managing different emotions can be hard, or kind of figuring that out. And one thing that helps me is..."

P10: And I tell them about how I do the Schwartz reflection thing, and things that help me. So it's more of like not my specific experience, but this general sort of-

Researcher: Yeah, okay.

P10: ... And clients often will want to know if I've participated in EMDR.

Researcher: Oh really?

P10: Mm-hmm (affirmative).

P10: Yeah, I've had several clients who are like, "I'm sure you've done this."

Researcher: Oh, that is interesting.

P10: Yeah, and so for me, what I share with them is I've done a lot of personal work, I've done the training. At EMDR training, we do participate-

Researcher: Yeah, you're a participant in that, yes.

P10: ... Yeah, you are, so I do know, I have had that experience. So I'll share that. I don't share whatever else.

Researcher: Yeah. That is so interesting. I don't think I've ever had a client ask me.

P10: Yeah, that is interesting. I wonder. I've had several people who are like, "I'm sure you've done this, so I trust you." I'm like, "Okay."

Researcher: Nice. Okay, last question. You've talked a little bit about it, but what's your understanding of clinical intuition, sort of what that is, how you would define it, how you feel it, and how does your intuition guide your professional judgment ... or maybe it doesn't.

P10: I would say it does. Hypnosis is really interesting, because when somebody's in trance, I go into this sort of outward focused trance, and I'm really focused on them ... and a lot of that is intuition and utilization, so it's whatever they brought into the room, whatever their goal is, and I have all these associations going on in my mind. And so I would just choose what stories to tell based on that, and how to kind of suggest different pieces and whether or not the person's explicitly resistant to something, or maybe it's more of an implicit resistance and they don't even know that they're struggling with that, and how I might present it.

P10: It happens more on almost an intuitive level. I feel like there's an intellectual part of it, but then it's ... Yeah, and what I've found from people, since I've started to

do more of the hypnosis work is that people will come back in and say, "That story, oh my gosh, that just connected with me so much."

P10: It's just like, I don't even know. It's like, "Oh, which story?"

Researcher: Wow.

P10: But hypnosis is interesting in that way 'cause you're telling stories to just kind of represent whatever it is that they need.

P10: And even that person who got triggered actually was like, "That story that you told was actually really helpful, and so I was able to move past the triggered part and I put that piece, and started doing some of these things that are helpful for me."

P10: But then other ways I access intuition-

Researcher: Well, and maybe you could define it. Define sounds too definitive, but how do you interpret, or what's your understanding, I guess?

P10: I guess my understanding of it is that sort of sense or that feeling, almost like a gut feeling, but it's more of a whole body, it can be anywhere, sort of sense or feeling of connection or disconnection or energy or sometimes it's emotions. It's interesting, the thoughts that maybe might come into your mind or the images or that sort of thing, with some people, and sometimes if it keeps coming, I might be like, "Huh, that's so interesting. Every time you come in, I just really ... this just pops in on my mind. It's just so odd, but I don't know, what do you think about that?"

P10: And sometimes the person might be like, "Oh, yeah. That makes total sense." So I guess it's just a listening to myself that's been honed through training and practice and meeting with people, and then, like I said, we just choose what therapies to use around that.

Researcher: Mm-hmm (affirmative). Mm-hmm (affirmative).

P10: Yeah.

Researcher: Nice.

P10: That's it.

Researcher: Okay, that's all I have for today.

P10: All right, well thank you.

Researcher: Thank you.

Round Three Interview Transcripts
P1 Round Three

Researcher: The first question is really broad and I'm wondering you can talk about your approach to working with trauma clients? Sort of, the uniqueness of trauma counseling, versus treating other clinical concerns. And so, some people have talked about they feel there really isn't a difference. Some people have said they have heightened sense of safety, a heightened sense of, perhaps, things could go wrong in a way that could go ... wouldn't go wrong with other clinical issues, that type of thing.

P1: I mean, because when we talk about trauma, we're talking about a pretty wide variety of presentation. So I mean, I certainly understand those comments with folks who have severe, ongoing trauma in childhood as opposed to somebody who is trying to overcome a fear of driving because of a car accident. And there's no light There's an awful lot of variation in that.

Obviously, everybody's gotta be taken as an individual, but when you first asked the question I initially was going to say, I always have an EMDR in the back of my mind when I know I'm working with somebody who is coming to see me specifically because of trauma. Then, as soon as I thought that, I became aware of the fact that I actually apply the EMDR in other situations that didn't seem to be so much trauma related, even though, theoretically, there's always some kind of trauma that underlies it.

For example, the first time I ever remember doing that was with a guy who ... Actually the first two times I remember doing that, was with a guy who had a relationship issue with his wife because of his anger management problem. And I had decided to target the anger. And that seemed to, actually make some difference for him. There are times when, instead of ... When it becomes revealed that there's more to a purpose presentation than just the issues itself.

In this particular case, he seemed to find a way of availing himself to anger management skills in a way he hadn't before. And I think that had to do with getting that emotional latitude that come with desensitization. What exactly the history of that problem was, I never knew.

So, I [inaudible] there was trauma with that person, but not in the presentation. And then there are folks who come and [inaudible] them. I wanna try and stay on mark here with the question.

Researcher: It's okay. It's not necessary.

P1: Then I'm thinking about somebody I'm seeing, actually now, who was referred to me because she had issues, has always been afraid to drive on the interstate or in the winter. And it's becoming critical now that she does because her husband is ailing and she needs to be able to step up and do transportation for

the family. And this is because of a single incident trauma back when she was 19 years old and just married and got into a horrendous car accident during the winter that just was like a movie accident.

When we targeted that, initially there didn't seem to be a lot of movement until she suddenly recalled that during that accident, her then newly married husband grabbed the wheel and yanked it. And she suddenly got this big flush of anger and thinking, if he hadn't done that, he probably would have been okay. And, so, what came out of that, was a lot of processing about how she has no voice in her relationship. And how that it replayed itself over, and over, and over over the decades, because she's 58 now, in various ways. Like where they're gonna move, or what house they're gonna buy, or whose family they're gonna spend holidays with And she just didn't have a voice.

And, so, that was more about the relationship than it was about the accident. And then that went back into earlier childhood, when her first years was in (name of country removed). And some very similar kinds of events that said to her that she doesn't have a say in what happens to her. It's funny how these things that may not seem like classic trauma, except for the actual classic trauma. The trauma itself was less of an issue than there was all the other stuff that Miguel Ruiz would call, the agreement she had made with herself in life.

I think that when you say, do I do something, do I have a different approach to people who have trauma? I guess I do, initially, if that's what they're coming in to talk with me about. In a way, I always have trauma in the back of my head because of things like this. You never know what is connected to what. And now that we're recognizing that neglect can be as damaging as outright abuse in childhood ... People don't necessarily look at their own childhood, in that way. So I kind of keep half an eye on that, as well, even if somebody is coming in saying, I'm depressed and I don't know why.

So, I guess what I would say is that, my awareness of trauma, in its many iteration, has effected my approach to almost everybody, I think, when I first see them. And as I move along because things tend to open up as you go in ways that wasn't initially the issue that brings them into counseling.

On the other hand, I've had people who have been in treatment before and have who gone through the whole myriad of medications, and hospitalizations, and so forth because the worst kind of abuse you can imagine, like being objected to child prostitution by one's own father. Who was a psychologist, by the way. Or the man who is now in his 30's who grew up with a pedophile father who regularly abused him in horrendous ways, and whose mother was, explicitly, complicit with that. And the first would [inaudible], because that's how he abuses, she is [inaudible] up through the father. And he's completely screwed up and has no possible way of trusting other people.

This sort of presentation makes my awareness a little more heightened to issues of safety and such. Although, oddly, he's never tried to kill himself, and he's never taken a drink, and never has done drugs because he had some sense in himself that, as fragile as he is, those things would completely destroy them. So there's some kind of strength there, some personal awareness. Very intelligent person, but very paranoid and distrustful. But, yeah, my presentation with him was bunches different than it might be with somebody who has come to me because they're trying to overcome the trauma of a crime that was committed against them, or if it's relationship issues, or something of that sort.

Researcher: Great, great. Thank you.

There seems to be a heightened sense of presence, which I would hope would be the case with all counselors, but particularly with the people I've interviewed, there seems to be this heightened presence in tracking with the client during session. That seems to be highly valued, while at the same time, there seems to be a lot of internal dialogue within this sort of counselor's head. Be it questioning, or anticipating a clients' response, or your own response, or checking out countertransference in your own mind during session. And I'm wondering if you can share your experience of balancing that close tracking with ... Anticipating your own response and all that internal dialogue in your head?

P1: Well, shamefully, I have to say, the thing that causes me to have that heightened awareness is a presentation of paranoia.

Researcher: Oh, really?

P1: Yeah. Regardless if we're talking about a straight-forward psychosis or if we're about, well like my client who was so terribly abused by his father He was paranoid, but he had a lot of reason to be and he wasn't skillful in whatever ways he needed to be in order to trust other people and learn who was trustworthy. So, when somebody presents in that way, I'm always a little on edge because I am aware of how easy it is to become part of the paranoid system. I think maybe somebody doing family counseling who doesn't want to be a part of the system. They want to stand outside of that and be the observer. Not that I do family counseling. That's just an understanding of it.

But I feel like it's just a little dangerous to be as relaxed as I might be with somebody else who is more integrated or who has a little more ego signs. I think that in terms of ... I understand what you mean by heightened awareness. I think that I've become more attentive to exactly how I respond in each moment. Then I have to learn little things about the person who, in a way, kind of teaches me how to stay out of the fray so that I can be objective and no part of the problem for that person. You know what I mean?

Researcher: Yes.

P1: And I might be a little but more aware of safety planning, even though I certainly do that with everybody. It may be more on the table, by my hand, with these folks than with other folks that I don't have to be ... I can be a little more blithe with. I don't have to worry about saying just the wrong thing or, inadvertently, turning into their paranoid system. I'm just reiterating myself, I guess.

Researcher: No, it's fine.

P1: Yeah, yeah. So, I guess, that's what I would say. I mean, I would like to believe that I'm always that mindful with each client, but if I'm seeing seven people in a day, I think I would be ... I don't think I would laugh in the business, to be honest. I think that I would probably ... There has to be people that I can safely relax with in order for me to be affective for everyone. Even if I have to heighten my focus for certain people, I'll do that. And almost be instinct, not even by choice. So maybe it's a fear thing, I don't know.

Researcher: Instinct. Can you say more about that?

P1: Yeah. That, is to say, my own preservation. If I know that I'm going to be ... For example, if somebody, one of my paranoid people calls me and leaves a voicemail that is just really, very inappropriate and then comes into session as though that's never happened. I have to put that one the table and find a way of cornering my client to working with me to work back through, but it teaches me ... I'm thinking about two things at once, so I'm going off track a little bit. Yeah, I think I'm still losing my track of thinking there.

Researcher: That's okay.

P1: Your question was what ... You wanted me to say more about instinct.

Researcher: Yeah, yeah. That seems critical to what you're saying. So I just wanted to know more about it.

P1: So, the instinct, I think has as much to do with what might be proper for me, in terms of my responses to my client as it is for me to want to be grounded in my own self. And to be a little but self-protected. So that's, I guess, what I mean by instinct. I think that if it's somebody that I can't just be a little relaxed with, then my instinct kicks in a little bit. It's sort of like a self-preservation instinct, I suppose, as much as it is a clinical instinct to be helpful to my client. I mean, there's both those things going on at the same time, as long as it's all explicit and discussed between us.

So, I can't remember, I was going with ... I always think in terms of cases.

Researcher: That's great. Yes.

P1: I know you're asking me questions about the principle, I guess, and practice, but whenever you do, I always start filing through my head what I may be relevant illustrations of whatever it is we're talking about.

Researcher: Which is great because a lot of people I talk to speak in generalities and this is much more helpful.

P1: Yeah. I'm too concrete to think right now. I always have to come down to cases for me.

Researcher: Yeah, definitely. Well, that's where it's at. That's what we're asking, about the work. So, it's great.

The question might be a little complicated, so feel free to just ask me to clarify. So far, what I'm finding in the data is that there's some evidence that experienced trauma counselors have conditioned beliefs or assumptions working with trauma clients. And, so, specifically about trauma itself, separate from clients. So, the thoughts about trauma seem to vary from trained or purposeful beliefs to reactions resulting, maybe, from mainstream socialization and education about trauma. So I'm wondering what, if you can reflect on some of your conditioned thoughts and beliefs you have about trauma, separate from perceptions about clients? And how that might feed into your work. If that makes sense.

And everything we do is conditioned, of course, so I'm not necessarily looking for anything negative, but some things that people have said would be, there's trauma everywhere.

P1: Well, there's two things. One is, I always, as I think many of us these days are keeping half an eye on neurology. When we think about, especially, developmental trauma and how that's an affect. In order to really understand my clients' capacity or change and how to either make change or work around a lack of capacity. I sort of keep that in mind in a way, I guess, to be forgiving to my clients who maybe don't make the kind of progress that other folks might.

So, I think in terms of long term work, even though EMDR is supposed to be a power treatment, but most people heal quickly, that my experience is when there is developmental trauma, which is not [inaudible] and that may be able to pull up some old anger, but teaching skills is teaching skills and encouraging people to practice them in real life is a long and hard thing.

So, long term work, I guess I make that assumption that I'm in for the long haul. I think that, also, the thing that I always assume ... I say it almost always bears out, but I think it would always bear out. So at just times when, maybe, I haven't found this. I think that it is fair to assume that there are some very

highly honed and useful skills that are developed as a direct result of feeling unsafe all the time.

And, so, those skills can be sublimated in a way to be truly helpful in their current situation. As opposed to just being an old habit, or a bit of armor, or something. I think that there are very few folks that I've worked with who have developmental trauma who are not very, very observant of other people. And very, I wanna say, insightful about ... Their theory of mind is very keen. And sometimes they're wrong, but I think that they pick up on real subtle stuff that, maybe people who are more relaxed in life don't necessarily pick up on, at least, consciously.

So, I think that the assumption that there are these very useful skills that are currently being used just to perpetuate a problem are ... You have to mine for those and help turn them to your clients' benefit. And to, sort of, honor them, to bring those up as assets. And things that, not necessarily that people can be proud of, but things that they can really acknowledge in themselves as positive. So, my assumption is that the nuggets of gold are there and that they can be useful.

Researcher: Have you, or rather, how have your own assumptions of trauma changed over the course of your career?

P1: Well, I think that it's changed in, probably, the same way that it's changed for all of us, given what we know about abusive childhood experiences. And how that it means much more than just being battered, or incested, or something of that sort. That there are more subtle things that can affect people in the very same ways that trauma effects people.

So, I guess, my view of trauma has broadened. And I think that that's, kind of, the culture of our business. I think I'm well in the school of fish. I'm swimming with the rest of them when it comes to those kind of assumptions and how that's changed over time. I think I completely reject the notion of personality disorders, especially, borderline personality disorder. And I completely accept the notion that their problems are, by a large, trauma based.

Researcher: So reject as far as concretely, like I'm diagnosing anybody with a personality disorder?

P1: Well, I certainly haven't in the last couple of decades.

Researcher: Really? That's interesting.

P1: I find that, you can really look at ... If you look at the overt presentation and you say, okay, this fits, my thinking is, so what? I don't know that that would ... If I do a really good assessment of a person and I document that assessment, I

think that's more informative to a future clinician that may pick up the case, than a diagnoses, which I think would actually be harmful, in a way. I mean, unless we're talking about a secondary psychosis of some sort. That's another matter, but when it comes to personality disorders, as much as clinicians are fond of saying that it's just a way of indexing or a way of describing and that they see their clients as individuals. I can't help but to leave, because I know I've been effected by it.

I used to be afraid of people with diagnoses with borderline personality disorder, but that distances me from my clients. If I can I understand something on a deeper level with and individual than just the diagnoses. That's just my feeling about it. Maybe that's one of the ways that I've changed over time is that I might [inaudible] at the idea of diagnosing somebody with a personality disorder, particularly borderline personality disorder and want to find them underlying trauma.

Maybe I'd be looking for something that isn't there and I make assumptions about my clients history that I shouldn't be making. I shouldn't always walk into these things with a certain amount of assumption. Hopefully, I can put that aside.

Researcher: Yeah. Yeah, I remember being at a training, oh many years ago. And they were talking about ... I mean, now that I feel like there's a common understanding that behind a bordering diagnosis is trauma and I remember a speaker challenging the audience, like, you come up with an example of a client that was diagnosed with borderline who didn't have a trauma background. And one person in the audience bravely said, well I've got somebody and man, they got into it. It was interesting.

He just said, it's not possible. He was firmly sure of that.

P1: Yeah. Yeah, well, that's a good reference.

Researcher: Yeah. Oh, yeah. Definitely.

P1: Thank you Marsha Linehan.

Researcher: Oh, yes. Oh my gosh, yes.

Alright, last question is about reflection, so if you could reflect on your reflection. Lots of people I've interviewed have talked about, that reflection is a routine part of their practice. And it seems to take the form of just solitary contemplation, to group consultation, occurring in the moment with a client, between sessions, spontaneously, or maybe some anticipatory reflections. So I'm just wondering if you could talk about your process and prompts you to reflect.

P1: Well, writing notes. That's when I said to one of my colleagues, I said, you know, writing a progress note is like look at the gist. He said, well, that's a very strange thing to say. And I said well, it is, but it really is true because it's ... I don't think I'm smart enough to really be so keenly aware of certain ... Putting facts together and coming up with insights in the very moment. It happens in movies a lot, but I don't remember it happening to me bunches.

And, so, what happens for me is that, things dawn on me as I'm writing my contact notes. That I wish would dawn one me in the moment of contact with my client, but it doesn't really happen that way very often with me. It's when I'm sitting there writing my progress notes that I start to think about the session and what made the issue that I didn't recognize in the moment and how I might fold that into my next session with my client.

So, I mean, if that's what you mean by reflection, I guess I might not ...

Researcher: Yes. Oh, absolutely.

P1: Yeah, it's most certainly in note writing.

Researcher: Do you have ... Oh, go ahead.

P1: No, it's alright. Go ahead.

Researcher: I was just wondering if you have, because you work for the ... Well, you've got a lot of people under your umbrella. You work the county, yes, correct?

P1: Yeah. That's correct, yeah.

Researcher: So do you have a real ... Is everyone writing their notes the same way, with some electronic records, or I'm wondering what that ... Or do you have a lot of freedom in how you write your notes? Or is it pretty rigid?

P1: So, yeah, you're right. We do have our EMR, it can be restrictive if you let it be, but what I've discovered is that they try and queue you to have all the components that would make insurance companies happy. And, so, I certainly fill in those blanks, but there are a couple of spaces in there that you can start to get into a little bit of narrative. In the past, when we didn't have that, it used to just be filled notes and everybody just ... Yeah, did with a lot of them. And I've always kind of stuck roughly to that, but I do that within a certain section in the EMR note. That is a field that allows me to just start typing.

Although, I have to say, there's something about it being an electronic record, and I don't why this is, that makes me a little squeamish about being as detailed as I might have been when we were doing paper notes.

Researcher: Oh, I couldn't agree more. Yeah, I hear what you're saying.

P1: And I've always written notes to myself, basically, because it's what I use to have continuity between sessions. And I don't want to deny myself the information I'm gonna need for my next session, but at the same time, there may be some things I'm gonna omit.

Researcher: Great. Well, that's it for questions.

P1: Wow. Okay.

Researcher: Yeah. So, thank you. And what happens from now, this will not be the last time you hear from me though. Although, this is the last round of interview questions. Either today or in a couple days, I'm gonna send you an email with some selected questions over the past three rounds and an open space for you to respond or add if you feel like there's any more information that you forgot that you just feel like would be helpful. So just I can have as much data to analyze as possible.

And, then, hopefully within, of I don't know how many months. It'll be months. Once I'm done with all the data analysis, I come up with a couple diagrams and some sort of summary that I will send out to everybody. And that will be the time for you to be able to just look at the end product to say, oh this doesn't jive with my experience at all or I agree with this part, or nope, looks good. I've got nothing to add. Or, you were way off base. So, just some final participant checking of my own interpretations. And that'll be months from now, but it won't be a phone conversation. It'll just be an email.

P1: Okay. Alright.

Researcher: So, any questions about any of that?

P1: The product is that something that ... I mean, I imagine you're gonna be writing up a dissertation of some kind?

Researcher: Yeah, this is a ... The first few chapters are all background. And those are done. And, so, all of the data analysis will be in the fourth chapter, which I haven't yet written. And, then, really with qualitative research, it's the appendices that adheres all of my notes, my own processing thorough out this whole time; all the interviews, the diagrams, how the diagrams developed over time. That's the bug bulk, I think of this research. And that comes at the end. So, that can be hundreds of pages. Whereas, the actual dissertation is really, maybe 30 pages or something like that.

It's interesting because it's taken so long. I don't know. It's just been an interesting process. But, yeah, it'll all be published in a dissertation. And I go through the interview with a fine tooth comb and remove anything that even mentions anything about locations, or states, or clients, issues. I block things out. So, you know, all of that stuff.

P2 Round Three

Researcher: Okay, so I've got four questions, and then I'll be following up with some clarifying questions as we go along, but if you'll remember, we're talking about countertransference in the case of working with trauma survivors, and how you make clinical decisions with those types of clients.

P2: Okay.

Researcher: My first question is about the uniqueness of counseling trauma survivors, and things that you are aware of that you may do differently, either internally or externally with a client versus when you're treating other clinical issues.

P2: Okay, so to answer your questions, I'm going to pull up a particular client, probably the client that's experienced the most trauma, and put that person in my mind as I'm answering.

Researcher: Okay.

P2: Does that make sense?

Researcher: Yeah, for sure.

P2: Okay, so what do I do differently, what do I watch for differently when I'm working with that person?

Researcher: Yeah, what is unique about the way you work with trauma clients versus maybe a client who's coming in for depression, who may also have a background with trauma, but you know, when the prime ... I understand, because I'm a trauma counselor too and it's all there, right, but ...

P2: Okay, so for someone that's coming for stuff that's just: "Help me figure out how to ... "

Researcher: I've got social anxiety, help me out.

P2: Okay, something not really ... and it's pretty plain that that is just what they're working on.

Researcher: Yeah, not complicated.

P2: Not complicated and whatever.

Researcher: Not B syndrome and not grounded in trauma.

P2: Okay. Well, when it's someone with trauma, I'm always mindful of what they're saying and how they say it, where they're referencing it to. When they're talking about something that's happened recently, I look at it in terms of okay, how did

this person react? Was it more on a primal level, or was it more ... would anybody in this situation react in that same manner?

I look at it that way, so then we know whether their reaction or what they're presenting is based on a prior history or if it truly is they got mad because somebody didn't take out the garbage, and that would anybody who would ask three times would be mad. And then also looking at their response, and I'm looking at the intensity of the response within that setting, and so on like that. Or it was somebody else that would come in, they would say, "I got mad. Duh-duh-duh didn't take out the garbage," I would say, "Okay," and then we'd just look at that and just progress with it with other questions. I've just taken it more of its face value.

With a trauma person, I'm constantly looking to see the intensity and is that touching on something we've talked about, or another history thing that goes in? Where does it slip to? Where does it slip from?

Researcher: So you're looking at ... I mean, your ears are perked for language, it sounds like, and intensity of reaction.

P2: Mm-hmm (affirmative).

Researcher: Okay. Anything else that ... it sound like maybe heightened sensitivity or a heightened awareness?

P2: Yeah, heightened awareness.

Researcher: Of their reaction.

P2: Of their reaction of what they're presenting, and then to see if it's connected in some way.

Researcher: Okay, so it sounds like you're ... then going further, your reaction and your response to how they react would be if it's just about the garbage and not grounded in any trauma, you sort of keep it within that context, whereas if it's grounded in trauma, you're going to broaden maybe that lens.

P2: Have you felt like that before?

Researcher: Yeah, okay, so then the client can make those connections.

P2: The client makes the connections. If they don't then they don't, but if they do make the connections, okay, tell me more. So then if they say, "Well, yeah, dot-dot-dot-dot." Okay, so how does that impact where you are now? What does that say about your current reality?

So another client where that was the case on how she was reacting to her children, she says, "I'm my mom. I'm my mom. I'm doing the same thing" Okay, so tell me more. Is that how you want to react? "No, I want duh-duh-duh-

dud-duh." Okay, so how can you make it different, because you're not your mom? So we'd look at that, because that experience was impacting or informing her response here, and then once she saw the connection, she could say, "Now I want to do some things differently." So that was very telling for her, but she has to make that connection for it to make an impact.

Researcher: Yeah. Great. Okay, so far with all the data that I've gathered, counselors seem to have a dual focus really closely tracking the client in session, or just having a heightened presence, while at the same time there seems to be a lot of internal dialogue, so in your head, sort of assessing and thinking and planning and maybe observing, but just a lot of internal dialogue about what's happening, while at the same time being present. So I'm wondering if you see it that way, or if you can talk about how you balance those things.

P2: I don't think you consciously balance it. It's almost like you're feeling it, you know? Then a conversation will pop in your head: Oh, that's not so. Oh, I wonder where that came from. A constant curiosity. Why are they feeling that way? I wonder where that came from? Duh-duh-duh-duh-duh, and so ... or a realization. That inner voice will have a realization: She's scared. Ah, okay. If she's scared, let's see, how do we know? Okay, and then I listen for something else.

Researcher: How do you determine what to do with all that internal dialogue?

P2: I watch to see where the client is going and I listen to the client, because I might guide a little bit, but they really have to lead the show. Because if they don't lead the show, then I'm putting stuff in there one, is not true, but they're susceptible. It could be very susceptible, and I'll take it as true. (Name removed) said. I hate that. One, I may put something in there that's not so, or two, I may push them into an area they're not ready to see or they're not ready to address or even consider, and then cause a problem. So I've just got to watch and listen. Tell me how does that work for you? Why does that make sense? So just keep them exploring themselves.

Then if I have a thought that says, "Ooo," then I might say, "Really? Tell me more about that," or "What makes you think that person was trying to hurt you?" Then we might do a little cognitive. What's the evidence that you're dirty? Well, okay, and what else tells me of that? What's the proof? So a little cognitive. And once they start challenging themselves, then it usually falls apart.

Researcher: It's nice when that happens.

P2: Yeah. You're lucky if it happens just like that.

Researcher: Okay, great.

P2: Does that answer that?

Researcher: It does, it does. I'm also finding that ... This is kind of a long one, so feel free to ask me to repeat part of it. I'm finding that trauma counselors have, as many of us do, but in this setting, conditioned beliefs or assumptions about trauma. These thoughts seem to vary from trained or purposeful reactions to maybe mainstream socialization about trauma, but what are those biases, assumptions, good, bad or indifferent, about trauma that you have, separate from your assumptions maybe about the client, but just about trauma itself. So those preconditioned beliefs. I mean, everything we have is preconditioned, but specifically about trauma, I'm curious about what beliefs you have, and where these came about.

P2: Well, trauma can come in all shapes and sizes, and it doesn't necessarily mean it hurts. Trauma can be anything that you find horrifying, distressing, life changing, so what the community believes and what clients come in thinking is that something terrible had to happen, but it's terrible for them. It doesn't need to be that it's on somebody else's scale. Then the other belief I hear clients coming in with is comparative trauma: "Well, it's not as bad as ... ," so they minimize their own pain, and I say, no, it's like apples and oranges. Your trauma cannot be compared to somebody else's trauma. Your hurt cannot be compared to their hurt. How can we? They're two different people, two different experiences.

Then we talk about the perspective-taking that everybody experiences. Family, everybody, experiences their experience from their own feet. I don't know about preconceptions. That's my preconception. It's a very open, understanding definition of trauma, but I know it can be and is defined very distinctively in different sets.

Researcher: It is or it isn't?

P2: It is.

Researcher: It is.

P2: So military trauma, domestic abuse trauma, they have their specific things that they look at it from.

Researcher: You mean the victim or the survivor?

P2: Just society.

Researcher: Society, okay.

P2: So we have to look differently at it and define it within the person. The person is the one in their interpretation of an event.

Researcher: Regardless of society plunking it into categories of you're this kind of trauma, you're that kind of trauma.

P2: Mm-hmm (affirmative).

Researcher: Okay. So it sounds like that openness to what trauma is, it sounds like you use that in session to either help normalize for the client, or educate them, or help themselves to not even minimize their own experience.

P2: Right.

Researcher: Okay.

P2: Right.

Researcher: Okay, great. Where do you think your ideas came from, your beliefs about trauma? Do you think they were there even before you started the work?

P2: No, no, no. It's from a lot of the reading, the workshops and stuff we've done. A lot of the reading, and also from talking to people.

Researcher: People like?

P2: Like students, like clients.

Researcher: Ah, okay.

P2: Yeah, and just hearing what they have to say and seeing the amount of pain that somebody else would just brush off causes them, or they minimize an experience. Someone has this big ... You know, they couldn't make sense of it, so they just said it didn't matter.

Researcher: Mm-hmm (affirmative), great. Okay. The other thing that I'm finding is that reflection seems to be a routine part of practice for expert trauma counselors, and it can be anything from writing to just solitary contemplation to group consultation to supervision, and it can happen writing notes afterwards or if somebody's out for a walk, but being able to reflect on the work seems to be the integral part of practice, so I'm wondering if you could just share your experiences with reflection. How it happens, when it happens, when you experience it. Is it anticipatory reflection or spontaneous?

P2: Yes, all of the above.

Researcher: Ah, okay, great.

P2: Because of who I am and what I do, I do tend to compartmentalize my life a little bit more than other people might. When I'm at school, I'm at school. When I'm at home, I'm at home. When I'm here, I'm here. However, there is the blending, and so that reflection comes as I'm preparing to see who I'm going to

see today, or I look at the week. Who am I going to be seeing? Who am I concerned about?

Then as I think about the cases and I think about what we've talked about last time, then some of that reflection will come up in that query. I wonder if, I wonder ... oh, what we talked about that last time, and then we did it again. I wonder where she is with that? I wonder if those nightmares are still happening? What's triggering those? There seems to be a commonality, so that reflection.

I went to a training, and immediately as they were discussing, it immediately flashed in my mind about one of clients. I think we talked about him last time, and it dawned on me where we were stuck in our work, that he, because of the trauma in his family of origin, he had recreated a family with the military. That was his family, and it had all of the components of and the attachment with family, so the healing happens retroactive rather than being able to access and resource anything within his family. So that insight, that reflection, came there.

Sometimes as I'm reading, then I'll come across, especially if I'm reading specifically for a particular client, for instance, getting more background on whatever, so I'm going to read a little bit more on that. Then I'll say, "Okay, how does this play into ... ," and then I'll reflect on my clients as I'm gaining that new information. How does that work? Does that apply here?

Researcher: Is it a lot in your head?

P2: Mm-hmm (affirmative).

Researcher: Do you think that's just because the nature of your practice, or your personality or ... ?

P2: Both. I'm not a person that's going to sit and do a journal. It's more paperwork.

Researcher: Yes. Yep.

P2: I find that motion help. It helps with anybody. Motion helps spring more thoughts, so as I'm walking, as I'm cleaning, doing whatever, sorting. Those mundane kind of activities tend to help me to be more introspective. I mean, that's what I find.

Researcher: Okay. Tell me more about compartmentalizing.

P2: Compartmentalizing when I'm at school, I'm at school. I'm being paid to be at school, so my phone goes in the drawer and I tell my clients here I answer the phone specific times, or you can text me and then I'll answer it at those specific times, because I'm on the clock; that's part of my job, and my job is very encompassing. I'm doing lesson plans, I'm doing teaching, I'm doing case management. I'm chasing children, I'm holding babies, yes.

Researcher: Lovely.

P2: Then I leave there, and I don't have anything with me, so I don't know who I'm seeing. I've seen it before, but I may forget because I left this morning, right?

Researcher: Okay.

P2: So 3:45 I leave the building, I get here. I have something to eat, so that transition time allows me to make that transition. That meal time, a little bit of walking, helps make that transition to the office. I go through, I pull out my calendar, see who I'm seeing, pull out the files, make that transition. Now I've got this hat on and I'm looking at this.

Okay, and then at the end of the day here, I'm closing it up. I do my notes, as many as I can, within that time. Then I close it up, lock it up, and I go home. Well, (name removed) sitting there at the door: "Grandma! Grandma!", so he jumps all over me, so I'm putting things away in my drive there, and then I get home. I play with (name removed). Our ritual is to have dessert together.

Researcher: Oh, nice.

P2: We have dessert every night; I get home that late. He's had dinner, we have dessert, and then some days he'll be with me that night, because I give (name removed) ... we have times that she goes out and we say it's Grandma night. It's Grandma night.

Researcher: Nice. Well, it sounds like the transitions are ... it's not just compartmentalizing, but there's a built-in, purposeful transition.

P2: Purposeful transitions, and they usually come with the drive from one place to the other. I also keep all the keys separately, so my office keys are different than my school keys, which are different than the mailbox, which are different than the house keys.

Researcher: Nice.

P2: I have a pile on the bottom of my purse, and so when I'm getting those keys, I'm getting my head ready for work, for school. So I get those keys in that pocket, and so on.

Researcher: Nice.

P2: Yeah, it works. Everybody does it different, but now I have two jobs. There's been times I've had three, so you know, we each do what we do.

Researcher: Do you think it impacts ... or rather, how does it impact your ...

P2: My practice?

Researcher: No, your empathy with clients. The other thing that I'm finding surprising is not a lot of talk about empathy, and maybe it's for a variety of reasons, but I'm wondering how ...

P2: Empathy? I feel with them, but I can't own it. It's the same thing with the kids at school. Yeah, they're in terrible straits. They're 16 and they've got this one-year-old, you know? They're living at home with mom and dad and they're kind of supportive, kind of not, or there's other situations that are even worse than that. I can't rescue them. I can't take them home and take care of them, so there has to be some kind of ... there has to be a boundary where I can be the teacher. I can be your support system here and keep everything as stable for you and supportive as possible, but then I need to let you go home. With here, I can be here, I can support you. I can feel for you, but I can't walk this road for you. But I'm going to be right here while you walk it, and it's okay. I don't know if I learned that doing special-ed for so long.

Researcher: Yeah, maybe you already had some pre-built-in skills before you even got to this career.

P2: Or doing the (organization name removed).

Researcher: Oh, yes, yes.

P2: See, I did that for years as well.

Researcher: Oh, my gosh.

P2: So for there, you never know what happened to that client. You do your disposition, you do your placement, and you may or may not ever see that person again. You have to trust that the disposition was going to take care of it. And some of those are heart-wrenching, and that's what you have to just say, "This is what I do. Next step, then that's for you."

But I think I learned that with special-ed first, took it to there, and I've taken it to here. I can be here for you. I'm your support person. I'll be here until you're done, until you don't need me anymore. I'll listen to you, I'll walk with you. I can't do the work for you, because it doesn't work. I can't take you home.

Researcher: Have you ever had to be direct with a client about that? Because you say it so beautifully here. Or do you not say it directly, and you say it indirectly, if you know what I mean.

P2: I've said it directly in a way. I've said it directly recently. As a client was telling me, we were talking about an incident. I said, "How did you manage that? What worked for you?", so they started telling me what they did. I said, "Good. The purpose of this is to help you learn these skills so that when you run into these, that you can put them in place yourself. You can say okay, do a reality check. Is

it about me? So it's really about you learning things you can apply on your own."

Researcher: Do you think that goes over well?

P2: That one's a little nervous about being independent.

Researcher: Oh, yeah.

P2: So she just kind of looked at me and said, "Yeah. I see. I see your point," but we'll do that several times.

Researcher: Yeah, I was just going to say that gives you more information then to know that that's an area that ...

P2: Yeah. Yeah, she likes having the safety net. The safety net is ... I do counseling I think differently than what I hear other people, in that I, like at school, I'm teaching for transition. They're going to be adults. Everything we do helps them move toward adulthood independence. Here, I'm teaching for transition. I'm not taking them home. They're not being mine forever. We're teaching them to be independent, to look at their issues, face them, or in trauma, resolve them. Look at them in a way that makes sense to them now. How does that make sense to you now? Then be able to use their skills to move forward, because I can't take them home.

Researcher: Beautifully said. Thank you. Anything else that cropped up in your mind?

P2: No.

Researcher: Okay.

P2: So you're golden?

P3 Round Three

P3: Just happy to keep helping you with your research.

Researcher: Thank you. Yes.

P3: You're welcome.

Researcher: Much appreciated.

So the first question is very general, and if you could just talk about the uniqueness of your experience of trauma counseling, versus treating other clinicals, concerns. Maybe how you approach it, or things that you might be hyper aware of, things like that.

P3: Okay. Trauma versus normal. Okay. Well, there's a ... People with trauma have a more delicate nature. Put it that way, maybe.

Researcher: Okay.

P3: I mean, there's a ... you know ... I suppose a lot of people would just say that they're triggered more easily but I would say that maybe it's ... there's a rawness to their wounds, right? That may be a way to think about it. So, then it becomes... then you need kind of both strength and tenderness. Maybe that's a way to think about it. You need that, really, for everybody. I just think that you have to sort of get there faster, stronger, or sooner, something with people.

There's also, I suppose, there's probably a stronger need to normalize. But, you know, they do freak out a little bit extra, I'll put it that way, about the level of anxiety. So they're anxious about being anxious. Yeah.

Researcher: So normalizing those symptoms more so than with other people?

P3: Well, yeah I think when I-I mean, with other people, you know, you just sort of start and then I realize that there's some trauma in the picture, you know... I go in that direction like, you know, there might be some trauma here, let me tell you a little bit about what trauma does to a human being. And, you know, when I say... So, like, I think I talked this over with you. Like, I have a, sort of in my head, five steps that you go through...

Researcher: Yes.

P3: ...when you're talking with somebody with trauma and the first being trauma education. So, that's a... There's a lot of normalizing that goes on in that step of like, "This is what trauma does to people, and, you know, that goes away when... that's in the picture because..." you know [inaudible]

Researcher: Is there anything that you're aware of that's different about your, maybe how your body reacts, thoughts that you have, when dealing with trauma survivors?

P3: I think my body slows down.

Researcher: Okay.

P3: I mean, I think what I... I mean I had a lot of clinicians talk about getting triggered or you know, maybe they're getting re-traumatized themselves, or something, but... I noticed that I... Well, let's see, maybe it would be like, if you're regular speed traffic, like going speed limit, 55, 75 miles an hour and then you realize, "Oh, trauma situation." So, you know, then it's like, "Okay, I'm gonna... I'm going to take my foot of the foot speed and coast for a while and maybe we're gonna go about 40 miles an hour."...

Researcher: Ahhh.

P3: ... "Just going to slow down here."

Researcher: Nice. The next question is, so far the data that I'm analyzing shows this kind of what you're speaking to, this sort of heightened presence and tracking of trauma survivors.

P3: Yeah.

Researcher: While at the same time, it seems like a lot of the people I'm interviewing are also spending a lot of time in their heads with some internal dialogue in the session. So, I'm wondering if... And that can be like questioning or anticipating a client response or even sort of monitoring yourself. And I'm wondering if you can share your experiences and sort of balancing that heightened presence along with your own internal dialogue in your head? Or maybe you don't experience that.

P3: Well, let's see, I suppose... Well, I'm pretty here and now focused anyway, with everybody.

Researcher: Ah.

P3: But, I suppose there's... So, if we're sticking with the analogy of like, "Oh, there's trauma here, so let's put off the foot speed kind of regular pace, let's go down to 40 miles an hour," maybe the... Yeah, I'll stick with the car analogy, let's just say it's bad weather. You know, and so you're paying more attention to the road, you know, like paying more attention to as if, like is the pavement slippery or not? You know, as if... You know, so there's paying more attention at the level of, you know, things can get out of control fast, I suppose that can be a way to think about it.

I don't, you know, I just think the thing about trauma, what it does, is that you just know that the quietness doesn't have a level of control that they would have in other areas of their life. And that there's an extra vulnerability, there's an extra feeling of nakedness and you know, shame, you know, inability to just sort of be normal, and... You know, so I think there's a lot of like simple tending to that. I mean again, like, it's not just normalizing it, it's more like tending to it like, "This isn't permanent," you know, "what you're going through here, even though it's been maybe a long time, years, it doesn't have to be permanent," you know, "People heal and people get through things. In particular, they can heal and grow in spite of what they've been through." You know, they learn about post-traumatic growth from me the whole through when they through trauma treatment. But you know, trauma education and then I remind people of that.

Researcher: Yeah.

P3: And that's in terms of internal dialogue. I mean, there's a lot of anxiety, of course, with trauma, so, you know, if you were to compare somebody with

trauma versus somebody that, I think I'm just going to call it an average depression, if there is such a thing... You know, somebody with an average depression, you're going to, you know, let's do a little something to energize them and with trauma, there's always an effort to, you know, help the fear come down...

Researcher: Yeah.

P3: ...while doing something that's soothing. So, there's a little... I mean in terms of internal dialogue, maybe that's what I'm doing. But I'm not doing internal dialogue at the level of, I don't know, "Holy crap, this is getting out of control," or something like that. I'm not doing anything like that. I suppose I'm a little more directive when I see, I'm just going to say "her," when I see her downward spiraling right in front of me, you know, I might say something like, "Okay, okay, okay... Wait, wait, wait...[inaudible] okay, this is what I think just went on in your head. Is this close?" And, you know, so I might see a little more directive at the level of, "Hey, let's not go off the road." It's not, you know, let's not steer this kind of a ditch.

You know, but again, I'm already keeping the pace a little slower anyway, just to give time, just to give her time.

Researcher: Yeah.

P3: To go through things.

Researcher: Can you share about your "here and now" focus? That's a...

P3: Well...

Researcher: ...yeah, I'm...

P3: Okay. There's... Let's see, if you look in psych, of course, the past shows up, in terms of theory, of course with anything, it's like one way to go psychodynamic.

Researcher: Right.

P3: And the contingencies in the current environment, certainly show up with respect to behavioral theory, while contingencies management stuff. And the third way psych came through with the focus on no human potential. Then there was sort of a future focus. But the "here and now," you know, like, what is the goals that they are sort of pulling this person forward, out of where they currently are. And, the "here and now" focus that is a part of almost everything I do, maybe that's a way to put it, it's sort of a blend of those three in the sense that you can see the person's past and their habits that were built in the past, they're coming into a current, right here, right now, interaction that is informed

partly by whether or not they think they can actually, you know, more forward towards some goal they want to get to in the future. And, so that, "here and now" focus has to deal with a kind of like watching all of that play out in a particular interaction and maybe you're just trying to illuminate it for the client. Because, change takes place in the "now," it doesn't change... I mean, I know it's sort of cliché-ish, but true, you can't change yesterday and tomorrow's not here, so, I mean, what you have is right now. And this is a place where change can happen, so, why not? You know, why not?

So, some of, you know, like, sometimes it's just really simple stuff for somebody... Just the other day, someone said, you know... Let's see, how did she put it? You know, "I'm just so lazy, I have to just have to kick myself in the ass and get this stuff going." You know, something like that. And I went, "Whoa, whoa, whoa, no ass kicking happens in my presence. And, you know, you're not going forward with this because you're not quite sure what to do and that's called, that's not called lazy, that's called being true to... That's called, you know, slowing your car down because there's fog all around you. And when that fog lifts, you'll pick up the pace, but, you know..." And she, you know, she said, "Okay, well then, I'm a little bit lazy," and I said, "I'm not saying you aren't a little bit lazy, maybe you are, but what about instead of, like, 'I'm just going to kick myself in the ass to get stuff going here,' what about saying, 'I need to play around with this a little bit, you know.'" And you know, so she shoots me a text later, maybe two days later, said, "Well, that's been amazing. The time I can hear that kind of negative thing coming, I sort of change what I'm saying to some sort of, like, 'why don't I just play around with this a little bit,' and it's been helping."

So, that would be one of those things where you can say, "well somebody in their past, you know, is basically, says, 'what a loser? You're not doing enough.'" And she does have an idea of maybe if she doesn't kick herself in the butt, that she's not going to get going to some future thing, but the modifications, that kind of external language and just pointing out that's some sort of inner voice stuff that's going on. And then, making the suggestion like, "Well, you know, just play around with that," idea of playing around instead of being some kind of harsh task master, like, easier to get a kid to do something when it's a game and it's fun when we're playing, than it is, you know... Treat yourself like you're some kind of child laborer. You need to be beaten to get stuff done. So, I don't know, there... I don't know if that example has, but that's kind of what I mean by "here and now" focus.

Researcher: Yeah.

P3: That kind of ties all the timeframes together.

Researcher: Right. Right.

P3: Past, present, future. Yeah.

Researcher: Do you find that you, in this point in your career, is that... Oh, is it... Well, I guess I'm thinking early on, it sounds like that would take a lot of energy to sort of maintain that. I mean, I think that's the ideal, and I'm wondering if you find it draining to...

P3: No.

Researcher: No? Okay.

P3: No. I find it a piece of cake.

Researcher: Ah. I bet it wasn't always that way.

P3: Maybe it wasn't, but my first... Maybe it wasn't super... The ideal, actually, Researcher, has a really... I can especially now, age (age removed), haven't found this work officially. You know, the first time I was paid to do something, it was in like 1980.

Researcher: Ah.

P3: So, what is that? 37 years? But, when I first started training in my graduate work, it was 1978 and I had the great... And the longer I'm alive the more I understand the incredibly great fortune of being trained in a "here and now" focus.

Researcher: Ah.

P3: Experientially.

Researcher: Bingo.

P3: And so, that was really my base, and then every other therapeutic process was woven into that, so, actually it's kind of amazing. Because I have been doing this for a long time. And I do remember posing that kind of a question to the instructor who, you know, I was learning the process from, doing experiential work. But, also then he became my mentor and I, you know, was in touch with him whenever I could be for that next 13 years between when I met him and when he died. And, I remember saying that maybe one into training with him, like, something like, "It's just too much to think about." And he didn't even entertain it, he was like, "Oh, yeah." He said something like, "Yeah, well, it won't be for very long." Like that's it. I mean there wasn't any instruction on it, there wasn't like, "Here, try this, try that."

And, you know... And I... He seemed to really enjoy himself in life. So, there was a lot of motivation to like, "Oh, so this 'here and now' stuff really makes a big difference." Which, it does. It's actually not energy draining at all. It's

actually... I think people... I think clinicians burn out and get energy drained because they're actually not doing the "here and now" focus.

Researcher: Yeah.

P3: You know, they're actually over there in their book trying to figure out what to do to the client, rather than relating to the client in the here and now about whatever the client walks in with that day. So, I actually think "here and now" focus has kept me young. I'll put it that way.

Researcher: Yeah. Yeah, that makes a lot of sense. It sounds like you some really good training from the get-go.

P3: Yeah. Yeah, the longer I'm alive, the more I realize... I use to actually, when I was training with other people, I started... I think he was 25 years ahead of his time. No, I actually think, no, he's like 50, he was like 50/60 years ahead of his time.

Researcher: Wow.

P3: I mean, I think if he were alive now, the kind of what seems unusual then and perhaps a bit radical... I mean, you know, in some circles, it would be much more... Like, I know that the recognition that I get for, like, a kind of unique whatever, and I think [inaudible] and I don't know, he had this theory in place by about 1963. [inaudible] like got ahold of the airwaves and medicine became the "thing." You know, but I mean, I'm starting to be known around here for somebody that, if you want to get off your meds. I don't do anything. I don't even talk to people about their meds. Literally. I mean, they get written down on a piece of paper. I don't talk to them about their meds. But people come in and they get off their meds. And it's really because they get cured.

Researcher: Yeah.

P3: And by cured I mean they grow. And by grow I mean, if you stay in the here and now you can help a person grown right here, right now. And if you do that with efficient frequency, eventually their brain grows, their mind grows, their heart grows, their [inaudible] repertoire grows and then they start fixing problems. And then from the inside out all of a sudden, you know, medication doesn't even make sense. It doesn't come into the picture at all.

And that's pretty... In a way that's pretty easy work. I mean, it's skilled work. I have no confusion that I'm masterful, I guess [inaudible] But, well, as I would say, the master makes it look easy. Right? But it is easy too. Once you master it, it's easy.

Researcher: Yeah, exactly. Exactly.

P3: That's the whole point of mastering something. Yeah.

Researcher: Yep. Okay, the next question is, I'm finding that expert counselors have, like all of us, I think, but at least the people I'm interviewing have conditioned beliefs or assumptions about trauma itself. And so, these thoughts can range from trained or purposeful beliefs to reaction resulting from mainstream socialization... And I'm wondering what some of your conditioned thoughts and beliefs you have about trauma. Separate from perceptions about the client. If that makes sense.

P3: Well, I believe it's a lot more common than people ... I'll say I'm never shocked when somebody reveals a traumatic situation or traumatic situations, so that's one that I have. You know, it's ain't so weird. So that's one. And this whole, me too thing that's going on, Charlie Rose is out ...

Researcher: I know! I was so ... yes.

P3: And Al Franken.

Researcher: Yes.

P3: And then we have Trump of course, whatever the fuck that means.

So I mean, let's just take whatever percentage that is and let's say every time somebody uses power over, that there's some potential of something trauma-ish going on. I mean I think trauma is pretty common, so that's one thing that I often think about trauma. And absolutely I have no confusion that trauma can be the impact of, the negative, let's see how do we want to put this, I do not wonder, not even for a split second, I'll put it that way, can all of this trauma be processed and become, basically a non-factor in this person's life? A non-negative in this person's life? Can negative impacts from trauma be eliminated from somebody's life? Yes. That's how fast I feel that.

So I think trauma can be completely processed and eliminated from somebody's life. And I think when people do that they up looking like Maya Angelou. And I say, if there's [inaudible] there's no reason why people can't become completely free, of the trauma. Like the wisest people in the planet. So, that's one. So I'd say over-processing and I guess, elimination or cure, however you want to word that. I mean, that's what I should call, I don't spell ... oh look help you manage your trauma, usually you go do you want to get rid of that shit? Let's get rid of that shit, if you want to. It might take some time, but do you want to get rid of it?

Researcher: Mm-hmm (affirmative)

P3: So there's that, I think it's really common, I think it can be eliminated from a person's life. They do have to, I think at some point engage in some forgiveness, and that can be a real sticking point for people, in terms of getting free from trauma. No problem if they don't want to. But there's one of the

things. Now, let's see, why don't you ask me the question again so I can see if there's anything else [crosstalk]

Researcher: Your conditioned beliefs or assumptions about trauma, whether they're purposeful, or if main stream or socialization.

P3: I think, I mean, it doesn't scare me, I guess. You know, I don't look at it like it's stage four cancer.

Researcher: Mm-hmm (affirmative)

P3: And we have very little time to ... I don't look at it that way. I don't think, I dunno. I don't at it like, I look at it like it's just a part of my job, and it's a part of my job that I can do well, or something like that. It's not a big boogie man, anymore. To put it that way.

Researcher: Mm-hmm (affirmative)

P3: Back in the day more of my socialization time, I guess I'll put it that way, I was around social workers, and these people who were like active case workers, helping out with family work, you know basically trauma was all that anybody had in their life, and that's a group of people that gets ... they can be a little ... I guess I'll just say high-strung about what people have been through.

Some of them, here they are, they went to college, they get a bachelors in social work, maybe their state has an exam or something that they need to take, maybe they get licensed, but generally not. Here they are at 22, 23 they're looking at jobs for case managers, for something like the [inaudible] child welfare. So they're getting all of the, those kids should be taken away from her mother, they're getting those cases and they're shocked by that stuff. And they get all social work-y on it, we need to get this kid out of there.

And I don't have any of that kind of panic, even with children. I don't want it to happen, but I also know ... I don't get into a panic because I also know that the kid has a good experience with counseling now, when she's 30 or 40 she might come back to counseling with somebody who does trauma treatment with her and she can eliminate the bullshit she's going through right now out of her adult life.

Researcher: Mm-hmm (affirmative)

P3: Maybe that's another thing that might be a little different, I'm not sure in how I look at it. And I would say that's the social worker, versus psychology. Perspective, which is that, the social work perspective is make sure that everything outside in the environment can be changed so that the child has a shot at something. Mine was like, well whether that happens or not, eventually there's another big opportunity is for that person to make a change as long as

they learn how to run their human psyche from the inside out, and they can fix a lot of that stuff.

Researcher: I like that differentiation there.

P3: Okay.

Researcher: Okay, last question is about reflection. Lots of counselors shared that reflection is a routine part of their practice and that can take the form of solitary contemplation, or group consultation occurring in the moment with the client or between sessions. Spontaneously or maybe anticipator reflection, and I'm wondering if you could talk about your reflection process and what prompts you to reflect?

P3: I have every work morning, in the old days. I used to open my calendar, which would be generally a At-A-Glance, I had an old Jill Hartman At-A-Glance [crosstalk]

Researcher: I have an At-A-Glance calendar that I'm looking at right now. That's what I use.

P3: Okay, alright. Well in the old days I would pull my At-A-Glace calendar out of whatever I was carrying, usually a purse, and flipped it open and start at whoever was coming in first, and then whoever coming in second and I would just sort of prep myself for the day. In the old days. As I got older I realized on the days I didn't do that, I wasn't as prepared for the day, and what I basically saw.

Eventually it became a meditated practice, so what I do every weekday morning, so this morning I got up, had coffee, opened my iPhone to my news to a meditation by a guy named Richard [inaudible] that I read in the morning, I keep them in an email. So I read that and then I sort of flip through in my iPhone, newspapers, in a paper-world it would be like just looking at the headline at the 2, 3, 5 newspaper and then I open my calendar and I actually do a meditated practice on each person, for instance I did one on you this morning. It wasn't, it's not like, yours certainly was pretty simple and pretty short. Which was, I hope she's doing okay, it's really freaking hard to do a dissertation, especially a qualitative one.

So that's all I did with you, was just sort of ... the idea, what I do is I basically empty my head of other people, other things, other whatever and then I just start at the beginning of the day, look at the person, turn the phone over, shut my eyes, just sort of pull them up in my head and then I just, the way I think of it is, I just let whatever rises up in me rise up.

And this is not a long process, it maybe, it might be a minute per person. It might be less. I just do that. I get the person in my mind, in all of my mind, I'll put it that way. And I just see, I open up to them, I'll put it that way. And I just

see what floats up. And I note that, I don't write it down, I just note it in myself and then I go to the next person and then I go to the next person. So that might be, beginning to end, probably total maybe 15 minutes. Just beginning to add in terms of looking. And I might also remember something like, oh that's right I was going to see if I could find an article or something, and that if it's an actual task, this is why it takes 15 minutes, if it's an actual task then I flip over to the place where I put my tasks and I type it in.

Today for sure, I had two meetings this morning, not clients but professional-ish meetings, one at 7:30 one at 9:00 and same thing with those too. And I have a support group tonight that I'm going to, so I thought about a couple of people there. So the whole thing, besides you I had five clients, or I will by the time I'm done I'll have five client appointments today and two professional.

What was that?

Researcher: Oh my gosh, your schedule, holy cow. Two meetings, a meeting with me and then five clients and then a meeting at night. That's ...

P3: I have 10 to 1:15 free. In my office in a really relaxed place. I'm not running the support group, I'm going to a support group.

Researcher: Yeah.

P3: I'm going, I'm not doing, I'm showing up, that's no work for me. I'm just going.

Researcher: That's true.

P3: I only thought of ... I just was thinking about oh I want follow up with what happened with the situation that they were talking about. The support group is like my (personal family tragedy described).

Researcher: Mm-hmm (affirmative)

P3: So, it's on Tuesday nights. This is not ... see let me just say something to you, when you react like, oh my god how do you do all of that? So this a thing I do where you're now thinking that. The first person I met with, she's writing a book and she's trying to figure out a character and she can't quite figure it out. So what that was for me was [inaudible] that was a [inaudible] meeting and I gave her a couple ideas of why I think that character isn't believable.

The second meeting was with a guy who is a friend of mine and he's thinking about shifting careers and he just wanted to bounce ideas off me. These are not preparation at all. I just showed up and had coffee. Second guy I had breakfast with. Then I had 10 to 1:15 free, and by noon ... so I'm just telling you that I had five, my noon re-scheduled for tomorrow at noon. And then I have three people after you. That's not a bad day.

Researcher: That's not bad, I have to admit that's not bad.

P3: No, that's a pleasant day. My days are quite pleasant.

Researcher: Mm-hmm (affirmative)

P3: On the whole, I have very pleasant days.

Researcher: Good. I think at this point in your career I would hope that you have pleasant days.

P3: Exactly. And I do see people my age, who have been doing this long as I do and they are like, bags under their eyes, looking like when do I get to retire? And I don't have that. I do think that, that had to do with that year in [inaudible] by the way. I don't burn out because I'm not spending a lot time trying to fix somebody's past. Or understand all the past [inaudible].

Researcher: Mm-hmm (affirmative)

Yeah that's intriguing, very intriguing.

P3: So that's my meditative practice. It actually it's a thing I noticed when I was younger, that it helped me to just kind of mentally prepare just to think about whose coming in, and then it actually has become a standard part of the morning to meditate on each person related to the day, that's maybe something to think about, each person.

Researcher: Mm-hmm (affirmative)

P3: And to, trust my psyche or something, my soul, the universes' energy, I don't know what it is, just trust that process of letting something float to the top.

Researcher: Yeah.

P3: Does that answer your question about meditated practice?

Researcher: Absolutely. Yeah, thank you.

P3: Okay

Researcher: Okay, so that is all the questions that I have.

What happens next is I am going to send you an email within the next few days that just has some of the questions that I've asked you over these last rounds. It's a web link, it's a secure link, for you to be able to respond and you don't have to respond at all. Some people just process more when they're writing so if there's something that maybe that you had forgotten to mention, or that you think would be interesting to add, it's just another way for me to get data to analyze. But don't feel like you have to respond, it's just another opportunity. So I will send you that email.

In a few months, I'm not quite sure how long it's going to take, when I have all of the data analyzed, I am going to send over email, I'm going to have two final diagrams and I think a small summary write up that I'm just going to send out to everybody and that allows you to respond like this isn't my experience at all, you're crazy, or yes I really resonate with this, or again, if you don't feel like responding, it's just an opportunity for participants to sort of check my own analysis of interpretation of what I've heard.

That's it. No more phone interviews or anything like that, you'll just hear from me over email. We'll see how long that takes. It's an interesting time.

P3: Okay cool.

Researcher: So thank you so much.

P3: You're welcome, and good luck. Because you have taken on a big task here. Keep at it and good luck with all that.

Researcher: Thank you so much, and have a good Thanksgiving.

P3: You too.

Researcher: Take care.

P4 Round Three

Researcher: Okay, so I have about four or so questions for you and just to sort of reorient you, so this is the last round of interviews and we're focusing on trauma counseling and your clinical decision making and trauma transference issues. Yeah, so any questions or anything off the top of your head?

P4: Nope.

Researcher: Great, well I really appreciate your time, and feel free to just think and pause and just kind of free associate. Don't feel like you have to have everything planned and organized.

P4: Sure.

Researcher: So, the first questions is, if you could just talk about the uniqueness of your experience of trauma counseling versus treating other clinical conditions. So, if you're maybe focusing with somebody maybe just on a piece of addictions or maybe depression, or something like that, is there anything that you're particularly aware of or what's sort of the different piece for you when you're doing some trauma work with somebody?

P4: Like, what would I do differently? Or, what [inaudible] are you asking?

Researcher: Yeah, what would you do differently What are you aware of that's different? Your reactions, or your attitudes and feelings about that.

P4: I think, well the biggest thing is I practice trauma-informed care. So, I guess for someone with trauma I'm probably a little bit more aware of triggers that they could have for their trauma, like loud noises, where they sit in my office. Let me try to think. Like, talking to them about their trauma I make sure no disappropriation happens.

So, I guess that would be kind of my main ... Really, it's that trauma-informed care piece. You know, I do a little bit more maybe like a suicide ideation check before they leave, or, like some safety stuff in case something triggers them after they leave my office.

Researcher: Okay, okay.

P4: Maybe a little bit more of that.

Researcher: So, it sounds like a lot of it centers around their, not trying to re-trigger them, or, their safety. Just sort of being hyper aware of their ability to cope.

P4: Right, so along with them just being mindful of reactions they could have. And, then again yeah like you talk through safety and all that.

Researcher: Is there, you mentioned making sure that they don't dissociate. Is that something that you have seen? Or, kind of what happens when that shows up?

P4: Yeah, I have seen it. I've seen it more in group sessions when somebody else might be talking about their trauma, and it might trigger something in them. It's happened a few times.

Researcher: Okay.

P4: Or, I don't know if it's ever happened individually.

Researcher: Well, I mean group it still applies, even in group.

P4: Yeah. Yeah, we have a ... I worked with a client who had DIDs. So, actually I should say one of my therapists worked with a client who had DIDs and I actually got called in to help support her. So, sometimes we would see that transition happen. But, yeah more in group. Like, I remember one time in particular where the client completely disassociated.

Researcher: How do you handle that in group?

P4: I do ground [inaudible].

Researcher: Oh, okay.

P4: So, just try to bring him back to the here and now. You know, I make sure other clients, because I think the other clients around him right away want to touch him. I make sure nobody touches him because it could, it can get, you know, they freak out they can get a little bit not violent, but, [inaudible], you know. And, I do more grounding just like bringing him back down, you know, hearing my voice. Like, so they know they're safe, this is where they are.

So, sometimes I'll do like physical grounding. And I used to do more trauma [inaudible]. We used to bring like a grounding basket with a little Play-Doh or Silly Putty where they could have it in their hands to do more physical grounding.

Researcher: Yes, yes.

P4: Yeah. Stuff like that.

Researcher: All those tactile things can be very helpful. Great.

P4: Yeah, exactly.

Researcher: So, so far the data that I'm analyzing through all of these interviews is showing that trauma counselors seem to have a heightened presence, or being able to really closely track the client in session, and how that's highly valued while at the same time there seems to be a lot of internal dialogue. So, in your own head as the counselor, be it like questioning or kind of what to do next or anticipating a client response. And, I'm wondering if you can share your experience of trying to balance really closely tracking and staying present with a client versus sort of being in your own head, whether you're anticipating a client response or questioning, things like that. Or, even if maybe that balance isn't an issue for you. If that makes sense.

P4: That's not too much of an issue for me.

Researcher: Okay.

P4: I try to like stay very present with the client. So, I guess I'm like-

Researcher: How do you do that?

P4: How do I do it? Well, it's so weird. Like, my best times to work with the harder clients, especially the trauma clients, are in the mornings because I'm less distracted. So, sometimes it's like scheduling them when I know I'm, like end of the day is not the best because, you know what I mean?

Researcher: Yes, yes.

P4: Sometimes I take my easier clients at the end of the day just to get it's easier. Not like really easy, like my lower maintenance clients, I should say.

Researcher: Yes, yes.

P4: At the end of the day. I just try to be really present with them. I mean, I guess like anticipate, I guess everybody anticipates. Like, I know something could happen. You know what I mean? I know somebody could dissociate, or they could get angry or different emotions come up. But, I just kind of stay with them throughout their hour with how they're doing. Or, what and how they're responding.

Researcher: Okay.

P4: I try not to jump too far ahead, the what if, cause never really works out how you planned.

Researcher: Yeah. Yes, definitely. Are there times when you need to sort of do your own internal grounding when you're trying to stay present with a client? Or, are there times when you ... Well, I guess you've already talked about times that you're more distracted than others. But, is there anything you do particularly if you seem to be more distracted?

P4: I do before sessions, like I don't rush into sessions. I usually take a minute or two just to like relax if it's someone I know is gonna be a lot. Like, high anxiety clients, especially, cause that energy is a lot for me. So, I do a little bit of that before I go on. I don't generally do, like if I have two clients in a row or three clients in a row, I won't open my door and let one out let one in. Like, I let one out, close my door for a few minutes, then let the next one in.

Researcher: And, how does that help you?

P4: It helps me stay centered.

Researcher: It helps you what?

P4: Oh, I'm sorry. It helps me stay centered. So, like just being present for them. Because, if I go from one to the other sometimes I still think about the other one. So, when that client leaves I'll take whatever notes I have to take. I usually take a minute just to like relax. And, so I go into the next one finished up with the one before me.

Researcher: Okay.

P4: So, I'm not thinking about that. Or like, I might prepare for like thinking about topics we could talk about if they don't come with anything. So, yeah.

Researcher: Okay. And, that's a good point. Do you find that it's more one way of the other where you're initiating the topic, or the client is?

P4: I generally, well I always let the client initiate. But, I usually have some sort of like, if it's a client who might not be in crisis or we've been working together for a while, I might have some ideas on where to take it, but I generally let them go where they need to go first.

Researcher: Okay. Great. This next question is a little long so feel free to ask me to repeat parts of it if you get lost along the way. So, the other thing that I'm finding in the data is that there's some evidence that expert counselors have conditioned beliefs or assumptions working with trauma clients, and so these are conditioned thoughts and beliefs about trauma itself, separate from beliefs about the client. And so, if you can kind of separate those two out. And so, sometimes these thoughts vary from trained or purposeful beliefs versus sort of reactions about trauma from mainstream socialization. So, I'm wondering what are some of your conditioned thoughts and beliefs about trauma? Again, separate from the client.

P4: Oh, that's a good question. So, I guess like a conditioned thought or a belief would be ... You know, that's a really good question. I don't know. I think, I guess one of my beliefs is that trauma victims don't, you know a lot of times they try to take the fault. Is that what you're kind of looking for? Like-

Researcher: Oh, yeah.

P4: Yeah.

Researcher: Yup, that's fine. That's-

P4: I mean one of my other beliefs is like, you know, or I mean one of my conditions is like cause a lot of times they try to take the fault. Sometimes, they do a little like justifying for the perpetrator.

Researcher: Oh, right. Right.

P4: So, that stuff doesn't [inaudible]. You know, just sometimes I just [inaudible] for that. I think somebody who's got pretty fresh trauma doesn't always have the self-awareness and how it's affecting them.

Researcher: They don't have the self-awareness?

P4: Yeah, they don't have the self-awareness on maybe what it's actually doing to them or how it's really affecting them. So, I go and like meeting

someone new I always keep that in mind. Like, they might not understand some of their behaviors they're experiencing or doing or acting out or some of the feelings they're experiencing, there's a link to their trauma. So, going into sessions with new clients I remember that or keep that in mind.

Researcher: Do you have a sense of where these beliefs came from?

P4: I think probably more experience, or just I've seen patterns.

Researcher: And, do you think that came up from, cause I think you've been where you're working now for a long time-

P4: Yeah.

Researcher: ... and anything before then in any of your internship work or pre-work before you got here, or do you think it all came from sort of the clients that you're working with in this setting?

P4: I think it's a lot, probably, I've learned a lot of that from or gathered those beliefs from the clients I've worked with. I mean, I don't think it goes with every single person, but I guess it's just seeing patterns or hearing similar stories or similar feelings.

Researcher: Do you think, because you work with a fair… I'm wondering if you think some of your beliefs about trauma would be different if you worked with a different population, but a population that has still experienced trauma? If that makes sense.

P4: Yeah, so I worked in outpatient for seven years, actually longer than that, like 10 years, before I moved to residential.

Researcher: Oh, okay.

P4: So, and I actually do a private practice on the side.

Researcher: Oh, wow.

P4: So, an outpatient setting.

Researcher: Holy cow. You're busy.

P4: Yeah. So, I think that the difference between residential and outpatient, I think in a residential setting you see more symptoms.

Researcher: In an, I'm sorry, was that outpatient or residential?

P4: No, I'm sorry in residential you see more like trauma symptoms and more because you see them all day long. So, in an outpatient, you know, a client might have a harder time later in the afternoon than at night. But, if you see them in the morning, you're not experiencing that part of their day with

them. So, in residential you see them all day long, so, you know if like 5:00 in the afternoon is triggering for them because that's when their abuser used to come home and hurt them, they might have more anxiety around 5:00. You know what I mean?

Researcher: Yes, yes.

P4: That's the difference that I notice between the two.

Researcher: Okay. So-

P4: But, yeah it's probably more from working with all different traumas with all different types of people and in all different settings.

Researcher: (Personal identifying information removed)

P4: Yeah. It's, I do.

Researcher: You have the same, or see it the same way?

P4: Yeah, I think I have the same approaches with everybody.

Researcher: Yeah, great.

P4: Yeah.

Researcher: Okay, so lots of counselors that I've talked to shared that reflection is part of their routine, part of their practice. And, this can take the form of group consultation or supervision, or just solitary contemplation occurring with a client or between sessions, sort of spontaneous reflection or anticipatory reflection. And, I'm wondering if you can talk about your reflection process when working with trauma clients and kind of what prompts you to reflect, and if you can describe that impact of your reflection process?

P4: So, like when I just like self-reflection?

Researcher: Well, it can be, you know, I've gotten so many different examples. It can be maybe reflecting with others, maybe you're more of an extrovert and do a lot of that. Or, maybe it's a lot of internal alone reflection. Maybe it happens in a session, or, all different kinds. Some people really write a lot and then that helps with their reflection, but it seems to be significant.

P4: So, I would say that like we're [inaudible], so we do a lot of group supervision. So, there and particularly now I'm supervising, so I don't always see clients as often individually. I usually see, like if it's a harder client then I get called in there on that. But, we do a ton of group supervision. So, I think my style, and I probably I don't want to say push amongst my therapist, but I probably encourage it amongst my therapist is to do more reflection with your peer or with me on how you're feeling

after, cause some of our sessions our groups too are pretty intense, so really talking about it afterwards.

And then, just for me personally I don't too much internal reflection anymore. I mean, I've done this for a while so I'm pretty good about if I have to go back and think about a day or think about what happened I can pretty much let it go by the time I get home from work. Where, like I can kind of separate myself from it. But, I do, so like the way with my therapists. I do one hour of individual supervision with the [inaudible] and then they have two group supervisions. So, they have a lot that they can reflect on and talk about.

Researcher: Yeah, that's a lot.

P4: Yeah.

Researcher: I'm so impressed, because you guys have such good practices over there. It's so impressive.

P4: Yeah, I really make sure. I'm big on [inaudible], cause like burnout happens and, you know.

Researcher: Well, and your role it sounds like you're pulled in when things get particularly tough.

P4: Yeah.

Researcher: And, how do you feel about that? Because, you're working with a tougher moment with a client or just a tougher case.

P4: I'm fine with that. Like I said, I've been doing this long enough where I'm pretty good at separating stuff. And, I don't have that, you know like when you're a newer therapist you sometimes have a little bit of fear about like do I say something wrong or do, you know, like what happens. So, I don't get that to watch. I'm pretty confident in the choices I make. And when I don't, like for me if I come out of something where I'm like, "Whoa, do I need to [inaudible]." You know (name removed), yeah, your family member. (Name removed), I'll call her and just run it through with her. Like, if I just need to say it out loud or just need a little bit of reassurance, but for the most part.

Researcher: So, your confidence, well obviously years of experience have led to that. And, it sounds like the confidence is a, because you have this confidence you don't see the need to reflect all the time.

P4: Yeah, yeah.

Researcher: Okay.

P4: That's just cause it's not a lot new to me, you know what I'm saying? Like, I don't get shocked anymore, I don't get ...

Researcher: So, you're not seeing new things?

P4: Yeah. I mean, every now and then you do and then you're like, "Whoa." But, again that's when I'll call (name removed) and just be like, "Okay, let me just tell you about this. Let me say it out loud." But, for the most part.

Researcher: Yeah.

P4: Yeah.

Researcher: Nice. So, it sounds like when you do, do you ever reflect on your work when things are going really well? Or, is it just this reflection comes up when it's like oh gosh I need to bounce this off somebody?

P4: I do. I probably do reflection every single day. Like, when I think about it or at the end of my day I'll be like ... like I think about the entire day as a whole. Or, yeah I guess if like a client has seen a lot of growth sometimes I do because I'm like what worked? You know what I mean?

Researcher: Oh, yes.

P4: Like, how did this process happen? Yeah, because then that's always good to know too. Like, when did I see the change? Or, you know.

Researcher: So, is this something that you encourage in your supervisees, being able to reflect on their own practice?

P4: To do like self-reflection?

Researcher: Mm-hmm (affirmative). Or, reflection with others.

P4: Yeah. I encourage it to everybody, cause I think you have to doing this work.

Researcher: Do you think your confidence came from something besides experience?

P4: I don't know. Probably just more experience. Like, the first time you sit down with a client who had recent trauma, it does something to you but then after you do it 100 times you take it in or you process it differently, so.

Researcher: Do you think you've built up a, I don't know, some kind of wall so you don't get as affected by it. Or, do you think you're just more effective at the work? If that makes sense.

P4: I don't think I built up a wall. I think maybe my work is more effective, or I think maybe I do things differently. I think, like when you're newer in this field and you [inaudible], like things like you take stuff home with you so

much. And then, you get to that point where you burn out so you have to view it differently. So now, I view it like thank god they're getting help. You know, so now I see it that way more.

Researcher: What was the last part?

P4: So now I view it rather than being like oh my gosh I'm going home and taking this all home, I view it more like thank god they're getting help. Like, now they're getting services involved and that [inaudible]. So, I wouldn't say I built up a wall.

Researcher: Okay. Okay. Great. Well, that's all the questions that I have.

P5 Round Three

(combined with Round Two questions)

Researcher: Okay. Again, just to sort of orient you, we are talking about your experience working with trauma clients and countertransference and clinical decision making. Feel free to just think and reflect, don't feel like you've got to answer right away, and just take some time to think. I have you on speaker phone so if something cuts out let me know, and I will let you know if I can't hear anything.

If you could just talk about the uniqueness of your experience of trauma counseling versus treating other clinical concerns, so maybe some things that you are, oh, particularly sensitive too or aware of, or don't think about in terms of the uniqueness of treating somebody, treating a trauma survivor.

P5: Well, I guess that question is probably a little difficult for me to answer because I've never not worked with women who are, who have a history of trauma. My original internship was here at (organization name removed), and then I continued my first job here and I'm still here.

Researcher: I can understand.

P5: [inaudible] experience I can't really separate, but I guess when I explain it to people I'm training, really trying to emphasis the approach is not what's wrong with you but what happened to you. How just viewing someone from that lens of what happened to you can sort of help when people become frustrated with clients behavior, or don't understand why she may be responding the way that she is, or communicating the way she is, or even making the choices that she has.

Researcher: Great, that makes sense. Is there anything that you ... I'm guessing that you have probably never had a client who you're just treating straight A&D, and never have had to even touch the trauma work?

P5: It's, I'm sure that I have, because not every client is at a point where she wants to address that. For some women they're not stable enough with their other needs to address trauma, because I always work from a safety first approach, like you need to be able to be in a safe place, have supportive people, actually have coping skills, before you really start digging into some of that very deep issues, like trauma. That might be where we start there with some clients, where we're just focusing on skills to achieve sobriety.

Researcher: Yeah, great. Could you reflect on an experience in which your clinical decision making was unsuccessful, and how did you respond and adjust your approach?

P5: I guess ... I know I have, it's just trying to think of one.

Researcher: I can certainly, you can let that sink in for a while, or I'm happy to let that bubble in your brain while I ask another question too, it's up to you.

P5: Yeah, I guess, I can't think of one just off the top of my head, although I know I've had situations where a client has directly told me she wasn't happy with what I was saying or how I was saying it. At that moment, I know I would have acknowledged that error because I guess, because I've been in this supervisor position for almost two years now some of my interactions are a little bit different. When I do have a client who's upset with a service, either with my staff or with me, I do just try to validate that right away, like, "I hear what you're saying, I hear what's not working, how do we move forward from here." Sometimes, I may try to explain where somebody is coming from or where I'm coming from, just to help a client understand that we're also human and can make mistakes. Just to reemphasis that when they advocate for themselves, that's something that can be changed, because just because we're the therapist doesn't mean it has to be this way all the time.

Researcher: Right, great. Okay, so the data that I'm looking at now from all of the interviews have shown that expert trauma counselors seem to have this heightened presence in just being able to really closely track a client in session that seems to be highly valued, while at the same time there seems to be a great deal of internal dialogue in the session. Just in your head, be it questioning or anticipating a client response or even your own response. I'm wondering if you could share some experiences of how you maybe balance tracking a client, staying present, with anticipating their response or even your own.

P5: Mm-hmm (affirmative). I guess what comes to mind for me in that kind of situation is when a client is probably sharing a detailed description of some type of trauma, just because that's when I'm having the most reaction in myself, and

really watching how they're responding to the details. I generally, I don't normally have clients go into detail when they're talking about trauma history, I prefer to focus more on present focus, but sometimes that just naturally happens in a conversation. When it does, I'm watching their body language like is there, are they actually experiencing emotion associated with what's happening and if they're not are they numb, are they dissociated, do they even understand what feelings might be associated with what they're describing?

That's one of those situations where I'm kind of watching how they're presenting and at the same time in my own head just noting that, and if that's something I want to address with them or if it's best to just let them go through this process and then go back. Depending on what that skill level is of that person, what I may already know of the situation, what our goal is for actually talking about that. Whether it's, she just needs to share, we're safety planning to prevent future situations, so I guess for every client and every situation they share that's a very unique balance, just depending on all those circumstances.

Researcher: Mm-hmm (affirmative), well it sounds like observing body language is something that you significantly watch for, and detail obviously when clients are sharing detail. In that determination when you're sort of observing that, is that a sense of is this safe or appropriate for this client to be going down this road or are there other questions that you're sort of asking?

P5: Yeah, and that's usually a lot of that context, like where are they living, who was this experience with, do they have the skills to process this? What day of the week is it, if it's a Friday afternoon this isn't the safe topic for us to get into because I don't know what your supports may be throughout the weekend. Just making sure too that whatever we're going into the client has the skills and the resources to be safe once we're done.

Researcher: Okay, well and that's something that may be ... oh, I'm just thinking out loud and how that's something that I think I'm finding is with some of these interviews is that, unique to trauma counseling is that heightened sense of awareness of safety and the external supports, and maybe being more concerned with that than with other sort of clinical concerns.

P5: Mm-hmm (affirmative).

Researcher: How do you determine when to let a client lead the session, versus when you take the lead?

P5: I guess that depends on what part of treatment we may be in. If it's like the first couple stages of treatment I think that the therapist is doing a little bit more of the lead because you're doing the assessment and the treatment, and the client just doesn't know what that stuff is. I mean, they're not supposed to, and that sort of thing you just have to get done. But then, once we're actually in regular

therapy it's that balance of following the treatment plan so the client is actually moving towards the goals they've identified, and then at the same time allowing them to focus on situations that may have come up that they really, are at the forefront of their mind.

Normally, when I start a session I just ask the client how it's been going since we last met. It's a little different for us because we are a day treatment program, so we see the women outside of their regular sessions, so there may be something in particular I know that we need to address. If it's just sort of an ongoing thing I'll just say, "So, here's where we left off last week." Pick up from there, and then sort of let the client go from there. I also do motivational interviewing, so really once we set the agenda for the day, however informally that may be, allowing the client to really guide it and determine what they hope to get out of it.

Researcher: Mm-hmm (affirmative), great. The other thing that I'm finding in the data is that experienced trauma therapists seem to have some conditioned, well I think we all do, but in this context some conditioned beliefs or assumptions when working with trauma clients. These thoughts tend to vary from being trained or purposeful beliefs to reactions about trauma from mainstream socialization, just some sort of preconditioned beliefs going in about what the nature of trauma. I'm wondering what are some of your conditioned thoughts and beliefs that you have about trauma, separate from your perceptions about the client.

It's a long question, so I'm happy to repeat any of that. It's just sort of like what are your preconditioned thoughts, so you probably have to think back because I'm sure they change over time. Separate from assumptions about the client, but just about sort of trauma itself.

P5: Well, again, I think there was, one of the (organization name removed) philosophies is really that trauma informed care and looking at it as what happened to you, not what's wrong with you. I also tend to have to remind myself that for many of the women that we're serving, their experiences are so much their norm that their reaction may throw me off because it's not my norm, and I might have a much more intense reaction, but that's because they may be desensitized to what they're experiencing. Or, nobody ever taught them that what's happened to them is not okay, and so just sort of reminding myself that their, maybe a lack of reaction, is because they're desensitized or they just don't know. Reminding myself that my beliefs are not the same as theirs and it's important for me to understand where they're coming from before jumping to any conclusions about what they might need.

Researcher: Great, thank you. How do you determine if your personal issues are being triggered, have been triggered by the client, or if it's more a client driven narrative being played out in session?

P5: I think I've gotten a lot better at that over time, just because once you've gotten regular supervision you start to think about that kind of stuff. I know that it's my stuff when the sessions are ending and I'm thinking about that client outside of session, but it's not productive thinking, like it's not treatment planning and future interventions, it's just replaying the situation over and over. Or, I'm frustrated with where that person is coming from and just needing to sort of catch myself either in session or afterwards like, "Whoa, that's my own stuff, let me just refocus on her, on what she might need." Again, the longer I've been doing that the quicker I've gotten at that too, where I can be in session and just almost catch a tone in my voice or just tension in my body that I'm kind of checking out, and I immediately re-correct myself.

Researcher: This actually leads to another question about reflection, and it seems like lots of responses I'm getting seem to be that reflection is a routine and pretty significant part of clinical practice. It can take the form of just solitary contemplation or group consultation, supervision, or reflection that maybe occurs with the client in the session or between sessions, spontaneously or maybe anticipatory reflection. I'm wondering if you could talk about your reflection process, and what prompts you to reflect and maybe the impact of your reflection process?

P5: Well, I think everything you mentioned is probably something I've done. Here, we make sure that we're all getting regular supervision, and I think the fact that I have a supervisor and I'm also a supervisor, it's just because I'm checking in with so many other people I remember to check in with myself more frequently. Also, we do a lot with students, and when we're teaching students we really emphasis the importance of self-care, so that's another reminder. I make sure when I have a rough day that I have one colleague who is also a supervisor, but she's somebody who I can vent too and then go into like how do I solve this, as opposed to just continuing a venting process, which isn't productive.

Researcher: Mm-hmm (affirmative). Is there any reflection about when things are going well with a client, or does it seem to mostly center around when things are just not going as you had hoped?

P5: No, we try to do a lot of strengths-based approach. That's something where we try to regularly share when things are going well with clients, so whenever we're staffing somebody and it's a particular rough staffing, I'll always end, "And, what is her strength?" And, have everybody who's working directly with her identify a strength. Or, when clients have accomplishments, at the end of our staff meeting we always list every accomplishment we can think of and actually give those clients a written kudos in a group, and when we hear regular things happening I'll send out emails just saying, "Hey, great job, this happened." We make sure we give staff kudos, just to acknowledge the hard work that people are doing with clients. We really try to, because there is so

much hard stuff that you hear and deal with, we try to really point out the good, too.

Researcher: Mm-hmm (affirmative). Is there, during, when you're reflecting on your own practice is it primarily with your own sort of supervisor and colleagues, or are you maybe more of an introvert where you're doing a lot of internal reflection?

P5: I think because I'm not working individually with clients, usually, I'm usually trying to share whatever I've done with a client with their team members, just because of that good communication. I think when I'm having, it's been a hard time around here, I try to remind myself too internally just of good things that have happened, and I actually have a folder of old cards and whatnot from clients that when it's kind of one of those rough times you can look back at.

Researcher: Oh yes, yes, I know that folder.

P5: I actually, it's funny, I just showed that to one of my colleagues last week just saying, "I have this, this is." Because, she had something a client gave her and she's like, "Oh, I wasn't going to keep it." And, I was like, "Keep it, because you just never know when those little mementos, you might need to remember."

Researcher: Absolutely, oh that's so important, yeah, definitely in this line of work. What's your understanding of clinical intuition, and how do you sort of experience it and use it, if at all?

P5: Well, I think that a lot of people when they get into this field already have sort of like a gut for wanting to work with other people and care about other people. Sometimes that's a really good thing, and sometimes it's because they have to address their own personal issues, and that can lead to some boundary stuff. Just that desire to help others I think is something internal, and then clinical intuition I think is something you develop over time from just working with other people, seeing how they handle situations, having a supervisor help you understand your own situations, and just really monitoring your own work with clients and how they've responded. Either done well, or if they respond negatively to what you've done, having to correct that. I think that intuition develops over time as long as you are aware of what's happening and you actually staff your cases.

Researcher: Mm-hmm (affirmative), and I just want to go back a bit to the sort of philosophy that your agency has about the trauma informed care and what happened to you versus what's wrong with you. How do you think that, how do you think the clients pick up on that message?

P5: Well, I think we do a lot of very small things that people may not be aware of, like I remember one of my, my colleague who works over in residential she always tells people, "Make sure your not jingling your keys as you walk through the hall." Because, we all have keys to get in our doors, because the

sound of keys can remind somebody of incarceration. When we're talking to new students and new staff about language, we're really sensitive to watching what people say and so instead of saying like you're an addict, we're talking about you're a woman with an addiction. Making sure that we are always talking about clients strengths when we're treatment planning or we're in team meetings or staffing's. I think too that we also make sure we correct outside people about some of the language or terminology.

Even when they have good intentions and their well-educated there's still some of that language stuff that people don't catch. Let me see else that we do ... I think too we're very careful, we have group rules, but our clients helped us create the group rules and instead of, "Don't side talk, don't do this." It's, "We will do this, we will do that." At the very end of the group rules it says something about we're going to do this for this hour because we are worth waiting for, so just trying to really help people understand that some of the structure that we have in our program is done with the intention to help them grow, as opposed to trying to limit them or stifle them or put people into a box about what treatment should look like. We really try to individualize that as well.

Researcher: Oh, excellent. Great. That's all the questions I have. A little bit about next steps.

P6 Round Three

Researcher: Okay. All right, so thank you for meeting with me.

P6: You're welcome.

Researcher: I know you're so busy.

P6: No, well, so are you. So, you know.

Researcher: Okay, so if you could talk about the uniqueness, and this might be different because of your position, but maybe thinking back to your past clinical work. Thinking about the uniqueness of your experiences doing trauma counseling versus treating other clinical concerns and sort of what makes your experience with it unique.

P6: Can you explain that a little bit more? So, my ...

Researcher: So, maybe how ... What are the differences in your ...

P6: The way I treat?

Researcher: Yeah, in your own internal experience in treating someone across from you. You're treating specifically for trauma versus maybe someone who has ADD or depression or general anxiety or a concern about parents or sort of what makes that experience unique for you.

P6: Okay. So, on one hand, I'll say on one hand it's not unique in that I do try to come a framework with probably most of the people I treat have trauma. Even if that's not their presenting issue. So, that's one thing. But the second one is, so, say their presenting issue is trauma. Maybe like a sexual assault, we'll say, so specific trauma. I do tend to feel a little bit more ... I don't want to feel this way, but I tend to feel there's more at stake if I do the wrong thing. And I don't think that's necessarily true. It just feels true. It's like ... And it could be because of my position, but nowadays, trauma informed is such a [inaudible] phrase and so there's trauma's treated as ... And in my own mind as something that's like higher level need or something and people with trauma are more vulnerable.

P6: None of that's necessarily true, but I'm just saying that's how. So, I'm like, "Oh, am I going ... " I'm just more aware of myself and my actions when it's someone who has trauma. So, I have that ... The shadow counselor is very aware. So, I think that's the main thing for me, is that a little bit more anxiety that I'm ... Am I going to mess up? Also, awareness of, in my case, and this might be less if it was at not a college center or something, but just ... [inaudible] of legal stuff. Like, I did not know for the longest time that if someone is going to be thinking about pressing charges, even if they're pretty sure they're not going to and it was 10 months ago, there are still trauma therapies that defense attorneys for the accused could use against.

P6: So, there's that added level of legally am I going to do the right thing, too. So, I guess I would say it's mostly ... There's a little higher level of anxiety.

Researcher: Yeah, sounds like the risks are higher.

P6: Yeah. Or at least I think there are.

Researcher: Perceive that.

P6: Yeah. Exactly.

Researcher: Great. So far in analyzing the data, I have found that there seems to be this heightened presence, closely tracking the client, while at the same time there seems to be a lot of internal dialogue with trauma counselors. And I'm wondering if you could share your experience of how you could balance staying present versus maybe anticipating their response or their response this closely. Yeah.

P6: Well, I find that a way for me to stay present is to actually ... This going to sound weird because I think it's the opposite. I tend to be someone in my counseling ... I'm pretty much the same in counseling as a counselor as I am literally everywhere else with just the idea that it's got to be about them, not me. And so I'm still pretty ... I self-disclose more than other people here, but it's ... I joke. I mean, I'm just very similar, but I'm very aware of that it has to be for them and everything I'm doing is ... I'm trying to be authentic but also professional. The problem with that is a lot of what I do is by the seat of my pants, and because I have been in the field for a long time, that's usually somewhat effective.

P6: But I find especially with high risk people and trauma being one of them, I can do that too much and so I actually have started doing the opposite over the years and I feel like I'm more effective which is when it's someone I actually am more ... I have a strong inner dialogue where I'm telling myself, "Pay attention. Think about what you're going to do next." So, I'm actually literally kind of talking to myself in a way that I normally don't too much, but I'm also aware that I could not see something ... I could rest on my laurels. I could be a little too casual or something. So, when there's someone with trauma, what I have to do is do an internal dialogue to stay present, to remind myself to pay attention.

P6: So, it's almost like, again, I guess, I read in one book they used to call the shadow counselor, so I'll just call it that. The shadow counselor is very much on duty. You know?

Researcher: Mm-hmm (affirmative). And you find it more so with-

P6: Yes.

Researcher: Yeah, trauma clients, yeah.

P6: So, I'm like ... Some people would suggest that's not as authentic or whatever, but for me, I have to do that because most of the time, like I said, I'm just kind of like me.

Researcher: Casual, spontaneous.

P6: Yeah.

Researcher: Go with the flow.

P6: Yeah. And I'm still that way. I try to be. But I just have a little bit more guards.

Researcher: It sounds like the internal dialogue is slightly different.

P6: Yes. It's more like reminders. It's like watch, listen. All this stuff that we should be doing anyway, but you know.

Researcher: Well, and it takes a lot of energy, I imagine, to just sort of stay at that level, especially if you have person after person after person you're seeing.

P6: Exactly.

Researcher: You've got to have something to keep you focused.

P6: Exactly.

Researcher: Yeah. Okay. Okay. Another thing that I'm finding is that it seems like there's conditioned beliefs about trauma that probably we all have but specifically the people that we're interviewing. Not about the clients, but conditioned beliefs about trauma. So, I'm wondering, these vary from trained reactions to cultural reactions to what mainstream society says about trauma and I'm wondering what some of your conditioned thoughts and beliefs are about trauma and maybe where they came from and how that happened.

P6: Well, mine have changed over the years, obviously. But one of the things I said, I had this place ... Well, it is kind of about the person, but maybe they were more ... The trauma makes them more vulnerable. More need to be treated with kid gloves, kind of. As far as trauma itself, my condition ... I'm trying to think. Because what I'm thinking about, almost all my thoughts about trauma have to do with the person who experienced trauma. But you're not asking that. Right?

Researcher: Well, if it's generalities, like yes, maybe trauma makes people more vulnerable. That's fine.

P6: Yeah, and I don't necessarily believe that but I know that there's part of my that has always felt that. I think that I tend to also forget often that men experience trauma, so that's one for me that I have to remind myself a lot because I tend to see the majority of people, at least in a personal violence, trauma where it's the perpetrator's male and the female is the one who I'm working with. I tend to think of ... I tend to put trauma in boxes and tend to think that in a personal violence, trauma ... I tend to [inaudible] trauma on a hierarchy and think like interpersonal violence is much more ... Well, actually some research shows that it is. But there's more symptoms of trauma than say it's a natural disaster type thing.

P6: I always think of trauma as like the third person in the room, almost. The way we talk about it, sometimes I feel we talk about it like it's ... It is its own person, its own thing. Which I don't believe intellectually, but I think sometimes we act as if that ... And also that it's there forever. And it is in a way, but I think that we

sometimes act as if people are going to be forever wounded. So, I think those are some things. I bet I'm forgetting a bunch of stuff or not thinking about the question right, though.

Researcher: Oh, no. This is fine. So, when you talk about maybe trauma being the third person in the room, is that purposeful externalizing to be able to talk about it more easily with people or do you think it happens naturally?

P6: I think it happens naturally. I think that ... And I don't know if it's even a positive thing. I just don't know. As we were talking, this has been ... This is the first time I put that kind of words to it. But I think even when we talk about it in staff meeting or wherever we talk about it, it always seems like capital T trauma. And I think maybe we do a disservice because we kind of separate it instead of, you know. Because my goal, I always tell my clients, it's kind of like ... I always use the picture of that dog and I'll use the nose and say right now your trauma is like ... It's like the nose is so swollen that the picture ... The nose covers the whole picture. So, the goal is, the nose isn't going to be gone because if we took the nose off it would be an ugly picture. But to have it the right size so that it's part of your life now, but it's not the whole. It's not covering everything else. But I think we do that, and I know-

Researcher: Trauma counselors.

P6: Yes, and I think I look at sometimes the person as their trauma instead of as a person who's experienced trauma.

Researcher: Do you think that's ...

P6: I think it makes it easier. I mean, it's not easy, but I think it makes it easier.

Researcher: As the counselor?

P6: Yeah, in a way ... I mean, it's not easy, but I think it makes it ... I think in the long run it makes it harder, but it's easier to just label someone as something and then just like ... This is her. She's trauma, so we're going to-

Researcher: This is what we're treating.

P6: This is what we're treating, what we're going to do, instead of saying, "Hey, she also is this, this, this and ... " You know?

Researcher: There was something else that you said in there that I wanted to follow up on. Oh, the sort of categorizing trauma and do you find that ... Again, it might be hard thinking about this particular job, but would you approach the work, the client,

any different depending on the type of trauma, even though in your own mind you might categorize, okay, this person was in a car accident and-

P6: I think I would be aware that interpersonal violence tends to have ... Kind of increase the symptoms a lot of times, and the severity. But other than that, I think I would treat all trauma the same, knowing that everyone has different symptoms of trauma and so I would definitely help them work on their symptoms. So, some of that might be different, but overall treating trauma, I might treat it the same because for a lot of people who ... Say they were in a car accident. A good percentage of the people who were in a car accident who have serious trauma symptoms from like a major car accident also probably have developmental trauma.

P6: So, in a way, what's happening to them is not just that isolated trauma, but then that triggers from their other trauma. So, I tend to kind of assume that in people, so intellectually, I believe that when it's interpersonal violence, there is a much higher chance of a DSM-5 diagnosis. And even people who have not have interpersonal violence, like I said, I suspect if you do their history, there's probably more. But I would treat them all the same to start with, and then see ... Yeah.

Researcher: Yeah, and then see where it goes.

P6: Yeah. Because I've worked with a couple people who have had horrific car accidents that impact them, you know, daily and I don't see any other history of trauma. But they definitely have most of the symptoms.

Researcher: Do you get to do much history taking?

P6: We do the intakes and I try to get more ... I don't like this form, but [crosstalk]

Researcher: Sometimes you're [inaudible] by the form, right?

P6: Right. Well, I just ... It just says ... It just has a blank, we can write whatever we want but it's a section on family and I usually just say, "Can you just tell me what it was like to be you growing up?" And then let them talk about whatever. So, sometimes, since there's not pointed questions, we do have the questions of, "Have you witnessed or experienced any traumatic events?" But also sometimes people don't share everything. We're asking them to share this stuff with a stranger. You know? I try to get as much history as possible.

Researcher: And that helps in your decision making or ... ?

P6: I think it helps ... I use it more in actual counseling to point out patterns. Or I use the word familiar a lot, so I'll ask someone, does that feel familiar? So, if they're being triggered, and also point out just ... Well, it makes sense based on this that you might still be experiencing this. So, I actually use it more just with them, talking.

Researcher: Yeah. How are we doing on time?

P6: I just need to leave at ... I need at like 12:52.

Researcher: Oh. Okay. I just wanted to know if I need to hurry, but we're doing-

P6: We're fine.

Researcher: Absolutely fine. Absolutely fine. Okay. This is the last question.

P6: Oh, really?

Researcher: Yeah. Keeping in mind that we've scheduled, because essentially this is the last one. There was less here than ... Anyway. So, I feel like I need to explain myself. I don't know why.

P6: Well, I expect you to explain yourself.

Researcher: Okay. Last question's about reflection, so lots of counselors have talked about reflection being part of their practice so whether it's a loan, reflecting out loud with the client, internal dialogue, when they're writing notes, when they're out doing something and then something reminds them. So, wondering if you could talk about how you incorporate reflection, do you, does it seem to be ... Happen spontaneously, planned, is it even part of your practice, your work? What prompts you to reflect, impact of your reflection.

P6: Well, I'd like it to be more part of my work and I tend to ... Like I said, I remind myself like by that red ... The shadow counselor that reminds me to like observe or whatever. I'm not great at it, but I'll just say that if it's left to my own devices, my reflection would look like ... I'm not really good. I would be thinking, "Oh, really? Why did you do that? You should have done this." So, it's very kind of an inner critic type thing.

Researcher: I was going to say, critical came to mind.

P6: Critical. So, I try to do ... I'm an external processor, so I talk out loud. I talk out loud. But I talk when I'm thinking, which drives people crazy sometimes. So, what I do is I find people who will listen while I talk while I'm thinking and don't

need much feedback. But I like it. So, I'm usually ... My reflection is primary when I'm worried about someone ... So, I'll go and talk or when I think I've messed up. So, primarily it's as needed. And it's with someone else. And often with like (name removed) because my clinical director. When I'm writing notes, a lot of times I'm just trying to get them done because I'm always a little behind. But when I have time, there is a section that says like treatment plan or whatever to write what you're doing next. And that for me is a prompt that helps me think about what I'm actually doing with this client. And that's really helpful.

P6: But that only happens when I'm not behind, so really, my main reflection is when I just feel odd about something or I feel like something's going wrong or ... Yeah, so as we're talking what I'm thinking is I would like to have more reflection. I've actually started meditating in the mornings and I'm trying to take moments of pausing throughout the day. So, my goal would be to add that, but right now I think the main thing is I do it as needed.

Researcher: And it sounds like it's more external and it's triggered by uneasy something or [crosstalk]

P6: Exactly, or I really think I've messed up or something. Yeah. That internal ... I think I do an internal reflection all the time, but for me, I'm constantly fighting that inner critic thing so I have the ... I just have the ... I just have to constantly ... It helps for me to check it out with someone else, because otherwise I'd be like, "Oh, you messed up so much." When in reality I did fine.

Researcher: Yeah, and just talking back and forth with yourself doesn't get you the other perspective you would need.

P6: Exactly. Exactly.

Researcher: So, since you're such an external processor, are the times when you're in meditation or quietly pausing, have you found that to be helpful just because you're such a ... Because that's not for everybody, so I'm just curious for somebody who's such an external-

P6: It's driving me crazy right now because I'm just doing ... Like, I have Head Space, you know, and that's ... And I'm doing that, and right now it's just 10 minutes in the morning or whatever. And I can't keep my brain from going everywhere during that time, and ... But I think it's going to be helpful. I think it's good for me. I'm never going to be someone that ... Like many of the staff people here are really mindfulness expert and meditation and that's not my thing. But I believe in it, and I feel like it's going to be helpful just to kind of have me focus at least just a short period of time. I cannot imagine doing it in 10 minutes.

Researcher: Yeah, okay.

P6: But during the day, just trying to add a few pauses, like really short ones like a minute or so and reflecting. I actually like the idea of before and after each client, just like ... I'm talking about half a minute, just preparing for that client and then at the end just okay how did that go, maybe jot down anything real quick that I need to do more reflection on. So, I haven't gotten there yet, though.

Researcher: Okay.

P6: But those are my goals.

Researcher: I see. Okay. You were talking about the just minute reminds me of an interview on NPR that I heard. Total side note, but Dan Abrams. I think he was the news person who had the panic attack on air and then wrote this book about he was a reporter working with combat .. You know, in the war zone, and he wrote this, came back, had this panic attack and was drinking and wrote this book on meditation and the importance of meditation. Had it all over the science-y research and he just wrote a second book and I heard that interview and the second book is like something like one minute for skeptics, something and something else.

P6: Oh, I like that.

Researcher: And he talked about how after he wrote his first book, he thought everybody would be like, "Oh, yes, we need to take an hour of meditation every day." So, the second book was like, "A minute is fine."

P6: Yeah, exactly.

Researcher: And he has all the science of it evidently to back it up that a minute is fine.

P6: That's good.

Researcher: So, I don't know, I felt like the need to-

P6: No, I really appreciate that.

Researcher: It's fine. It really is fine.

P6: Yeah, because there's no way an hour ... And that, I mean, I'm sure I could work up to that. I don't want to. You know? But I do like some of it even if it's just having me be still and ... But it's also counter indicated with a lot of ... With

certain trauma and think people maybe try too hard to get people to do mindfulness and meditation. I'm like, it's not [crosstalk]

Researcher: Like it's the panacea for everything.

P6: Exactly.

Researcher: Well, okay, so it sounds like the ... At least talking to others, externalizing, and then-

P6: And then when write notes. It does help. It will-

Researcher: And then does it change the direction? It just gives you more feedback to then maybe change your ... Or perception maybe of what happened?

P6: I think sometimes it changes. It mostly helps me, which I guess would help me as a counselor. I think there sometimes ... Yes, sometimes it's helped change the direction. Those are the ones though where I consult, and so my reflection is more with someone and then they offer some suggestions. But most of the time, I think what it changes is my anxiety level. Which actually makes me a better counselor if I don't have that anxiety level, so in that ... But I don't think it necessarily changes the course of treatment.

Researcher: Yeah. Just changes you internally?

P6: Exactly.

Researcher: Okay. Great.

P6: Yeah.

Researcher: Good. Okay.

P7 Round Three

Researcher: Okay. The first question, fairly straightforward, if you could talk about, for you, what makes counseling trauma clients different from treating other clinical issues, so sort of the uniqueness about the trauma work, things that maybe you're hyper aware of, or more sensitive to, or less so, any kind of, what's the uniqueness about trauma counseling?

P7: Well, the first thing that comes to mind is that I'm getting to the point in my career where I feel like all counseling, all therapy, is trauma therapy, so there's that. But in terms of the way that I approach the work and what

really feels relevant to me and perhaps more important in working with someone with severe trauma, perhaps, is the importance of psychoeducation because there's so little knowledge about how trauma affects us. I find, as a feminist therapist, that it's extremely beneficial when somebody knows that what they're going through makes sense, so this is what it tends to look like, and oh, yeah, that's exactly what's happening for me, and that there are reasons for why they are feeling the way they're feeling that are not only psychological, but also physiological, and fairly common. So, I think psycho education is really important. I'm getting to a point where I feel like I have enough materials that I've generated over the years and I kind of have a packet that I give to people in the beginning that's kind of an orientation to work.

Researcher: To trauma work, in particular?

P7: Mm-hmm (affirmative), just mostly to save time. I taught a group once to save myself the time of the psychoeducation. I was like, how about if I just put everybody through a group so that then, all of that is done. I can just do it all at once. So, anyway, [inaudible] efficient. I'm not sure if it was. It was a lot of fun. And then, I think other elements of trauma therapy that feel particularly important are incorporating the body into the work using the body as a source of really important information, wisdom, change, healing, release, working through memories that are held there, that sort of thing, helping the body become an ally rather than a fear place or a place where you hide. That feels really important.

It feels really important to pace and do the stabilization works. So if somebody comes in with depression, say, they can usually just dive in to the depression work. I mean, you might still do psychoeducation, you might still incorporate the body, but there's no sensitivity to doing the work. Whereas in trauma, pacing is really important, and it's very easy to activate someone into a trauma response without realizing it's happening, and then there's a potential dissociative process between sessions, and then they're going back in and they're really, you know, not harmed, per se, but a version of that by the work. So, that feels really important to be careful about.

I think the dissociative process is really common with trauma and missed a lot of the time. It feels like, I mean, that's an important area of screening at the beginning, and I think it's easy to miss. I just had someone come from residential, no, sorry, intensive outpatient program to do early identification of psychosis.

Researcher: Oh, yeah.

P7: And the person had had a voice in their head since they were in fourth grade and had been through numerous types of treatment. Numerous folks had worked with them and they ended up in this program, and then while they were in the program, had been hospitalized. In the hospitalization, someone had discovered trauma, which I'm still not clear how they couldn't have put that together before that, but it's possible-

Researcher: Isn't that amazing?

P7: Well, it's possible they didn't disclose, but yeah. And so then, they discharged them from that program and referred for EMDR because they realized it was trauma-based, and this voice in the head was part of a dissociative process. Anyway, I think that's important to screen. I think the shared power in their peer relationship is different than with other presenting concerns or more important than other presenting concerns. Whether it's depression-related trauma, or sexual abuse, or interpersonal violence, that need for choice autonomy and shared decision-making in their peer relationship seems extremely important. I'm positive and a little bit of hesitating because it's also really complicated if somebody is in an extremely vulnerable place, they also need to know that they're very secure, that they're very held, they're taken care of, that the therapist knows what they're doing. It's this balance that I think is more difficult with trauma work than it is with other presenting concerns. That's what I had.

Researcher: That's nice. Yeah, yeah, lots of things to be aware of, for sure.

P7: I'm sure there are many things that I'm not thinking of, but that's what comes to mind.

Researcher: Yeah. The sensitivity and pacing, can you talk a little bit more about that as far as you're being more sensitive and you're monitoring the pacing and helping them to do the same or ...

P7: Yeah. I have to watch myself, as a therapist, because I'm not sure if I'm different, necessarily, but I'm ready to do the work and ready to go in and let's do this. I can see the intensity and I'm interested in intensity. And so, I have to watch my own process with that and not go too fast and not go too deep too fast, so that's part of what I'm referring to, my own process around that. I think people are more resilient than they realize, but I think they're also more sensitive than they realize, so both can be true in different ways, right. Let's see. Let me if I can be more concrete.

For example, when someone comes in and they're ready to do EMDR, the stabilization phase is really important in that. Often times, people come in and just want to start spilling the memories. That can be really activating for them. And so, having a really clear discussion about what's actually

happening when they're talking about it, helping them recognize that activation that I might be absorbing and just having a frank discussion about pacing and how important it is. Sometimes, people have had to wait so long to do the work that they're not willing to wait any longer. And so then we have to talk about session frequency and we have to talk about between session stabilization, we have to talk about coaching calls and sort of extra padding around it. I think that's what I mean by sensitivity to it. It can look different for every person, of course, and trying to find that match for them. But what we're trying to avoid is intense activation between sessions where they don't have that containment. I don't know if I'm answering your question.

Researcher: Yeah, yeah.

P7: Yeah?

Researcher: Tell me about your interest in the intensity.

P7: My interest in the intensity? Well, it's kind of why I'm here. Somebody told me once, this represents it for me. I was doing some training with some graduate students and we were talking about trauma. It was kind of just a round table discussion, pretty open. Someone said that talking about trauma with me, as the professional, felt like sitting around a campfire. They couldn't figure out how I made it feel so comfortable at the same time that we were talking about something so horrible, 'cause we were talking about pretty specific examples and how you work with specific presenting and experiences.

And so, yeah, and I don't know. I was talking to someone today. It's like, I'm not afraid of the darkness. It's okay if you want to go in there. I'm happy. I can go in with you. So, I don't know. It's just why we're here, and I feel like that's what's in some way helpful to people, is if you're not afraid of what they're afraid of.

Researcher: So maybe, I guess, maybe a fearlessness or a comfortableness maybe even more so than interest?

P7: Yeah, yeah, yeah. It's like, I've seen what happens when you come out the other side, right, and so I'm not afraid of what that process is in there. And, I think, again, one of my edges that I have to watch is if somebody is not ready to do the work because they're so fragility, that's different than if somebody is not ready to do the work because they're not ready to do the work. If you're not ready to do the work, call me when you're ready.

Researcher: Yeah, makes sense.

P7: I think that's probably what I mean more. It's like, I'd rather do the work. If the work is intense, that's fine. I don't have a problem with that at all. In fact, how could the work not be intense? So, let's do it.

Researcher: Yeah, okay. I guess I wanted to clarify what that meant.

P7: Okay, okay.

Researcher: Okay, so, so far looking at the data, it seems like trauma counselors have this heightened sense of tracking and really staying with the person while at the same time, a lot of internal dialogue, like, either they're planning the next thing to say or monitoring that pacing, like, geez, how is this client reacting? So I'm wondering how you sort of balance that intense presence, if you feel like you have it, along with all of the internal dialogue that happens that may get you out of staying present and tracking. It seems like there's this dual attention that happens, even more so than in a regular conversation.

P7: Right.

Researcher: You were probably doing the same thing. It just seemed so much more intense.

P7: Oh, yeah, yeah, yeah, yeah. Yeah, that resonates for me. I don't know that I have really, I'm sure I do, but it doesn't feel like a conscious thought process.

Researcher: It's just more automatic. It just-

P7: It's more of a sensing.

Researcher: Oh, okay.

P7: Yeah, no. It feels more like a sensing, for me. It's like one of the skills I've been working with on a personal level is being more in what some theories would call core self. When I'm not in core self, being able to track that really closely because my experience has been if I'm not, then it negatively affects the therapeutic process and affects the other person's experience and can actually activate different states of consciousness for them, which would not necessarily have happened if I had been in core self, then it would have gone differently. When you describe that process, you're talking about the dual attention. That's what I've been really aware of. Most recently is tracking my own centeredness as I'm also tracking what's happening for the client. It's not like a magic formula, but if I'm centered, the work happens really naturally and really well. It seems more effective. I take notes in session.

Researcher: Oh, okay.

P7: I didn't use to. I used to really have judgment about people who did that and then I worked in systems where I saw so many clients, I just could not track. And so now, I find that really that might be a pro way that that's happening, that dual attention that tracking is happening, because I can jot down a few words that someone is saying and be able to, you know, I think it helps me process that tracking. I think it helps me track, and then I can refer back to something verbatim that they've said in session. It's really helpful in a way. I think that's a very concrete way, usually. For me, it helps me not have to then keep it all in here. It's a way of, you know, it's there. The writing process helps me process it, too, I think.

Researcher: Well, and even retain it because we know right from research that the physical act of writing, it really helps.

P7: Exactly, exactly, yeah. I'm doing a lot of part work with people right now, so being able to track which aspect of self active and what that part is holding is really helpful. So, yeah. It's, I don't know that it feels fully conscious, though. I think it's more embedded now. I mean, I remember that feeling of, like, when am I gonna say this? I need to remember to say this.

Researcher: I think that's exactly what I'm hearing from people, is that early on in their career, that sort of happens, but there's sort of this ... It's still there, but it's maybe more sensing or it's just automatic. It just happens. It's natural.

P7: Yeah. I mean, even as you and I are talking, I'm more tuning into your reflection of what I've said and how it feels like I answered your question. Somehow I can relax and be ready for, you know?

Researcher: Yeah, yeah. Where are we at? Oh, yes, condition beliefs about trauma. The other thing that I'm finding is there are, I think naturally in any professions, some condition beliefs about, in this case, trauma. So, separate from the client, but what are some of those pre-conditioned beliefs or assumptions about trauma?

P7: That I have?

Researcher: Yeah, and so they can range from-

P7: I might have a hard time doing that. You're gonna have to tell me.

Researcher: Well, you probably know. They can range from, like, trained or purposeful reactions about trauma to more mainstream socialization things that you might hear about trauma. It's probably changed over the course of your career, maybe what you thought of trauma early on versus now. You've been very clear with me, I think, over these three interviews about, you

know, it's all trauma work, essentially. That's one of your core beliefs about trauma ...

P7: I see what you mean, okay.

Researcher: Separate from the client, but it's like what, yeah.

P7: Okay, I get you now.

Researcher: I think you have it, I think you have it. I just need to hear it.

P7: Yeah, yeah. No, that makes sense. For some reason, I was hearing assumptions as a negative, like assumption-

Researcher: Well, it could be biases. Yeah, there's definitely biases.

P7: Which I'm not sure I would necessarily be fully aware of that is why.

Researcher: Yeah, yeah.

P7: Assumptions, beliefs about trauma, I think trauma is on a continuum of anything from a mild adverse life event to something that anybody would label as trauma. I think that trauma is fairly misunderstood. I think that it is ubiquitous in some ways, again, across that continuum or spectrum. I think that it can generate resiliency in growth and it can also really be damaging. I don't think it's necessarily always something that is wounding in a way that someone can't respond to in ways that are really productive for them. I have an emerging recognition of the extent of socialization as a traumatic force, for men, in particular.

Researcher: I'm not following.

P7: I think men are traumatized by the socialization that they experience in this [crosstalk].

Researcher: Oh, okay, about how they're socialized. I see, okay.

P7: Mm-hmm (affirmative). I think that contributes to a great deal of balance against women by men and toward minorities. I think trauma can be healed. I think that there are methods that really work. I think that people underestimate their ability to recover from trauma. I think there's a huge, huge ... On one hand, that trauma can be like X, Y, Z, just apply the formula and you will get better, prevent yourself from getting cancer, prevent yourself ... I mean, it's something, you know, we're supposed to be able to control everything now to this opposite extreme where people feel like trauma is just a permanent condition and you can never recover from it.

Now, let's keep in mind that I'm in private practice, not in a hospitalization institutional setting where people are really, really, really struggling. So, that's a privileged view that I have. I think that on a really sort of philosophical spiritual level, being human is traumatizing and human suffering is, you know, trauma is a euphemism for suffering and everyone suffers. That's just the way that it is. It's just part of our life. I think trauma has really physical consequences in terms of health conditions, chronic health conditions. I think the body carries the trauma in very clear, very direct ways. I think that trauma is passed generationally in many ways. I also think that trauma cannot touch the core self. It's untouched. Part of the trauma work is helping people come back to that core.

Researcher: It sounds hopeful.

P7: What other things would I have?

Researcher: Well, just reflecting on that, yes, it sounds ... I can see if I was working with you as a client, I would think, okay, okay, all right, there's some hope here.

P7: Well, I have a lot of hope.

Researcher: Yeah, which is also, yeah, that makes sense. Yes, and thank you for pointing out the privileged, yeah, which doesn't mean that there's not hope for other circumstances, but it's just different. It's just-

P7: And it's not that I don't have folks who are hospitalized at times. I have a quarter of my case load that's [inaudible], so I have folks that are in pretty serious financial situations, and I have folks who are in very seriously oppressed positions in society. It's not that I don't have people in serious situations, but it doesn't compare to an inpatient long-term care. That's different universes.

Researcher: Yeah, definitely, definitely. Okay. Lots of counselors have shared that reflection seems to be a big part of their process, and so I'm wondering if you can talk about how reflection comes into your process. It can be ... I've heard ranges from just sort of solitary reflecting about the client or about the work. Maybe it's consultation with other people. Maybe it's reflecting when you're out jogging, or doing yoga, or between sessions, or you only reflect when you're looking at the notes before a case and sort of what you kind of do or how reflection happens.

P7: Reflection happens for me several of those ways. I do reflect before I see someone. I reflect after I see them. I think I reflect after more. I had a process for a while where it was very difficult for me to write notes because I was reliving the session as I wrote the note. It was just visceral, like, emotional sort of process. And so, I think writing the note is a way

that I absolutely process what's happening and what the pieces are. And then before my next session, I review the note and reflect again. I do consult, not as often as I used to. I don't feel the need as often as I used to. I don't feel like, especially like today, about this kind of a thing.

Researcher: That sense of urgency.

P7: That's not there, yeah. There are times when I'm thinking about clients. When I have a really full case load or when I have somebody that I'm really concerned about, I will think about them, reflect on them between sessions, but again, not like I used to. I just don't.

Researcher: Like, less frequently?

P7: Yeah.

Researcher: Less infrequency?

P7: Yeah. When I'm not working, I'm not working. When I'm not working, I just have ... When I'm present, I'm as present as I possibly can be. When I'm doing something else, I'm doing that.

Researcher: What does the reflection lead to, or what has it led to?

P7: I mean for me, as a psychodynamic, primarily psychodynamic therapist with pretty heavy dose of boost philosophy, meditation sort of concepts, I just completely forgot your question.

Researcher: Oh. Where does reflection lead to?

P7: Apparently nowhere, that's great. It leads me, so yeah, the psychodynamic and that sort of background, it's for conceptualization. It's for understanding the context for someone, what the factors are that have contributed to their current distress, what aspects of self seem to be, sort of around dominant and what sort of counterbalances are gonna be needed for them potentially. I might think about the interpersonal patterns and the therapeutic relationship, but that also isn't as much anymore. I might think of resources that I feel like would be useful for that person. I mean, there are times when I'll send somebody an email with a resource that we hadn't specifically discussed because it just occurred to me. Sometimes it happens when I'm thinking about other cases. There will be, like, an aha moment of a connection. I'm doing a lot of reading right now, so I'm thinking about cases in reading. That's happening. I just went to an EMDR, well, I didn't go to the actual conference. I did an online live, but ...

Researcher: I was there.

P7: Oh, yeah?

Researcher: That was my first national EMDR conference.

P7: It was a good one this year.

Researcher: Have you been to a national conference before?

P7: I went to the one in D.C. a couple years ago, yeah.

Researcher: To me, I've been to a ton of conferences 'cause I love professional dialogue, but they had to set the bar for organization [crosstalk]. I was blown away. I have never been to a big conference like that, that was so well organized.

Researcher: All that is good to hear. That one seemed particularly good.

P7: Yeah, it was good. I really liked ... I did the online, the live stream.

Researcher: Oh, yeah.

P7: And I really liked it. I was surprised. The ones that they selected were very well done. That, I definitely reflected on clients in that, and then a couple of the talks really got me excited about some other pieces that I'm exploring. So, I think about clients when I'm reading.

Researcher: Nice. Do you ever think about it when things are going really well?

P7: Oh, yeah, absolutely.

Researcher: Like, wow, this is flowing ideally.

P7: Totally. Yeah, again, recently, the way that's been showing up is when I'm feeling [inaudible], it just, like, the session runs itself. The client is doing-

Researcher: And your reflection has probably got you to the point where you were able to connect and really centered.

P7: Oh, yeah. I can feel it. It's a visceral experience.

Researcher: So that must be leading to what's.

P7: It seems to be a pretty significant piece. Yeah, no, I have, I mean ... I have this running joke with a few of my clients that there's a part of me that wants to get pom poms and do a little cheer for them because they're just doing such amazing things in their life. The joke is that the pom poms would be for me. They would not actually be for me. That's why I don't get them.

Researcher: Really more beneficial for you.

P7: You want to spell their name out. Like, okay, you need to go back to junior high and go do some cheerleading or something because it's clearly not ... I

mean, this is not about the client, but it's about this excitement for them, this part of me that's just thrilled for them and wants to convey that to them somehow.

Researcher: Yeah, and celebrate.

P7: Yeah, yeah, yeah, but that's another piece for consultation. I have colleagues that I can just, you know, we get so excited when things are going well for somebody. I have a pretty common thing that I do with people. I often wish that I could videotape them today and then play it in our first session because they could never have predicted where they would be, which of course means there's a session in the future that we'd love to be able to play for them today that they can't yet, you know, even imagine being able to feel. So, I often will say something like that with somebody.

I have a progress checklist that I really like that I will give to people from time to time. One side has all the current concerns and what kind of rating they're feeling about that and what their goals are. Then the other side is all there is, they feel like they're making progress and that it's a way of really celebrating, really making it concrete for them. They can see what's actually happening for them and they wouldn't necessarily be able to ... I mean, it's feedback that I've gotten from a lot of people that it's really helpful when we can make something really concrete.

Researcher: Yeah, you can see it, nice.

P7: So we do that. I mean, I'm really, really loving my work right now, loving my work right now. You're catching me at a time when I'm just, like, I have warm fuzzies about being a therapist. I've taken a number. I'm really full right now, which I did not anticipate. I didn't expect at this stage of my life that I would want to have more.

Researcher: Wow.

P7: It's sort of perplexing. But, that's, yeah.

Researcher: Is it word of mouth, do you think?

P7: It's a lot of sources.

Researcher: Okay.

P7: Yeah, sometimes. Sometimes I've gotten a number from the counseling center for some reason, which I didn't get any last year, so I don't know why. I've gotten some from some professional in the (organization names removed) is a really good one, and then some word of mouth, and then some stuff that I do for the institute. People always get to know me through that.

Researcher: Well, that's all for these questions, but I thought up another question that's a side note. I'm curious how you ... I don't know if balance is the right word. The Buddhist principle of no self and your core self, belief and practice, how are you ...

P7: Well, I'd say them as the same thing.

Researcher: Say more, if you don't mind.

P7: Sure. My interpretation, my understanding of no self is actually that everything is connected, that when we are identifying as I, that that's actually ego. That's the ego. And when we are just being, then that is the essence of [crosstalk] self.

Researcher: Okay, okay.

P7: And so core self, sometimes, I mean, I've heard it referred to as higher self, true self, core self, essence, like that sort of thing. I think it's that.

Researcher: Okay, so really the lack of self, or the lack of ego. Okay, okay.

P7: Being-

Researcher: I was just curious. There's a lot of ... I mean, that word self is of course around a lot, and I think, oh, how does that work with this Buddhist principle for no self, so just curious.

P7: Yeah. I mean from a Western perspective, self is ego.

Researcher: Yeah.

P7: From the Eastern perspective, self transcends.

Researcher: Good point, yeah.

P7: Yeah, it's like non-attachment. It's, like, really hard to describe non-attachment.

Researcher: Yeah, especially for Westerners. It's very, very difficult.

P7: Yes, yeah. I usually talk to people 'cause I love that [inaudible]. I think it's really helpful.

Researcher: Yes.

P7: What I end up talking with people is that is what it's not, right? It's not attachment and it's not aversion. It's what's left when you're not doing that.

Researcher: Yeah, trying to explain something is the absence of something. That's an interesting [inaudible].

P7: Yeah.

Researcher: Yeah, nice.

P7: So that would be my answer.

P8 Round Three

Researcher: ... Reflect and I have you on speaker phone, so if you can't hear me and vice versa, feel free to just stop and ask for me to repeat something.

P8: Okay.

Researcher: So, like I said, I've got four questions and, you know, we'll just see how long this takes, maybe 45 minutes or so, depending on how much is there. Sound good?

P8: Sounds perfect.

Researcher: Thank you, okay. The first question is fairly open-ended. If you could just talk about the uniqueness of your experience of trauma counseling versus treating other clinical conditions.

P8: The uniqueness of ...

Researcher: It could be the uniqueness of maybe your approach, or just your experience with them, or things that maybe you have a heightened sense of, things that you don't even consider, if there's anything that sort of sets that sort of treatment apart from how you would approach other diagnoses or symptoms.

P8: Well, I'd probably say ... Interesting. I'm trying to think of kind of how my brain wraps around this. I think probably because a lot of times, therapy, for me, it seems like it has to be a pattern with regular problems, like let's say it's anxiety or it's depression or something like that, as a therapist who works primarily in CBT, I would tend to kind of look into it from the standpoint of symptomatology, and then look at issues of behavioral activation or the things that they could practice in between that are very specific to working on that piece of their symptomatology, or that piece of their disorder. It might even be data gathering where I need more data about something, so I have them track data about their symptoms, or about their issues.

But with trauma, it's interesting because I'm not doing that same sort of pattern work. It's interesting, too, is it does seem to be a lot more linear with other disorders where there's a certain one spot and I'm working towards getting to another spot. Generally speaking, with depression and anxiety, I'm looking at it, and just basic anxiety or generalized anxiety disorder or panic disorder of some sort or depression, I am looking at it from the standpoint of I want to get their

symptomatology so that they're functioning better. It's just sort of a general functioning thing, whereas with trauma, it seems like it's more ... It's still like I'm treating ... I'm not treating symptoms. I mean, I have that data in my notes and I'm aware of it, but I'm looking for something different. I'm watching the pattern emerge in a more ...

I'm trying to kind of grasp how I think it through in my own head because it's more deep work. It's more not just behavior in between and that if I can really work on the behavior, that I can end up getting some traction in therapy because it isn't, for me, the way I work with trauma, it isn't behavior like depression's behavior and anxiety's behavior, and certainly thinking, as well, but it's more like trying to put together puzzle pieces and trying to help the person see how these things all fit together and how their thinking got distorted somehow in the way they put the puzzle together originally. It's almost like this process of deconstructing it and not having such a connection with the actual puzzle pieces or their own ... Because these ideas about where they fit in, but just having this ability to look at them differently than they were able to look at it before.

You're trying to bring them up and you're trying to help them just lay them out, almost like you are putting a puzzle together. You are trying to figure out, okay, I thought that green was grass, and that was my mistake. It wasn't grass. It's trees, and so now I have to be thinking of doing this differently because I made that initial decision that green meant grass, and now I'm having to decide, is it trees? Maybe it's trees, but maybe it could be a lot of other things that are also green. That's sort of how I find myself working.

I'm often, I think, as surprised as the client. It's funny because with anxiety and with depression, and I'm not saying those aren't difficult disorders, but they're a lot more predictable, I think. With traumas, I have to throw my own any kind of preconceived notions or any kind of ... Six cases ago, I worked on someone who had a similar sort of symbolism when I'm doing EMDR with them, maybe some kind of piece, and then I have to just let it sit there on my board and not make any judgment that it is grass or it's trees, but I have to be just as open-minded as I'm hoping that the patient is.

It's so different. Each time I hear someone's story or they are processing the story, it's almost like my own internal process is fighting any kind of judgment, any kind of hypotheses that would be ... Well, I would say, no, I take that back. I do have a lot of hypotheses, but I'm really open about them. It could be this, or it could be this, or it could be this. Then as the puzzle pieces begin to, and enough weeks go by, or enough sessions go by and the puzzle pieces are far more prolific, there are many, many more of them, it seems like they just gently fall into place. It's very nice that way, to me, because it just seems like they start understanding it. I start understanding, almost at the same time.

Like I'm saying ... And I do work with some in depression. I work with some with just generalized anxiety or health anxiety disorder, those sorts of things. It's just so ... 'Cause you're always just focusing on behavior, behavior, behavior, and now, now, now, whereas trauma is so much about the past that is affecting the now. With depression, I'm not spending a whole lot of time in something that might be six years old and delving into it again, and again, and again with such precision and such depth, whereas with ... You're just kind of gauging like, on a scale of 1 to 10, how much story did you have? Those kinds of things. It's just so different.

Researcher: Yeah.

P8: And it's a complete switch, too, mind-wise, between working some diagnoses versus PTSD.

Researcher: Yeah, definitely sounds like ... What a great image of the puzzle pieces. It's a lot, it's different, yeah. It's very different in the piece about not making judgments and yeah, that's great. Okay. Thus far, what I've learned is that expert trauma counselors seem to have a heightened presence or somehow just really closely tracking a client in session, and that seems to be highly valued, while at the same time, experiencing a great deal of internal dialogue in this session whether it's questioning, or anticipating, or clients' response, or even your own response. I'm wondering if you can talk about your experience with that, or how you balance staying present with anticipating their response or even your own response, if that makes sense.

P8: Yeah. Normally, I tend to do, and I think this is just for me, it's what's most useful and that's probably why I keep ... I keep pretty copious notes. For me, that ends up helping enormously because I can certainly ... It's almost like I am writing out the puzzle pieces. It's almost like that's my job in depression, is to be a witness and to be present in their experience. I always feel like the better I ... The more detailed or the more clearly I write that information out, the more it's going to be possible for us to find those, gosh, you know, each of those separate puzzle pieces. I'm taking really ... I'm a really ... I mean, you should see my notes for when I ... Each time, each half through of the target, and then done processing it, I'm taking the notes about it. For me, I'm not sure if you've read the research just as I have on note taking versus typing, which, I'm funny. I'm old school 'cause I used to do EMDR where I would actually have a computer kind of EMR.

Researcher: Oh, yes.

P8: Often times even in real time, but the thing that I noticed is that you just don't have as much retention. It's funny 'cause new research has come out that says exactly that.

Researcher: Yes, oh yes.

P8: Your retention with just writing ... With typing things into an EMDR versus your retention when you actually write it with your hand, I mean do handwriting, and I'm a real firm believer in that. I take those notes. For me, being that present in it that I'm just taking all of those notes and I have them as a record of what we've talked about, I have them as a record of what they've said in the past. Then it gives me the ability to keep looking back on them. Sometimes, I'll know, okay, there's a puzzle piece.

I feel like I am experiencing it in real time just like they are. It's real interesting to me. It's just the ability to, when I'm writing it down and then I'm remembering, oh my gosh, there was another piece that goes with this one. It was two times ago. I can just look back in my notes, and sometimes I will even remember it. I don't have to look at my notes and when we're actually talking after the session, I'll bring it up and they'll go, "Oh my gosh, that's right." It just seems to all fall into place.

I hope I'm answering your question okay, but that's the, for me, that writing down and just being there for them, almost to write out the story ... Almost like writing out the story of their limbic system because when they're processing it, it's so much like it was encoded, snippets of information, and they're very disjointed and very seemingly senseless. I mean, they're sensible, but they don't make sense at first. It's not like there's this absolute, like I can ask a question with the person with depression, and I can ask certain things and the answer is gonna make sense because the experiences, and it's probably because they are disorders of different parts of the brain. And so, you end up ... When you're working with people, you get that sense of it. You get that sense of, it isn't in the same part of the brain. It just isn't.

Researcher: So, it sounds like the writing keeps you more present versus being a detractor in the session.

P8: Yes.

Researcher: Wow, okay.

P8: And I also think, too, for people, I think it's the importance of the writing. I let people know. I mean, it's actually part of my introduction at my practice. I let people know I will be writing in sessions. If they want to write in sessions, they're welcome to do that, too. But, I let them know that because I want them to know that I see that it's that important that I'm writing it down. This isn't something that it's like, oh, no big deal. It's sort of, to me, almost like when you're in a lecture. You're writing down the most important things that they say, the most important things that the professor says. If I think it's important, I'm writing it. I remember when I was teaching that [inaudible]. I guess that's not

important. I think I just want my patients to understand, I really, really deeply see what they're saying as important.

Researcher: Wow. So, it sounds like you're writing, like, I'm imagining all of the sort of EMDR sort of questions and asking them what they notice. Just in general, you're a writer, not just with that EMDR protocol, it sounds like.

P8: No. I am just, I'm always writing.

Researcher: Oh, that's fantastic, fantastic. Do you ever have any clients ask what you're writing?

P8: Once in a blue moon, interestingly, 'cause I do write that into my introduction at my practice, so most people understand what I'm writing is I write about what they tell me. I even tell people, if you want to see my notes, I mean, there's nothing surprising. They won't be surprised at all what I have in there because it's all information that would be ... It's just things that they've already said, so it isn't ... I don't know. It isn't some kind of mysterious information or anything like that.

Researcher: Does it ... I'm thinking about your own ... Does it prompt you to say things, or is it more of tracking that history? I love that writing the story of their limbic system, so I'm wondering, when you're writing, does it prompt anything within you? Or, is it more of just sort of tracking?

P8: I would say it's probably two things. It is the tracking. There's no doubt about that, but I would say that probably the biggest part of it is that I need to be grounded in the history. I need to make sure that I'm tracking the history. I am deeply understanding the history as far as, as I'm writing it, I'm encoding it. That's the best way to put it.

Researcher: Oh, yeah, that's great, okay. This kind of leads to ... I'm gonna change my question order because we're talking a little bit about reflection. A lot of counselors have shared that reflection is a routine part of their practice, and it seems to take the form of solitary contemplation to group consultation occurring spontaneously or maybe anticipatory reflection. I'm wondering if you can talk about your reflection process, and maybe what prompts you to reflect or the impact of your reflection process. This could be between sessions, just whenever you do it. Counselors really seem to have this ... They reflect at certain times, and it just seems to be very ... Oh, what's the word I'm looking for? Purposeful, I guess.

P8: I would say that for the most part, my reflection time is ... I do have a consultation. We meet maybe once a month. We both are working a lot in trauma, and so we will bring cases to that peer supervision group. That is one form of that, but probably the most I do is, and I don't know if I do it as purposely as I ought to do it, but I definitely do it consistently. That is, I have a

sense of when a session is, I would say, is progressing. I think that would be the way. It isn't even about whether there's SUDS, beginning SUDS, ending SUDS. It isn't that. It's a lot of things. I think it's just a self-sense. Whenever I have that, that this is not progressing as it could be, or this is not progressing as it should be, those are the ones I will spend more time in. I think they tend to switch bases anyway. There might be one, or two, or three that I'm thinking a lot about and I'm thinking about the last session. It's almost like I can review the sessions throughout the session. I can start it again in my head and go all the way through, and see if there is any piece of it that I could have made it different, or that I think something I didn't pick up on. I have one right now that I'm that way, and I think I'm going to ... I actually think I'm going to switch protocols. I mean, not, but I'm gonna switch to one of the different EMDR protocols. I think I may need to do a lot more. Unless when he comes in this next time, his SUDS just decrease. But other than that, I feel like there's something in that particular case that I need to change the focus on because it's not moving forward as I think it could be. That's probably my biggest one that I'm thinking quite a bit about right now because it just doesn't feel good. It just doesn't feel like it's ... Somehow or another, it's something I don't know if I'm missing something or if whatever, but it's just this sense of, like, ugh, this one is not progressing as it needs to be progressing.

Researcher: Okay, so this felt senses sounds like it's maybe thoughts and maybe a physical sensation in you that this is just not going as anticipated.

P8: Yes.

Researcher: Yeah.

P8: Yeah, and so whenever I end up at the end of a session, and I always know because it's always the case I'm thinking about in between. It's because there was something missing, either ... I'll kind of tick down, in my head, some of the ideas I might have. Like, so, from the therapy as alliance standpoint, okay, yeah good. From the have there been any ruptures in the alliance, no, those kinds of things. Then I will sort of hit on a few different essential hypotheses about what I could try the next time or what I might be missing. That's generally what I do.

Researcher: And does that come at all different times, and it happens in your head and not on paper or ... I mean, sometimes it sounds like you consult, but does this happen mostly in your head by yourself?

P8: I would say yes.

Researcher: Okay.

P8: Yeah, and then sometimes those will also obviously be the ones that I'm gonna talk to, the person that I do consult with, I will talk to her about those cases. Generally speaking, it's almost like a sense of dissatisfaction. I'm dissatisfied

with that session. It's strange, kind of. It just, overall, that isn't ... It just isn't going in the direction it feels like would be best it could be going in.

Researcher: Do you ever bring that up with the client? Like, there's something not going well here, or anything like that?

P8: Only if I feel like it is the therapy, itself. Then, I might. But because if I feel like I'm not a good match, like if the therapy is alliance issue, I might then. But otherwise, I tend to struggle with it for a little while and see if there's something I can solve. If it's solvable, then I will do that. If it isn't, then ... 'Cause it's funny. I haven't had that experience a whole lot in ... I mean, as far as ... Usually, if it's just the whole therapy, itself, doesn't really feel like it's progressing, versus, in other words, I'm getting old-fashioned resistance, which I don't really believe in, personally.

Researcher: Right, right.

P8: But I mean that sense of this person doesn't really want to work in therapy. It's funny. When I'm not enjoying it, that's actually one of my criteria, is I usually very much enjoy it. From time to time, I will have this experience where I'm not enjoying this. This is not pleasant. But again, very, very, very, very rare that I feel that way. Most of the time, I struggle with a little bit, I'll try something new the next time, and that's it. That was all that was needed. I'm able to sort of break that impasse or get some place a little bit further with a case that I haven't gotten, and that was all I needed.

Researcher: Any reflection that occurs when things are going well?

P8: A reflection when things are going well ...

Researcher: Maybe not, I'm just curious.

P8: No, actually, that's a good question. I think when it comes down to it, that, and maybe I just expect things to go well. I don't know if I have this, just, very intense belief in clients' abilities to figure themselves out and to move forward, and some that I think when things are going well, I do an evaluation on that. It's like, especially, too, with ... Especially with the EMDR, if there's any subtleties, any little things I'm doing differently in a case, let's say, or this particular case that I ... Because it is moving forward so fast, and I think is it anything I'm doing versus I ... My experience is, quite truthfully, it's rarely what I'm doing. It's almost always what they're doing. It's their desire to get better, or to improve, or to whatever. It seems like that's what is making the big difference.

Researcher: Great, great. Okay, last question, so far, again, I'm analyzing all of this data, and so far it seems like there's some evidence that experienced therapists have conditioned beliefs or assumptions working with trauma clients. And so, these thoughts can vary from trained or purposeful beliefs to reactions about trauma

resulting from mainstream socialization, and I'm wondering what are some of the conditions, thoughts, and beliefs that you have about trauma or that you've developed over the years about trauma, itself, separate from maybe your perceptions about your clients? That was kind of a mouthful, so if you need me to repeat, I'm happy to.

P8: Okay, so yeah, do say that again. I think I have the gist of just my-

Researcher: It's a lot.

P8: Yeah, my assumptions about trauma in general, like what it does, or what it is, or?

Researcher: Yeah, some of your conditions, thoughts, and beliefs about trauma. For example, I imagine a new, maybe somebody who isn't as experienced might think that trauma clients could be scary and potentially difficult to work with and that maybe they're blaming all of their problems on the past. I imagine people who just aren't experienced may have some of those conditioned thoughts. And so, there seems to be a difference, but we still have conditioned thoughts and beliefs about trauma. As somebody who's an experienced trauma therapist, what are some of those thoughts?

P8: I would say ... Let me see how I could.

Researcher: Yeah, feel free to take your time.

P8: Okay. I think ... Let me see. I would probably, for me, and I don't know any other way to sort of when I look at it, and I will have to admit, I often think, and hopefully this doesn't make me sound really conceited, but I'm often really glad that they're coming to see me, as opposed to someone who has less experience because ... Especially when I get a trauma case that's really horrendous. I think of how many people over the years have come to me and said, "My last therapist," fill in the blank, and I just cringe for my field and I cringe for ... And I can understand how excited people would be because trauma is very, very fascinating. It's very interesting how the brain figures out how to survive horrible things and manages to get up the next day and go to work, or get up the next day and get their kids ready for school and send them off to school. It's awe inspiring. It's amazing, and yet, it's excessively complex and very, very difficult. I think I shared with you earlier, I think that for me, a lot of it is being able to be so patient in letting the person tell the story as it was encoded, not to make any kind of assumptions about how it was encoded before I even hear the whole thing, or that I again, and again, and again because everyone is going to do it differently. Everyone, because their particular trauma is their very own fingerprint, it's unique. There's no comparison, really, to someone else's trauma. Yeah, there's symptom comparisons, same thing with depression, same thing with anxiety, but there's no similarities. And so I think for me, I'm glad when I

get a complex case and that it isn't someone, this person going into therapy and being treated by a naive therapist or someone who really doesn't specialize in trauma so that there isn't harm done because I've met people who I tried doing this 6 years ago, I've tried doing this 10 years ago and this is what happened with that therapist. And so, I didn't want to do it again. Having that sense of having to get that person's confidence and getting that person's buy-in that I will do my best to not do what was done to them before. I think probably my other assumptions is that there is a lot more tread lightly. I have this sense that I need to tread much more lightly with these kinds of cases than I might otherwise do with a depression case or an anxiety case where I'm pretty straightforward, pretty assertive with them, and for behavior activation. I'm like, okay, let's get on this kind of thing. It feels so much more ... And so I approach it a different level of, I guess, gentleness than I would pretty much any other case. It's just ...

Researcher: What are you weary of?

P8: I think the main thing is, is I don't want to re-traumatize anyone. It's almost like letting it be where it needs to be with enough respect to that person's ability to process it because I think sometimes, especially too, when ... If you've worked with enough of these kinds of common cases, you realize, too, it's like people can sometimes jump right in and I want the whole story.

Researcher: Oh, yes.

P8: That may not be in any way, shape, or form good for that person. It might be, but it might not be. And so, in a sense, you're trying to do two things. I mean, the person will often come in and they will admit they want to work on the trauma, but you're also doing this assessment of really how ready are they 'cause there's a part of them that wants to, but there's that other part of them that does not know what's gonna happen. I've had a case, just recently, who had such a terrible trauma. The original trauma was so bad that they ... Weeks afterwards, when they were diagnosable with PTSD, they actually even lost their sense of taste.

P8: Because it was so awful, they could not sleep. They lost enormous amounts of work 'cause they couldn't taste anything.

P8: And so as soon as I heard the story of and their experience with treatment then, and I ... I'm sort of walking this ... It's interesting. Because so much of my practice is trauma and a lot of it is becoming word of mouth now, so I also have that as part of my assumption, is that I'm not just treating one person. I'm treating a class of people who know about me and are talking about me. That's not in any way paranoia. That's just a fact. I'm part of a system, and they know everyone in that system who come to see me may end up being that person who talks to someone else and says, "Oh, yeah. I had that experience, and I went and saw her." I almost feel like I'm not just ... I'm treating that person, but I'm

treating all of these other unknown people. That's kind of my assumption, too. I can't just ... I'm aware that I might be treating more than one person at this time, if that makes sense.

Researcher: Oh, yeah.

P8: I have this obligation to be always, always be patient. I mean, it's a constant you must be patient, you must be patient because it took this person, some people years to get where they're at. For me to think I'm going to undo that in five sessions is just naive and for me, that's part of that almost like there's all these nameless faceless other people I am having to consider because I can't be ... I have to be vigilant. I can't be lazy about this or impatient about it because it could be that finally because someone's partnered with someone else, and then they end up having some conversations, and then they end up saying, "Hey, I went and got help for that," and that they would finally get help because I work within a closed system.

Researcher: Right, right.

P8: They don't talk, and they don't get help. I mean, they really, really don't. To me, each time I'm able to be and help someone, I really feel like, wow, I am potentially changing a system. I take that really seriously because I think it would be so much better if people came in right after. Within the first month or two months after something that's ... Instead of waiting 6 years, 8 years, 12 years after an incident. So I have this when I'm approaching it, I do see those other faceless people sitting in the wings. I use that as my own reference point.

Researcher: Oh, I like that.

P8: Making sure that I'm doing work that could continue to make a difference not just for this person, but for ... Because it's a closed system. That's how closed systems work.

Researcher: Yeah, oh, that's great. You mentioned the sort of doing two things at once, and one of them was assessing readiness. I'm curious, I mean, of course I work with trauma clients, too, and so I'm thinking about, oh, you know, making sure that they can sue themselves, making sure they have some, maybe, external supports, other things that you sort of keep an ear out to sort of assess, can they calm themselves down in and out of session. Are there any other things that you do to sort of assess readiness?

P8: Usually, actually, I will often ... I always check in, obviously, in the very beginning of the session. I'm asking specific things to see if there's been any kind of decompensation between this session and the last session. That's part of what I'm doing, and then also for them, asking them, are they doing the things that they ... Are they doing their meditation [inaudible] basically a safe place

every day? Are they doing these specific things that are to keep themselves tracking along as far as the treatment goes? But, I always check.

Sometimes I usually will check in, any thoughts since the last session? I'll usually kind of pick down some things like, have you noticed any ... Has it been a good week, bad week, kind of thing, and are you sleeping, all of that kind of stuff. I usually know what their sleep status is, and it's one of my main things I will check in on. If I know that their sleep status has changed, like I didn't sleep at all this week, I'm gonna delve in. We may not be doing the EMDR that week because if they aren't sleeping, then something's going on and I need to know about it.

Researcher: Great. The other thing that I just want to unpack a little bit is talking about their story. I'm wondering, oh, do you get pulled in by their story? I imagine newer counselors sort of get voyeuristic about things. It's easy to do that, but you seem to be very attuned to their story, and I'm wondering about your experience being pulled in or holding back or I don't know, your experience around that. It just seems intriguing to me.

P8: That's interesting. That's an interesting question. I don't think I get ... I think I'm constantly seeing their story as the puzzle pieces. I'm moved by their story. I guess I wouldn't say I'm touched, but they trust me that much now, that I'm impressed that they survived that story and that they're still functioning in a relatively normal way, considering their story. But, I don't really ... It's interesting. I think when I was younger, I used to just get intrigued by the story, itself.

Researcher: Oh, yeah.

P8: Now even when I think about the story, I don't think about the story. I think about the puzzle pieces. I see that it's almost like I have ... I'm a real visual person. My own sense of almost like ... When a case comes up in my mind, it's almost like I can throw the puzzle outline up in my mind's eye, and sort of have a sense of how many puzzle pieces are there like, wow, we're far. There's a lot missing. This isn't making sense to me. It's not falling into place for me. Then other cases, it's like I can really see how it falls in and that we're so close, and that it's beginning to really transform and I'm beginning to see things, see the patterns in things and see how much sense things make.

And so, it's interesting. I don't think I even ... I don't even think I hear it as a narrative anymore as much as I ... It's almost like the psychological components of the thoughts and the meaning of different things in a sense the negative cognitions, which are often, we only pick one negative cognition, but there's so many that are attached to pieces of the narrative, or pieces lost in the aftermath,

sometimes days later, weeks later, especially 'cause I think I shared with you, I worked law enforcement.

Researcher: Yep.

P8: They do this thing. It's called the cert. What a cert is, it's basically a big giant meeting where they do a complete after action of some kind of critical incident.

Researcher: Oh, wow.

P8: And so, they break it down. This will last four or five hours, sometimes an entire day. I've been to a daylong one before. It was a really, really big and made the national news kind of thing. They look it from the standpoint all the way from dispatch from the original call coming in. Maybe if there's six different people who called 911, each of those different ones is reviewed. Did we do anything right? What did we do right? What did we do wrong? It gets kind of broken down like that. And so for a lot of these people, sometimes part of their problem is that cert.

Researcher: Oh, yeah.

P8: They're having to watch their body camera and they're watching other people's body cameras, and they're hearing the dispatch again because they were one of the responding officers, let's say. And so, I may end up ... That may be the moment in time when some of the negative cognitions came in. It wasn't necessarily because they would have spontaneously created that cognition. It's because it was said in a meeting, and all of a sudden, you're integrating somebody else's. I hope that makes sense.

Researcher: Yes, oh, yes.

P8: And so as a result, the complexity of how these fall together in the original trauma development, and then how they get deconstructed and then reconstructed, which is really what [inaudible] are supposed to do. It's almost like we deconstruct, so now we're looking at all the puzzle pieces, and now we're gonna construct and make sense of them this time, and in a way that's more resilient and in a way that's more useful for the person. I tend to see that now. It's less about the actual narrative than it is about the process of the narrative. It's almost like there are two threads. Here's the actual narrative of the story from beginning to end, and then this is when the processing began, which began afterwards. It's almost like, yeah, that's that's the story, okay, yeah, let's move on. Now we're gonna talk about how did I explain that thing to myself? How did I ... Because you know, PTSD doesn't happen necessarily in the time.

Researcher: Right.

P8: It happens after the fact. And so, I'm interested in the story since. That, to me, is what's so much more interesting.

Researcher: Oh, that's great. Thank you. Okay, well, that's all my questions. Thank you.

P8: All right. You are very, very welcome. If you ever find yourself in Vegas, make sure you look me up.

Researcher: Well, I am definitely ... Yes, there will be ... 'Cause we may be done with questions, but this will not be the last you hear from me.

P8: Oh, okay.

Researcher: I'll explain that in a bit.

P9 Round Three

(combined with Round One questions)

Researcher: Okay, so the first question is if you could describe your process when making clinical decisions with trauma survivors? So this could be anything from, you know, when you first get a phone call or do an assessment, all the way through mid-treatment and beyond. Wherever you want to start.

P9: Sure. It's a very, very broad area.

Researcher: Yes.

P9: I do my best to keep the whole person in mind, and what resources they have. I mean, safety first. So, is this person safe in this moment? In terms of suicidal thoughts, homicidal thoughts, harming themselves in one way or another. That might be through substance use or self-harm or gambling ... you know some way to escape the pain. Some avoidance behavior, perhaps.

Researcher: Mm-hmm (affirmative).

P9: And looking at safety at the beginning, and then over time, looking at some way to work directly with whatever trauma there was and the impact of it. Which, doesn't always mean... I don't have a rigid idea about what that entails. I think there's some themes that's usually talking about it and complaint... Reckoning with how it affected their belief system, the beliefs about themselves, their beliefs about relationships, et cetera. Thinking about what kinds of resources and support they have currently, and what they need to develop.

Researcher: Mm-hmm (affirmative).

P9: Which fits with both safety and connections.

Researcher: Yeah.

P9: And thinking about what I think theoretically. Sometimes I'm working too many NDRs, sometimes I need to do more systematically informed, being aware of that a lot of influences [inaudible].

Researcher: How do you determine when to sort of vacillate between all of those sort of theoretical approaches?

P9: Well, the client is part of that decision-making.

Researcher: Okay.

P9: So, often at the beginning of treatment, once they're at a place of safety, which sometimes that's the very beginning symptoms. Talking about options, there are treatment goals. Sometimes people just want to be able to get back to some sense of normalcy and they're not ready to or motivated, look at the trauma itself and there's some risks and benefits of that, even that may vary. Then when you talk about different approaches I might make a recommendation for that. NDR is a better fit for some people than others. I don't think any one approach is the right one for everybody. So collaborative [inaudible].

Researcher: Great.

P9: Let me know if the background noise is interfering. I'm at home with rustling leaves and squeaky toys.

Researcher: I can't hear anything yet.

P9: Okay. Okay.

Researcher: How do you experience countertransference?

P9: We all experience it constantly, right? I experience it all the time, [inaudible] I'm more aware of it sometimes then less aware other times, I look for times that the ... effecting negatively the process sometimes there might be a trauma that's so horrific that I want to avoid it too. And I don't want to be complicit in avoidance in a client situation. Sometimes I'm curious, right? Like you were just curious about (city removed), It's caring and compassionate but it's also curious. Right?

Researcher: Right.

P9: Trying not to let my curiosity be the driving force. [inaudible] that to an interest level rather than a curiosity level. Caring about the experience of somebody else, without it being something that's just gratifying in terms of, oh, that's interesting and fascinating. Curiosity is not bad, it can be a wonderful quality, but it can be problematic if that's the driving force.

Researcher: Mm-hmm (affirmative)

P9: So, that's customary of countertransference that we like to keep an eye on.

Researcher: How do you tell within yourself if that ... cause I recognize this feeling, how do you tell if that becomes sort of the driving force? That curiosity?

P9: I check in with myself and others, I may consult, about my motivation for asking questions.

Researcher: Mm-hmm (affirmative). So checking in about your motivation, yeah.

P9: I make that as conscious as I can.

Researcher: And you what?

P9: I make that as conscious as I can, what my motivations are.

Researcher: Right. Absolutely.

How do you think that affects your decision-making? With your ... this sort of internal dialogue about your countertransference reactions?

P9: I think countertransference is always affecting our decision making. I think at best, bringing into my awareness and I weigh it out with other things. Like, sometimes the answer is the same. I may want to know something more about somebody because I'm curious and it may also be feeling like you [inaudible] for them to talk about it.

Researcher: Mm-hmm (affirmative)

P9: So, you'll have to read me the question again to know if I answered it or not.

Researcher: Just how countertransference, you know, it seems like it's happening, or that's your understanding of countertransference, that it's happening all the time, how does it affect or interplay or intersect with your decision making?

P9: I certainly, just to not have it be the main factor.

Researcher: Mm-hmm (affirmative)

P9: I think it's always there.

Researcher: Yeah.

P9: But I don't think that's a bad thing. I think countertransference might ... part of my countertransference in my caring and being interested in somebody's else's story.

Researcher: Right, that was you're ... you're reading my mind, I was going to ask you about sort of any, sort of positively driven countertransference and when that shows, yeah.

And do you, let clients know? Or how do you decide when you let clients know if you're experiencing ...

P9: Let clients know what?

Researcher: Well, if you're experiencing ... I guess what countertransference do you self-disclose, and how do you make those decisions?

P9: Mostly just what's in the moment.

Researcher: Okay.

P9: Like being sad in the moment with them, without sharing perhaps and that's the balance thing too, because it's important they not believe that they need to protect me or any other clinician from whatever it is they need to share.

Researcher: Mm-hmm (affirmative)

P9: But more in the moment, but it wouldn't ... but if I had a dream the night before [inaudible] between the times of seeing the person, would not usually share that. If I had had a similar experience, sometimes that's judicious and to the benefit of the client but not that depends a lot on whether it's a resolved experience for me and what I can see being beneficial without being [inaudible] myself.

Researcher: Okay. And then, going back to clinical decision-making, all of those decisions that go into clinical decision-making with trauma survivors, if you could share a little bit about how those decisions that you come to are different, with trauma survivors, as opposed to treating clients with other non-trauma issues.

P9: Yeah, I don't think I make a huge distinction other than general safety and a kind of, tenderness and awareness about what the person is ready to address. I would have those same considerations with most any client.

Researcher: Okay.

P9: I don't have a sharp demarcation between trauma clients and other clients. Partly cause I think most people have experienced some version of trauma, broadly defined anyway.

Researcher: Yeah, absolutely.

P9: Different levels of extremity.

Researcher: Do you find that clients who maybe come into ... oh they say maybe they want to talk about their depression or social anxiety, that underneath that is maybe being driven by a trauma.

P9: Often, yes. And I think we as clinicians get caught up in thinking that everybody who's experienced trauma is going to develop or is at risk for PTSD, and I think just reading something recently that was reminding me that somebody can develop depression or anxiety or other ways or substance abuse disorders from traumatic experiences just a few incredibly ...

Researcher: So developing something else and not just PTSD as a sort of default?

P9: Right.

Researcher: Yeah.

P9: Right. So sorry, I think you asked something and then I went on a tangent.

Researcher: Oh no, that's okay.

P9: Can you bring me back to the question?

Researcher: Just wondering about, you know, you're ... when clients come in with a different issue ...

P9: Oh, do they often come with, yeah ...

Researcher: Yeah, I mean the trauma might be driving that, you know, do you find that more clients are sort of aware of that or not? We find that certainly some are, just don't identify it right away, but they know that trauma is behind it. But it might be easier to say, oh I'm coming in for anxiety. Or if you find that many clients aren't aware that trauma may be driving some of those other diagnoses?

P9: I would say there's a mix. Some people are aware of an event, but not aware of those effects, and often people have defenses that have worked for many years, and they wear out, so they're not working anymore but the client isn't really aware that, that's what's happened.

Researcher: Mm-hmm (affirmative)

P9: Because they've had this long-term defense support, which is just not talk about it, or make the story what you believe about it.

Researcher: Yeah.

P9: And then there are others who have come in or presenting issues that seem quite distanced with it, anything traumatic and in the [inaudible] social interview I gather information that gets my attention and they still may not want to address it, which is their choice.

Researcher: Right.

P9: I might just connect dots in a way that they haven't.

Researcher: Mm-hmm (affirmative) great.

So, so far looking at the data, it seems that expert trauma counselors seem to have this heightened presence with clients or really closely tracking all sorts of things in session and that seems to be highly valued, while at the same time it seems like there's a lot of internal dialogue happening for the counselor. Whether it's like questioning or anticipating their own response or the client's response, sort of that countertransference check, and I'm wondering if you can share your experiences of sort of balancing staying present with the client, versus sort of anticipator response?

I know it's a long question.

P9: Yeah, I think that's the art always, of doing therapy, is staying present in the room with the people in front of me, along with keeping a clinical head.

Researcher: Oh, I like that term.

P9: [inaudible] the bigger picture. Being aware of things that are not about ... some of its context versus process, but some of it's also beyond that to the bigger picture, what do we do? And what's my goal?

Researcher: Mm-hmm (affirmative)

P9: Creating a balance. Of thinking short and long-term. I'm also [inaudible] short term.

Researcher: Can you share a little bit about how you stay present? How you keep yourself present?

P9: Oh it's [inaudible] memorization. Memories as much as I can. Trying to be nonjudgmental with others. I'm interested, that's certainly part of it.

Researcher: Sorry, could you repeat that last part?

P9: I'm interested, that's part of it. So intrinsically I'm interested in what's going on with somebody else, and just my attention [inaudible] and if I find myself bored with the content then I'll think about the process.

Researcher: Mm-hmm (affirmative)

P9: I'll think about, did I get enough sleep? What are the organic factors that might be involved.

Researcher: Yeah, great.

This next question is a little bit long and complex, so feel free to ask me to repeat. It seems like ... well this question is about sort of your conditioned beliefs, or assumptions, about trauma and it seems like probably ... well all of us have conditioned beliefs and assumptions, but particularly with trauma counselors it seems like there's the thoughts of trauma seem to vary from sort of trained or purposeful beliefs, to reactions about trauma maybe from main stream socialization and I'm wondering if you could share what some of your conditioned thoughts and beliefs you have about trauma. Separate from your perceptions about the clients themselves.

So some people have said, you know, trauma is at the core of everything, or you know ...

P9: Trauma happens. They might just put in sort of a trauma happens ... I think, I dunno, part of it is filter of the person experiencing it. So somebody might experience a marital affair and they might truly experience the betrayal and they can never trust anyone ever again, and the word trauma is being thrown about so much these days.

Researcher: It is. [crosstalk] and I'm not helping.

P9: You are actually, in your research. So for somebody else it would not even be that personal. It would be like, okay we screwed up, yeah that hurts and I [inaudible] what we're doing in this marriage, or this relationship or whatever. That may not be an example of trauma exactly, but the level of ... the depth of pain is contextual. That is there are experiences that [inaudible] have had.

I think my beliefs about trauma, is that it's a normal part of life, I don't believe that it has to be spiritual explanation.

Researcher: What do you mean by that?

P9: Well I don't believe people earn or deserve or that it's Karmic or ... I think it's just part of life. Life includes suffering and beauty. It's just part of what we get. And it's unevenly orchestrated, or orchestrated sounds like somebody is doing it, but it's unevenly distributed. Certainly we can look at patterns clinically with ... somebody who's been sexually abused might more likely to end up in another sexually abusive situation. It's not like their fault, or their choice, but [inaudible] makes that more likely. It isn't about the deservingness of that person at all.

Researcher: Yeah.

P9: [inaudible] to throw out that category, the hurt, the client might come at ... some of them will get [inaudible] Puerto Rico are likely to experience it quite differently because they know citizens of the United States are being treated for just other very accessible comparisons.

Researcher: Mm-hmm (affirmative) that's a great comparison. Go ahead.

P9: Sorry, I can probably refine it a little more but that's all I've [crosstalk]

Researcher: That's great.

Where do you think, along the way, where do you think your beliefs about trauma, how have they developed or came from, or their origins? And have they changed over time?

P9: I would say probably yes to the latter, because life continues to happen. I think they've developed through experiences both lived and shared with me. There's some images that I have from my internship, the whole imagining of an experience where the client could be problematic and trying not to build up [inaudible] to protect against that, and yet to [inaudible] with openness. Then if you've heard trauma in general has developed your lived ... values [inaudible] cultural, sub-cultural groups that have been drawn to a different time through contact with people who've experienced different types of trauma through reading, through just [inaudible] you know.

Researcher: Mm-hmm (affirmative)

Next question is about reflection, and many counselors have shared with me that reflection is a routine part of their practice, and it seems to range from solitary contemplations to group consultation, maybe occurring in the moment with a client or purposefully or spontaneously between sessions, and I'm wondering if you could talk about your reflection process?

P9: That includes all of that. So when I write a note, there's some reflection in note, there's some reflection in that, thinking back on the session, thinking about things from different angles, often when I get better clinical insight, or different one, consultation with peers. Reflection just as I'm thinking back on my day, thinking about an individual, sometimes I prefer they come in and take a few minutes looking at the notes, [inaudible] with the client. And that's at my desk, don't always pull that off. Meditate some, I'd like to do more. I don't have a script when I [inaudible]. Reading, so when I'm reading I reflect about cases where the particular things I'm reading are apparent.

Researcher: Mm-hmm (affirmative)

P9: In this interview, I'm reflecting.

Researcher: Great, great.

P9: It's not a regular practice, but you know, if you are asking me ... when interns are asking me about trauma in their supervision process.

Researcher: Mm-hmm (affirmative)

P9: Or just talking about a case.

Researcher: What do you think the impact of your reflection is on you work with clients?

P9: Well I hope it makes it better.

Researcher: Could you be more specific?

P9: It helps me see things from different perspectives. It's a part of the consultation process, so of course you get different perspectives from somebody who's not sitting in the room. And different experience and sometimes direct orientation. And then just my own reflection helps me ... helps me get more in my clinical head and less in the being in the moment. Or more in the moment, and less in ... helps balance that out.

Researcher: Mm-hmm (affirmative)

Do you find that your reflection process, mostly occurs when you're feeling stuck or something isn't right? Or do you also find yourself reflecting if, wow this is really going well, or this person is making great progress, or I did great with this person?

P9: When I'm consulting I tend to choose cases that I'm having some sort of issues with, some difficulty with, some challenge. More aware that I'm, losing some kind of perspective that I think I need to have. In my own reflections, some of those are just more organic and so it's whatever comes up. Sometimes that can be happiness about some good work that ...

Researcher: Mm-hmm (affirmative)

P9: I also might, ruminate on something that didn't go well. So it can be any of that.

Researcher: Great.

Well that's all the questions I have. Did anything else come up for you?

P9: No, other than just the enjoyment of thinking aloud.

Researcher: Oh, well thank you, thank you.

P9: Yeah.

Researcher: Good.

P9: You're welcome and thank you.

P10 Round Three

Researcher: So the first question may be a little difficult because you only deal with trauma clients. I don't know if only is too strong of a word.

P10: It's primarily.

Researcher: Maybe you can think back to your other clients or imagine you have clients with other disorders that you're treating, and if you could sort of describe the uniqueness of your approach with trauma clients as compared to treating clients with other disorders. So if there's a physical difference in you that you notice or you approach it a little differently, questions, or some of the things that have come out so far have been, just a little more hypervigilant about things, sort of treading carefully, that type of thing. I don't want to put words in your mouth, but that's the kind of thing. What is just a smidge different in treating trauma clients versus other disorders.

P10: Yeah.

Researcher: Like somebody who has ...

P10: I would say that I ... that really that tuning in, and that watching micro, sort of facial expressions and ...

Researcher: Watching yours or watching the clients?

P10: Watching theirs.

Researcher: Watching theirs.

P10: Watching their sort of micro, facial expressions.

Researcher: Okay.

P10: Like earlier today I was working with someone who has a significant history of trauma. We were redoing, we were resetting the affect protocol and just that sense of, I could tell that the calm place was not calm anymore. Just by her facial expressions, and I said, "Let's check in about this." And she was able to reprocess and we switched gears and went to IFS. But that flexibility, I feel like that's there with other clients too.

Researcher: Hm hmm

P10: But, um, sometimes if, for instance I was working with somebody whose primary concern is, you know like a psychosis, or it gets much more concrete, like let's do this, and then this and then, it's like kind of more laid out. Whereas the trauma

work is more intuitive and more let's go where you need to go. And psychosis may be a part of that, but if it's the primary presenting thing.

Researcher: Um hmm

P10: Then it's like a psychosis, or is it, or would be more skills training of activities of daily living.

Researcher: Yes

P10: Or, case management, less of this intuitive work.

Researcher: Mm-hmm (affirmative) Good answer, thank you

P10: Yeah

Researcher: Next question, there seems to be some dual awareness that I've noticed from the other people that I've interviewed of really closely tracking, the sort of like the micro expressions is a perfect example. So really tuning in and closely tracking whether it's words, or facial expressions, body language, things like that. There seems to be this sort of hyper awareness at the same time a fair amount of internal dialogue that the clinician is doing. Sort of maybe anticipating uh, a reaction, or where you're going to, making decisions in your head about where to take this next, and so I'm wondering if you could share about that sort of dual awareness of staying really closely present and tracking, which takes a fair amount of energy.

P10: Mm-hmm (affirmative)

Researcher: And, that internal dialogue, and maybe that's not how it worked for you. I don't want to put words in your mouth, um, but if you could speak to that a little.

P10: Yeah, well I would say tracking is both kind of an external process, but I'm also tracking what's going on with me. So physically I'm tracking what's going on with me, you know thoughts and tracking those.

Researcher: Hmmm

P10: And sort of, sort of what's our goal in therapy? What's our goal in overall, and what's our goal today with this session?

Researcher: Mm-hmm (affirmative)

P10: I'm tracking that piece and way over here, or really is way over here is where we need to be? And maybe it's more of this fluid space where we go over here now.

So, I'm sort of internally tracking where I'm at in connection with the client and what they're experiencing. But again, for me I feel like it's more somatic, like I really feel a lot in my body and so I just bring attention to that. You know

Researcher: Internally, or in the room?

P10: Internally, and then like today I made a choice point to bring it into the room and it was deeply healing for the person. And they were like "yeah actually my legs were like numb, I just want to kick and I want to move." They were able to do some completion of movement

Researcher: Nice

P10: And did some verbalization with that, and you know, at the end of the session they said, I've told this story so many times, but this is the first time that it's ever felt held. And then I felt powerful telling the story. I guess that's an example

Researcher: Mm-hmm (affirmative)

P10: Of both tracking where they're at and you know what are realizing right now as you tell me this story? Oh, my jaws clenched, okay, and tuning and helping them tune into body and then also being tuned into my own experiences. If they had said "Oh no, it's still on my face," I would have like "Oh, it's coming back."

Researcher: Mm-hmm (affirmative) How do you make the decision to share what's going on with your body? Like that was a clear example of therapeutic effectiveness and of course you never know, but is there something, I guess I'm imagining if you're tuning into something in your body are you saying that that might be a parallel experience with the client? Or something different? Or is that part of the decision?

P10: That's part of the decision. Part of it was the story was about being trapped. Or around not being able to move, not being able to get away. Eventually getting away, but not being fully supported and getting away and the aftermath. Kind of all these pieces.

Researcher: Mm-hmm (affirmative)

P10: And so my mind went to Peter Levine

Researcher: Oh

P10: And his healing trauma, he is [inaudible]

Researcher: Oh yes, oh yes

P10: And that exercise

Researcher: In fact that's who I immediately thought of

P10: Yeah, where he does, and my mind went there. So my clinical decision-making with this client somatic work has been the most effective.

Researcher: Ahhh

P10: EMDR is too scary

Researcher: Yeah

P10: It's a little too scary for them. And so, that's where my mind went clinically. And then, I just thought. You know I wonder what it would be like if she could get away?

Researcher: Oh, Wow!

P10: If she could feel her legs and identify what they want, or what they need? And then she was able to do that.

Researcher: And were you feeling that in your body?

P10: Yeah, I felt like a numbness

Researcher: Ahhh

P10: Which was interesting, I felt like a tingling in my lower legs and like a numbness her and she said "you know when I first started talking about this I felt like a real numbness." And I just said "I'm feeling something in my legs here." Like I didn't say what it was

Researcher: Yeah

P10: I would just say "Gosh, I feel something in my legs." (Laughter)

Researcher: Oh fantastic!

P10: Yeah, so that was really cool. That was like a highlight.

Researcher: Yeah, fantastic, oh my Gosh. When you get feedback like that and you're so in tuned.

P10: Yeah, but that's an example of how I do that.

Researcher: Yeah, that makes sense. Okay, fantastic! Yeah, it's a good example, bringing in your own self-awareness plus just that education, that. You know what you know about the field out there and what you studied. And, the client's presenting issue, and your relationship, I mean it's like a good

P10: Yeah

Researcher: Yeah, I couldn't have wrote that better myself.

P10: (Laughter)

Researcher: Okay, um, next question is about your beliefs about trauma and um, probably everybody has a belief about trauma. But it seems like there's sort of the conditioned beliefs that we have about trauma, and then, um, yeah, so I'm wondering what your conditioned beliefs about trauma and there's like the train, you know what we learned from training. So maybe Peter Levine or sort of a real purposeful vs. like mainstreamed socialization or kind of what we believe about trauma there. And I'm wondering what your beliefs are about trauma, separate from your clients. So just about the nature of trauma, traumatic experiences, kind of where they came from?

P10: Yeah, well most people that recover from a trauma in their life, it's a very small percent of people who develop those traumatic stress disorder. So my belief is, and am I even able to separate this at this point? (Laughter) I might not be able to. So it stems from that, you know, PTSD is a disorder of non-recovery, that a person can never recover from.

Researcher: Mm-hmm (affirmative)

P10: That it's this being stuck in the trauma and the [inaudible] van der Kolk, you know his own being, where he talks about, in his book, where he talks about how the reward to that, so to develop PTSD

Researcher: Yes

P10: Is that snapshot of the trauma that never changes. But when they get the EMDR, or they get the IFS treatment or whatever treatment that helps them. They can then turn that into long term memory. And it can be reprocessed and they can move forward and heal. Um, my belief, my main belief about trauma is that people who experience trauma, and who have a life experience that's it's a sort of fractured sense of self. That makes the internal world a lot scarier. Then the actuality of kind of facing that trauma as it is today.

Researcher: Hmmm

P10: And so that's, I feel like that's the hardest part about trauma, is that it can be so scary and so overwhelming for a person's system. That it's showing up every day, they're reliving it every day, but the idea of doing the treatment to address and move it to long term memory, like who would I be without this?

Researcher: Hmmmm

P10: What is this? You know there's just so much fear in them. Which is just so interesting to me, and really kind of sad. About the disorder, but I love that it is something that people can heal from.

Researcher: Um hmmmmm, any exceptions to that do you think?

P10: That people can't heal? No, I believe everybody has the ability to heal. I think the exceptions would be in the environment.

Researcher: Ohhh

P10: And so if the environment is supported, then they have what they need externally as well as internally. Then they [inaudible] But, um, I think some people don't, like there's a part of them that doesn't want to heal. Because again there's that "what would I be without this?" Or the healing journey would be to scary.

Researcher: Mm-hmm (affirmative)

P10: You know, but I believe everybody can heal. I worked with somebody who went through so much trauma, and just so like compounded, compounded, compounded. And when I left the county they actually yelled at me for not helping them work through the trauma in the time that I'd been there. And it was

Researcher: Oh the client did?

P10: The client did, yeah, it was like an attachment thing.

Researcher: Ohhh

P10: He's like your leaving and

Researcher: And I haven't worked through

P10: You didn't even help me. But that person also said, "you know, I don't really want to heal from this, I want to be angry, I want to be hurt. I want to be mad. Like I

don't want to heal." And so that part of them that was so stuck in the trauma didn't, like couldn't let go to heal, said no. But I believe that they you know, that they could still heal.

Researcher: Mm-hmm (affirmative)

P10: They probably have done some healing work since then [inaudible]

Researcher: Let's hope

P10: Yeah

Researcher: Yeah, it is very sad to encounter those clients who, their identity is so wrapped up in the trauma.

P10: Yeah

Researcher: That really mad, or letting that go, or chipping away at it seems like not something that they want to do, but yet they still come in to try to do some work. But,

P10: Um hmmmm

Researcher: Cling so tightly, yeah that identity piece.

P10: The other piece that's really hard is substance abuse. Where people cling so hard to the avoidance mechanisms. That help, but then in the long term, just really mess up their life.

Researcher: Mm-hmm (affirmative) mm-hmm (affirmative)

P10: And so I think that with the substances on board we can do some work. But, hopefully, I mean effective therapy doesn't happen when somebody's high. (Laughter) And so I think that's the

Researcher: That would make a great t-shirt, I just have to say, or a bumper sticker, or something. So true, yeah, definitely. Okay, last question.

P10: Okay

Researcher: Reflection seems to be a huge part of people's practice, and um it seems to range from solitary internal reflection, to maybe group consultation, seems to happen when writing notes, seems to happen when mowing the lawn. So I'm wondering

how you incorporate reflection. What it kind of looks like, feels like, sounds like, when, where? Are there times when you don't reflect?

P10: Yeah, let's see. Well I do, I'm part of a consultation group. So that's been immensely helpful. Then my partner in practice, (name removed) and I, we do a consultation as well.

Researcher: Oh nice

P10: And so we're more available to each other and so that if we have an immediate consult need we can call each other.

Researcher: Ahh

P10: And so that's a really good connection.

Researcher: Mm-hmm (affirmative)

P10: And then I also when I'm writing notes, of course and reflecting. Before I meet with someone, I kind of like to go back and read through the last note, or sometimes even the last few notes to kind of like catch the thread of what we're working on. And then I really try not to reflect when I'm not here.

Researcher: Ahhh

P10: So I really try to do most of my reflection here and in the space and outside of the space. Unless I'm in another therapist's office doing a consultation group or like part of this book club for therapists. Where we read books like Peter Levine or [inaudible] and in that space, in that professional space, I'll do some like "Oh, How can I use this?"

Researcher: Yeah, yeah

P10: Reflection, but I really try to hold the outside space as my time.

Researcher: Mm-hmm (affirmative)

P10: And if I notice thoughts coming in, then I'm like, "Oh that's something that I really need to look at." And I try to, again compartmentalize and set time to do that - Monday through Wednesday.

Researcher: Um hmmmm, um hmmm. Yeah, fantastic! I forgot what I was going to say. Is, are the reflections mostly, I guess, is it when things are particularly going well and

you're trying to like chip away at a problem or something that doesn't feel right? Or, I guess, kind of what's the substance of the journey.

P10: Well if it's reaching these outside of these doors and things are going right

Researcher: Okay

P10: Then there's some sort of, there's something that's like AHHH! This isn't going right. If it's reaching me at like a training, or the book club, or you know in some professional setting like that, then it could be any number of things. And it's like "Oh this would work so well for so and so." Or maybe I should try this.

Researcher: MMMM

P10: And that sort of thing, and it's not always like a major problem, it's just like a therapeutic intervention that may be helpful for them.

Researcher: Mm-hmm (affirmative)

P10: But if it's something where I'm like mulling it over and like you know, out on a trail run with my dog and it pops into my head. Then generally it's kind of a problem that I really need to allot some time to, just to think about maybe address in case consultation, or call my partner and talk about just sort of having that second view and that. I also try and do just professional reading. I guess I do professional reading outside of work and outside of the book club. And so during those times I'm also reflecting.

Researcher: Ahh, mm-hmm (affirmative),

P10: So, I guess I do a lot [inaudible] to it.

Researcher: The boundaries around time, did that come from just naturally who you are? Or was that learned over time?

P10: Kind of learned

Researcher: Oh, okay

P10: That was learned

Researcher: Okay

P10: When I worked at (name removed), you know, you work, when I was a case manager/counselor at my full time job, you know I did 4-6 crisis shifts a month

Researcher: Oh wow!

P10: And then, when I became a manager, I no longer needed to do the crisis shifts, but I was continuously on call. So somebody could call me at any time, all the time,

Researcher: Oh boy

P10: I could be out on the canoe in the lake and the phone would ring cause something happened. (Laughter) So it was like this sense of like, oh, work is really disrupting my life. I'm not as effective at work because I'm not as restful and so that was the reflection piece there.

Researcher: Did, um, and that was just part of, I mean that was nothing that you could change.

P10: Right

Researcher: Just because that was the nature of the work. Do you think you would have gotten to where you are without that? (Laughter) Cause that's a pretty extreme experience.

P10: Yeah, I don't know. Because I think I needed that! Because I have a natural penchant for working too much.

Researcher: Ahhh

P10: And my friends would say "You work too much." Or my husband would say "Do you have to work every day?" You know

Researcher: Yes, yes I do

P10: Substitute work for the care homes, or whatever, and I'm like "Oh they need me!" And I'd pick up a shift.

Researcher: Mm-hmm (affirmative)

P10: So I just have this penchant for kind of overworking.

Researcher: Ahhh

P10: And so it took sort of this extreme sort of place in my personality to feel like "Oh you don't need that, you can actually be a bit more balanced and things work better."

Researcher: That sounds lovely

P10: It's good, I like where I am today.

Researcher: Yeah, you seem to

P10: Yeah,

Researcher: Okay, anything, that's it, that's all I have. Is there anything about trauma or counseling that you feel like there's a big hole that's missing? Or that something that you didn't touch on, anything that seems like geez she never asked about x, y, z, that's a big part of you work? As far as countertransference? Or decision-making?

P10: Right, I don't think so. I think you covered all the bases.

Researcher: Okay

P10: Yeah

Researcher: Great

P10: Yeah

Researcher: Thank you