“It gave me a voice when I couldn’t express what I was feeling”, 'exploring the experiences of trauma-focused counselling with clients who use substances: a qualitative study.

Thesis

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Abstract

Background: It has been recognised that providing effective and appropriate therapy for those who have experienced trauma is important in reducing both individual impact and the impact on public health. Subsequently, research into understanding Adverse Childhood Experiences (ACEs) and their impact on physical and mental wellbeing, along with implementing Trauma Informed interventions and services has begun to receive more attention in the UK. This research is a qualitative study that explored the experiences of clients who have accessed counselling for childhood trauma alongside using substances. It focused on the perspectives of these individuals and their experience of accessing and engaging in counselling. The current study considers the context of mental health service provision in the UK, the link between ACEs and substance use and the emerging focus on Trauma Informed Approaches (TIA).

Aims: The study aimed to explore the experiences of clients who self-reported substance use alongside engaging in and completing trauma-focused counselling. Furthermore, to explore the implications of trauma informed principles within the counselling service.

Method: Ten in-depth qualitative interviews were conducted with participants who had completed trauma focused counselling through a third sector counselling organisation. Participants were offered the options of attending interviews in person, via telephone or through online video calling software (VoIP). The data from interviews was then transcribed and analysed through reflexive thematic analysis.

Findings: From the analysis of the patterns across the dataset, four themes and associated subthemes were developed, “Challenges with accessibility”, “Safety and Trust, “The many roles of the therapist” and “Reflecting on the therapy journey.”

Conclusion: The results of this study support existing literature on trauma-informed approaches and practices and importantly, how this is perceived by clients who are users of counselling and other public services. The recommendations of ensuring safety, collaboration and being responsive to individual needs highlighted in current good practice guidelines for trauma informed services were supported in this study. Furthermore, the implication of

trauma affecting groups and communities as well as individuals, points to a need for a community-based approach including after-care considerations.

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1. Background Literature and Study Rationale

1.1 Introduction

This research study aimed to explore the experiences and perspectives of clients who had recently completed trauma-focussed counselling through a third sector organisation. These individuals had self-reported to have been using substances and/ or alcohol at the commencement of their therapy sessions.

Firstly, where third sector counselling organisations are situated in relation to overall mental health care provision is demonstrated and the concept of the 'treatment gap' is explored. This gap is often thought to be filled by third sector organisations and offers an important context to the current study.

The concept of Adverse Childhood Experiences (ACEs) is discussed, following its origins in awareness campaigns, into the widespread investigation of childhood adversity and the subsequent effects of this across an individual's lifespan. The influence of research into childhood adverse experiences and subsequent research highlighting the prevalence and impact of trauma, along with the pathways between adversity and negative outcomes, are then explored. Research is presented that has examined the neurobiological, social, and psychological understanding of the mechanisms of how trauma affects various aspects of life. The field of developmental criminology is also introduced as a way of understanding the experiences of individuals who are both trauma survivors and perpetrators, along with the role of social factors and the idea of trauma being repeated inter-generationally.

Current literature on trauma is then discussed with specific emphasis on how this has evolved from a prominently medical diagnosis of PTSD to an understanding that is wider in breadth and the newer diagnosis of complex trauma is presented. Importantly, also recognising how a focus on adverse experiences contributed to a change in the way trauma is conceptualised. Along with a change in trauma discourse, there has also been an increased understanding of the co-morbidity of trauma and substance use.

This overview is followed by detailing the interventions that have been developed to support those who have experienced adversity and trauma, including principles of Trauma Informed Approaches (TIA). The aim of such approaches, being an understanding of the nature and impact of trauma, along with promoting

principles and interventions to prevent re-traumatisation. The counselling organisation that participants in this research had previously engaged in explored, specifically, the nature of the support offered by this service and its relationship with trauma-informed principles.

With this background and context in mind, the Methodology section gives thorough details about the design of the study, with clear rationales regarding the decisions made in the collection and analysis of research data. This includes how ethics were carefully considered throughout, before detailing the results in the form of themes, capturing the essence and story of participants' experiences. Finally, conclusions that can be made are reflected on, including directions for future research.

Due to the use of Thematic Analysis in the analysis of data, a reflexive statement is presented, positioning myself in the research as an active part of the research process. This highlights how the research topic, the design of the study, and analysis were all chosen and completed through my unique lens as researcher and individual who has engaged in Counselling Psychology training.

1.2 The organisation and funding of Mental Health Services

Support for Mental health difficulties in England and Wales is found across different services and organisations (NHS UK ,2021). This includes statutory NHS- based primary care services who offer support to those experiencing 'mild to moderate' mental health difficulties and NHS secondary care services that provide support and treatment for those individuals living with more complex or enduring mental health difficulties. Tertiary or 'inpatient' hospital units are often both NHS and privately funded. Finally, there exists the varied selection of charity or voluntary sector organisations who offer mental health advice, support, and counselling within local communities.

It is reported that about a quarter of people with depression and anxiety in England receive treatment that is most often in a primary care setting (Singleton, Meltzer & Jenkins, 2003). Primary care services in England are more often than not, associated with the Improving Access to Psychological Therapies (IAPT) model of treatment and commissioning. The IAPT public health programme was initiated in 2008 with the aim of increasing access for people experiencing anxiety and depression to psychological therapies. Founded with the aim to reduce the

economic impact of mental illness, specifically by enabling people to return to work and therefore reduce the benefit cost (Clark, 2011). Working in accordance with NICE Guidelines and evidence-based research findings, the prominent modality of therapy that is Cognitive Behavioural Therapy (CBT) has become widely promoted in IAPT services (Pickersgill, 2019). IAPT has continued to expand since it's conception but there are mixed conclusions about its effectiveness (Marks, 2018), with some claiming that when reviewed, only a very small number of individuals recover (Scott, 2018).

Services and service provision is affected not just locally by their funding and policies, but such policies are impacted by wider strategies published by NHS England and the UK Government. Such strategies are ultimately influenced by current affairs and politics. The current key strategies in regard to Mental Health Services are detailed in NHS Long Term Plan (2019) and the recognition that equal attention and duty be given to physical and mental health, also described as a 'parity of esteem', in No Health Without Mental Health (2011). While government funded services form a large section of support that is offered for mental health difficulties in the UK, the voluntary sector, sometimes referred to as a 'third sector' has played a crucial role in filling gaps in treatment provisions. Such gaps seen as a 'failure' in the part of statutory services (Newbigging et al., 2017). Furthermore, voluntary services have been seen offer specialist support for those in specific communities, most notably for people from Black, Asian and minority ethnic (BAME) communities, women during the perinatal period (Coe & Barlow, 2013) and young people (Thomas, Pilgrim, Street & Larsen, 2012).

There is consistently a high demand for mental health services and mental health problems are the largest source of disability, with The Centre for Mental Health estimating that the economic and social costs of mental illness in England in 2009–2010 was £105.2 billion, that increased to £119 billion in 2020, (O'Shea & Bell, 2020). In response, the government have offered guidance to services around having adequate funding to effectively meet the demand (NHS, 2014; NHS, 2019).

Crucially however, individuals who are experiencing mental health difficulties alongside substance misuse often fail to have their needs met by the NHS (The Guardian, 2015). Whist societal stigma in relation to substance use continues to persevere and can act as a barrier to accessing support and treatment, (Evans-

Lacko & Thornicroft, 2010; Balhara, Parmar, Sarkar & Verma, 2016), services also continue to exclude individuals who don't meet their 'criteria' and mental health services have been known to not offer support for those whose primary issue is perceived as substance use. Whether this is due to austerity, the way services are set up separately, or other political factors, it is important to note that those with dual diagnosis often have more complex needs and are at a higher risk of self-harm and suicide (Gates et al., 2017). But it is this population who have reported difficulty in getting the right help and experience a 'revolving door' scenario whereby they are told to stop using substances to access therapeutic help, only to revert to using substances to cope during the long waiting times (NHS APA, 2022).

1.3 Mental health awareness and Adverse Childhood Experiences (ACEs)

The increase in demand for mental health services is thought to be due both to the impact of societal stress along with anti-stigma campaigns that encourage people to seek help. The documented ever- increasing demand for services may be due to people feeling able to access relevant support. Campaigns created by UK-based organisations such as the 'Mental Health Foundation' and 'MIND' have worked to raise awareness of mental health difficulties with the aim of reducing stigma and encouraging more people to seek help. This is important, especially in relation to those who have experienced trauma, sometimes historically, being able to speak out. In 2014, The Independent Inquiry into Child Sexual Abuse (IICSA) was set up in the wake of serious high-profile instances of non-recent child sexual abuse. One strand of the Inquiry, The Truth Project encourages survivors of childhood sexual abuse to share their experiences, to understand what happened for them and what could have protected them at the time. Between June 2016 and December 2019, 3,646 experiences were shared with the Project, demonstrating when given the opportunity, individuals wanted to share their stories if they believed it would be used in a meaningful way.

Published in 1998, the pioneering US 'CDC-Kaiser ACE Study' aimed to investigate different childhood traumas (Felitti et al., 1998). This was one of the largest investigations, involving responses from over 17,000 adults and prompted huge growth in research examining both the prevalence and nature of childhood trauma and its impact across the life span on physical and mental health. The study followed on from the ACE-Aware Movement also based in the US, that aimed to

raise national awareness and understanding of ACEs. The movement was driven by advocates within paediatric services working to implement universal screening and programs to address ACEs. ACEs have since continued to receive much attention in literature in the UK and Worldwide.

Following this, definitions of adversity and trauma have been presented by various researchers and organisations. The US-based, Substance Abuse and Mental Health Services Administration who describe leading public health efforts to "improve the lives of individuals living with mental and substance use disorders and their families" (SAMHSA, 2023), state that adverse or traumatic experiences are events, series of events or a set of circumstances, experienced by individuals as emotionally or physically harmful (SAMHSA, 2014). An event becomes traumatic when it overwhelms the neurophysiological system with stress and leaves people feeling unsafe, vulnerable, and out of control (Macy et al., 2004). ACEs have been defined as "intra-familial events or conditions causing chronic stress responses in the child's immediate environment", (Ashton, Bellis, Davies, Hardcastle & Hughes, 2016, p.3). This includes psychological, physical, sexual abuse or neglect and can also include households involving domestic violence, parental separation, mental illness, substance misuse or incarceration. In the initial Kaiser ACE study, adults were asked to retrospectively rate their experiences of seven types of adverse experiences that included psychological, physical or sexual abuse, violence against their mother or living with household members who were substance abusers, mentally ill, suicidal, or ever imprisoned (Felitti et al., 1998). It was found that many had experienced at least one adverse childhood experience (49 per cent) and 13 per cent had experienced four or more of these experiences. Further studies have found similarly high levels of self-reported ACEs. The Crime Survey for England and Wales (2016) asked adults aged 16-59 if they had experienced abuse as a child. The survey showed that 9% of adults aged 16 to 59 had experienced psychological abuse, 7% physical abuse, 7% sexual assault and 8% witnessed domestic violence or abuse in the home.

1.4 The impact of ACEs on adult mental wellbeing

Subsequent research has assessed the impact of ACEs and conclude that there is an increased risk of experiences of mental health difficulties in adolescence and adulthood following experiences of ACEs (De Venter, Demyttenaere & Bruffaerts, 2013). An alternative definition of ACEs has subsequently been offered to capture

the long-term impacts of adverse experiences. Bouiller & Blair (2018, p.132), suggest ACEs are "potentially traumatic events that can have negative lasting effects on health and wellbeing." A strong link is seen between childhood trauma and adult mental distress (Bentall et al., 2014), as well as a relationship between the severity, frequency and range of adverse experiences and subsequent poor adult mental health (Dillon, Johnstone, & Longden, 2012) including an increased risk of depression and suicide (Felitti & Anda, 2010; Merrick et al., 2017). The cumulative effects of ACEs in particular, have been studied, demonstrating that adults who have experienced four or more ACEs have a higher risk of depression and suicide attempts, (Felitti et al., 1998), and overall decreased self-rated mental health (Iowa ACES 360, 2015). Findings also demonstrate a link between ACEs and obsessive-compulsive symptoms, anxiety, difficulties with emotion regulation and adult psychosis (Briggs & Price, 2009; Burns, Jackson & Harding, 2009; Varese et al., 2012). The use of a 'ACE Score', whereby the higher number of ACEs an individual accumulates correlates to the severity of the impact they experience, has been critiqued for assuming that all ACEs contribute equally to a person's experience. Relative to other ACEs for example, sexual abuse has been demonstrated to have especially powerful impact on development and maltreatment is more likely to lead to mental health difficulties (Noll, Trickett & Putnam, 2003; Negriff, 2020).

In order to seek where prevention and treatment may be possible, research has aimed to increase understanding of the impact of adverse experiences across the lifespan. There have been many theories presented about the influence of adversity on adult wellbeing and health. Adverse experiences in childhood may lead to individuals having a reduced ability to trust others and know what to expect from them, leading to difficulties in forming and maintaining relationships, and as a result have reduced support networks (Kendall-Tackett, 2002). This is seen as a key factor in maintaining positive mental wellbeing and resilience to stress (Ozbay et al., 2007). It is argued that individuals may develop maladaptive beliefs and adverse experiences in childhood may also interfere with how individuals perceive stressors, responding more intensely to stress (McLaughlin et al., 2010). Furthermore, psychological inflexibility, described as "feeling as though one's negative thoughts make one a negative person and feeling unable to act in accordance with one's values" (Makriyianis et al., 2019, p.1), has been

presented as a mediating factor in the experiences of ACEs and subsequent experiences of depression and anxiety.

A link has also been presented between experiences of multiple ACEs and a higher risk of adolescent interpersonal violence perpetration including bullying, physical fights and dating violence (Duke, Pettingell, McMorris & Borowsky, 2010). It is important to highlight that some individuals who are victims of trauma, may also have behaved in ways that may be felt as traumatic to others. There are also clear links between early life trauma and anti-social behaviour (Maxfield & Widom, 1996), and childhood experiences such as poverty, maltreatment, school exclusion and police contact are also associated with serious offending and frequent criminal convictions in adulthood (Armstrong & Kelley, 2009), A longitudinal study based in Cambridge labelled The Cambridge Study in Delinquent Development (CSDD) followed the lives of over 400 boys since 1961 and discovered that a combination of childhood adversities often led to a combination of adult adversities including offending behaviours. The field of developmental criminology has examined, predominantly quantitatively, the interlinks across the life span between traumatic experiences and criminal behaviours (Ardino,2011; Foy, Furrow & McManus,2011), highlighting that individuals carry forward their past experiences. Earlier traumatic experiences therefore have a lasting effect and impact behaviour in the present.

Adverse experiences in childhood have been shown to create brain changes which can disrupt development and lead to negative impacts later in life, both physical and psychological in nature. Various brain regions including the hippocampus, pre-frontal cortex and amygdala are vulnerable to toxic stress related experiences of ACEs (Boullier & Blair, 2018) and exposure to early adversity is linked to impaired physiological responses, including an impaired stress response (Shonkoff et al., 2012). Toxic stress in childhood is seen as the result of strong, frequent, or prolonged activation of the body's stress response in the absence of a supportive adult relationship (Sofer, 2019). Toxic stress leads to increased inflammation in the body and reduced immune function, (Bouiller & Blair, 2018), which may contribute to an increased risk of later infection, cardiovascular disease (Dong et al. ,2004), pulmonary disease (Anda et al., 2008) and autoimmune disease (Dube et al.,2009). Ultimately, ACEs increase the risk of early death (Felitti et al., 1998;

Brown et al., 2009). However, these brain changes can be viewed as adaptive survival responses (Teicher & Samson, 2016).

The expression and transmission of stress and adversity has also been explored at a biological and genetic level. Alterations in DNA sequences located at the end of chromosomes called Telomeres, has been associated with ACEs and long-term poor health outcomes (Burgin et al., 2019). Telomere lengths have been presented as a biomarker for health risks and shorter lengths have been linked with early adverse experiences and psychopathology (Wade et al., 2020). Researchers have also added that maternal adverse experiences lead to shorter telomeres of the next generation (Epel, 2020).

The risk of developing ACE-related disorders is heightened during certain vulnerable developmental phases (Herzog & Schmahl, 2018). Further evidence points to sensitive periods and specific ACE sub-types linked to neurobiological alterations, such as changes in the amygdala and hippocampus. Stressful childhood and adolescent experiences become 'biology' due to their effect on brain structure and function (Anda,2009). However, it is important to consider the variation in individual's responses to adversity and trauma (Barlett & Sacks, 2019).

The presence of resilience resources such as having a trusted adult relationship or participating regularly in sports in childhood or engaging in the community as an adult reduces the risk of mental health difficulties by half (Public Health Wales, 2017). As well as recognising resources, individual difference in how people respond to adversity and their level of resilience challenges the deterministic view that ACEs lead to specific outcomes. Not all individuals who have experienced histories of ACEs develop depression. Resilience- or the "ability to demonstrate stable levels of functioning despite adversity" (Poole, Dobson & Pusch, 2017, p.1), appears to act as a buffer against depression. In this way, some have advocated for the more hopeful position of 'flipping the narrative' and recognising strengths rather than being deficit focused (Hardt & Rutter, 2004).

The demonstration of the widespread impacts of ACEs further highlights the importance of understanding how to prevent these experiences but also how to support those who have had such experiences. Existing research offers insight into the difficulties that individuals may face and understanding how their experiences

may shape their current problems, importantly also recognising factors of resilience. Support that is commissioned and offered by mental health services are based on current understandings of client difficulties and the evaluation of what is the most suitable or effective interventions to relieve such difficulties. Therefore, how services make sense of trauma and how this can be addressed, is key in understanding what clients are able to access in terms of support in the community. As with many other public services, what is available is dictated by published guidelines and where funding is allocated. Subsequently, as the conceptualisation of trauma has changed over time, so has relevant service provision.

1.5 The changing conceptualisations of trauma

Post Traumatic Stress Disorder (PTSD) was first included in the Diagnostic Manual DSM-3, (American Psychiatric Association, 1980), and has since become a well -established diagnostic category. In DSM-5 (American Psychiatric Association, 2013), PTSD was moved away from being viewed as an anxiety disorder and into its own distinct category (Friedman, 2014). In order to receive the diagnosis of PTSD, an individual must meet the criteria set out in the DSM-5, which includes symptoms having lasted a month, that the individual was exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence. They are also required to experience intrusion symptoms such as nightmares, flashbacks, or unwanted upsetting memories, demonstrate avoidance of reminders of the trauma and that such symptoms have led to functional impairment (American Psychiatric Association, 2013).

There has been a noticeable shift in recognising a distinction between experiences and symptoms of PTSD and those of what is now labelled as 'complex trauma.' Complex trauma has been described as a "type of trauma that occurs repeatedly and pervasively over a period of time within specific relationships and contexts" (Courtois, 2004, p.1). Complex PTSD, sometimes called Complex Trauma, or CPTSD, is recognised as a separate clinical diagnosis to PTSD in the diagnostic manual ICD-11, published by the World Health Organisation. This states that in addition to the core symptoms of PTSD, the criteria for a diagnosis of Complex Trauma, are when an individual recognises difficulties with managing emotions, has persistent beliefs of self-worthlessness or guilt and has difficulties in

sustaining interpersonal relationships (NICE, 2021). Furthermore, individuals may experience alterations to consciousness and identity (Courtois, 2014).

In contrast, Complex Trauma or CPTSD is not recognised as a distinct diagnosis category in the current DSM-5. Following reviews (Resick et al., 2012), the American Psychiatric Association (APA), concluded that there was not enough evidence to distinguish CPTSD from PTSD, arguing that a very high percentage of those who would meet criteria for the diagnosis of CPTSD would also meet the criteria for PTSD. Following this, many have advocated for it to be included not just as a subtype of PTSD but as its own distinct diagnosis, arguing that there are clear and relevant qualitative differences in individual's experiences of CPTSD compared to PTSD, which should be considered (Powers et al., 2017). The conceptualisation of complex trauma may better describe the effects on children and young people that are exposed to chronic interpersonal trauma, van der Kolk et al. (2009).

One of the key criticisms of the ACEs model is its strong biomedical emphasis, which some have argued could lead to socio-economic conditions being overlooked (Taylor-Robinson et al., 2018), arguing that ACEs are instead a complex social problem which has been medicalised. The 'Power Threat Meaning framework' offers another alternative conceptualisation of trauma. This biopsychosocial framework has been presented in contrast to psychiatric diagnosis and aims to consider the social and political contexts of individuals in order to aid understanding of their past and current experiences of trauma (Johnstone et al., 2018).

The Power Threat Meaning framework (PTMF) was developed in collaboration between a team of psychologists and a group of service users, carers, and other campaigners who offered examples of good practice that was not based on diagnosis. The framework was published in 2018 (BPS, 2018), and highlighted how the current use of mental health diagnoses was reinforcing oppression and reducing the opportunity for individuals to create their own meaning of their experiences. It aimed to bring to light an alternative conceptualisation that instead of locating mental health difficulties as a problem within an individual that requires 'fixing', shines a light on the role society and social inequalities

play in the experience of emotional distress. Currently, the PTMF has been applied in developing service pathways (Turri et al., 2020; Bostock & Armstrong, 2019), and therefore aids in designing services that meet people's real needs and suggest ways of accessing support that is not dependent on having a diagnosis. Whilst the framework has been adopted by certain professionals and services who wish to take a de-medicalised approach in working with mental health, there is resistance and criticism to the approach in certain areas. Part of this may be due to the under-staffing and under-resourcing of services which makes service change and transformation more challenging.

In line with understanding the role social factors play in creating adversity and trauma, the definition of ACEs has expanded since the seminal ACE study, to include social experiences such as parental divorce or separation, emotional and physical neglect, and experiences related to social hardship e.g., homelessness and discrimination (Bartlett & Sacks, 2019). Due to its consequences, poverty can be also viewed as an ACE (Evans & Kim, 2013). Crucially, these types of ACEs are seen to be more common within ethnic minority and socially disadvantaged groups (Hatch & Dohrenwend, 2007; Paradies, 2006). Focusing on the social aspects of trauma highlights the complex web that exists inter-generationally. Abuse, neglect, and other adversities are seen to show intergenerational continuity (similarities are seen between parents and their children) and the impact on health and wellbeing can be observed across generations. Some have emphasised the influence of a social learning process in creating intergenerational continuity. The concept of 'learned helplessness' has been offered as an explanation for the patterns that have been observed. Learned helplessness is defined as continuing to be in a state of shock following adverse events outside of one's control and therefore a feeling of a lack of personal control, often seen as a passivity in making changes to one's situation, even if it is viewed as adverse (Seligman, 1985; Maier & Seligman, 2016).

There is a link between a mother's experiences of ACEs and the intergenerational risk of negative behavioural outcomes in their children (Cooke et al., 2019). It is indicated that the early child-rearing experiences of parents may be carried forwards into parenting practices with their own children and thus links to the

child's risk for ACEs. Significantly, parents' responses to their own experiences could impact the nature of the care they can offer their children (Narayan, Lieberman & Masten, 2021). Parents who have histories of trauma and poor attachment experiences, and subsequently may also experience symptoms of PTSD may need to, as best they can, protect their children from adversity and provide more nurturing care (Harper- Browne, 2014). This demonstrates how relationships are a key component of understanding trauma and attachment theory highlights the importance of a consistent and reliable relationship between a child and its caregiver. Attachments are formed from early experiences and seen to influence subsequent social and emotional development (Bowlby, 1988). In the US, The Minnesota Longitudinal Study of Risk and Adaptation (MLSRA), research project highlighted the strong predictive power of early attachment relationships. It concluded that children are more likely to thrive when parents are sensitive to a child and respond effectively (Sroufe & Siege, 2011; Simpson, Collins, Farrell & Raby, 2015). This 'attunement' is seen as an important part of secure attachment development as children whose experiences were perceived, made sense of and responded to, in a timely manner ultimately learned that their caregivers were reliable (Ainsworth, Blehar, Water & Wall, 1978; Schore & Schore, 2008).

In contrast, disorganised attachment stems from internal conflict elicited in a child when it perceives frightening or abusive parental behaviour, where they both want to be cared for by that person but simultaneously want to flee the source of fear (Main & Solomon,1986). Parental invalidation has subsequently been studied as an ACE and when considering generational trauma, it is argued that invalidation stems from ineffective responses from a parent to a child when a child is communicating their experiences. Healthy environments are seen as where a caregiver provides containment, models, and aids a child in regulating their arousal levels (Ogden et al., 2006). Healthy emotional stimulation in early development is crucial in later emotional regulation (Davies et al., 2002).

Following the growing evidence of the complex interactions between trauma, culture and poor health outcomes, focus has been turned to how to break the cycle. Some argue that long-lasting benefits across generations would be achieved by reducing or preventing ACEs, others have highlighted how effective mental health

and substance use care being provided to adult populations who may be having and raising children could also disrupt the cycle (Lander, Howsare & Byrne, 2013).

1.6 Adverse experiences and substance misuse

The use of substances has been described as "the most common coping strategy to ease or numb pain of trauma and associated symptoms" (Campbell, n.d., p. 12) and alcohol abuse is the most prevalent comorbid condition with post-traumatic stress disorder (PTSD) [Kessler et al., 1995]. Those who have experienced trauma may self-medicate using stimulant or other drugs to maintain alertness and psychoactive drugs to try to block the distress of intrusive thoughts and traumatic memories (Dass- Brailford and Myrick 2010). Substance use may play a role in regulating post traumatic shame in individuals who experienced childhood abuse and neglect (Holl, Wolff, Schumacher & Hocker, 2017). Those seeking help for drinking problems are significantly more likely to have experienced childhood trauma (Schwandt et al., 2013). Due to their ability to reduce negative mood states, harmful behaviours such as drinking alcohol and using other substances can act as a means of coping with stress (Dembo, Williams, Wothke, Schmeidler, & Brown, 1992; Kendler et al., 2000; Douglas et al., 2010).

The World Health Organisation (WHO) defines substance misuse as "the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs", which can lead to severe impacts to various aspects of a persons' life. Alcohol dependence has been described as the most common form of substance misuse but substances can also include heroin, cocaine, crack, cannabis, glue and aerosols, (WHO, 2019). Alcohol misuse is defined as consuming more than the lower-level limits. Lower-level limits include not regularly drinking more than 14 units per week (National Health Service, 2019). Drinking above this level can lead to alcohol dependence, which is "a strong, often uncontrollable, desire to drink" (DrinkAware, 2019).

Experiences of ACEs have been strongly correlated an increased risk of health-harming behaviours such as smoking and drinking heavily (Bellis et al. 2014). Those who had experienced four or more adverse experiences were shown to be four times more likely to be a high-risk drinker and eleven times more likely to have smoked cannabis (Bellis et al. 2016). A correlation has been shown between ACEs and excessive alcohol use across race/ethnicity, with the exception of heavy

drinking (Lee & Chen, 2017). Experience of each individual ACE shows an increased risk of alcohol abuse as an adult and this risk increases substantially with the experience of multiple ACEs (Anda et al., 2002). Similarly increasing ACE levels have been linked to increased use of tobacco and illicit drugs. Specifically, as the number of ACEs increases, so does the likelihood of early drug initiation, drug use problems and addiction (Dube et al., 2002). Furthermore, an individuals' ACE score also had a strong graded relationship to lifetime drug use (Dube et al., 2003).

1.7 Therapeutic approaches to comorbidity

Experiences of trauma have been linked to increased risk of substance use and similarly, the diagnoses of PTSD and Substance Use Disorder (SUD) frequently occur together. A number of psychological therapies have been developed to work with comorbidity but there is no current agreement about which therapies are most effective as the evidence base is limited (Jhanjee, 2014). Therapies that have been reviewed include safety seeking therapy (Najavits, 2004), trauma focused individual psychotherapy and group -based therapies (Roberts, Roberts, Jones & Bisson, 2016). Experiences of clients within therapy groups for substance use has been qualitatively analysed (Sugarman, Meyer, Reilly & Greenfield, 2021). With the exception of a few studies examining the qualitative experience of clients' who have engaged in trauma-focused therapies (Shearing et al., 2011; Stige, Rosenvinge, & Traeen ,2013), reviews of therapy for trauma appear to quantitively measure symptom reduction. It is important to recognise that much of the research reviewing both trauma therapies and substance use therapies also originate from within the US, with much less literature available from the UK. Novel approaches to working with individuals who have substance abuse issues have been examined, including art therapy, music therapy alongside CBT, sailing adventure therapy and mindfulness-based relapse prevention (Holt & Kaiser, 2009; Dingle, Gleadhill & Baker, 2008; Marchand et al., 2018; Marlatt, Bowen, Chawla & Witkiewitz, 2008), but there appears to be limited exploration of the qualitative experiences of clients engaging in such therapies. Reviews also demonstrate overall poorer treatment outcomes for people experiencing co-morbid trauma and substance use than those without comorbidity (Berenz & Coffey, 2012).

Working with comorbid substance use and trauma is seen to present specific challenges to therapists (Back, Waldrop & Brady, 2009). It is thought that substance use, and withdrawal can cause difficulties with concentration, lack of quality sleep, along with possibly worsening mental health symptoms (Brady & Sinha, 2005). There is concern that it may mean that individuals may not be able to cope with working through traumatic memories and trauma therapy could be destabilising or even retraumatising. Whilst trauma has been found to reduce the effectiveness of treatment for Substance Misuse Disorder (SUD) [Ford et al., 2007], psychological therapy is effective for individuals with Substance Misuse Disorder and co-morbid PTSD (Carletto et al., 2018). Fundamentally, for those with this comorbidity, some therapy is better than none (Jhanjee, 2014) and current National Institute for Health and Care Excellence (NICE) guidelines state that people with PTSD should not be excluded from treatment based solely on comorbid drug or alcohol misuse (NICE,2018).

Stemming from the traditional standpoint that clients' substance use should be addressed first, and then the trauma (Covington et al., 2008), a period of abstinence or reduced substance use is still often preferred before trauma therapy commences (Back, Waldrop & Brady, 2009). In contrast to this, there is a growing movement towards more widely implementing integrated interventions (Kileen, Back & Brady, 2015), but both systemic and professional barriers are required to be overcome in order to facilitate this (Blakey & Bowers, 2014). One major barrier to this integration is the different and separate structures and funding for mental health services and substance misuse services. Services for the prevention and treatment of substance misuse have historically been delivered separately from other mental health and general health care services and were founded with the needs of men in mind (Covington, 2008). Although many people receiving support for mental health difficulties experience comorbid substance use difficulties, the majority of these individuals receive no substance misuse interventions and similarly, those under substance misuse services do not receive any mental health interventions (Weaver et al., 2003).

1.8 Emergence of Trauma Informed Approaches

Historically, services have run without acknowledging, understanding, or addressing the impact of trauma and therefore the need for tailored responses

(Harris & Fallot, 2001). Some have stated that trauma can be overlooked due to the tendency to defend against engaging with the reality and impact of violence and abuse in society (Ringel, 2012). Historically, funding and research has predominantly prioritised for evaluating specific therapies for Post-Traumatic Stress Disorder (PTSD) [Bloom, 2000.] However, a move towards Trauma Informed Approaches (TIA) involves adopting a broader definition of trauma that extends further than that of PTSD and also includes social trauma and an understanding of how multiple traumas intersect (Sweeney & Taggart, 2018).

Importantly, there is a clear distinction presented between trauma-specific services which are seen as offering clinical interventions and that of trauma-informed approaches which addresses organisational culture and practice (De Candia, Guarino & Clervil, 2014). Trauma specific services have largely included evidence-based therapies for the treatment of the diagnosis of PTSD. Research focused on specific therapies and their effectiveness in reducing symptoms of PTSD, including Trauma focused Cognitive Behavioural Therapy (Cohen, Mannarino, & Deblinger, 2006), Cognitive Processing Therapy (Monson et al., 2006) and Eye Movement Desensitization and Reprocessing (EMDR) [Shapiro, 1995]. Specific recommendations for the treatment of complex trauma are yet to be developed (Mind, 2021). A multimodal approach which includes aspects of cognitive behavioural therapy, a focus on client safety and the regulation of their emotions has been suggested (Cloitre, Koenen, Cohen, & Han, 2002), targeting not just the individual but also interpersonal and environmental factors (Bloom, 2000; SAMHSA, 2014).

Historically, positive therapeutic change for individuals has been treated as synonymous with symptom reduction. In the example of the rise of Cognitive Behavioural Therapy (CBT), within the UK, the measuring of effectiveness was through data from specific outcome measures. This subsequently held a positivist view of recovery (Williams, 2015) and directly linked to funding provided by the government for schemes such as Improving Access to Psychological Therapies (IAPT). Prior to this, the recovery movement was presented as an alternative to the conventional medical model and promoted the idea of not defining individuals that are experiencing mental health difficulties as having an 'illness' that is 'treated' and instead came from the premise that recovery is defined by living a satisfying life.

Whilst trauma specific services are more likely to be trauma-informed, organisations that do not offer specific trauma interventions, can still adopt trauma informed approaches. Trauma informed principles are important for all public service organisations and involves integrating an understanding of trauma throughout a whole system to enhance services being provided to people (Champine, Land, Nelson, Hanson & Tebes, 2019). Some changes at a policy level are appearing, including that in the UK the NHS has outlined its strategic direction for working with victims of sexual abuse and emphasise the need for services to be trauma informed (NHS England, 2018) and research on adverse childhood experiences is a viewed as a key driver of trauma-informed approaches (Sweeney & Taggart, 2018).

TIAs have received more attention in a variety of fields over the past few decades, however, how this is applied in practice has not been operationalised, with different frameworks and terminology used across differing service types. Various principles of TIAs have been suggested, the most common of which involve ensuring client safety and collaboration (Sweeney, Clement, Filson & Kennedy, 2016). The leading institution on the field of Trauma Informed Care-SAMHSA, describe key principles of TIA including safety, trustworthiness and transparency, peer support and mutual self-help, collaboration and mutuality, empowerment, voice and choice, cultural, historical and gender issue responsiveness (SAMHA, 2014). The SAMSHA's widely used description states that a system is trauma informed if it shows a realisation of the impact of trauma and pathways towards recovery, a recognition of the signs and symptoms of trauma, a response that integrates knowledge into practices and efforts to prevent re-traumatisation.

Importantly, Trauma Informed Approaches represent an ideological shift, where relationships become the focus and this relational focus transforms the experiences of people using services (Sweeney, Filson, Kennedy, Collinson & Gillard, 2018). As a result of this shift, it is seen that TIAs are a prevalent strategy to address ACEs and more outcome evaluation studies are starting to be conducted both within mental health settings and settings such as services for children, adolescents, carers and within the justice system (Azeem et al., 2011; Lotty, Dunn-Galvin & Bantry-White, 2020; Olaghere, Wilson, & Kimbrell, 2021; Petrillo, Thomas & Hanspal, 2019). Importantly, a socio-ecological model of TIA provides understanding that considers the interplay between individuals, their families, and

the wider community (Oral, Ramirez et al., 2016). A community-based response to trauma has been suggested, which promotes the integration of these principles in all organisational settings. It is proposed that ACEs can be alleviated through trauma-informed social environments that promote healing, recovery, and resilience (Matlin, Champine et al., 2019). This is not exclusive to healthcare settings or organisations that offer trauma-informed interventions but involves considering the community as a whole.

Organisations can be transformed into trauma informed systems that are sensitive to the needs of traumatised individuals (Harris & Fallot, 2001). Upon review, the implementation of trauma informed principles within substance use services was found to improve client experience (Lotzin, Buth et al., 2019; Bartholow & Huffman, 2021). Contemporary theories of trauma also conceptualise substance use as a mechanism to cope with effects of trauma and promote practices to enhance coping and resilience in the treatment of co-occurring trauma and substance use (Goodman, 2017). Adaptations to trauma are emphasised over symptoms, and resilience emphasised over pathology (Butler 2011).

Another area where trauma informed principles and interventions have been implemented and reviewed is within the criminal justice system. Individuals who have been imprisoned have a high prevalence of experiences of trauma and substance use (Fazel et al., 2016). Implementing trauma-informed, gender-responsive interventions for women in prison, along with holding a holistic view of substance use can lead to both a reduction in mental health symptoms and qualitatively meaningful change (Petrillo, Thomas & Hanspal, 2019). Due to the prevalence of trauma for individuals involved with the justice system, criminal justice agencies are working to incorporate into all services key trauma informed principles including trauma awareness, safety, flexibility, and a focus on building positive relationships (McAnallen & McGinnis, 2021).

The counselling organisation that collaborated with this study, offers counselling for survivors of abuse, who subsequently may use substances as a way of coping with their difficulties. This organisation specifically offers trauma-focused interventions including up to twenty-four sessions of one-to one counselling to "enable recovery from past abuse." The organisation offers trauma-specific services in the way of trauma-focused counselling that is provided by counsellors who are termed "specialists in working with people that have experienced trauma"

and are registered with professional counselling associations such as the British Association of Counselling and Psychotherapy and the UK Council for Psychotherapy. They publicise their counselling approach as humanistic and integrative, working from the three-stage model of recovery (Herman, 1992), in order to establish coping strategies to promote safety and stability before moving on to processing trauma, where appropriate.

Whilst they do not claim directly to be a specifically trauma-informed service, there is evidence of ways that the organisation has worked to apply trauma informed principles throughout the organisation. This includes stating that they commit to offering a supportive and safe place for clients and demonstrate prioriting collaboration through the offer of a client focus group to hear the views of those who have used their services. The organisation was also founded almost thirty years ago by an individual who had themselves been a survivor of abuse and struggled with addiction. In this way, the organisation was started as a way of raising awareness of how people that have survived abuse may develop an addiction to drugs or alcohol as a way of coping with their trauma. Subsequently, service user-involvement appears to have remained an imbedded part of the organisation. As well as individual counselling, the counselling organisation also work to reach out into the community and have developed a number of community projects aimed at providing the opportunity of connecting together those who have a shared understanding of their experiences in fun and meaningful activities to build confidence.

In both human and economic terms, the cost of not addressing the traumatic stress associated with these adverse experiences is seen as significant, both on individuals and society (DeCandia, Guarino & Clervil, 2014). TIAs have real potential to improve services for those who need them most (Johnson, 2018), and better meet the needs of those accessing services (Sweeney et al., 2018). However, there are barriers around engaging with TIA in the UK due to continual service changes and austerity which has reduced resources (Sweeney, Clement, Filson & Kennedy, 2016). The mental health charity MIND published the report 'we still need to talk' (Mind, 2013) and highlighted barriers experienced by people in accessing psychological therapies within NHS England. They highlighted that such barriers included homelessness and co-occurring substance misuse.

1.9 Rationale and Research Aims

Although there has been important research and applications of research, aimed at preventing experiences of ACEs, (Garner, 2013), this study was focused on the tertiary level of intervention which is focused on adults accessing support for the impact of early life adversity and trauma. Furthermore, in contrast to the majority of research in this area that is quantitative, it was a qualitative exploration of the experiences of individuals who have completed trauma-focused therapy alongside experiencing comorbid substance misuse.

The way that trauma is conceptualised within services and society, has changed over time, with trauma informed approaches taking more of the spotlight in recent years. Therefore, it appears crucial that the way in which clients who have experienced trauma are brought to access services and receive support also matches this shift. There still appears to be a gap between support offered for substance use and that for mental health difficulties. Furthermore, the way the effectiveness of this support is analysed is largely quantitative. Quantitative research is largely concerned with the measuring of symptom reduction. The poorer outcomes noted for those experiencing co-morbidity, could partly be explained by the gap between support for mental health and those for substance misuse, with individuals being declined access to psychological therapy due to the narrative that they are firstly required to reduce substance use. The research question for this study is how does this client group experience their therapy journey? The research aimed to explore and voice these experiences.

Specifically, the study aimed to explore:

- The experiences of clients who have self-reported substance use and have engaged in and completed trauma-focused counselling.

- What developments could be made to ensure this client group are able to access therapy that meets their needs and contribute to the development of the counselling service.

- The implications of trauma informed principles within the counselling service and wider community.

2. Methodology

2.1 Theoretical position

In line with the concept of "Big Q" (Kidder and Fine, 1987) qualitative research, this study was designed to be a "fully qualitative" study (Clarke and Braun, 2018, p.107), whereby, qualitative methods were intentionally used within a qualitative paradigm (Terry et al., 2017). This research is underpinned by the theoretical assumptions of critical realism (Bhaskar, 1989), which holds a philosophy that sits between those of naive realism and relativism on the spectrum of philosophies. On one end of the spectrum, naive realism is founded on the assumption that there is one 'real' truth' that can be discovered and captured, whilst on the other end, relativism argues for the existence of multiple truths or realities that are socially constructed (Braun & Clarke, 2013, p. 27). Therefore, in its positioning, critical realism pursues the existence of a reality that is experienced by individuals but recognises that these representations are fundamentally mediated by contextual elements such as culture and politics. In this way, it recognises both the role of people in creating a social world but also the influence of personal and societal factors independent of this (Bhaskar, 1989), and importantly highlights how meaning is context-bound (Pilgram, 2014; Sims-Schouten, Riley & Willig, 2017).

This theoretical positioning allowed research that focuses on giving voice to participants' experiences (Braun & Clarke, 2013), and therefore the underlying philosophy guided not only the research question, but the questions asked at interview and the analysis of subsequent data. The critical realist philosophical standpoint was chosen in relation to this study as it acknowledges the meaning individuals make of their experiences of accessing and engaging in trauma focused counselling but also recognises the influence of culture, discourse and politics in the meaning that is made. Furthermore, as it is not associated with any particular set of methods, critical realism has been highlighted as appropriate for analysing social problems and suggesting solutions for social change (Fletcher, 2017), which fits with the research area and aims of considering potential improvements and implications.

2.2 Reflexivity Statement

As the research intentionally embraced researcher subjectivity it was crucial that my positioning as the researcher and in relation to the research topic was fully examined and clearly stated. This statement predominantly spans the four years I experienced as a trainee counselling psychologist but inevitably all of my experiences in roles related to mental health and psychology that came before, also feature in forming the lens that I view the world through now. During my doctoral training I held various roles, including trainee psychodynamic therapist in a third sector organisation in England, a CBT therapist in another third sector organisation in Wales (which has a different approach and provision of mental health services), but where I feel I experienced most about the policies, competing demands, commissioning and ultimately the gap between services was working as an assistant psychology practitioner in an NHS IAPT Service.

Working in an IAPT service involved completing assessments for those who had self-referred for psychological therapy and this gave me insight into what provision was available or not for those individuals and the guidance that was followed regarding referral pathways. One thing I had noticed at the time was the trend for those who were using substances or alcohol to be referred on to specialist counselling services or told they needed to seek support to stop using substances before they could access psychological therapy. I began to wonder what the experience was like for such individual to then access and then engage in psychological therapy for trauma.

During my counselling psychology training, I developed a greater understanding of trauma, formulation as an alternative to diagnosis and a critical evaluation of medical model of distress. Furthermore, I developed an appreciation for the importance of social justice and an understanding of power dynamics in society, along with an awareness of the impact of language and discourse. Formulation is a key part of psychologist's work (BPS,2017) and results in the ability to understand how people make sense of their experiences and allow reflections on where change may be possible.

I was aware when beginning this research that I would have an 'outgroup' member status. This was because I was proposing research and ultimately interviewing individuals who had experienced specific traumas, used substances as a way of coping and had subsequently sought counselling. While I aimed for their

experiences to be heard, I wanted to avoid the 'poor them' trap (Division of Counselling Psychology Wales, 2021). At the start of conducting the research, but even more so as it progressed, I began to see that participants had wanted to take part in the research in order to give something back and have their experiences heard. Many were curious about what the outcomes of the research might be. Whilst I was very aware that this study was not intended or designed in a way to make any generalisations, it began to feel like a shared aim of the participants and I that there could be some meaningful implications to conclude from the research process and for me, this gave the research another level of meaning.

2.3 Research design and data collection

Face- to face interviews have long been part of practice in qualitative research and remain a prominent method (Oltmann, 2016). In its original design, this research was to offer participants the option of attending an interview face-to-face, over the telephone, or real time over the internet with Skype or similar video calling Software (otherwise known as Video over Internet Protocol [VoIP]). The purpose of offering participants this range of options was to encourage participants to attend an interview by being flexible and provide the best way for them to feel able to share their responses openly. Researchers have reviewed the use of VoIP in qualitative research and highlighted that using programs like Skype allows participants to be authentic in their responses and it almost exactly mimics face-to-face interactions, including in the ability to exchange non-verbal cues and gestures visually which allows successful interaction (Goffman, 1959; Saarijärvi & Bratt, 2021). The benefit of using VoIP and telephone interviews included that the locality of participants was not a barrier for them to engage in the study, should they no longer reside near where they accessed the therapy previously (Lo Iacono, Symonds & Brown, 2016). Furthermore, it also gave the best opportunity for in-depth authentic interview data due to participants' opportunity to choose their preferred mode of interview.

Following the outbreak of COVID-19 in 2020, the option of face-to-face interviews was suspended, in line with Government Guidelines around social distancing and limiting contact with others. Subsequently, for a period of time, all participants that were invited to interview were offered the options of telephone or VoIP. Coincidentally, by this point, all participants who had been invited to interview, had chosen either telephone or VoIP interviews. By October 2021, when

Participant 8 'Nathaniel' was contacted to take part in the study, the option of face -to-face interviewing was recommenced with strict adherence to COVID-19 policy including the wearing of face masks and remaining 2 meters apart during the interview. This was the only interview conducted face to face as all other participant's preferences had been via telephone of VoIP, when asked.

Prior to asking the interview questions, participants were read the consent form and asked to provide verbal informed consent to take part (Appendix B). Participants were given the opportunity to ask any questions about the interview before it commenced and were also asked some demographic questions (Appendix C). The interview schedule questions were open-ended (Appendix D) and there was the opportunity to flexibly ask unplanned questions, probing further where suitable, to ensure the generation of rich and detailed data for analysis (Braun & Clarke, 2013).

The development of the interview schedule began with drafting questions that were relevant to the research aims. It became apparent that for clarity it would make sense to ask questions in chronological order and therefore three sections were created: 'introduction and first contact',' experience of counselling' and 'ending of counselling'. The questions were also discussed and edited with the research supervisor. The interview was subsequently piloted in October 2019 in order to test the guide and improve on the questions asked (Creswell, 2007). As a result of the pilot interview, some questions were adapted, and some new questions were added. For example, in addition to the question "What brought you to seeking counselling?", a more direct but tentative request for information was added, "If you feel comfortable doing so, please could you tell me very briefly about your background or previous experiences that may be relevant to what led you to seeking counselling." The purpose of this was to capture a brief description of the client's background, to give some further context of each of the participants involved in the research. It felt important, due to the variety of what can be meant by trauma, to be able to clearly see what types of traumatic experiences the participants had experienced.

2.4 Recruitment and Participants

The study involved the recruitment of ten participants and support with the recruitment of participants was provided in agreement with a counselling service

in England that provides therapy for clients who have experienced childhood abuse and use substances. Sampling was purposive so that only those individuals who met the inclusion criteria would be asked to participate. All participants who took part in the research reported having experienced childhood trauma including childhood abuse or witnessing domestic violence. Therefore, many of the participants had experienced multiple ACEs in their early lives. Many reported subsequently experiencing trauma in adulthood, including abusive relationships and/or sexual violence.

Reported histories of trauma

Type of trauma	Number	Percentage (%)
Childhood abuse	*10*	*100*
Childhood domestic violence at home	*6*	*60*
Adulthood abusive relationship	*3*	*30*
Adulthood sexual violence	*2*	*20*

Demographic Information

The range of ages for participants in the study was between 24 and 62 years and the majority of participants reported their gender as female. Similarly, with the exception of one individual, all participants reported their ethnic background as White British (see Appendix F for further demographic information).

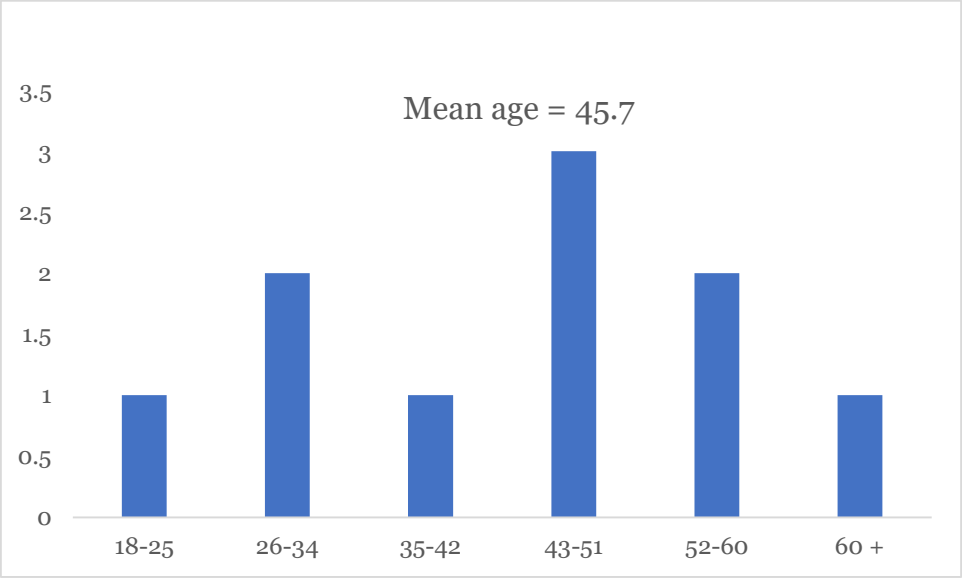

Chart 1. Ages of participants

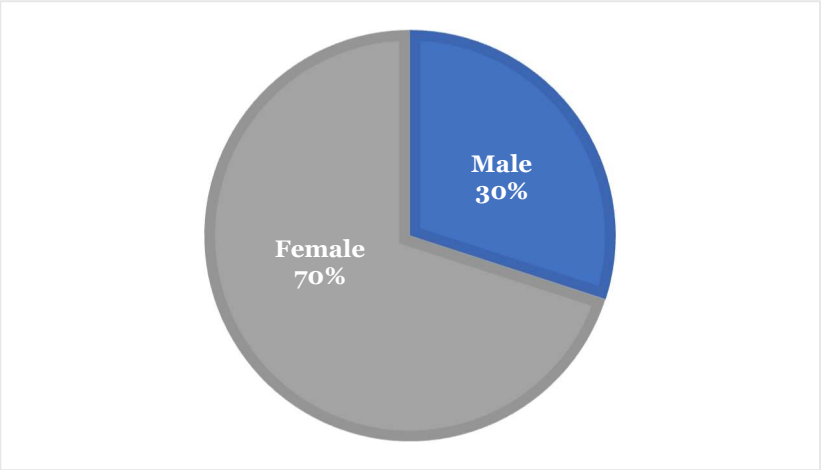

Chart 2. Gender of participants

Participants were initially recruited by telephone, where they were introduced the study, could ask questions about the research, and asked if they would be interested in taking part. Subsequent to this initial telephone call, some participants requested further information to be sent to them via email or post and they were sent the participant information form and consent form to read. If they wanted to take part, participants were asked to either email the researcher or call the counselling service who would be able to pass on a message to the researcher. Once they agreed to take part, they were asked for their preference of interview mode and an agreed interview time was scheduled. In order to maintain anonymity, all participants were assigned a pseudonym and participants were given the choice of what name they wished this to be. All participants were able to choose a suitable pseudonym which was used to represent them throughout the rest of the study.

2.5 Ethical Considerations for Recruitment

In collaboration with the counselling service, considerable thought was given to research inclusion criteria. Participants for the study were UK residents, 18 years or above, who had previously completed trauma-focussed counselling at the service. Participants were selected from the organisation's client database, based on the criteria that they had completed trauma-focused counselling in the last 2 years and who were recorded as having used substances (alcohol or drugs) during their assessment with the organisation through the use of Alcohol Use Disorders Identification Test (AUDIT) [(Babor, Higgins-Biddle, Saunders & Monteiro, 2001] and Drug Screening (DAST-10) [Skinner, 1982] questionnaires during the assessment process.

Only participants who gave consent to be contacted again in future for research purposes were contacted for recruitment and they were only contacted when three months had passed since the end of their counselling sessions. This time period was chosen in consultation with the counselling service, with the rationale that this time period would be enough time for participants to have consolidated their therapy sessions and therefore have had the opportunity to reflect on their experiences and the outcomes of their therapy. However, three months was also not too long a period of time that they may not be able to recall their experiences and it still had relevance.

During the time frame of the study, each client who met the inclusion criteria and gave consent to be contacted for research purposes was considered for participation. Once three months had passed from the end of their counselling, the researcher was provided with contact details for relevant participants. There was no further screening process but during the initial telephone recruitment call, some individuals declined to take part for various reasons. Some expressed not wanting to take part either due to fear of difficult thoughts and feeling being re-triggered or they did not feel comfortable discussing their experiences of something that felt very personal to them. Some clients were also unable to be contacted successfully.

2.6 Ethical Considerations for Interviews

Research was given full ethical approval by UWE Ethics Committee (Appendix E). In-depth qualitative interviews appeared best suited to this study as they offer rich

and detailed data about participants' experiences while allowing the data to be collected in a way which prioritised ethical practice. While participants were not asked to speak in detail about their previous traumatic experiences, it was important to be aware that the interviews may still have triggered difficult emotions for participants. Therefore, interviews were conducted in a sensitive way to foster trust and empathy and therefore to not only encourage open dialogue but also prioritise the wellbeing of the participants. The counselling service had also offered the option to participants of a brief time-limited post-interview telephone debrief, to be provided by one of their qualified counsellors. Furthermore, each participant was also provided with a copy of the participant information sheet prior to interview, which contained information about the study and also had details of where to seek support, should they feel they need emotional or therapeutic support at any point in the future (Appendix A).

As detailed in the participant information form, the substance use policy employed by the counselling service for clients during therapy was followed for the interviews. This stipulated that no substances or alcohol are to be consumed prior to a session in order for clients to be able to fully engage.

As the majority of the interviews were conducted over the telephone or VoIP, it was important to be able to record informed verbal consent from participants. This was done by reading out the consent form in full and then asking each participant if they gave their consent to take part in the research, to which participants replied either yes or no and this was recorded on the audio device that subsequently recorded the rest of the interview.

2.7 Piloting

A pilot interview was conducted in October 2019. As chosen by the participant, the interview was conducted over the telephone at an agreed time. The participant provided verbal informed consent over the telephone after being read out the consent form and this was recorded along with the rest of the interview. The interview lasted approximately forty minutes and the audio recording of the interview was transcribed. Immediately following the interview, notes were made on initial impressions of the content, in order to explore reflexivity. It has been presented that the continuous nature of qualitative interviewing involves redesigning the questioning being used (Rubin and Rubin, 1995) and therefore

reflections were made on any beneficial changes to the interview schedule. Some changes were subsequently made, including adding questions about the practical aspects of attending counselling for participants e.g., getting to the location, and financial implications, further questions about how client's felt about their relationship with their counsellor and the meaning or importance for each client that the service was specialised in working with both childhood trauma and substance use. This was due to the participant in the pilot interview discussing these areas which felt meaningful and would add to further depth of information for analysis.

2.8 Implications of COVID-19 on Data Collection

As well as a temporary block on face-to-face interviews, COVID-19 also created a delay in the recruitment process. In keeping with the inclusion criteria of the study, it meant that participants could not be contacted for recruitment until three months had passed since they finished their counselling sessions. Thus, there was a period of time when no clients were ending counselling. The inclusion of some participants who had received part of their trauma focussed counselling virtually was also an unexpected addition to the design of the research but nonetheless their insights were included.

2.9 Data Analysis

Data collected from the interviews were transcribed and analysed using reflexive Thematic Analysis (Braun & Clarke, 2019; 2021). As the study's aims were focused on exploring the lived experiences of the participants and the sample size was modest, Interpretative Phenomenological Analysis (IPA) was initially considered as a method for data analysis. Ultimately, TA was decided upon as it allowed the identification, analysis, and reporting of patterns across the dataset (Braun and Clarke, 2006), and was deemed the most appropriate method of data analysis as the aims of the study were to explore participant experience whilst acknowledging the contextual factors that influence their experiences and how they make sense of them. The research extends further into other aspects about their experience of the service in which they engaged with, and wider context of mental health and counselling services. TA was applied to make sense of the experiences and reality of participants who have completed trauma-focused counselling and used substances. TA has been described as a flexible method which can be applied within a range of theoretical underpinnings. This study is underpinned by the

theoretical assumptions of critical realism, which recognises the way individuals make meaning of their experiences and how the broader social context impacts this (Willig, 1999). The sample of participants while seen to have some similarities such as those detailed in the inclusion criteria, also demonstrated many differences (different ages, genders, previous experiences of therapy, the nature of traumatic experiences they had experienced, type and level of substance use they had engaged in).

Throughout the report, it is important to note that the use the words 'participant' and 'client' and 'therapist/therapy and 'counsellor/ counselling' have been used interchangeably. This firstly reflects that the participants in the study were also clients in the service and secondly, participants often themselves used the words counselling and therapy at different times to mean the same thing.

The data was analysed through reflexive Thematic Analysis. This meant that researcher subjectivity was not only reflected on throughout the research process, but embraced as a resource, and while the analysis and subsequent codes and themes that were generated, were done so following the flow of the data, the data was inevitably interpreted through the lens of previous knowledge and experiences of the researcher. In the case of this study, the data was interpreted with prior knowledge of the principles of trauma informed approaches and the impact of trauma.

It was important to detail how reflexivity would be built into the analysis of data. At each stage of the analysis, myself as researcher/ interviewer and also therapist would reflect both mentally and then through written reflexive notes about the process of the analysis and what part my experiences and beliefs played in it. For example, having worked in mental health services prior to completing the study, I had insight into the everyday functioning of services and the challenges that they face. Furthermore, my identity as a therapist whose ethos of therapeutic change is fundamentally a relational one, also guided and influenced the relational aspects of themes that were captured in participant's responses. The interviews themselves were also inevitably conducted in a relational, compassionate, and empathic way, in keeping with my interpersonal style.

Data analysis followed the six-phase guide presented by Braun and Clarke (2006):

1. *Familiarisation:*

The researcher transcribed each of the interviews by listening to each audio recording and typing onto a laptop computer word document what was heard verbatim. During the transcribing process, full stops were used to indicate any silences or gaps between speech with a smaller number of full stops indicating a short pause while a larger number of full stops indicated a longer pause. Also indicated were other noises made for example "(sigh)" or "(laughs)" to add richness to the analysis.

Once each of the interviews had been fully transcribed from audio recordings, each transcript was read through, and casual notes were made in the margins about any initial impressions and any preliminary ideas or patterns observed across the transcripts. For example, participants mentioning waiting times and focus on their relationship with their counsellors.

2. *Generating initial codes:*

Throughout the analysis process, a code was used as a building block for subsequent themes and defined as an interpretation by the researcher of patterns observed across the data set (Byrne, 2021). A document was created that included a full list of words or phrases that were generated from looking through each transcript in turn and then were colour-coded to illustrate any similarities, links or patterns throughout. (Appendix H). Initial codes were continually checked for relevance to the research question. The researcher also reflected on the labels given to each code and whether this captured something meaningful about the data.

3. *Identifying themes:*

As the method of analysis was reflexive thematic analysis, theme generation was seen as an outcome of the process and importantly, data interpretation involved making sense of the data, not just summarising (Maguire & Delahunt, 2017). From the initial codes, the idea of the "Central Organising Concept" was borrowed from Braun and Clarke (2019) to develop clusters of codes that had shared meanings. At this point, the transcripts were re-read, and themes identified were reviewed to ensure they represented participant experience. At this point, some changes in the

themes were made, specifically, two initially separate themes were combined (see Appendix I).

4. Reviewing themes:

A visual map of themes was created with lines around and between the themes to explore the relationships between the themes and where the boundaries laid (Appendix J.) This involved a few attempts and themes were moved around various times. From this visualisation, the researcher aimed to develop a story which included the patterns of shared meaning amongst the themes, (Clarke & Braun, 2018, p.108.)

5. Defining and naming themes:

For each theme highlighted, a summary was written that captured the essence what it meant and how it fitted into the story as a whole. Relevant data extracts from participants were included to evidence each theme. Themes were also discussed with a supervisor, to check that the theme names were representative of client experience and their meaning continued to be understood when the themes were without the evidence supporting them (Braun et al., 2016).

6. Producing a report:

To ensure participant anonymity, pseudonyms were used in place of participant names as detailed in the method, and further amendments were made to the final report to ensure there was no identifying information was included (King, Horrocks & Brooks 2018). A final thematic diagram was also presented (Appendix K).

2.10 Participant involvement in the Research

Following interview, participants were asked if they consented to being contacted again at a later date in order to be asked for their impressions and reflections on the research ideas being presented. General feedback was requested regarding the themes that were concluded from interview data, along with feedback specifically related to the language used in the themes. Though a brief description of the themes were sent to those participants who had consented to be contacted via email following interview (Appendix L), unfortunately there were no responses and therefore participant feedback could not be included in the process, as hoped.

3. Results and Discussion

3.1 Thematic Analysis

The analysis of the data related to client's experiences of therapy resulted in the development of four themes and corresponding subthemes (Table 1.) Each will be discussed in detail. Firstly, client's experiences of recognising having a need for therapy and their experiences of accessing it. This is followed by an exploration of the concepts of safety and trust and how this was perceived by clients through their experience of the environment and how this linked to their ability to open up in therapy. The theme "The many roles of the therapist" is then discussed, demonstrating the different aspects clients recognised in their therapist. Finally, "reflecting on the therapy journey" highlights how clients evaluated their therapy experience as part of a larger journey of recovery, with a hope to find and maintain a continued connection to the service and the meaning this had for them.

Table 1. Final Themes

Theme 1: Challenges with accessibility	Theme 2: Safety and Trust	Theme 3: The many roles of the therapist	Theme 4: Reflecting on the therapy journey
Subtheme 1: Ready to seek help, having to wait	Subtheme 1: Welcoming environment	Subtheme 1: The therapist as 'Care Giver'	Subtheme 1: Grateful but just the beginning
Subtheme 2: Service balancing need and resources	Subtheme 2: Sharing the "deep stuff": client's ability to open up	Subtheme 2: The therapist as 'Validator'	Subtheme 2: Continued connection
		Subtheme 3: The therapist as 'Teacher'	

3.2 Theme 1: Challenges with accessibility

Participants detailed their experiences of seeking therapy through the third sector organisation and how they were feeling at the point of accessing the service for support. Participants discussed the challenges of waiting to start therapy and their awareness of the counselling service's position of balancing meeting the need and demand for their service, with their resources to provide support. There appeared to be an agreement amongst participants, that this was the norm across counselling and mental health services and subsequently the expectation that with a good service comes a long wait time.

Subtheme 1: Ready to seek help, having to wait

Participants described feeling at a point of needing help and support when they had their first contact with the counselling service. Many highlighted feeling at a point of desperation or crisis and had accepted that they required help instead of continuing to cope alone with their difficulties. Two examples of this were:

> *"I needed help there and then."*
>
> (Michael, 50, Male)
>
> *"I was in a really bad way."*
>
> (Amy, 29, Female)

The above participant quotes demonstrate an urgency felt by the participants at that time. During their research interviews, all participants shared brief information about their previous experiences and backgrounds that had led up to the point of them seeking counselling. Many participants described multiple traumatic experiences both in childhood and adulthood of a physical, emotional, and interpersonal nature and the subsequent impact that this had on their life. Participants expressed how they felt when seeking support and the majority described being at crisis point, for example:

> *"I was just extremely raw, very sad, very depressed, and low and scared and I was just desperate, I needed anything to help me at that point. Literally, I've always suffered with depression and what I didn't realise at the time- PTSD. I just knew that I needed help, I couldn't keep going, where I was, or it was just going to lead to suicide.*
>
> (Alice, 31, Female)
>
> *"I was getting increasingly anxious, my health was going down, I was getting to the point where I didn't know if I was going to have a successful suicide attempt before being able to get into a service."*
> (Jemma, 24 Female)

These participants detailed how they felt that their physical and mental wellbeing were deteriorating without support and indicated a fear of it having led to suicide if nothing had changed for them. There is an increased risk of suicide for individuals who have experienced multiple ACE's during their earlier years (Ports

et al., 2017; Dube et al., 2001) and drug use has also been observed as a mediating factor in the link between experiences of ACEs and attempted suicide (Lee et al., 2021).

It appears that participants had reached a pivotal point where they decided to take action to seek help. In relation to readiness for therapy, individuals are seen to seek help in relation to childhood trauma, when experiencing situational demands that outweigh their resources. However, self-management, or the belief that one can cope by themselves, can contribute to a delay in help seeking (Stige, Traeen & Rosenvinge, 2013). Substance use could be viewed as a form of self-management, and those with experiences of trauma appear to be overrepresented in delayed help seeking populations across the world (Fikretoglu, Liu, Pedlar, & Brunet, 2010; Fortney et al.,2016). This trend could be partially explained by individuals avoiding trauma-related triggers (Stige, Traeen & Rosenvinge, 2013). However, for the purpose of this study, all participants had the experience of deciding to reach out for support. One example of this was described by Alice, who indicated that this was her first experience of feeling ready to accept help:

> *"I was at a place finally where I was ready to maybe accept help or felt I could reach out, I felt that actually maybe it could be something that could be assisted with, it wasn't something that was going to ail me forever."*

Alice highlighted that she may not have previously felt ready for accepting help or reaching out for support, seemingly due to feeling that she couldn't be helped. Internal stigma or negative beliefs that individuals hold about themselves for having experienced trauma is another potential barrier to seeking help (Murphy & Busuttil, 2015). Thus, promoting the ongoing importance of anti-stigma and awareness campaigns. Campaigns such as England's 'Time to Change' campaign formed to reduce stigma against people with mental health problems, are aimed to correct misinformation, challenge discrimination, and ultimately reduce barriers to people accessing and feeling able to reach out for support.

As well as recognising the readiness of clients in first seeking therapy, it is important to also consider the effect of previous experiences clients have had with counselling services and/ or mental health support. Some participants described negative experiences they had at other services prior to this one:

"…The counsellor dosed off and I'm thinking that's disgusting, so rude… I wasn't happy, I'm here to talk to you to get some advice and help about what I have been through and you're dosing off. I'd never go back there again."

(Chloe, 48, Female)

"But once they heard that I, you know, had a drink at all, they just put it down to that- well they were like umm.. this service isn't for you…"

(Alice, 31, Female)

This demonstrates how these prior experiences may influence client's expectations of further support and therapy. Both Chloe and Alice were able to reach out again to a new service for help but how many individuals may have decided against this after a negative experience. Some participants highlighted having an open-mind or having "no expectations" about the therapy they were waiting for. This could highlight a level of cautiousness, not wanting to have too high expectations, either as therapy was a new concept or that previous experiences of therapy have fallen short. Examination of client's experiences of unhelpful therapy is often related to a breakdown of the therapeutic relationship and specifically, a lack of collaboration and caring from the therapist (Bowie, McLeod & McLeod, 2016). Chloe's description demonstrates a decision to not return to therapy after her experience with a specific therapist, not seeing the value in returning and possibly left with the feeling that the therapist was uncaring or unable to meet Chloe's needs. Alice's narrative highlights her perception that the result of disclosing alcohol use was to be declined support from a particular service. Consequently, this may have acted to re-affirm the stigma surrounding substance use and those who have had this response from services may be left feeling isolated with their distress.

Crucially, positive, or helpful experiences within services and therapy can act to heal or repair previously unhelpful ones. Nathaniel highlighted how his experience at this current service acted to repair his beliefs about counselling:

"They [the service] gave me faith back into counselling again."
(Nathaniel, 51, Male)

All participants in this study indicated that they had, at some point in their lives, experienced difficult interpersonal relationships. Therapy is a relational process

and can work to offer a reparative relationship, offering something different to those relationships clients may have had experience of outside of the therapy room. The concept of relational therapy is explored further in the discussion of *Theme 3- ' the many roles of the therapist*', but with regard to the challenges in accessing support and therapy, previous relational experiences are likely to influence both client's expectations of future therapy and their beliefs or hope in the process of therapy/counselling. They may have questions about their expectations of therapy; whether it will be a good experience or be beneficial for them. Whilst clients reached a point of readiness for support, they also expressed an awareness of service provision.

Subtheme 2: Service balancing need and resources

Participants spoke about their perception of the counselling service having long wait times due to the service needing to balance their resources with the demand of people accessing the support offered. It was described as an almost impossible task and participants reflected on aspects that they felt were outside of the service's control. Some expressed hesitancy to criticise the service based on this, but all communicated a wish that this could be improved so that others could have a better experience. Participant's responses indicated a perception that this is an issue faced by many services, especially third sector organisations that may be charity funded.

> *"I know they are busy; I know there's only so many counsellors they've got and it's all free so I can't complain too loudly."*
>
> (Michael, 50, Male)
>
> *"Everywhere has that same problem, especially the free charity based, you know? But it's such a small number of counsellors as well and I was trying to get a specific kind of service."*
>
> (Jemma, 24, Female)

The above examples demonstrate a level of hope and optimism in the wait, while others also indicated a resignation to an accepted norm of having to wait a long time to access something worthwhile, for example:

> *"Everybody knows if you have a good service, you have to wait a little bit, so it's worth waiting."*

(Amy, 29, Female)

"The wait seemed endless, but I knew it would be worth the wait in the end."

(Sarah, 58, Female)

The above quotes indicate that 'good services' are likely to be in demand by many people and therefore this means that there is an inevitable wait time. It demonstrates how counselling services like this one, are offering support that is widely needed by those in society. Importantly, such services need to decide how to allocate resources including funding. During the 2020/2021 financial year, the counselling service acquired the large majority of their funding through grants and donations and subsequently the majority of this was spent on staff costs (taken from their annual report published online).

During the interviews, participants were asked about their reflections on the service being free to access and all participants stated that this was an important factor in them being able to access therapy. As indicated in the participant demographics, seven of the ten participants stated that they were unemployed at the time of interview.

" I wouldn't have been able to have afforded it, having not worked for a long time…I don't have money to pay for therapy."

(Lemonie, 55, Female)

"Being on a low income, it was really, really important."

(Sarah, 58, Female)

"It's really important, so people like me can actually get to access those services…I didn't have any money, I didn't even have a fixed abode, so if I had to pay, I wouldn't have had that stabilisation I needed, to have got me out of the cycle I was in."

(Jemma, 24, Female)

Jemma continued on to express that she felt she wouldn't have been able to have accessed a trauma-specific service "I've had a look and they're just so expensive".

Highlighting that it is not just about accessing any therapy for free but being able to access therapy that is specific to client need.

While counselling from the service was free of charge, some participants highlighted other related costs involved in attending their sessions such as travelling on a bus to get there. Alex described his choice to prioritise this cost over other essential items so that he could attend his sessions. In this way, he fundamentally prioritised his mental health over his other basic needs.

> *"I am on benefits at the moment, and there's even the bus fare getting there, I mean some days it was a choice between getting the bus or buying food, and it was always getting the bus each time, because it was that important."*
>
> (Alex, 49, Male)

This quote highlights the social contexts and needs of clients which need to be considered. In line with the idea of the 'hierarchy of needs' (Maslow, 1943), which has maintained its relevance into more modern times, psychological therapy is viewed as developing needs that are higher up the pyramid such as improving social connections and self-esteem. Below this are physiological and safety needs such as access to shelter and food and personal security. In Alex's case, in order to be able to develop the needs nearer the top, there was some sacrifice of the fundamental needs below them.

3.3 Theme 2: Safety and Trust

Participants highlighted the importance of feeling safe and being able to trust their therapist and the overall service. Participants expressed ways in which they experienced feeling safe and this included feeling that the environment was comfortable and welcoming. They reflected on their experience of opening up in therapy and vitally, how this was linked to the trust they had developed. This was trust in the environment that it won't feel threatening, trust in the therapist to help them through the process and trust in the time they had available; that they didn't have to rush and could go at the pace they required. Participants described how this impacted their relationship with their therapist and how important this was in being able to get the most from their experience of therapy.

Subtheme 1: Welcoming environment

Participants spoke of their first experience of entering the physical space, their impressions, and the feelings they associated with this. They described the space as immediately welcoming and calming and this led to a sense of feeling at ease there. Many used the words "calm" and "welcoming" in their responses, for example:

> *"It's very calm and very welcoming… I felt at ease there."*
>
> (Alex, 49, Male)
>
> *"Lovely and very welcoming."*
>
> (Eliza, 62, Female)

Participants described that they felt effort had been taken to create a place of comfort and safety. They highlighted that this experience was due to the physical space but also the people who inhabited the building. Participants appreciated the opportunity to make refreshments.

> *"You can see the effort put into making you feel comfortable… I could help myself to a cup of tea and that was nice… it was very important, to feel welcomed and that there's nice people around."*
>
> (Lemonie, 55, Female)
>
> *"There's a waiting room that's quite nice, and someone pops out and asks do you want a cup of coffee?"*
>
> (Jemma, 24, Female)

The importance of the waiting space at the service was articulated and in particular, the way in which it left participants feeling. Some participants described initial feelings of anxiety or nervousness at their first visit but found that the environment helped them feel calm and over time this also became a familiar space. The waiting space appeared to serve a purpose of creating a sense of calm and security. The added option of being offered refreshments also implies that the service was aware of and considered client need from the offset. Both participants

talk about the presence of others and their experience of the waiting room being part of a routine or ritual that remained a constant during their therapy journey.

This may demonstrate a deviation from what is viewed as a traditional approach in psychotherapy or counselling services. It may have felt important for the participants to mention as it was not what they had expected. Many services can appear cold or clinical and this can maintain a power imbalance between client and therapists or clinicians. Instead, the experience of waiting for counselling for the current participants was normalised, met with warmth and the routine, soothing activity of having a cup of tea was incorporated.

Some participants also highlighted noticing specific items in the waiting room, including a noticeboard with leaflets and messages written by other service-users:

> *"There's lots of like leaflets up and a big board behind me that had 'you're beautiful' and nice things that other people had written while waiting for their counselling, so it was a small but comfy space on the inside."*
>
> (Jemma, 24, Female)

Seeing such messages could act to offer hope and connection to those waiting to begin their sessions. Such reflections also link to the *subtheme: continued connectio*n and illustrate the space for user involvement in services. While this was not directly concluded by participants, the way in which they described the environment and in particular, the waiting area demonstrated a space which acted as a buffer from the outside world and as a separation from the therapy room. Thus, the waiting room had an important function.

Once in the counselling room, participants spoke of the adaptability of the environment. They described how it was able to be changed to fit their needs and to ensure that there was nothing that could unintentionally trigger their symptoms of trauma. The rooms also had the presence of sensory objects that were perceived as grounding.

> *"My counsellor created a safe space for me right from the very beginning"*
>
> (Sarah, 58, Female)

"They were really accommodating… it held me in place…the environment was flexible and trigger-free"

(Jemma, 24, Female)

"They made sure you felt warm enough, cool enough, there was drinks, sensory things to ground yourself"

(Alice, 31, Female)

Consideration was given to many factors about the physical space- what and how things were placed and the temperature of the room. It also implies that participants were directly asked about their needs, and they had the experience of these needs being met.

Jemma recalled the conversation she had with her counsellor and the questions they asked:

"Okay this is the room, what do you like about it? What don't we want…shall we get rid of this? Is that okay? Where shall we sit? Would you prefer to sit on the floor? We can use the beanbags…"

This demonstrates a personalised approach and by asking directly about her preferences, her counsellor was able to know what might have an impact for her during their sessions. She later described an item being removed –"we'd just get rid of it", the use of "we" demonstrated that it was an agreed action between her and her counsellor. Jemma's narrative indicates that care and consideration had been given.

Of key importance is how this was demonstrated throughout the service environment and that there was a continuity. This modelling of care and flexibility offers the message that clients are valued and worthwhile. In contrast, if a therapy room was unkempt or rigid, this could demonstrate a lack of care or clients could see their previous experiences of neglect and/or their negative sense of self as reflected back at them by the state of the room. Furthermore, research has highlighted a high level of client re-traumatisation within substance use services. This impacts service users' interaction with services, demonstrating the need for trauma informed spaces (Cheema, Milne & Stacey, 2021).

Subtheme 2: Sharing the 'deep stuff': client ability to open up

Participants highlighted how having a longer period of counselling meant that they didn't feel rushed or pressured, that they had enough time and therefore didn't have to discuss their experiences of trauma straight away.

> *"They didn't rush you, and you took your time talking about things, and they didn't go into the trauma bit just like that."*
>
> (Chloe, 48, Female)
>
> *"My counsellor was able to work with trauma and not rush that through.. there were many sessions in front of me"*
>
> (Sarah, 58, Female)

This illustrates the benefit of clients feeling in control of what they share and even feel able to stop talking if this became too overwhelming. They also indicate a flexible and personalised approach to meeting their needs. Adding to this, some participants reflected on how different their therapy experience would have been if it had been for a shorter duration, and the impact they believe this would have had on their therapy experience.

> *"I was able to go into depth…there was a lot of revelation that happened later, that if it had been shorter, that wouldn't have happened… it [exploring trauma] didn't start straight away… that's what's good about it, you could become put off… I would have found it overwhelming"*
>
> (Eliza, 62, Female)
>
> *" I knew it would stop at some stage, but, I knew it wouldn't be immediate, it wouldn't be within the next week or the next two weeks, it would be within the next month or couple of months… so from that perspective, it was far more beneficial for me…you're really getting into some deep stuff, that you've been burying for quite a long time and it allows you, certainly for me, to be much more open and honest."*
>
> (Alex, 49, Male)

Whilst recognising that it was important for the participants to talk about their experiences at their own pace, it highlights that there was a need and motivation for them to talk through their story with their counsellor and when ready, this

would be about parts that had been 'buried' deep. This sharing could be seen as a way to develop a trusting relationship. There is power in a person telling their story and when services recognise this (Covington & Russo, 2016). Fundamentally, the participants reached a point of feeling safe enough with their counsellor to be authentic and honest about their experiences. It is crucial that this storytelling is done in a way that does not lead to re-traumatisation, that it is done with a purpose for the client and in a way that facilitates a sense of safety and containment in the therapeutic relationship.

Safety has been described as one of the '3 pillars' of trauma informed care, along with connections and managing emotions (van der Kolk & Courtios, 2005.) A defining feature of the experience of childhood trauma is that of feeling unsafe and mistrusting others (Seita & Brendtro, 2005). The term psychological safety has been defined as "the ability to feel safe, within oneself and safe from external harm" (Chadwick Trauma-Informed Systems Project, 2013, p.13). Importantly it is how safety is perceived by clients, how triggers are managed and the congruence across the service in how this perception of safety is maintained (Wilson, Pence & Conradi, 2021).

Safety is linked to the development therapeutic relationship. Specifically, the quality and the level of the relationship experienced. Relational depth is described as "a state of profound contact and engagement between two people, in which each person is fully real with the Other, and able to understand and value the other's experiences at a high level" (Mearns & Cooper, 2005, pxii). Clients have detailed their experience of 'letting go' in order to fully engage with their therapist in a deep way and therefore making the decision to drop their protective stance (McMillan & McLeod, 2006). When a client is able to hold trust in their therapist, is when they can make the decision to be vulnerable and take a leap of faith (Knox & Cooper, 2011).

> *"Because he was so genuine, I actually felt able to, to speak and open up and yeah trust that he [counsellor] was actually there for my benefit*."
>
> (Alice, 31, Female)

Trust is a crucial component in any deep therapeutic relationship but appears particularly vital for those clients who have prior experience of unhelpful or even damaging relationships.

> *"...other counsellors that I've had, where I've spoken about one thing... and I've kept something back that is massive, because I just felt like they got what I was talking about already and I didnt want to complicate it anymore."*
>
> (Jemma, 24, Female)

The experiences described by participants in this research, demonstrate how they perceived both the physical environment and the relational aspects of the service. Their reflections highlighted the importance of these and crucially how the trauma-informed principle of safety was perceived consistently across the whole service. All of the participants interviewed had described within their reasons for seeking therapy, times in their lives when they did not feel safe. Many participants reported early life traumas and difficult relationships with family members. These individuals therefore may have needed to learn to develop a sense of safety. Developmental trauma whereby there is a disruption during a critical period of child development can lead to difficulties in developing secure attachments and subsequently, difficulties in forming and maintaining future relationships. Attachments are viewed as originating from a need for safety and a secure base (Bowlby, 1988). Thus, a trusting relationship with their therapist may have been a reparative experience for participants, offering hope and demonstrating their ability to form positive relationships and develop personal boundaries.

> *"It gave me a feeling of more security in life. Feeling peace because there are some decent people in the world that will help... they just really cared."*

This quote highlights how for Lemonie, experiencing a positive relationship with the service provided a sense of security and hope that positive relationships with others is possible and that others can be trusted.

Whilst this highlights the importance of the relationship for the effectiveness of individual therapy, it is important to note that social factors which can act as a barrier to accessing support and potentially perpetuate trauma, can remain unaddressed if the focus is solely at an individual level. This demonstrates the limitations of applying trauma informed approaches to services and specifically, to individual care, whilst ongoing inequalities exist in wider society.

3.4 Theme 3: The many roles of the therapist

Subtheme 1: The therapist as the 'care giver'

Participants spoke about personal qualities they noticed in their therapist. Many reflected that they felt genuinely cared for.

> *"They treat you as a human being."*
>
> (Nathaniel, 51, Male)
>
> *"I think I felt a slight sense of peace, that I was listened to and understood and cared for.*
>
> (Lemonie, 55, Female)

Whilst some participants expressed clearly how working with and reducing their substance use was a part of their therapy experience, many talked little about this. Some did not see substance use as a problem for them, while others reported that feeling that they could freely talk about their use of alcohol or drugs if they wanted to, was what was most important. Significantly, participants expressed how their experience of their most recent therapist meant they could talk about their use of substances without fear of judgement. For example:

> *"Being to tell them [I'm drinking] and not being berated is a nice thing."*
>
> (Jemma, 24, Female)
>
> *"[Therapist] was really lovely; he was very genuine and kind and attentive. I didn't feel judged or that he didn't understand, I was able to express it [substance use]."*
>
> (Alice, 31, Female)

Some participants described feeling cared for by their therapist, not just through what was talked about, but also through their perception of non-verbal communication and experiences.

> *"Empathy just oozed from every pore of [therapist] body… you know when you can see that someone is feeling what you are going through."*
>
> (Sarah, 58, Female)
>
> *"She [therapist] knew what mood I was in straight away… before I even said anything… she really listened, and she calmed me down."*

(Chloe, 48, Female)

Attunement is a nonverbal process of being fully with and responding fully to another person. The presence of attunement is argued to be vital in a positive therapeutic relationship (Schore & Schore, 2008). Positive relationships are necessary for human development and also for healing and growth, and qualities of the therapeutic relationship have long been presented as the most important factors in creating positive change (Asay & Lambert, 1999). Positive connections with others are core to developing resilience in those exposed to trauma as children (Bernard, 2004). Thus, through relationships, trauma survivors can learn to feel safe and develop new ways of relating to people, potentially mitigating the destruction caused by trauma (van der Kolk, 2014). In contrast, participants reflected on previous experiences of relationships different to this one, for example, Lemonie described non-caring therapists as "damaging".

Relationships are viewed as holding a crucial role in the recovery process. Traditional approaches highlight supportive social networks as playing a key role in recovery but still view recovery as a predominantly individual process (Slade, 2009). In contrast, the relational position presents all identities as products of relationships and relational therapy suggests that human growth and development occurs within relationship itself (Banks, 2006).

Subtheme 2: The therapist as 'the validator'

Participants spoke about feeling heard and understood as being crucial in developing their connection with their therapist. They described being given the ability to understand their experiences and a voice to express this. Participants described feeling that they had a shared understanding with their therapists, that they were on the same page.

> *"When you talk to somebody that knows what you are talking about, knows where you are coming from, you've got a connection then haven't you, for me that was the most important thing."*
>
> (Nathaniel, 51, Male)
>
> *"Before I doubted whether what I had been through was a trauma. I felt seen and heard. I felt less isolated and alone with it. It gave me a voice when I couldn't express what I was feeling"*

(Eliza, 62, Female)

"I really struggled with having someone who understood me or got what I was talking about… yeah [previous] counsellors who were just like.. not listening, just talking about their own experiences, which sometimes did but mostly didn't correlate with what I was talking about."

(Jemma, 24, Female)

The above interview quotes demonstrate the importance of feeling understood and listened to. This appears to link to the concept of empathy, a quality heavily researched in relation to therapeutic relationships, and which is an ability for an individual to truly appreciate the experience of another. Those who have experienced trauma, may feel that no one is able to understand their experiences and may even be unable to perceive others' empathy for them (Wilde, 2019). However, empathy was something that a number of participants recognised in their therapists.

Michael described of his perception of empathy in his therapist:

"When I told her some bad stuff she would look almost as though she was going to cry, something like that, facial expressions, and then, at the end when we said goodbye at the end of each session, she had a huge smile from ear to ear…"

(Michael, 50, Male)

This indicates the presence of mutual empathy whereby a therapist not only has an impact on their client, but a client witnesses that they have impacted the therapist also (Jordan, 2001).

Subtheme 3: The therapist as 'the teacher'

Along with their relational experiences of their therapists, participants clearly spoke about a learning process as part of therapy. They not only developed ways to express their understanding of their experiences but learned ways of coping and moving forwards. Participants described specific techniques and strategies that their therapist had offered them. Some learned about trauma psychoeducation and the effect of trauma on the body and described how this led to increased understanding and a sense of empowerment.

Some participants highlighted the link between their brain and body:

> *"…that flight instinct, it's like flight would kick in and my heart was racing, and you could feel all the blood rushing to your muscles, you want to run, fight you know? And then past that you become so lethargic and tired, you know that's the hypo-arousal when you just become numb, and you stop caring…so the window of tolerance is just when you are you know more stable, more rational in your thinking and you're calmer. You're sort of neutral, balanced, safe. Then it's just understanding those little moments, those triggers that are happening, before you get to the full point of a panic attack."*

This quote demonstrates how Alice learned about the experiences in her body and the meaning this had for her. She explained this new understanding through the use of new language. It indicates how this learning of concepts can then be taken forwards and create a sense of empowerment.

> *"There was a focus on coping strategies. I learned a lot of skills… that's been something very important, I still use those techniques today. Knowledge is empowering."*
>
> (Jemma, 24, Female)
>
> *"They talked about PTSD and how it affects the brain, and they went into the science of it which was useful. How can we try and move things forward? How to calm yourself down, get routine back…"*
>
> (Alice, 31, Female)

Participants spoke of the benefit of their therapist sometimes taking the lead, making suggestions of what may be helpful for them and giving them ideas and strategies to try. A consequence of this learning process also appeared to be the ability to create a new understanding or perspective of their experiences and difficulties.

> *"They [therapist] explained things to me in a different way and helped me how to help myself really. I managed to cut that down [alcohol use] through the sessions, so they helped me with that as well. I used breathing techniques they gave me to take away."*

(Sarah, 58, Female)

"I knew I was hurting but I didn't understand before…they spoke to me in a different way, and I just got it. They helped me work on myself … [therapist] gave me a book on boundaries, helped me with breathing techniques which was cool. They help you manage your trauma."

(Amy, 29, Female)

These experiences reference participants being given the opportunity to develop themselves by learning how to help themselves. While participants indicate that they were provided with tools from their therapist, they also express how they then went on to use these resources. The motivation to take and apply what was taught also highlights the notion of autonomy. Importantly, the trauma-informed principle of collaboration and in particular, clients being 'active collaborators' has shown to lead to more effective therapy and also reduced the power dynamic (Kelly, 2015). Respecting this autonomy by demonstrating that clients have the capacity and responsibility for their quality of life (Kelly, 2015). This position can lead to clients being given ownership of their recovery and may be a more motivational and empowering stance.

3.5 Theme 4: Reflecting on the therapy journey

Participants reflected on their therapy experiences as part of a wider journey of recovery. They situated this experience in relation to other times of difficulty and support given during their lives. Most spoke exclusively about the helpful and beneficial parts of their recent counselling.

Subtheme 1: Grateful but just the beginning

Gratitude was demonstrated towards the service for existing and therefore having the opportunity to have counselling. There were many overall comments about the service giving clients a good experience.

"I was given the opportunity to talk about stuff. I owe them a great deal; I am immensely grateful."

(Alex, 49, Male)

"I am very grateful for them; it changed my life dramatically."

(Amy, 29, Female)

On reflection, participants expressed recognition for the specialism of trauma and substance use in the service and a sense that anything less would not have been effective. Many described the counselling they received 'just what they needed'.

> *"Literally, the perfect, specialised place-they were the right people for me. Anything else would have been putting a Band-Aid on a decapitation… Just so much gratitude, endless gratitude. How wonderful it was that the service is literally open to anyone. I'm just really glad they exist."*
>
> (Alice, 31, Female)
>
> *"There was a lot of cross-over between those things [trauma and substance use] for me so I thought it would be important [that the service was specialised] "I was very grateful that they are here… that the service is available."*
>
> (Nathaniel, 51, Male))

Nathaniel highlighted in making sense of his experiences, there was a 'cross-over' between trauma and substance use for him, he reflected feeling pleased that both could be addressed. Many participants described substance use as a way they had learned to cope with intense emotions. The shift in the way that trauma is viewed, recognises that extreme or even dangerous behaviours when viewed through a trauma lens, can be seen as adaptations to past traumas and a way to communicate pain (Filson, 2013).

However, it is important to explore how the definition of trauma is decided both within academic literature and within society. Whilst it appears there was a benefit to many of the study's participants in labelling their past experiences of trauma in developing their understanding of their current difficulties and having those experiences validated, they may have been offered the label of 'trauma survivor' by the counselling organisation based on a specific list of experiences that have been agreed to be classed as traumatic. Alternatively, the term psychological trauma refers to the impact on an individual rather than an event itself and therefore, this will vary from person to person (Law et al., 2021). Importantly, the impact of trauma can often be hidden and may never be disclosed. This highlights how trauma-informed principles are for everyone, and their application assumes that many people within society will have experienced something that they may feel as

traumatic and therefore all services can be sensitive to this in order to best meet the needs of all people who use their services.

Specifically, the label of trauma survivor ascribes an element of resilience which may align with recent literature on post traumatic growth (Regan, 2017). This is the idea that from challenging life events can come and new meaning to a person's suffering. It remains unclear as to what leads to growth in some individuals and not in others, and how post traumatic growth is conceptualised, with some describing it as a personality change (Jayawickreme,& Blackie, 2014), and others as a cognitive reconstruction of the narrative of a person's experience (Pals & McAdams, 2004). But importantly, it assigns significance and hope to an otherwise purely negative experience. It would seem however, that those who do not recognise or agree with their experiences as being akin to trauma, may not reach out to access trauma-specific services and support which could benefit them.

Related to understanding the meaning people make of their experiences and emotional difficulties, Counselling Psychology is able to hold a flexible position in defining distress, which considers both the potential usefulness of diagnoses and labels alongside the subjective meaning and narrative held by individuals about their experiences. With this lens, wider issues of society such a social justice, the impact of stigma and power imbalances can be explored as part of a person's story. There is also a fundamental responsibility to consider changes in practice and policies to improve the experiences of service users and ensure that their experiences are heard and understood.

When participants were asked to describe the ending of their counselling, many highlighted experiencing a range of emotions:

> *"It's sad, when that came to an end, but we did do a lot of preparation coming up to it and what was going to happen and talking about how much progress I'd made from the beginning, how much more capable I was of dealing with life."*
>
> (Jemma, 24, Female)
>
> *"It was quite a sad time I think, but a happy time as well because I know that I came quite a way and that I had done it."*
>
> (Sarah, 58, Female)

"It's a work in progress. I could have gone on… it was difficult stopping."

(Eliza, 62, Female)

"It was sad as I was getting comfy… I wasn't even close to finishing in my head, I still needed somebody to talk to."

(Michael, 50, Male)

Following their counselling sessions, many participants described feeling that they needed and wanted further therapy, and this was just the start of a longer journey for them.

"I've healed a lot, but I still have a while to go yet."

(Amy, 29, Female)

"There's still a way to go but compared to how I was before, I'm now functioning."

(Jemma, 24, Female)

In their reflections of their counselling and recovery journeys, participants highlighted outcomes of their therapy including increased understanding of their experiences, improved functioning, improved relationships with others, and increased self-esteem.

"A better understanding of what's going on for me has definitely helped in a positive way."

(Nathaniel, 51, Male)

"I've been able to vocalise with my actual close friendships… so I feel like I have more support overall…because I wasn't able to talk about anything [previously]."

(Alice, 31, Female)

"I think throughout the sessions, with help I was able to establish more self-worth and more self-respect."

(Sarah, 58, Female)

Addiction recovery literature often focuses on abstinence, having been used as an indicator of treatment success (McLellan et al., 2007), in the same way studies of trauma therapies have been judged for success based on the presence of symptom reduction. Recovery has largely been viewed as a clinical outcome and described as 'recovery from' by professionals (Davidson, 2003). In contrast, some have argued for a more holistic viewpoint and research analysing client's perception and meaning of recovery demonstrated that they often felt it was an ongoing and lifelong journey. They also described successful recovery as noticing positive changes in emotions and thought patterns along with improvements in feelings on guilt, shame, and self-blame (Costello, Sousa, Ropp & Rush 2020). This has clear implications for the reporting of recovery or therapy success as measuring symptoms is likely to offer limited insight into the change that participants reported.

Subtheme 2: Continued connection

In interview, participants spoke about the importance of having a continued connection to the service and other service- users/peers. Those who had accessed follow-up groups, described their importance in maintaining momentum and engaging in activities with others. Those who did not, ended sessions feeling a need for wanting a follow-up, or more information of where they could receive further support. A few participants described that the ending of their therapy felt sudden, and they were left without a "safety cushion." (Alex)

> *"I had continued connection in the group. It's been quite nice to have that continuation. It's nice to have ongoing support."*
>
> (Jemma, 24, Female)
>
> *"There is that opportunity, there doesn't have to be just that cut. You don't just get dropped at the end of it."*
>
> (Eliza, 62, Female)

The above quotes demonstrate the importance of having the opportunity for ongoing social connections for those finishing counselling. This highlights the need for resources to be directed towards creating these opportunities and fundamentally reducing social exclusion (Malloch, 2010). Isolation has been described as being the core of human suffering and therefore connection is seen as

a key part of healing and growth (UK Addiction Treatment, 2018). The role of peer connections is also important in creating positive pressure and encourage people to stick with their recovery goals (Victor, Qualter & Barreto, 2019).

Nathaniel reflected that remaining involved with others from the service acted to motivate him:

> *"It has helped me get out more, being around people, it motivates me to do things, I'm not so isolated. I still feel a part of it, still involved. It keeps the momentum going for me in going forwards."*

In contrast to this, addiction recovery has been described as a largely solitary process and one where individuals are working to develop a new sense of self. Practices of addiction have been considered to be part of an individual's identity and ways of being with others (Hughes, 2007). The formation of a new identity was something Jemma highlighted as an important outcome of her therapy experience:

> *"I used to be like ' I'm a trauma victim, this stuff happened to me'... so that was really important to me, establishing a separate identity."*
>
> (Jemma, 24, Female)

Importantly, those who have experience of using a service and are 'experts by experience' can meaningfully offer hope to those earlier in their recovery journey and this form of helping others can become part of a new identity.

4. Conclusions and Implications

4.1 Summary of Findings

The aims of the research were to explore and understand the experiences of clients who had completed trauma focused counselling alongside substance use. Through the use of in-depth qualitative interviews, rich data was collected regarding these experiences and, the result was comprehensive accounts of the participant's experiences and stories which can now be heard. Furthermore, these experiences offer important insights into developments to be considered when working with this client group.

The participant's journeys through the counselling service from first contact to reflections upon ending their sessions was illustrated by themes that captured this journey. Exploring participant's experiences led to themes highlighting four key parts of their journey.

Challenges with accessibility

This theme demonstrated how many participants had reached a pivotal point in reaching out for help. Many had described feeling at crisis point and that they could no longer cope on their own without support. Whilst these individuals had reached a readiness for accessing therapy, for many the wait time to begin sessions felt long. This theme also captured the context of the counselling service in its provision and how the participants had accepted that in order to access what they had perceived as a good service there was the expectation of a long wait time.

Safety and Trust

This captured how participants were made to feel during their time with the counselling service. Many of the individuals reported a feeling of welcome and calm that was experienced from their very first visit to the physical location. Furthermore, a sense of safety and trust extended from the waiting room to the counselling room and to their therapists. Ways the individuals developed feelings of safety and trust included feeling that the service was flexible and personalised to their needs. Having a longer period of counselling meant they had time to explore what mattered to them without feeling rushed. The participants valued their experiences with their therapist as this offered a different and possibly reparative relationship in contrast to previous relationship experiences.

The many roles of the therapist

This highlighted how participants related to their therapist in different ways. When first describing their therapists, participants highlighted their caring nature and how their therapist made them feel cared for. Along with this, therapists were also viewed as understanding, and participants felt heard by them. Participants described their therapists sharing knowledge and skills to help them in developing their understanding of their experiences and learning to manage.

Reflections on the therapy journey

The final theme captured individuals' thoughts about ending therapy, many highlighting that they felt this was just the start and that they required further support. The participants described ways they benefited from therapy with the service including improved relationships with others, increased self -worth, and sense of identity. The theme also captured the importance of having a continued connection with the service and to peers after ending therapy. These connections encouraged participants to maintain momentum in their recovery journey and reduced isolation.

The importance of relationships and connections was apparent across all of the themes. Participants perception of safety and trust within the counselling service, was directly related to the staff within the service and participants witnessing that they were motivated to meet their needs. The focus on relationships and connections was also evident in the developing of a deep and trusting relationship with their therapist and through ongoing activity groups with peers once their therapy had completed. This is significant to trauma informed approaches which is fundamentally inseparable from a relational approach.

The experiences of participants in this study indicate that they perceived trauma informed principles within the counselling service including trust, safety, empowerment, and peer support. Interestingly, participants did not comment a great deal on substance use during their interviews. However, they did indicate that they felt able to express it without judgement. This indicates that the service holds a trauma informed lens which views substance use (and other seemingly harmful behaviours) as adaptive ways of coping with distress and incorporates an inherent understanding of the impact of trauma for individuals. Both trauma informed practices and a relational approach offer hope and reduce isolation

(Filson, 2016). The principles of trauma informed approaches are a vital part of both preventing re-traumatisation and in offering conditions that promote continued healing and recovery. The application of these principles provides a space which encourages individuals to engage, and if this is involvement in specific trauma informed interventions, also allows clients to feel able to open up and therefore receive an effective service. In the wider community, the principles validate people's experiences, and its strengths-based focus and hopeful stance are a crucial part of healing from trauma.

4.2 Limitations and opportunities for future research

Participant sample limitations

When observing the demographic information from the participants of the current study, the majority were female and reported White British ethnicity. However, this ratio of male to female participants, does mimic the demographic of individuals who access the counselling service overall. Therefore, it could be seen a representative of the service's client population.

Researcher out-group status

As described in the reflexive summary of this research, the researcher acknowledged their status as an out-group member in relation to the participants who were involved in the study. Due to the nature of this research, it was important to engage the participants in the process of the research where possible and this included receiving feedback on the questions asked at pilot interview and requesting feedback from participants on theme summaries. Many participants following interview also asked questions about what would happen following the interview and how the information might be used, and the researcher was able to express the aims of research to consider developments and implications. Following this, many participants stated that they hoped their answers and experiences could be used in a meaningful way for the benefit of others and subsequently, a shared aim emerged between researcher and participants. Participants were contacted following their interviews and provided with an overview of the themes of the study to review and reflect back on, importantly, to ascertain that their views and experiences had been captured accurately and represented in a meaningful way. No participants responded to this communication and therefore the research did not benefit from their thoughts on the analysis. This highlights the difficulties

faced by researchers in integrating service-user involvement but also in relation to this specific study, it may have been a continuation of the challenges in making contact initially in the recruitment process and therefore maintaining contact with individuals in this client group also proving difficult. Alternatively, it may also have been that the researcher satisfactorily answered the participants questions at the end of the interviews regarding the purpose of the study. Expressing the aim of offering the counselling service feedback and improving the experiences of other service-users going forwards, was enough for participants to feel confident that their views would be represented appropriately in the study.

Further research opportunities

Extending the aims of the study to a wider pool of participants in different regions of the UK or those who have accessed support through statutory services, could offer further insights into the experience of this client group. Furthermore, research could include perspectives from therapists and policy makers alongside clients to offer richer data from a wider span of the context.

During the analysis of the data set, it became apparent that there was an unexpected focus on the period of time following the end of therapy and post-therapy activities and groups. This was fundamental in understanding the importance of relationships and connections in the participants' therapy journey and therefore further focus on this, the nature of post-therapy connections and the meaning of this for individuals would be valuable. The current study also recruited participants from three months following the end of their counselling sessions, so a further follow-up after a longer period of consolidation may also be a further opportunity for more insights into their experiences.

The study could have benefited from greater involvement of user-led research methods. These involve engaging those with lived experience of using relevant services in aspects of the research design and analysis. User-led research aims to reduce the otherwise inherent power imbalance between researcher and participant. This is particularly important in relation to trauma research as participants are likely to have experienced 'abuses of power' previously in their lives and user-led research also promotes the trauma informed principles of collaboration and empowerment (Sweeney and Taggart, 2018).

4.3 Implications for services and practice

The results of this study support existing literature on trauma-informed approaches and practices and the importance of this as perceived by clients who are users of counselling and other public services. The implications of understanding participant's experiences of their therapy journey include offering evidence to inform service-level therapeutic practice and healthcare policy. This has relevance to the field of Counselling Psychology as it is relevant to both clinical practices in individual level work and highlights the role of psychologists in advocating for developments on a broader service and community level to improve client experiences.

The results of this study support existing literature on trauma-informed approaches and practices and the recommendations of ensuring safety, collaboration and being responsive to individual needs highlighted in good practice guidelines for trauma informed services were supported in this study. Whilst the overall aim of trauma informed practices is to prevent re-traumatisation, current good practice guidelines highlight prioritising that people feel safe and that their voices are heard. Furthermore, that service users are involved in the development and organisation of services and that services are culturally competent and therefore responsive to individual need rather than a 'one size fits all' philosophy (UK Government, 2022). All of the above guidelines can be seen within the themes from this study representing participants experiences of the counselling service.

As well as demonstrating areas of further interest and supporting the importance of trauma informed principles already highlighted in the literature, it also presents some important concepts to be considered including the need for flexibility, post-therapy connections and a community approach. Upon contacting services, participants described often being at a point of crisis or feeling that they could no longer manage without support. In relation to help-seeking behaviours, there is a responsibility of services to ensure adequate promotion of their support to those that may need it and importantly, highlighting the services values could act to encourage individuals to seek help.

The themes from this study also capture the importance of a flexible approach to meet individual needs. Feeling that they were understood and that their therapist knew how to support them was crucial in client's experiences of developing safety

and trust and fundamentally, an effective therapeutic relationship. Flexibility was reported in the environment and layout of the therapy rooms which could be changed. The implication of this may be for services to consider how they offer therapeutic flexibility whilst remaining within guidance provided by UK Government and organisations such as NICE. Upon recent evaluation, there has been an increase in the offering of person-centred counselling in local services and a recent study demonstrated it to be just as effective as CBT in an NHS IAPT service (BACP, 2021).

Currently, many services will discharge clients when therapy is finished, which often means that clients have no further contact with the service from that point. One of the themes generated from this study, however, demonstrated how follow-up contact was an important part of client's experiences of recovery and in particular, ongoing connections with peers aided a continued trajectory towards their goals. This is of particular importance when considering the relational nature of complex trauma and the development of positive and possibly reparative relationships. Furthermore, involving clients in services conducting of research, development and peer support offers meaningful opportunities. The themes illustrating the experiences of the study participants support the importance of acknowledging the role of meaningful relationships and connections in healing from the impact of trauma. Something the biomedical approach has not considered (Van der Kolk, 2005). The importance of combating isolation also appears crucial and in this study participants highlighted the role of recovery or post-therapy groups and activities that created a continued connection. Participants also highlighted other ways a peer connection was created including by having messages in the waiting room for others to read before their sessions. It seems important to consider other ways that peers can offer support to each other and have an ongoing social connection to enhance the end of therapy and maintain motivation towards their goals. Related to this is also giving clients a voice by involving them as experts by experience or in research projects and/or changes in policy and practices, strengthening collaboration and empowerment (Rose, 2019). This offers a focus on strengths and an opportunity for post traumatic growth (Regan, 2017). Furthermore, reparative environments and relationships exist both in the therapy room and in continued connections with others.

The role of the service provider is key in the experiences of participants. How the service is set up, its policies, practices, ethos and how this is perceived by clients, impacts their experience of the service and recovery journey. It is important to consider how a service can best be organised and operate in working with trauma in a trauma-informed way. Crucially, how staff members and therapists can be supported to adopt this attitude to their practice, through training, reflective practice, and trauma informed supervision. Trauma informed supervision involves creating a "culture of safety, empowerment and healing" (Simons, Kimbie & Tyack, 2021), and offers an opportunity to reflect on the impact of therapeutic work and develop practice and skills. This can work to reduce the negative impact of vicarious trauma (Jones & Branco, 2020). Importantly, reflective practice supports a relational focus and creates space to explore and understand difficult feelings elicited when working in trauma settings (McDermott & Husbands & Brooks-Lewis, 2018.)

4.4 Conclusion

Whilst there has been extensive change in attitudes and practices as a result of research adding to the understanding of experiences of trauma, further development is still required. There is growing literature on the consequences of Adverse Childhood Experiences and on the application of both Trauma Informed approaches and interventions within specific organisations. Trauma Informed approaches are crucial in reducing the ongoing impact of trauma, preventing re-traumatisation, and arguably stopping the cycle of generational trauma.

Previous research demonstrates the strong co-morbidity of trauma and substance use and yet, there is little qualitative research on the experiences and stories of clients who have engaged in trauma focused counselling for childhood trauma alongside substance use. This is especially important as there are poorer outcomes demonstrated for this population (Berenz & Coffey, 2012). Historically, mental health services and substance use services have operated separately and it appears that this continues to be a barrier for clients in accessing support. Some have reported being declined therapy from organisations due to their substance use. This is in contrast to the understanding of substance use as a coping strategy for psychological distress.

Qualitative themes were generated that captured the essence of the stories of the individuals who participated in this study. The themes both offer a deeper understanding of their experiences and guidance to where future service developments could be made. The themes highlight the responsibility of services to ensure they publicise their services widely into the community. This is especially important for reaching those with specific needs such as having experienced childhood trauma, as many reach a point of crisis before seeking help. The themes also illustrate the necessity for services to have a flexible approach to meet client needs. This is something that could be hindered currently by clinical guidelines and funding predominantly being granted on the basis of quantative reporting of symptom reduction. Other definitions of recovery and positive change need to be actively considered. The study also highlights the importance of the service as a whole, that it has trauma informed principles consistently throughout. This means it is trauma informed all the way through a client's journey.

It is the role of psychologists and other healthcare professionals within services to advocate for continued change towards trauma informed approaches. This can include creating a consistent sense of safety and trust throughout services, understanding distress through the lens of formulation, adopting a relational and community-based approach, and being guided by people who are using the services. This is to ensure that clients both reach out for and receive the most effective support and ultimately lessen the overall impact of trauma both for those individuals and for wider society. It is important to consider where psychologists work within mental health care and whilst there are positions that exist within third sector organisations, many psychologists appear to work predominantly within statutory NHS services, where the possibility of more flexible approaches may be more difficult to establish.

4.5 Reflexive Conclusion

Working in an Adult Community Mental Health Team, I find that establishing new processes and more importantly, attitudes across the multidisciplinary team is difficult. Promoting an understanding of trauma through the lens of formulation and utilising the Power Threat Meaning framework offers an important alternative to a medical diagnosis but there are reasons why integrating this into existing services can be challenge. Whilst my aspirations following this study

include working to develop trauma informed approaches within my workplace, including the key areas of after care and post-therapy connections along with ways of ensuring consistency in service users perception of safety and a flexibility in approach within the service, I am keenly aware that during times of high stress, low staff numbers and increased pressure on the team, there is likely to be increased resistance in considering new ways of working and making changes. However, as a counselling psychologist I feel that it is important to advocate for such changes. I would like to expand on how service-user involvement is part of the service. For example, following a therapeutic intervention such as a Dialectical Behaviour Therapy (DBT) programme, to invite group members to return once they have completed their therapy to facilitate parts of the current group that is running as this would not only offer the past group members an opportunity to see their own progress and offer something back to the group, but offer hope and motivation to those currently engaging in the programme. Another key aspiration following this study is to share the findings and recommendations to the collaborating counselling organisation, in order for them to evaluate where there may be room for developments and also celebrate where clients have perceived positive aspects of their experience of the organisation.

Through completing this research, my understanding of the research topics has expanded, and I recognise how this piece of research has ultimately become a representation of all of the learning and personal development throughout my doctorate and reflects how I view myself as counselling psychologist/therapist and what I see as being key in the work I can do. Whilst during the doctoral training there is a clear leaning towards holding a critical stance and questioning the supposed 'status quo', much of the focus is on developing as a therapist working with individual clients and I wonder if there is room for more of a community-led approach to the training programme. While counselling psychology involves a keen focus on the centrality of the therapeutic relationship, it also promotes an awareness of the wider systemic context. It has been important for me to recognise the limitations of working with individuals without considering the role of social factors and where change can be made at a wider level. Isolation is a huge factor in creating suffering and therefore the theme of having a continued connection in the form of ongoing connections with peers and being offered after care by services is key. This connection works to maintain momentum, allow the opportunity for

individuals to offer something back to services. Therefore, promoting the development of post traumatic growth and allowing people to make new meaning of their experiences and identity. Crucially, I also recognise that trauma-informed approaches are for the benefit of everyone and should be applied in all services working with people, not just those that offer trauma-specific services.

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6. Appendices

Appendix A: Participant information sheet

Participant Information Sheet

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Who are the researchers and what is the research about?

Thank you for your interest in this research looking to explore clients' experiences of accessing and engaging in counselling. [redacted] is a counselling organisation that offers counselling both for childhood abuse and substance use and the aims of this research are to understand and explore your experiences of having counselling when you also may have been using drugs or alcohol. I hope to suggest where improvements could be made to meet the needs of clients reaching out for counselling. My name is Hayley McNamee and I am a Trainee Counselling Psychologist in the Department of Health and Social Sciences, University of the West of England, Bristol. I am completing this research for my Professional Doctorate in Counselling Psychology Thesis. The research is anticipated to be completed and submitted by September 2021. My research is supervised by Dr Zoe Thomas. She can be contacted at the Department of Health and Social Sciences, University of the West of England, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY [Tel: (0117)3283794 Email: zoe2.thomas@uwe.ac.uk] if you have any queries about the research.

What does participation involve?

You are invited to participate in a qualitative interview – a qualitative interview is a 'conversation with a purpose'; you will be asked to answer questions in your own words and interviews usually last around 45 minutes, but we will have up to an hour. The questions will focus on your therapy journey, from your decision to seek counselling, your first contact with the service and your experiences of attending counselling sessions. Due to current COVID-19 restrictions, the interview can be conducted through Video Call or over the Telephone, you can choose your preferred interview method. The interview will be audio recorded and I will type-up (transcribe) the interview for the purposes of analysis. The aim of the analysis will be to identify common or important themes across the participants' responses. On the day of the interview, I will talk you through a consent form and ask you to verbally agree, if you are happy to go ahead with the interview. I will also ask you some demographic questions (age, gender, ethnic background etc.). This is for me to gain a sense of who is taking part in the research. I will discuss what is going to happen in the interview and you will be given an opportunity to ask any questions that you might have. You will be given another opportunity to ask questions at the end of the interview.

Who can participate?

Clients over the age of 18 who have completed trauma-focused counselling sessions at the [redacted] within the last 2 years.

Alcohol and substance use

If you agree to take part in the study and schedule to attend an interview, it is important that prior to the interview, you ***do not*** consume alcohol or other substances such as recreational drugs. If you have any questions about this, please feel free to ask.

How will the data be used?

Your interview data will be anonymised (i.e., any information that can identify you will be removed or changed) and analysed for my research project. This means extracts from your interview may be quoted in my dissertation and in any publications and presentations arising from the research. The responses to the demographic questions for all of the participants will be compiled into a table and included in my dissertation and in any publications or presentations arising from the research. The information you provide will be treated confidentially and personally identifiable details will be stored separately from the data. You will be asked for a preferred pseudonym (an alternative first name) that will be associated with the data you provide that may be included in the final report, instead of your actual name. If you don't have a preferred pseudonym, one will be randomly assigned.

The personal information collected in this research project (e.g., the interview audio recording and transcript, the consent form, and the demographics form) will be processed by the University in accordance with the relevant data protection legislation (please see the GDPR privacy notice for more information).

What are the benefits of taking part?

You will get the opportunity to participate in research on an important social and psychological issue and your contribution may be used to suggest possible important service changes to benefit future clients.

How do I withdraw from the research?

If you decide you want to withdraw from the research, please contact me via email hayley2.mcnamee@live.uwe.ac.uk. Please note that there are certain points beyond which it will be impossible to withdraw from the research – for instance, when I have submitted my dissertation. Therefore, I strongly encourage you to contact me within a month of participation if you wish to withdraw your data.

Are there any risks involved?

We don't anticipate any particular risks to you with participating in this research; however, there is always the potential for research participation to raise uncomfortable and distressing issues. For this reason, we have provided information about some of the different resources which are available to you. Following the interview, you will also be offered a ten-minute telephone debrief with a counsellor at the [redacted].

Support Helplines:

Samaritans: 116 123 (available 24/7)

Bristol Mind Line: 0808 808 0330 (Wednesday to Sunday from 8pm to midnight)

For details of helpline available outside of Bristol, you can call the National Mind InfoLine: 0300 123 3393 (Mon to Fri, 9.00am – 6.00pm).

Local Counselling Services:

- The website of the charity **Mind** enables you to find free or low-cost counselling in your local area via the Local Mind services. Search for your local mind: https://www.mind.org.uk/information-support/local-minds/ Then, search for low-cost counselling via the website of your Local Mind (e.g. Local Mind for Bristol is: https://bristolmind.org.uk/support_type/counselling-low-cost-and-free/
- The **British Association for Counselling & Psychotherapy** (http://www.bacp.co.uk/) **It's Good to Talk** website enables you to search for an accredited counsellor or psychotherapist in your area: http://www.itsgoodtotalk.org.uk/
- The website of the **British Psychological Society** enables you to 'find an accredited psychologist' in your area: https://www.bps.org.uk/public/find-psychologist
- And specifically, to find a psychologist who specialises in psychotherapy: https://www.bps.org.uk/lists/ropsip or IAPT trained members (IAPT is Improving Access to Psychological Therapies and IAPT trained members will usually be trained in Cognitive Behavioural Therapy): https://www.bps.org.uk/lists/iapt.
- If you are registered with a GP Surgery in Bristol you can contact **Vita Minds**, who are a free confidential service that offers a range of courses and support for anyone experiencing psychological and emotional difficulties. They can be accessed through referral by GP or directly via an online contact form. Website: https://www.vitahealthgroup.co.uk/nhs-services/nhs-mental-health/bristol-north-somerset-south-gloucestershire/self-refer/

Appendix B: Participant consent form

Consent Form

Thank you for agreeing to take part in this research on experiences of accessing and engaging in counselling.

My name is Hayley McNamee and I am a Trainee Counselling Psychologist, studying in the Department of Health and Social Sciences, University of the West of England, Bristol. I am collecting this data collection for my Professional Doctorate in Counselling Psychology Thesis. My research is supervised by Dr Zoe Thomas. She can be contacted at the Department of Health and Social Sciences, University of the West of England, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY [Tel: (0117)3283794 Email: zoe2.thomas@uwe.ac.uk] if you have any queries about the research.

Before we begin I would like to emphasise that:

-your participation is entirely voluntary

-you are free to refuse to answer any question or to stop participating without giving a reason

-you are free to withdraw from the research [within the limits specified on the information sheet].

You are also the 'expert'. There are no right or wrong answers and I am interested in everything you have to say.

Please sign this form to show that you have read the contents of this form and of the participant information sheet and you consent to participate in the research. I will give you a copy of the form which I have signed to keep for your records.

_____ (Signed)

_____ (Printed)

_____ (Date)

Please return the signed copy of this form to me.

Researcher signature _____

Date _____

Appendix C: Participant demographic form

Some questions about you

In order for us to learn about the range of people taking part in this research, we would be grateful if you could answer the following questions. All information provided is anonymous. Please either write your answer in the space provided, or circle the answer, or answers, that best apply to you.

1	How old are you?			
2	I am:	Man	Woman	Other: _____
3	I am:	Full-time employed	Part-time employed	Full-time student
		Part-time student	Other: _____	
3a	If you work, what is your occupation?			
4	How would you describe your sexuality?	Heterosexual Bisexual Lesbian Gay Other: _____		
5	How would you describe your racial/ethnic background? (e.g., White; Black; White Jewish; Asian Muslim)	_____		
6	Do you consider yourself to be disabled?	Yes	No	
7	How would you describe your relationship status?	Single Partnered Married/Civil Partnership Separated Divorced/Civil Partnership Dissolved Other: _____		

Thank you!

Appendix D: Interview schedule

Interview Schedule

Introduction/ first contact

- *When did you first think about accessing counselling?*
- *How did you hear about the service?*
- *Tell me about your experience of first contact with the service/ what happened?*
- *What did you think about the location of the service/ the feel of it?*
- *How did this make you feel?*
- *What do you remember thinking about the service (anything good? anything you didn't like?)*

Experience of counselling

- *Have you had experience of counselling previously?*
- *If so, how did counselling with this service differ? (how did it help, what was difficult, did anything not work as well as hoped?)*
- *(If video counselling) How did you find this way of counselling? How did it differ from previous experiences of counselling you have had?*
- *What brought you to having counselling? (did counselling help with more helpful ways of coping?)*
- *If you feel comfortable doing so, please could you tell me very briefly about your background or previous experiences that may be relevant to what led you to seeking counselling.*
- *Was it important to you that the service is specialised in working with a) experiences of childhood trauma and b) substance use?*
- *What were you hoping for from counselling? Do you feel this was met?*
- *Were there any practical factors you had to consider in regards to attending counselling sessions- i.e. getting there, fitting it in with other commitments?*
- *Was it important to you that the service was a free of charge service?*
- *What was your experience of your counsellor? - how did they make you feel? Was there anything they did that you found helpful or not helpful?*
- *What would you like the service to know about your experience of having counselling?*
- *Are there any ways you believe the service could be improved for clients having counselling?*
- *Is there anything you would say to someone who is considering accessing counselling at the service?*

Ending of counselling

- *Was the ending of counselling discussed between you and your counsellor?*
- *How did the ending of counselling feel like for you?*
- *How have you felt since the end of counselling?*
- *Has the counselling had any long term affects for you?*

- *Is there anything else you would like to say about your experience?*
- *Do you have any questions?*

Appendix E: Ethical approval letter

This appendix has been removed for containing personal information.

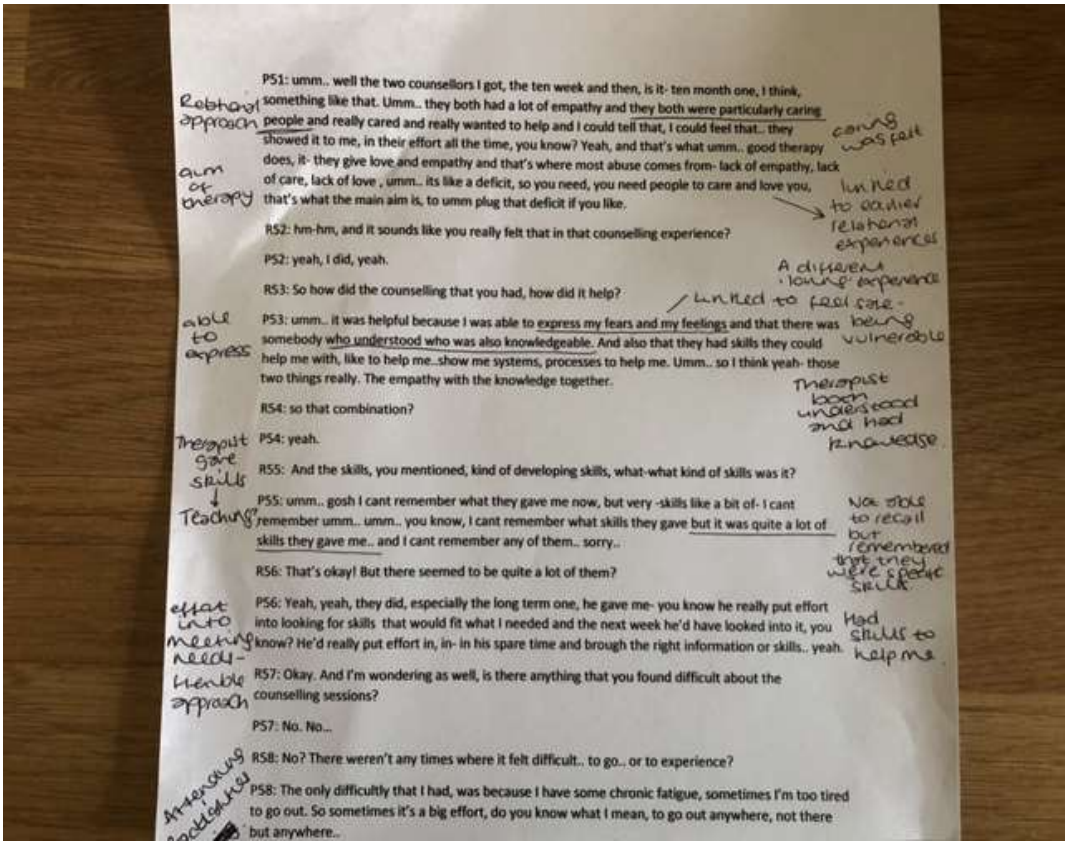
This appendix has been removed for containing personal information.

Appendix F: Summary table of participant demographics

Descriptor		Number of participants
Age		
	18-25	1
	26-34	2
	35-42	1
	43-51	3
	52-60	2
	60+	1
Gender	Male	3
	Female	7
	Other	0
Employment	FT Employed	2
	PT Employed	0
	FT Student	1
	PT Student	0
	Unemployed	7
	Other	
Sexuality	Heterosexual	8
	Bisexual	1
	Lesbian	0
	Gay	0
	Other	0
	Declined to answer	1
Ethnic Background	White British	9
	White Caribbean	1
Consider self as disabled	Yes	4
	No	6
Relationship Status	Single	7
	Partnered	2
	Married/ Civil Partnership	0
	Separated	1
	Divorced/ Partnership Dissolved	0
	Other	0

Appendix G: Example of interview transcript and coding

Example 1



P51: umm.. well the two counsellors I got, the ten week and then, is it- ten month one, I think, something like that. Umm.. they both had a lot of empathy and they both were particularly caring people and really cared and really wanted to help and I could tell that, I could feel that.. they showed it to me, in their effort all the time, you know? Yeah, and that's what umm.. good therapy does, it- they give love and empathy and that's where most abuse comes from- lack of empathy, lack of care, lack of love , umm.. its like a deficit, so you need, you need people to care and love you, that's what the main aim is, to umm plug that deficit if you like.

RS2: hm-hm, and it sounds like you really felt that in that counselling experience?

PS2: yeah, I did, yeah.

RS3: So how did the counselling that you had, how did it help?

PS3: umm.. it was helpful because I was able to express my fears and my feelings and that there was somebody who understood who was also knowledgeable. And also that they had skills they could help me with, like to help me..show me systems, processes to help me. Umm.. so I think yeah- those two things really. The empathy with the knowledge together.

RS4: so that combination?

PS4: yeah.

RS5: And the skills, you mentioned, kind of developing skills, what-what kind of skills was it?

PS5: umm.. gosh I cant remember what they gave me now, but very -skills like a bit of- I cant remember umm.. umm.. you know, I cant remember what skills they gave but it was quite a lot of skills they gave me.. and I cant remember any of them.. sorry..

RS6: That's okay! But there seemed to be quite a lot of them?

PS6: Yeah, yeah, they did, especially the long term one, he gave me- you know he really put effort into looking for skills that would fit what I needed and the next week he'd have looked into it, you know? He'd really put effort in, in- in his spare time and brough the right information or skills.. yeah.

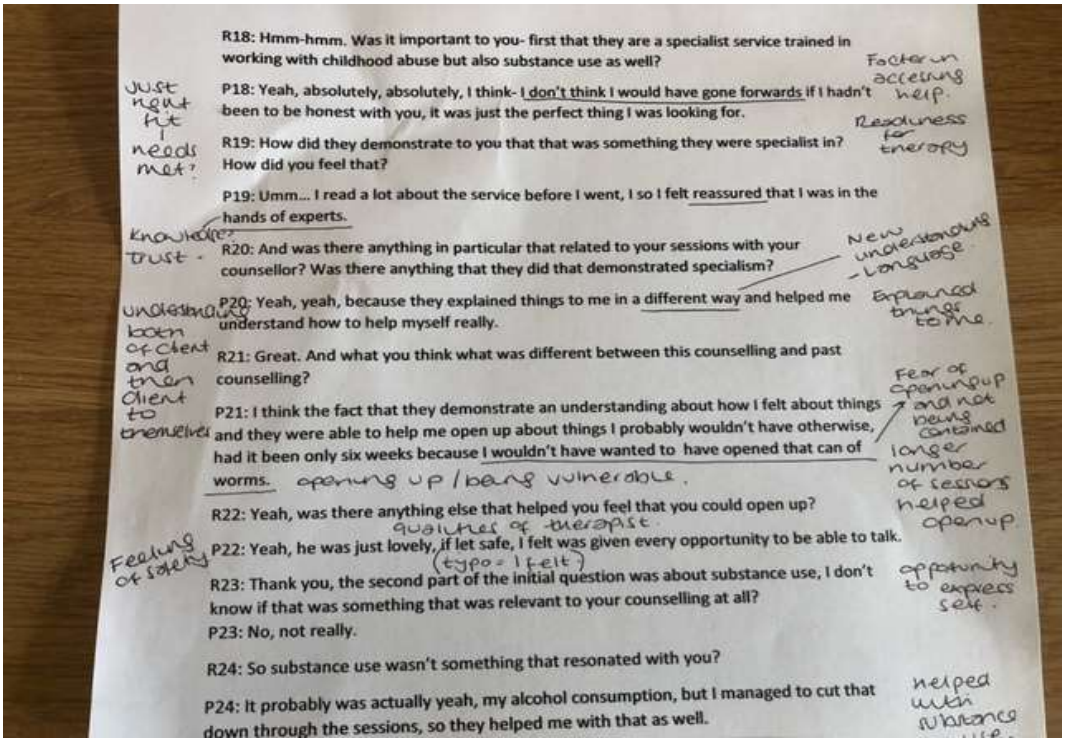
RS7: Okay. And I'm wondering as well, is there anything that you found difficult about the counselling sessions?

PS7: No. No...

RS8: No? There weren't any times where it felt difficult.. to go.. or to experience?

PS8: The only difficultly that I had, was because I have some chronic fatigue, sometimes I'm too tired to go out. So sometimes it's a big effort, do you know what I mean, to go out anywhere, not there but anywhere..

Example 2



R18: Hmm-hmm. Was it important to you- first that they are a specialist service trained in working with childhood abuse but also substance use as well?

P18: Yeah, absolutely, absolutely, I think- I don't think I would have gone forwards if I hadn't been to be honest with you, it was just the perfect thing I was looking for.

R19: How did they demonstrate to you that that was something they were specialist in? How did you feel that?

P19: Umm.... I read a lot about the service before I went, I so I felt reassured that I was in the hands of experts.

R20: And was there anything in particular that related to your sessions with your counsellor? Was there anything that they did that demonstrated specialism?

P20: Yeah, yeah, because they explained things to me in a different way and helped me understand how to help myself really.

R21: Great. And what you think what was different between this counselling and past counselling?

P21: I think the fact that they demonstrate an understanding about how I felt about things and they were able to help me open up about things I probably wouldn't have otherwise, had it been only six weeks because I wouldn't have wanted to have opened that can of worms.

R22: Yeah, was there anything else that helped you feel that you could open up?

P22: Yeah, he was just lovely, if let safe, I felt was given every opportunity to be able to talk.

R23: Thank you, the second part of the initial question was about substance use, I don't know if that was something that was relevant to your counselling at all?

P23: No, not really.

R24: So substance use wasn't something that resonated with you?

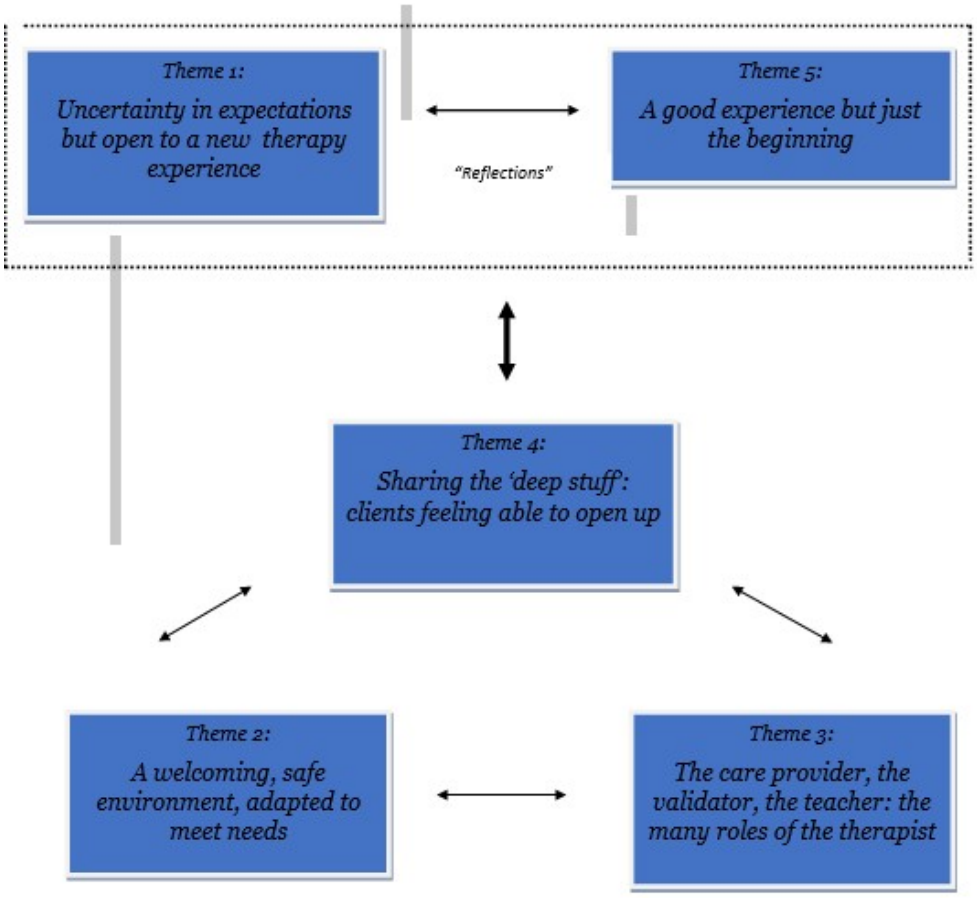
P24: It probably was actually yeah, my alcohol consumption, but I managed to cut that down through the sessions, so they helped me with that as well.

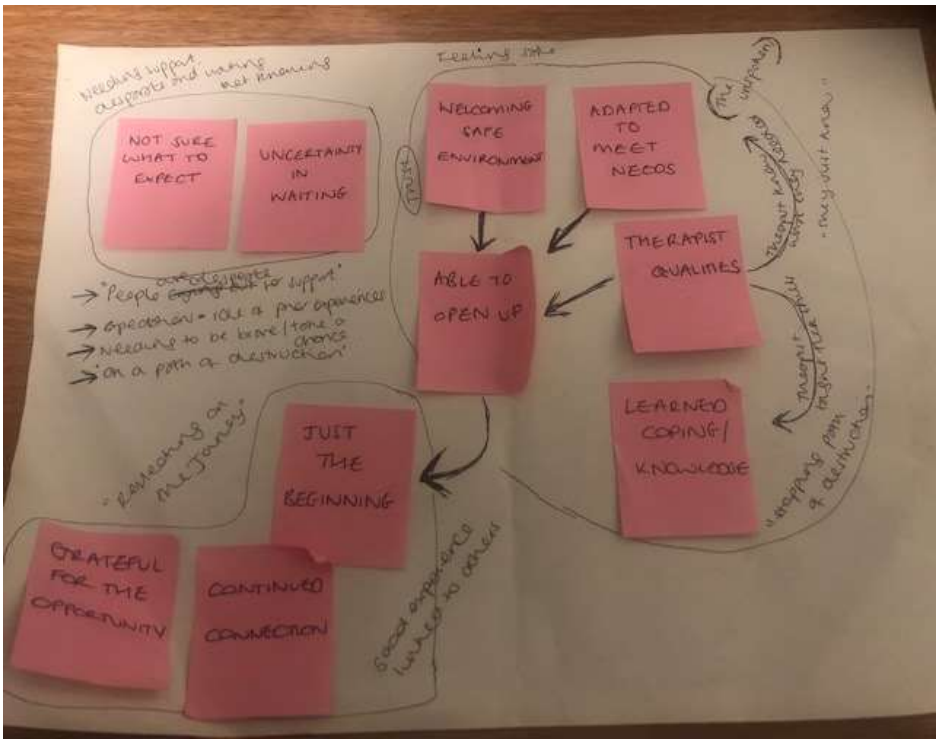
Appendix H: List of initial codes

Appendix I: Example of codes and themes development

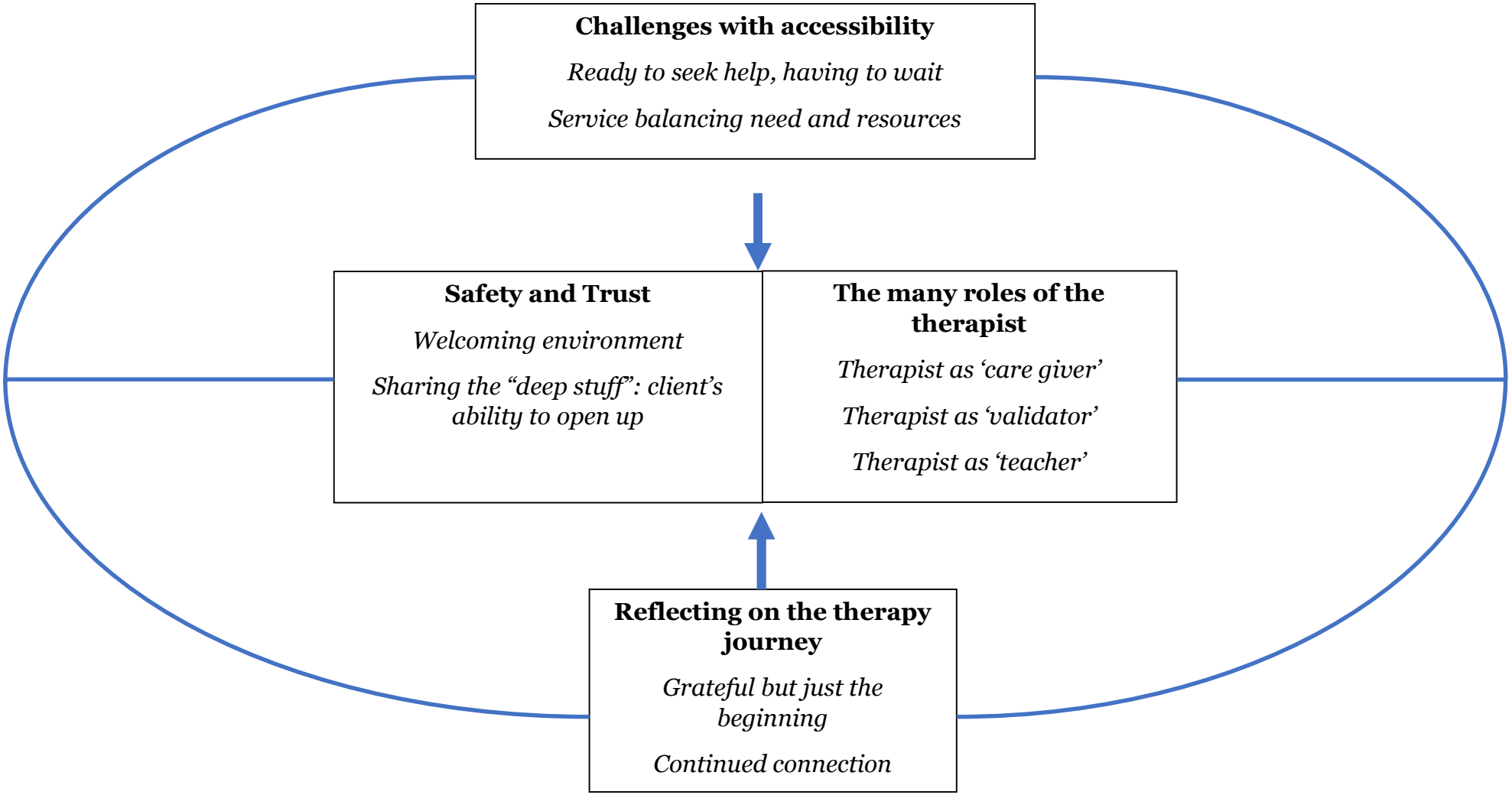
Transcript data	Initial coding	Initial theme	Final theme and subthemes
"The environment very calm and very welcoming, I felt at ease there" (P1) "It's really lovely, I really like it there, I think it's a very calm relaxed environment" (P3) "I trusted them…the only way they would share information was if you were a threat to yourself or someone else.. they're thinking of you, protecting you and others" (P5) If I hadn't felt safe I wouldn't have been able to have engaged in the process" (P6) "I could trust them with my stuff" (P4) "They made sure you felt warm enough, cool enough, there was drinks, sensory things to ground yourself" (P3)	Calm environment Felt welcomed and relaxed by nice people around Importance of feeling safe in order to engage Environment adapted to fit with client needs	A welcoming, safe environment, adapted to meet needs	**Theme 2: Safety and Trust** Subtheme: *Welcoming Environment* Subtheme: *Sharing the "deep stuff": client's ability to open up*
"I was just very open-minded" (P1-19) "I wanted to get as much as I could from counselling" (P1-18) "I'll give it a shot" (P8-49) "I was forced into it" "The wait seemed endless, but I knew it would be worth the wait in the end" (P6-9) "I needed help there and then" (P7-8) "I needed it the same day.. a lot of people on the waiting list need it straight away" (P3-43)	Mixed expectations about therapy Uncertainty in waiting Long waiting time but worth it Urgency in support needed	Uncertainty in expectations but open to a new therapy experience The context and challenges with accessing support	**Theme 1: Challenges with accessibility** Subtheme: *Ready to seek help, having to wait* Subtheme 2: *Service balancing need and resources*

Appendix J: Early thematic maps





Appendix K: Final thematic diagram



Appendix L: Theme summaries sent to participants for feedback

Theme 1: Challenges with accessibility

Participants detailed their experiences of first seeking therapy through the third sector organisation and how they were feeling at the point of accessing the service for support. Participants discussed the challenges of waiting to start therapy and their awareness of the counselling service's position of balancing meeting the need and demand for their service, with their resources to provide support. There appeared to be an agreement amongst participants, that this was the norm across counselling and mental health services and subsequently the expectation that with a good service comes a long wait time.

Subtheme 1: Ready to seek help, having to wait

Participants described feeling at a point of needing help and support when they had their first contact with the counselling service. Many highlighted feeling at a point of desperation or crisis. Many participants had accepted that they required help instead of continuing to cope alone with their difficulties and felt in a place where they were able to accept support, when previously they may not have been ready. Participants also spoke of their previous experiences, the influence of this on their expectations of further support and how positive, or helpful experiences within services can act to heal or repair previously unhelpful ones.

Subtheme 2: Service balancing need and resources

Participants spoke about their perception of the counselling service having long wait times due to them needing to balance their resources with the demand of people accessing the support offered. It was described as an almost impossible task and participants reflected on aspects that they felt were outside of the service's control. Some expressed hesitancy to criticise the service based on this, but all communicated a wish that this could be improved so that others could have a better experience. Participant responses indicated a perception that this is an issue faced by many services, especially third sector organisations that may be charity funded. During the interviews, participants were asked about their reflections on the service being free to access and all participants stated that this was an important factor in them being able to access therapy.

Theme 2: Safety and Trust

Participants highlighted the importance of feeling safe and being able to trust their therapist and the overall service. Participants expressed ways in which they experienced feeling safe and this included feeling that the environment was comfortable and welcoming. They reflected on their experience of opening up in therapy and how this was linked to the trust they had developed. This was trust in the environment that it wouldn't be triggering or threatening, trust in the therapist to help them through the process and trust in the time they had available; that they didn't have to rush and could go at the pace they required. Participants described how this impacted their relationship with their therapist and how important this was in being able to get the most from their experience of therapy.

Subtheme 1: Welcoming environment

Participants spoke of their first experience of entering the physical space, their impressions, and the feelings they associated with this. Many participants described the space as immediately welcoming and calming and this led to a sense of feeling at ease there. Many used the words "calm" and "welcoming" in their responses. Participants described that they felt effort had been taken to create a place of comfort and safety. They highlighted that this experience was due to the physical space but also the people who inhabited the building. Participants appreciated the opportunity to make refreshments. Consideration was given to many factors about the physical space including both the waiting area and then the therapy rooms- what and how things were placed and the temperature of the room.

Subtheme 2: Sharing the 'deep stuff': client ability to open up

Many participants highlighted how having a longer period of counselling meant that they didn't feel rushed or pressured and they had enough time and therefore didn't have to discuss their experiences of trauma straight away. Other participants also highlighted feeling able to able to stop talking if this became too overwhelming. They also indicate a flexible and personalised approach to meeting their needs. Adding to this, some participants reflected on how different their therapy experience would have been if it had been for a shorter duration, and the impact they believe this would have had on their therapy experience.

Theme 3: The many roles of the therapist

Subtheme 1: The therapist as the 'care giver'

Participants spoke about personal qualities they noticed in their therapist. Many reflected that they felt genuinely cared for. Some participants reflected on previous experiences of relationships different to this one and some expressed how their experience of their most recent therapist meant they could talk about their use of substances without fear of judgement. For those who spoke of substances not being a key feature in their therapy, many still highlighted that having a non-judgemental response from their counsellor after discussing substance use, if this came up, was important and added to the care they felt from them.

Subtheme 2: The therapist as 'the validator'

Participants spoke about feeling heard and understood as being crucial in developing their connection with their therapist. They described being given the ability to understand their experiences and a voice to express this. Participants described feeling that they had a shared understanding with their therapists, that they were on the same page.

Subtheme 3: The therapist as 'the teacher'

Participants clearly spoke about a learning process as part of their therapy. They not only developed ways to express their understanding of their experiences but learned ways of coping and moving forwards. Participants described specific techniques and strategies that their therapist had offered them. Some learned about trauma psychoeducation and the effect of trauma on the body and described how this led to increased understanding and a sense of empowerment. Participants spoke of the benefit of their counsellor sometimes taking the lead, making suggestions of what may be helpful for them and giving them ideas and strategies that they could take forwards.

Theme 4: Reflecting on the therapy journey

Participants reflected on their therapy experiences as part of a wider journey of recovery. They situated this experience in relation to other times of difficulty and support given during their lives. Most participants spoke exclusively about the helpful and beneficial parts of their recent counselling.

Subtheme 1: Grateful but just the beginning

Participants demonstrated gratitude towards the service for existing and therefore having the opportunity to have counselling. There were many overall comments about the service giving clients a good experience. On reflection, participants expressed recognition for the specialism of trauma and substance use in the service and a sense that anything less would not have been effective. When participants were asked to describe the ending of their counselling, many highlighted experiencing a range of mixed emotions. Following their counselling sessions, participants described feeling that they needed and wanted further therapy, and this was just the start of a longer journey for them.

Subtheme 2: Continued connection

Participants spoke about the importance of having a continued connection to the service and other service- users/peers. Those who had accessed follow-up groups, described their importance in maintaining momentum and engaging in activities with others. Those who did not, ended sessions feeling a need for wanting a follow-up, or more information of where they could receive further support. A few participants described that the ending of their therapy felt sudden, and they were left without a "safety cushion."

Appendix M: Research Summary

"It gave me a voice when I couldn't express what I was feeling", exploring clients' experiences of trauma-focused counselling and the use of substances: a qualitative study.

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Abstract (150 words)

Background: Trauma has a widespread impact on individuals and society and there is a strong co-morbidity between trauma and substance use.

Aims: To explore the experiences of clients who have self-reported substance use and have completed trauma-focused counselling for childhood trauma. To explore what developments could be made and to consider the implications of trauma informed principles within the counselling service.

Methods: 10 in-depth qualitative interviews were analysed through reflexive thematic analysis to capture key shared themes across the data set.

Findings: 4 themes and related subthemes were presented; 'challenges in accessibility', safety and trust', ' the many roles of the therapist' and 'reflections on the therapy journey.'

Conclusion: Clients would benefit from services that are perceived as consistently safe and trustworthy. Continued connections for clients following the end of therapy have important relational impact. Stigma and isolation can be challenged by viewing substance use through a trauma-informed lens.

Keywords: *trauma-informed; trauma-focussed ;substance use; adverse childhood experiences; qualitative methods*

Background and Rationale

While government funded services form a large section of support that is offered for mental health difficulties in the UK, the voluntary sector, sometimes referred to as a 'third sector' has played a crucial role in filling gaps in treatment provisions.

Reports have consistently demonstrated that there is a high demand for mental health services and the documented demand for services could also be due to more people feeling able to access relevant support. Campaigns created by UK-based organisations such as the 'Mental Health Foundation' and 'MIND' have worked to raise awareness of mental health difficulties with the aim of reducing stigma and encouraging more people to seek help. In the same way, research into understanding Adverse Childhood Experiences highlighted the prevalence of these experiences within society. Further research into their impact on physical and mental wellbeing has also received more attention in the UK. The demonstration of the widespread impact of ACEs highlights the importance of understanding how to prevent these experiences but also how to support those who have had such experiences.

There has been a noticeable shift in recognising a distinction between experiences and symptoms of PTSD and those of what is now labelled as 'complex trauma.' Services have historically run without acknowledging, understanding, or addressing the impact of trauma and therefore the need for tailored responses (Harris & Fallot, 2001). However, there has been a move towards trauma informed approaches involves adopting a broad definition of trauma and an understanding of how multiple traumas intersect (Sweeney & Taggart, 2018). Importantly, there is a clear distinction presented between trauma-specific services which are seen as offering clinical interventions and that of trauma-informed approaches which addresses organisational culture and practice (De Candia, Guarino & Clervil, 2014). Trauma Informed Approaches represent an ideological shift, where relationships become the focus and this relational focus transforms the experiences of people using services (Sweeney, Filson, Kennedy, Collinson & Gillard, 2018).

The leading institution on the field of Trauma Informed Care-SAMHSA, describe key principles of TIA including safety, trustworthiness and transparency, peer

support and mutual self-help, collaboration and mutuality, empowerment, voice and choice, cultural, historical and gender issue responsiveness (SAMHA, 2014). The SAMSHA's widely used description states that a system is trauma informed if it shows a realisation of the impact of trauma and pathways towards recovery, a recognition of the signs and symptoms of trauma, a response that integrates knowledge into practices and efforts to prevent re-traumatisation.

Even though the use of substances has been described as "the most common coping strategy to ease or numb pain of trauma and associated symptoms" (Campbell, n.d., p. 12), there is little qualitative exploration of this co-morbidity, with mental health and substance use services historically, largely operating separately. A number of psychological therapies have been since been developed to work with comorbidity but there is not an agreement currently about which therapies are most effective. With the exception of a few studies examining the qualitative experience of clients' who have engaged in trauma-focused therapies (Shearing et al., 2011; Stige, Rosenvinge, & Traeen ,2013), reviews of therapy for trauma appear to focus on quantative research relating to measured symptom reduction.

The way that trauma is conceptualised within services and society, has changed over time, with trauma informed approaches taking more of the spotlight in recent years. Therefore, it appears crucial that the way in which clients who have experienced trauma are brought to access services and receive support also matches this shift. There still appears to be a gap between support offered for substance use and that for mental health difficulties and furthermore, the way the effectiveness of this support is analysed, is largely quantitative and based on symptom reduction. The poorer outcomes noted for those experiencing co-morbidity, could partly be explained by this gap and individuals being declined psychological therapy due to the narrative that they are firstly required to reduce their substance use.

Aims and Study Design

The study aimed to explore the experiences of clients who had self-reported substance use and engaged in and completed trauma-focused counselling. It also aimed to explore what developments could considered in relation to this client

group, contributing to the development of the counselling service and considering the implications of trauma informed principles within the counselling service.

Methods

In line with the concept of "Big Q" (Kidder and Fine, 1987) qualitative research, this study was designed to be a "fully qualitative" study (Clarke and Braun, 2018, p.107), whereby, qualitative methods were intentionally used within a qualitative paradigm (Terry et al., 2017.) This research is underpinned by the theoretical assumptions of critical realism (Bhaskar, 1989). This theoretical positioning allowed research that focuses on giving voice to participants' experiences (Braun and Clarke, 2013), and therefore the underlying philosophy guided not only the research question, but the questions asked at interview and the analysis of subsequent data. The critical realist philosophical standpoint was chosen in relation to this study as it acknowledges the meaning individuals make of their experiences of accessing and engaging in trauma focused counselling but also recognises the influence of culture, discourse and politics in the meaning that is made.

Data was collected through in-depth qualitative interviews of ten participants. These were individuals who had completed trauma focused counselling a minimum of three months prior to interview and who had self-reported use of substances at the start of their therapy. Based on participant preference, eight interviews were conducted via telephone, one was through an online video platform, and one was in person face-to-face. The benefit of using VoIP and telephone interviews included that the locality of participants was not a barrier for them to engage in the study, should they no longer reside near where they accessed the therapy previously (Lo Iacono, Symonds & Brown, 2016). Furthermore, it also gave the best opportunity for in-depth authentic interview data due to participants' opportunity to choose their preferred mode of interview.

Support in the recruitment of participants for this study is provided in agreement with a counselling service in England that provides therapy for clients who have experienced trauma including childhood abuse and use substances. Sampling was purposive in order that only those clients who met the inclusion criteria could be asked to participate.

Table 1: Participant Demographics		
Ages of participants	24-62 years	(mean 45.7)
Gender	Male	3 (30%)
	Female	7 (70%)
Racial/ ethnic background	White	9 (90%)
	Other	1 (10%)
Employment	Full time employed	2 (20%)
	Full time student	1 (10%)
	Unemployed	7 (70%)
Sexuality	Heterosexual	8 (80%)
	Bisexual	1 (10%)
	Declined to answer	1 (10%)
Relationship status	Single	7 (70%)
	Partnered	2 (20%)
	Separated	1 (10%)
Disability	Yes	4 (40%)
	No	6 (60%)

In collaboration with the counselling service, considerable thought was given to research inclusion criteria. Participants for the study were UK residents, 18 years or above (so they are able to consent for themselves), who had previously completed trauma-focussed counselling at the service. Participants were selected from the organisations client database, based on the criteria that they had completed trauma-focused counselling in the last 2 years and who were recorded as having used substances (alcohol or drugs) during their assessment with the organisation through the use of Alcohol Use Disorders Identification Test (AUDIT) [(Babor, Higgins-Biddle, Saunders & Monteiro, 2001] and Drug Screening (DAST-10) [Skinner, 1982] questionnaires during the assessment process. Only participants who gave consent to be contacted again in future for research purposes will be contacted for recruitment and they were only contacted when three months had passed since the end of their counselling sessions.

Ethics

Research was given full ethical approval by UWE Ethics Committee. In-depth qualitative interviews appeared best suited to this study as they offer rich and detailed data about participants' experiences while allowing the data to be collected in a way which prioritises ethical practice. A time-limited post-interview debrief was offered to be provided by a qualified counsellor from the counselling service and participants were provided with details of local support services, should they feel they need emotional or therapeutic support at any point in the future. Full informed consent was obtained before participation in interview.

Reflexivity Statement

As the research intentionally embraced researcher subjectivity it was crucial that my positioning as the researcher and in relation to the research topic was fully examined and clearly stated. This statement predominantly spans the four years I experienced as a trainee counselling psychologist but inevitably all of my experiences in roles related to mental health and psychology that came before, also feature in forming the lens that I view the world through now. During my training I held various roles, including trainee psychodynamic therapist in a third sector organisation in England, a CBT therapist in another third sector organisation in Wales (which has a different approach and provision of mental health services) but where I feel I experienced most about the policies, competing demands, commissioning and ultimately the gap between services was working as an assistant psychology practitioner in an NHS IAPT Service.

Working in an IAPT service involved completing assessments for those who had self-referred for psychological therapy and this gave me insight into what provision was available or not for those individuals and the guidance that was followed regarding referral pathways. One thing I had noticed at the time was the trend for those who were using substances or alcohol to be referred on to specialist counselling services or told they needed to seek support to stop using substances before they could access psychological therapy. I began to wonder what the experience was like for such individual to then access and then engage in psychological therapy for trauma.

During my counselling psychology training, I developed a greater understanding of trauma, formulation as an alternative to diagnosis and a critical evaluation of medical model of distress. Furthermore, I developed an appreciation for the importance of social justice and an understanding of power dynamics in society, along with an awareness of the impact of language and discourse.

I was aware when beginning this research that I would have an 'outgroup' member status. This was because I was proposing research and ultimately interviewing individuals who had experienced specific traumas, used substances as a way of coping and had subsequently sought counselling. While I aimed for their experiences to be heard, I wanted to avoid the 'poor them' trap (Division of Counselling Psychology Wales, 2021). At the start of conducting the research, but

even more so as it progressed, I began to see that participants had wanted to take part in the research in order to give something back and have their experiences heard. Many were curious about what the outcomes of the research might be. Whilst I was very aware that this study was not intended or designed in a way to make any generalisations, it began to feel like a shared aim of the participants and I that there could be some meaningful implications to conclude from the research process and for me, this gave the research another level of meaning.

Analysis

Data collected from the interviews were transcribed and analysed using reflexive thematic analysis (Braun & Clarke, 2019; 2021). This allowed the identification, analysis and reporting of patterns across the dataset and was used to make sense of the experiences and reality of participants who have completed trauma-focused counselling alongside using substances. This method was used to both explore the perspectives of participants whilst also taking into account the context from which these experiences originated. The analysis followed the six stages presented by Braun & Clarke (2006), and subsequent themes captured the therapy journey of the participants.

Results

From the analysis of the patterns across the dataset, four themes and associated subthemes were developed, “Challenges with accessibility”, “Safety and Trust, “The many roles of the therapist” and “Reflecting on the therapy journey.” For the purpose of this article, the themes Safety and Trust and Reflecting on the therapy journey will be reported. Safety and Trust comprised of two subthemes; 1) Welcoming environment, 2) ‘Sharing the deep stuff’ client’s ability to open up. Reflecting on the therapy journey is also comprised of two subthemes; 1) Grateful but just the beginning, 2) Continued connection.

Theme: Safety and Trust

Subtheme: Welcoming environment

Participants spoke of their first experience of entering the physical space, their impressions, and the feelings they associated with this. They described the space as immediately welcoming and calming and this led to a sense of feeling at ease

there. Many used the words “calm” and “welcoming” in their responses, for example:

> *“It’s very calm and very welcoming… I felt at ease there.”*
>
> (Alex)
>
> *“Lovely and very welcoming.”*
>
> (Eliza)

Participants described that they felt effort had been taken to create a place of comfort and safety. They highlighted that this experience was due to the physical space but also the people who inhabited the building. Participants appreciated the opportunity to make refreshments.

> *“You can see the effort put into making you feel comfortable… I could help myself to a cup of tea and that was nice… it was very important, to feel welcomed and that there’s nice people around.”*
>
> (Lemonie)
>
> *“There’s a waiting room that’s quite nice, and someone pops out and asks do you want a cup of coffee?”*
>
> (Jemma)

Participants articulated the importance of the waiting space at the service and in particular the way in which it left them feeling. Some participants described initial feelings or anxiety or nervousness at their first visit but found that the environment helped them feel calm and over time this also became a familiar space. The waiting space appeared to serve a purpose of creating a sense of calm and security. The added option of being offered refreshments also implies that the service was aware of and considered client need from the offset. Both participants talk about the presence of others and their experience of the waiting room being part of a routine or ritual that remained a constant during their therapy journey.

Once in the counselling room, participants spoke of the adaptability of the environment. They described how it was able to be changed to fit their needs and to ensure that there was nothing that could unintentionally trigger their symptoms

of trauma. The rooms also had the presence of sensory objects that were perceived as grounding.

> *"My counsellor created a safe space for me right from the very beginning"*
>
> (Sarah)
>
> *"They were really accommodating… it held me in place…the environment was flexible and trigger-free"*
>
> (Jemma)
>
> *"They made sure you felt warm enough, cool enough, there was drinks, sensory things to ground yourself"*
>
> (Alice)

Consideration was given to many factors about the physical space- what and how things were placed and the temperature of the room. It also implies that participants were directly asked about their needs, and they had the experience of these needs being met.

Subtheme: Sharing the 'deep stuff': client ability to open up

Participants highlighted how having a longer period of counselling meant that they didn't feel rushed or pressured, that they had enough time and therefore didn't have to discuss their experiences of trauma straight away.

> *"They didn't rush you, and you took your time talking about things, and they didn't go into the trauma bit just like that."*
>
> (Chloe)
>
> *"My counsellor was able to work with trauma and not rush that through.. there were many sessions in front of me"*
>
> (Sarah)

These participant's responses illustrate the benefit of feeling in control of what they shared. Other participants also highlighted feeling able to able to stop talking if this became too overwhelming. They also indicate a flexible and personalised

approach to meeting their needs. Adding to this, some participants reflected on how different their therapy experience would have been if it had been for a shorter duration, and the impact they believe this would have had on their therapy experience.

> *"I was able to go into depth…there was a lot of revelation that happened later, that if it had been shorter, that wouldn't have happened… it [exploring trauma] didn't start straight away… that's what's good about it, you could become put off… I would have found it overwhelming"*
>
> (Eliza)
>
> *" I knew it would stop at some stage, but, I knew it wouldn't be immediate, it wouldn't be within the next week or the next two weeks, it would be within the next month or couple of months… so from that perspective, it was far more beneficial for me…you're really getting into some deep stuff, that you've been burying for quite a long time and it allows you, certainly for me, to be much more open and honest."*
>
> (Alex)

Trust is a crucial component in any deep therapeutic relationship but appears particularly vital for those clients who have prior experience of unhelpful or even damaging relationships.

> *"…other counsellors that I've had, where I've spoken about one thing… and I've kept something back that is massive, because I just felt like they got what I was talking about already and I didnt want to complicate it anymore."*
>
> (Jemma)

The experiences described by participants in this research, demonstrate how they perceived both the physical environment and the relational aspects of the service. Their reflections highlighted the importance of these and crucially how the trauma-informed principle of safety was perceived consistently across the whole service. All of the participants interviewed had described within their reasons for seeking therapy, times in their lives when they did not feel safe. Many participants reported early life traumas and difficult relationships with family members. These

individuals therefore may have needed to learn to develop a sense of safety. Developmental trauma whereby there is a disruption during a critical period of child development which can lead to difficulties in developing secure attachments to those around them and subsequently, difficulties in forming and maintaining future relationships. Attachments are viewed as originating from a need for safety and a secure base (Bowlby, 1988). Thus, a trusting relationship with their therapist may have been a reparative experience for participants, offering hope and demonstrating their ability to form positive relationships and develop personal boundaries.

> *"It gave me a feeling of more security in life. Feeling peace because there are some decent people in the world that will help… they just really cared."*

This quote highlights how for Lemonie, experiencing a positive relationship with the service provided a sense of security and hope that positive relationships with others is possible and that others can be trusted.

Theme: Reflecting on the therapy journey

Subtheme: Grateful but just the beginning

Participants reflected on their therapy experiences as part of a wider journey of recovery. They situated this experience in relation to other times of difficulty and support given during their lives. Most participants spoke exclusively about the helpful and beneficial parts of their recent counselling.

Participants demonstrated gratitude towards the service for existing and therefore having the opportunity to have counselling. There were many overall comments about the service giving clients a good experience.

> *"I was given the opportunity to talk about stuff. I owe them a great deal; I am immensely grateful."*
>
> (Alex)
>
> *"I am very grateful for them; it changed my life dramatically."*
>
> (Amy)

On reflection, participants expressed recognition for the specialism of trauma and substance use in the service and a sense that anything less would not have been effective. Many described the counselling they received 'just what they needed'.

> *"Literally, the perfect, specialised place-they were the right people for me. Anything else would have been putting a Band-Aid on a decapitation… Just so much gratitude, endless gratitude. How wonderful it was that the service is literally open to anyone. I'm just really glad they exist."*
>
> (Alice)
>
> *"There was a lot of cross-over between those things [trauma and substance use] for me so I thought it would be important [that the service was specialised] "I was very grateful that they are here… that the service is available."*
>
> (Nathaniel)

Nathaniel highlighted in making sense of his experiences, there was a 'cross-over' between trauma and substance use for him, he reflected feeling pleased that both could be addressed simultaneously. During the interviews, many participants described substance use as a way they had learned to cope with intense emotions. The shift in the way that trauma is viewed, recognises that extreme or even dangerous behaviours when viewed through a trauma lens, can be seen as adaptations to past traumas and a way to communicate pain (Filson, 2013).

When participants were asked to describe the ending of their counselling, many highlighted experiencing a range of mixed emotions:

> *"It's sad, when that came to an end, but we did do a lot of preparation coming up to it and what was going to happen and talking about how much progress I'd made from the beginning, how much more capable I was of dealing with life."*
>
> (Jemma)
>
> *"It was quite a sad time I think, but a happy time as well because I know that I came quite a way and that I had done it."*
>
> (Sarah)

"It's a work in progress. I could have gone on… it was difficult stopping."

(Eliza)

"It was sad as I was getting comfy… I wasn't even close to finishing in my head, I still needed somebody to talk to."

(Michael)

Following their counselling sessions, many participants described feeling that they needed and wanted further therapy, and this was just the start of a longer journey for them.

"I've healed a lot, but I still have a while to go yet."

(Amy)

"There's still a way to go but compared to how I was before, I'm now functioning."

(Jemma)

In their reflections on their counselling and recovery journeys, participants highlighted outcomes of their therapy including increased understanding of their experiences, improved functioning and relationships with others and increased self-esteem.

"A better understanding of what's going on for me has definitely helped in a positive way."

(Nathaniel)

"I've been able to vocalise with my actual close friendships… so I feel like I have more support overall…because I wasn't able to talk about anything [previously]."

(Alice)

"I think throughout the sessions, with help I was able to establish more self-worth and more self-respect."

(Sarah)

Subtheme: Continued connection

In interview, participants spoke about the importance of having a continued connection to the service and other service- users/peers. Those who had accessed follow-up groups, described their importance in maintaining momentum and engaging in activities with others. Those who did not, ended sessions feeling a need for wanting a follow-up, or more information of where they could receive further support. A few participants described that the ending of their therapy felt sudden, and they were left without a "safety cushion." (Alex)

> *"I had continued connection in the group. It's been quite nice to have that continuation. It's nice to have ongoing support."*
>
> (Jemma)
>
> *"There is that opportunity, there doesn't have to be just that cut. You don't just get dropped at the end of it."*
>
> (Eliza)

The above quotes demonstrate the importance for participants of having the opportunity for ongoing social connections. This highlights the need for resources to be directed towards creating these opportunities and fundamentally reducing social exclusion (Malloch, 2010). Isolation has been described as being the core of human suffering and therefore connection is seen as a key part of healing and growth. This is connections both generally and with a peer group. A study focused on understanding loneliness, found that peer groups can create positive pressure and encourage people to stick with their recovery goals Victor, Qualter & Barreto, 2019).

Nathaniel reflected that remaining involved with others from the service acted to motivate him:

> *"It has helped me get out more, being around people, it motivates me to do things, I'm not so isolated. I still feel a part of it, still involved. It keeps the momentum going for me in going forwards."*

In contrast to this, addiction recovery has been described as a largely solitary process and one where individuals are working to develop a new sense of self.

Practices of addiction have been considered to be part of an individual's identity and ways of being with others (Hughes, 2007). The formation of a new identity was something Jemma highlighted as an important outcome of her therapy experience:

> *"I used to be like ' I'm a trauma victim, this stuff happened to me'... so that was really important to me, establishing a separate identity."* (Jemma)

Importantly, those who have experience of using a service and are 'experts by experience' can meaningfully offer hope to those earlier in their recovery journey and this form of helping others can become part of a new identity.

Discussion

The aims of the research were to explore and understand the experiences of clients who had completed trauma focused counselling alongside using substances. Importantly, this aimed to fill the gap in qualitative research in this area, exploring what developments could be made to the counselling service and considering the implications trauma informed principles. Through the use of in-depth qualitative interviews, rich data was collected regarding these experiences and as the interviews were conducted with ethical considerations in mind, the result was comprehensive accounts of the participant's experiences and stories which can now be heard. Subsequently, the participant's journeys through the counselling service from first contact to reflections upon ending their sessions was illustrated by themes that captured this journey.

The importance of relationships and connections was apparent across all of the themes. At the point of accessing the service, participants presented as largely alone with their difficulties and their subsequent experiences of the service, specifically in feeling safety and trust was impacted by the people within the service working to meet their needs. The focus on relationships and connection was also evident in the developing of a deep and trusting relationship with their therapist and through ongoing activity groups and connection with peers once their therapy had completed. This is significant in relation to trauma informed approaches which are formed of principles and practices that are inseparable from a relational approach.

Safety has been described as one of the '3 pillars' of trauma informed care, along with connections and managing emotions (van der Kolk & Courtios, 2005). A defining feature of the experience of childhood trauma is that of feeling unsafe and mistrusting others (Seita & Brendtro, 2005). The term psychological safety has been defined as "the ability to feel safe, within oneself and safe from external harm" (Chadwick Trauma-Informed Systems Project, 2013, p.13). Importantly it is how safety is perceived by clients, how triggers are managed and the congruence across the service in how this perception of safety is maintained (Wilson, Pence & Conradi, 2021).

Safety is linked to the development therapeutic relationship. Specifically, the quality and the level of the relationship experienced. Relational depth is described as "a state of profound contact and engagement between two people, in which each person is fully real with the Other, and able to understand and value the other's experiences at a high level" (Mearns & Cooper, 2005, p.xii). Clients have detailed their experience of 'letting go' in order to fully engage with their therapist in a deep way and therefore making the decision to drop their protective stance (McMillan & McLeod, 2006). When a client is able to hold trust in their therapist, is when they can make the decision to be vulnerable and take a leap of faith (Knox & Cooper, 2011).

Addiction recovery literature often focuses on abstinence, having been used as an indicator of treatment success (McLellan et al., 2007), in the same way studies of trauma therapies have been judged for success based on symptom reduction. Recovery has largely been viewed clinical outcome and described as 'recovery from' by professionals (Davidson, 2003). In contrast, some have argued for a more holistic viewpoint and research analysing client's perception and meaning of recovery demonstrated that they often felt it was an ongoing and lifelong journey. They also described successful recovery as noticing positive changes in emotions and thought patterns along with improvements in feelings on guilt, shame, and self-blame (Costello, Sousa, Ropp & Rush 2020). This has clear implications for the reporting of recovery or therapy success as measuring symptoms is likely to offer limited insight into the change that participants reported.

The experiences of participants in this study indicate that they perceived trauma informed principles within the counselling service including trust, safety,

empowerment, and peer support. Interestingly, participants did not comment a great deal on substance use during their interviews. However, they did indicate that they felt able to express it without judgement as needed and it indicates the service holding a trauma informed lens which views substance use (and other seemingly harmful behaviours) as adaptive ways of coping with distress from trauma and incorporates an inherent understanding of the impact of trauma for individuals. Both trauma informed practices and a relational approach offer hope and reduce isolation. It has been suggested that trauma-informed approaches offer hope that the impact of trauma can be overcome (Filson,2016.)

Limitations and Future Research Opportunities

As described in the reflexive summary of this research, the researcher acknowledged their status as an out-group member in relation to the participants who were involved in the study. Whilst participants were invited to offer feedback during the research process, it would have benefited from more user-led research methods which include those with lived experience of using relevant services engaging in all aspects of the research design and analysis to reduce the otherwise inherent power imbalance between researcher and participants.

Extending the aims of the study to a wider pool of participants in different regions of the UK or those who have accessed support through statutory services, could offer further insights into the experience of this client group. Furthermore, research could include perspectives from therapists and policy makers alongside clients to offer richer data from a wider span of the context. Further focus on the nature of post-therapy connections and follow-up after a longer period of consolidation following therapy may also be a further opportunity for more insights into client experiences.

Conclusions

The results of this study support existing literature on trauma-informed approaches and practices and the importance of this as perceived by clients who are users of counselling and other public services. The implications of understanding participant's experiences of their therapy journey include offering evidence to inform service-level therapeutic practice, healthcare policy and the role of counselling psychology.

The themes from this study capture the importance of a flexible approach to meet individual needs. Client's feeling that they were understood and that their therapist knew how to support them was crucial in developing safety and trust and fundamentally an effective therapeutic relationship. The themes illustrating the experiences of the study participants support the importance of acknowledging the role of meaningful relationships and connections in healing from the impact of trauma. The importance of combating isolation also appears crucial and in this study, participants highlighted the role of recovery or post-therapy groups and activities that created a continued connection.

The role of the service provider is key in the experiences of participants. How the service is set up, its policies, practices, and ethos and how this is perceived by clients, impacts their experience of the service and recovery journey. It is important to consider how a service can best be organised and function in working with trauma in a trauma-informed way. Crucially, how staff members and therapists can be supported to adopt this attitude to their practice, through training, reflective practice, and trauma informed supervision. Trauma informed supervision involves creating a "culture of safety, empowerment and healing" (Simons, Kimbie & Tyack, 2021), and offers an opportunity to reflect on the impact of therapeutic work and develop practice and skills. This can work to reduce the negative impact of vicarious trauma (Jones & Branco, 2020). Importantly, reflective practice supports a relational focus and creates space to explore and understand difficult feelings elicited when working in trauma settings (McDermott & Husbands & Brooks-Lewis, 2018).

The findings have clinical implications and relevance to counselling psychology based on the understanding of trauma through formulation as an alternative to medical diagnosis. This also involves holding a flexible view of the meaning of recovery. Whilst counselling psychology involves a keen focus on the centrality of the therapeutic relationship, it is also important to have an awareness of the wider system context and what follows the end of therapy.

Key points

- Relationships and connections with both therapists and peers are a crucial component in a positive client experience.

- Client's gain the most from their therapy experience when they perceive a service as consistently safe and trustworthy.

- Client's view their experience as one part of a longer therapy journey and having a continued connection following therapy with the service and their peers within post-therapy groups works to maintain motivation and reduce isolation.

- Recovery has different meanings for all individuals and likely extends beyond symptom reduction. Part of recovery can include the use of service users as experts by experience and therefore part of a clients' identity development.

- A service holding a trauma-informed lens which views substance use as an adaptive coping strategy means that clients benefit from the ability to express their use of substances without fear of judgement or stigmatisation.

- In order to sustainability maintain a trauma informed approach for client, services need to consider support required for staff and therapists through training opportunities, supervision, and reflective practice.

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