



The Generation Game

Trauma and the Instance of Intergenerational Transmission in the Context of
Northern Irish Psychotherapeutic Practice

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Table of Contents

List of Figures and Tables	iii
Acknowledgments	iv
Abstract	v
Chapter 1. Introduction	1
Chapter 2. Literature Review	
2.1 Introduction	3
2.2 Trauma – PTSD.....	4
2.3 Attachment – Neuroscience	6
2.4 Intergenerational Trauma	10
2.5 Northern Ireland	12
2.6 Conclusion.....	14
Chapter 3. Methodology	
3.1 Introduction	16
3.2 Research Aim	16
3.3 Research Design and Rationale.....	16
3.4 Recruitment and Sample	17
3.5 Data Collection.....	21
3.6 Data Analysis	22
3.7 Ethical Considerations.....	23
3.8 Summary	24
Chapter 4. Findings	
4.1 Introduction	26
4.2 Theme 1: The Experience of Working with Trauma in Northern Ireland	27
4.3 Theme 2: The Experience of Trauma Pre/Post the Good Friday Agreement	30
4.4 Theme 3: The Instance of Intergenerational Trauma in Northern Ireland	33
Chapter 5. Discussion and Conclusion	
5.1 Introduction.....	37
5.2 Theme 1: The Experience of Working with Trauma in Northern Ireland.....	38
5.3 Theme 2: The Experience of Trauma Pre/Post the Good Friday Agreement	40

5.4 Theme 3: The instance of Intergenerational Trauma in Northern Ireland	43
5.5 Conclusion.....	48
References	52
Appendices	57
Appendix 1. Sample of Contact Email.....	57
Appendix 2. Confirmation Email	58
Appendix 3. Research Interview Questions	59
Appendix 4. Information Form.	60
Appendix 5. Consent Form	61
Appendix 6. Demographic Sheet	62
Appendix 7. Thematic Coding Rough Work	63

List of Figures and Tables

Figure1. Window of Tolerance	8
Table 1. Demographic	20
Table 2. Coding sample.....	23

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Abstract

The focus of this study is the instance of intergenerational transmission of trauma as experienced by psychotherapists working in Northern Ireland. This study researched the literature relevant to trauma, post-traumatic stress disorder, and intergenerational trauma in Northern Ireland in relation to the Troubles/Conflict. A qualitative research approach was adopted for this study. This approach was chosen to facilitate a rich, deep and non-superficial understanding of the experiences and processes of therapists working with trauma victims. Five psychotherapists with extensive experience working with trauma in Northern Ireland were recruited and interviewed. They brought broad experience from their varied therapeutic practice modalities. The data was collected using a demographic questionnaire and audio-recorded, semi-structured interviews. Best practice ethical considerations were adopted throughout the study. Thematic analysis was used to process the interview data. This process provided a rich and complex account of the obtained data, which was then divided into three main themes. The themes that emerged were: the experience of working with trauma in Northern Ireland; the experience of trauma pre and post the Good Friday Agreement; and the instance of intergenerational trauma in Northern Ireland. These themes were discussed using the lens of the reviewed literature and conclusions were outlined.

Chapter 1. Introduction

Part of human existence is the experience of stress and trauma. When a traumatic event or experience occurs, the body's unconscious stress "smoke-detector" takes over, triggering the fight-flight-freeze response (Rothschild, 2000; van der Kolk, 2015). Difficulties occur when the traumatised individual is unable to discharge the immense energy that the body produces in response to the traumatic event (Levine, 2010; van der Kolk, 2015).

Where an individual has been exposed to either a single traumatising event or to extreme and prolonged stressful situations, post-traumatic stress disorder can result. This condition brings with it a myriad of distressing and debilitating symptoms, which can have a severe impact on the mental health of the individual and their family (Rothschild, 2000). Intergenerational trauma occurs when someone from a younger generation experiences traumatic symptoms related to the trauma experienced by an older family member. This is irrespective of whether the younger member experienced the traumatic event or not (Kaitz, Levy, Ebstein, Faraone, & Mankuta, 2009).

For almost thirty years the sectarian political Conflict known as the Troubles existed in Northern Ireland.¹ Over 3,600 people lost their lives and in excess of 40,000 were injured with citizens enduring bombings, shootings, riots and general civil unrest (Breen-Smyth, 2013; Bolton, 2017). Twenty years on from the Good Friday Agreement, the painful

¹ Conflict and Troubles are used to describe the violent political and sectarian situation that occurred in Northern Ireland between 1968 and 1998.

impact of the Troubles is still being felt. Those directly impacted by the events and the generations that followed are experiencing symptoms of post-traumatic stress disorder (Fargas-Malet & Dillenburger, 2016; Hayes & Campbell, 2000).

With that in mind, this study sets out to explore the instance and transmission of intergenerational trauma in Northern Ireland, as experienced by psychotherapists working in the field of trauma. In doing this, it will investigate and review the relevant literature relating to post-traumatic stress disorder, intergenerational trauma and the experience of intergenerational trauma in the context of Northern Ireland. It will explore with five accredited Northern Irish psychotherapists, their experiences and understanding of trauma and intergenerational trauma in their client practice. It will further enquire into their awareness and clinical experiences of the transmission of intergenerational trauma, with reference to attachment and the cultural issues that might apply in Northern Ireland, both before and after the Good Friday Agreement.

From the perspective of intergenerational trauma and its instance in Northern Ireland, this study will inform the existing literature available in the field of psychotherapy.

Chapter 2. Literature Review

2.1 Introduction

This literature review begins by laying out the research strategy and analysis used in relation to the study's aim – exploring the instance and transmission of intergenerational trauma as experienced by psychotherapists working in the field of trauma in Northern Ireland. It examines the literature relevant to the themes of trauma, post-traumatic stress disorder (PTSD), attachment theory – and its neuroscientific implications, along with the concept of intergenerational trauma, which is then situated in the context of the Troubles/Conflict of Northern Ireland.

From the study's main objective, key concepts and terms were identified. These include, trauma, PTSD, attachment and neuroscientific implications, intergenerational trauma, its instance in Northern Ireland and the implications for psychotherapeutic practice. Definitions and explanations of trauma, PTSD and attachment were researched from the core text of trauma specialists including; Bowlby, Gerhardt, Levine, Main, Ogden, Rothschild, Schore, van der Kolk the Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM - 5) and the Oxford dictionary of psychology. Internet searches using Google and Google scholar were made using the key search words 'intergenerational trauma', 'transgenerational trauma' and 'intergenerational trauma in Northern Ireland'. As a result a number of journal articles and reports were discovered and their relevance to the research question assessed. A number of academic databases were searched using the same key search words as above and eSource produced two

studies relating to trauma in Northern Ireland. Discovery, ProQuest, OpenDOAR.org and Google file type: pdf were also accessed and searched. Other texts, articles and reports were researched from the references and bibliographies from the eSource dissertations. This literature review is divided into four subheadings; trauma and PTSD, attachment and neuroscience, intergenerational trauma, and Northern Ireland.

2.2 Trauma – PTSD

This section of the review covers the aetiology of trauma and PTSD. It explores what the main theorists in the field have to say about its origins, contributing factors and some of the more obvious symptoms and implications for mind and body. It offers a number of definitions from both theorists and the DSM-5.

At the core of trauma is stress. Stress is something that occurs as an everyday response to both positive and negative life experiences, for example starting a new job, getting married, acquiring an illness or working to deadlines (Rothschild, 2000). The Oxford Dictionary of Psychology (2009) offers the following definition of trauma: ‘A physical injury or wound, or a powerful psychological shock that has damaging effects’ (p. 780). An individual who experiences a traumatic event can be said to be in fear of imminent annihilation (Rothschild, 2000; Burrows & Keenan, 2004b).

Rothschild (2000) suggests that trauma is a ‘psychophysical experience’ (p. 5) in that the traumatic experience has an impact on the mind and the body – irrespective of whether there has been actual physical injury (Rothschild, 2000). Trauma is not just the

overwhelming experience that happened to the individual, it also involves the imprint that occurs as the result of the experience on the mind, brain and body (van der Kolk, 2015). In the extreme case of a traumatic incident – a car accident, or prolonged exposure to a perceived life-threatening situation – traumatic stress occurs (Rothschild, 2000).

Stress that lingers long after the traumatic event is referred to as post-traumatic stress (Rothschild, 2000). It is worth noting that for many individuals who experience a traumatic event, they appear to have the capacity to self-regulate – with support from their communities without any long lasting symptoms or ill effects. On the other hand PTSD occurs when the individual's fight-flight-freeze stress response does not return to homeostasis (Herman, 2001; Levine, 1997; Rothschild, 2000).

A traumatic experience causes the amygdala – the brain's 'smoke detector' – to activate the fight-flight-freeze response. This autonomic response to stress is designed to facilitate escape, or to fight off danger, or to play dead in the face of imminent death. Once the threat has passed and the energy that was mobilised has dissipated, the body returns to homeostasis. The difficulty arises when the stress response has not had a chance to discharge and the amygdala remains on high alert and as a result is prone to misinterpret situations as dangerous when they are benign. PTSD is the resulting outcome (Herman, 2001; van der Kolk, 2015).

The Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5) (American Psychiatric Association, 2013) outlines the criteria for a clinical diagnosis of

PTSD. These include being exposed to the likelihood of death or its threat, or of sexual violence – either by direct experience or witnessing someone else in these situations (American Psychiatric Association, 2013). Symptoms occur under two main headings, hyperarousal (fight & flight) and hypoarousal (freeze) (Ogden, Minton, Pain, & Siegel, van der Kolk, 2007). Early onset symptoms can include hyper-vigilance, intrusive thoughts, dissociation, flashbacks, nightmares, sudden mood swings, insomnia, an inability to deal with stress and exaggerated startle and emotional response (American Psychiatric Association, 2013; Burrows & Keenan, 2004b; Kring, Johnson, & Davidson, 2014; Levine, 1997; Ogden, Et al, 2007).

Levine (1997) posits that the symptoms of PTSD are the body's way of managing the enormous energy that results from the response to threat, that gets trapped in the body and continues to re-trigger the fight-flight-freeze response. Some symptoms show themselves shortly after the initial incident while others may take months or years to manifest (pp. 146 – 150). In the introduction to the section on PTSD in the DSM – 5 the point is made that there are very varied individual psychological responses as a result of a traumatic experience. There is no one-size-fits-all when it comes to the diagnosis of PTSD (American Psychiatric Association, 2013).

2.3 Attachment – Neuroscience

This section explores what the main theorists associated with the field have to say about susceptibility to PTSD. It explores what these theorists have to say about attachment styles and early development, how they can impact on the capacity to handle traumatic

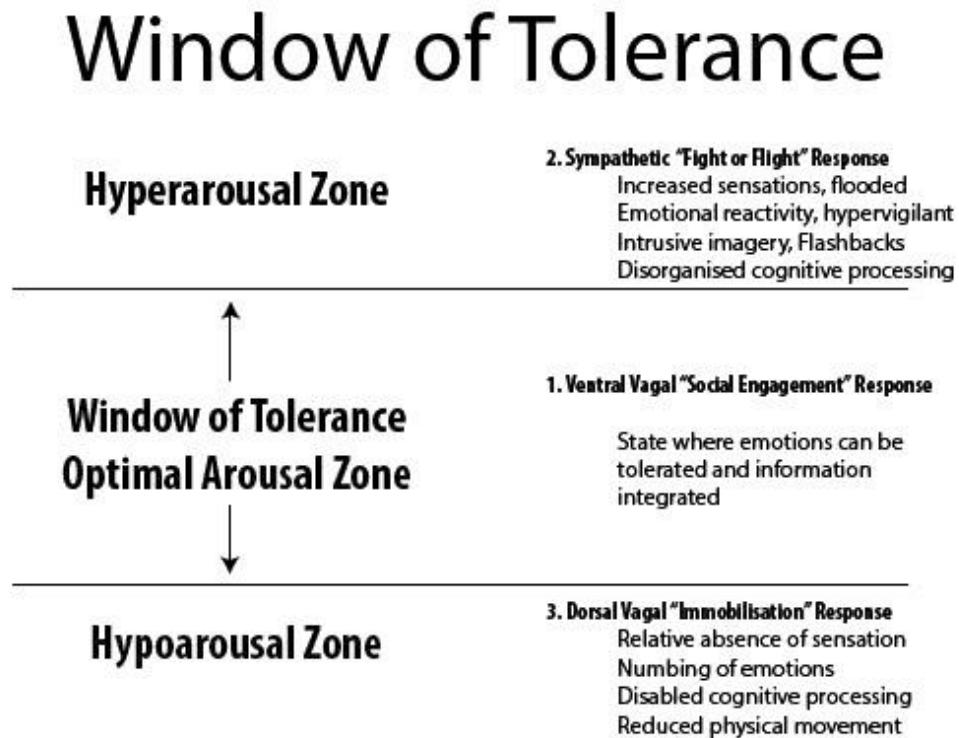
events throughout the individuals' lifespan. It examines the link between attachment types and how these characteristics can be passed from generation to generation.

In terms of susceptibility to PTSD, early development trauma in infancy can play a major role. Infants come in to the world with 'feelings of distress that they are utterly unequipped to manage on their own' (Wallin, 2007, p. 48). Gerhardt (2015) posits that the new-born infant is totally dependent on its caregiver for affect regulation and that physiologically is still part of the mother's body. The mother attends to, and regulates the infant's physiological needs in the early months of life. The mother is almost as one with the infant. She identifies with the baby so strongly it is as if the infant's needs are hers (pp. 38 – 39). The infant is totally dependent on the primary care giver to help them modulate their overwhelming feelings (Wallin, 2007; van der Kolk, 2015).

How this attachment relationship with the mother or primary caregiver develops – whether it is consistent or not, secure or insecure – sets the stage for the way the infant will go on to deal with arousal throughout its life (Bowlby, 1973; Ogden, Et al, 2007). The mother's capacity to regulate the child's hyperarousal and hypoarousal (fight-flight-freeze response) in a secure attachment style facilitates the development of resilience or Window of Tolerance (see Figure 1) in the child to life stressors (Ogden, Et al, 2007, p. 27). This resilience is developed by the primary caregivers – parents – resolving what are to the infant terrifying needs of hunger (producing a bottle or breast), fear (reassuring touch and soothing sounds) or tiredness (being held or stroked) in this brand new environment. As time passes the infant builds a healthy resilience by realising that they

are not abandoned when left for extended periods (Ogden, Et al, 2007, p. 27; van der Kolk, 2015).

Figure 1. Window of Tolerance²



If on the other hand the mother has experienced trauma in the last trimester of pregnancy or up to the first two years of the new-born's life (at a time when the infant's brain is rapidly developing) or if the primary caregiver or mother is not emotionally available or acts in a hostile, violent or rejecting manner to the infant, then the attachment skills of visual contact, touch and listening for stress won't be available to assist affect regulation. Instead of modulating and repairing the distress, the infant is left in a traumatised state.

² Window of Tolerance adapted from (Ogden, Minton, & Pain, 2006, p.27, 32)

The infant is said to have a disorganised attachment style (Main 1995). This means that when the infant is in distress its natural instinct – to turn to the primary caregiver for regulation – is met with more terror and stress (Schore, 2012; van der Kolk, 2015; Wallin, 2007).

Children who experience this developmental trauma through a disorganised attachment style – where the parent is traumatised or is actively violent or abusive to the child – move swiftly from a state of hyperarousal to one of hypoaroused dissociation in an effort to survive (see Figure 1). This disorganised attachment style has a number of signs that help in identifying it. One involves the child initially wanting to be close to the primary caregiver but then they freeze and withdraw from them. Another is the child wanting to be close to the primary caregiver but then avoid contact at the same time. A further sign is the child showing distress and moving away from the primary caregiver. Other indicators include looking dazed and fearful (Main 1995; Ogden, Et al, 2007; Wallin, 2007).

Schore (2012) posits that the ‘overwhelming stress of maltreatment in childhood is not only connected to behavioural issues but impacts on brain development’ (p.62). He further states that ‘During the intergenerational transmission of attachment trauma, the infant is matching the rhythmic structures of the mother’s dysregulated arousal states’ (p. 62) (Howe, 2011). Wallin (2007) cites Main’s research into intergenerational transmission of attachment styles stating that ‘disorganised parents were themselves gripped by unresolved experiences of childhood trauma or loss’ (p. 38).

2.4 Intergenerational Trauma

As an illustration of the intergenerational transmission of trauma Gabor Maté (2012) in his book 'When the Body Says No' cites Morrow's description of intergenerational characteristics of trauma.

'The generations are boxes within boxes: Inside my mother's violence you find another box, which contains my grandfather's violence, and inside that box (I suspect but don't know), you would find another box with some such black secret energy' (p. 216).

Across the literature a number of terms are used to describe this process: transgenerational trauma, multigenerational trauma, historical trauma and intergenerational trauma (McNally, 2014). For the purposes of this review the term intergenerational will be used, as it is the most commonly used term in the literature. One definition of intergenerational trauma suggests it is the impact on a younger-generation family member of the trauma suffered by an older family member whether or not the younger family member was exposed to the traumatic event (Kaitz, Levy, Ebstein, Faraone, & Mankuta, 2009). In other words it can be described as the impact on the mental health of the offspring of the generation who experienced a traumatic event (Holocaust survivors or witnesses to other catastrophic or violent events) (Fargas-Malet & Dillenburger, 2016; Smith, 2012).

Shabad (1993), references Freud's paper on 'Remembering, Repeating and Working-Through' (Freud, 1914/2001), when discussing the compulsion to repeat in the context of

intergenerational trauma. That which has not been worked through, he posits, is passed on to the next generation. He gives the example of a parent being shocked and then berating themselves for repeating a hated behaviour of their own parents with their children. He suggests that it relates to the inability – for whatever reason – of the adult, being unable to access the repressed grief of their childhood experience. Thus they may be doomed to repeat the behaviour intergenerationally. This offers a psychoanalytical perspective of intergenerational trauma transmission.

The review of the literature on intergenerational trauma suggests that considerable research had been undertaken into the impact of trauma on the families of Holocaust survivors (McNally, 2014). Danieli (2016), suggests that for over fifty years the question of whether survivors' experience during the Holocaust and their life circumstances afterward, impacted their children, has been answered. She states, her study empirically demonstrates that this is so, it happens 'primarily through the parents' adaptational styles' (p.8). Conversely a study into the intergenerational effects of trauma in midlife on the offspring of Holocaust survivors posited that although these offspring had witnessed the effects of their parents' trauma, they appeared to have absorbed the resilience of their parents (Shrira, Palgi, Ben-Ezra, & Shmotkin, 2011).

Another study on the intergenerational effects of trauma from terror asserts that some parents, who have experienced PTSD, may have exaggerated responsiveness to their children – for example overprotectiveness and intrusiveness. Their interactions with their children come from a place of hyperarousal and can create a disorganised attachment.

This effect can also occur from a parent who is hypoaroused or in a dissociative state, where they are not able to be present to their children's need for stress regulation. This again can lead to disorganised attachment, creating the susceptibility for future vulnerability to PTSD (Bolton, 2017; Kaitz, Et al, 2009; Fonagy, 2006).

2.5 Northern Ireland

From 1969 up to the Good Friday Agreement in 1998 the political and sectarian violence known as The Troubles or "Conflict (depending on the political perspective) existed. In that period over 3,600 people were killed and more than 40,000 were injured in a civilised society (Fargas-Malet & Dillenburg, 2016; McKittrick, 2007). An Omnibus survey in 2010, discovered that over thirty per cent of the population of Northern Ireland had been directly affected by the Troubles/Conflict (Breen-Smyth, 2013).

Commonplace experiences, prior to the peace process, included being searched going into public buildings and shopping areas, being stopped at checkpoints, being diverted as the result of security alerts and regular media reports of violent events. Hanging over all of these everyday experiences was an ever-present anxiety varying in intensity with the time of year and the nature and occurrence of specific events. For a small country it is highly likely that everyone knew someone who was directly affected (Bolton, 2017).

Fonagy (1999) posits that the traumatic impact of the Holocaust was in no small way due to the fact that it occurred in a society that appeared to be civilised. In that context, it turned on a group within and stripped them of all humanity, dignity and safety. The same

people who treated the Jews in this dehumanising brutal fashion continued to behave normally in other relationships, which added to the cruelty (p.109).

According to a report by the Irish Peace Centre (2010), the intergenerational experience of the Conflict in Northern Ireland corresponds with international trends that have been identified in the research literature. It makes the point that the effects of violence and injustice experienced by a generation, can be passed on to the next generation if not addressed (p. 78).

In the context of the Troubles/Conflict clinical levels of PTSD were found in the children of people who had witnessed the shooting of 13 civilians at the “Bloody Sunday” civil rights march in Derry in 1972 (McGuigan & Shevlin, 2010 as cited by Fargas-Malet & Dillenburg, 2016; Hayes & Campbell, 2000). In terms of identifying the causes of transmission, a number of theoretical positions have been put forward: psychodynamic (the child unconsciously absorbs the effects of the trauma from the parent); socio-cultural (what is traumatically experienced in the family and the greater community impacts on the children); communication (this is relevant to attachment styles and the impact on a child from a traumatised caregiver) (Burrows & Keenan, 2004a; Fargas-Malet & Dillenburg, 2016; Shabad, 1993).

In terms of addressing the impact and transmission of intergenerational trauma in Northern Ireland, it is recognised that in a population of just over 1.6 million the Troubles/Conflict has impacted almost everyone. It is recognised that the majority of

Troubles/Conflict related deaths occurred in socially disadvantaged urban areas (Bolton, 2017; Fargas-Malet & Dillenburg, 2016). A number of projects have been implemented to support people recover from the effects of the conflict as part of the commitment of the 1998 Good Friday Agreement. Some have directly focused on working with the parents and children from both the Catholic-Nationalist-Republican and Protestant-Unionist-Loyalist communities. Their focus has been on addressing the impact of trauma on the parents and their children (Burrows & Keenan, 2004a; Burrows & Keenan, 2004b).

McNally (2014) in his research study 'Transgenerational Trauma and dealing with the past in Northern Ireland' suggests that a large-scale qualitative study be undertaken to explore the life experiences of people who have been traumatised, injured, or bereaved during their childhood as a result of the Northern conflict. He recommends that the study include young people now as well as those who were young during the darkest times of the Troubles (p. 7) Bolton (2017) agrees with this assertion, he states that various groups in Northern Irish society – mental health, community support and criminal justice, are aware of the consequential effects of the Troubles on the subsequent generations.

2.6 Conclusion

In the process of reviewing literature related to the instance of intergenerational transmission of trauma in Northern Ireland and how psychotherapists working in the region experience this, this review has focused on the understanding and impact of trauma and PTSD. It explored the relevance of attachment theory and its neuroscientific implications in relation to possible transmission of trauma/PTSD. It studied the nature of

intergenerational trauma. It outlined a psychoanalytical understanding of the intergenerational transmission of trauma. It discovered that in one study – of adult children of Holocaust survivors – the children of the survivors had developed their parents' resilience to trauma (which would appear to contradict the majority of studies into the impact on children of Holocaust survivor's experience).

From the perspective of Northern Ireland, the researched literature indicates that intergenerational trauma is widely experienced as the result of the Troubles/Conflict. However there is a lack of published research on the instance of intergenerational trauma as experienced by psychotherapists working with traumatised clients in Northern Ireland.

Chapter 3. Methodology

3.1 Introduction

This chapter outlines the aim of this study. It puts forward the argument for taking a qualitative approach to the research. It explains the method used to recruit the participant sample, the method of collecting and analysing the data and the overarching ethical considerations employed throughout this process.

3.2 Research Aim

The aim of this study was to explore the instance and transmission of intergenerational trauma in Northern Ireland, as experienced by psychotherapists working in the field of trauma. Specifically, it has inquired into their knowledge and understanding of intergenerational trauma. It has enquired into their experience of the transmission of intergenerational trauma with reference to attachment and cultural considerations in the context of their clinical practice in Northern Ireland both pre and post the Good Friday Agreement. A detailed review of the literature relating to the instance of intergenerational trauma and its transmission in Northern Ireland indicated there was a lack of research into the experience of psychotherapists working with trauma.

3.3 Research Design and Rationale

This study has adopted a qualitative approach to enquire into the experience of therapists working in the area of trauma in Northern Ireland with specific focus on their experience and understanding of its intergenerational transmission. This approach was chosen to

facilitate a rich, deep and non-superficial understanding of the experiences and processes of therapists working with trauma victims (Harper & Thompson, 2012; Polkinghorn, 2005). A thematic analysis method has been adopted to analyse the data. This technique offers a clear and academically flexible approach to evaluating qualitative information (Braun & Clarke, 2006).

3.4 Recruitment and Sample

As qualitative research is focused on the in-depth analysis of the personal experience of a purposive sample group (Harper & Thompson, 2012), McLeod (2011) recommends five or six participants as a suitable sample cohort. This present study recruited five fully qualified accredited psychotherapists with significant trauma therapy experience in Northern Ireland. Initially the plan was to enlist therapists with at least twenty years practice spanning pre and post the Good Friday Agreement. The rationale for this was that these therapists might have extensive experience of intergenerational trauma in Northern Ireland. Additionally, it was hoped to recruit psychotherapists with a variety of theoretical approaches. The reasoning behind this was the desire to gain as broad a body of experience as possible of therapists working in different modalities with traumatised clients.

The recruitment process used in this study, initially involved researching the Internet for community based organisations across Northern Ireland that were focused on working with trauma victims of the Troubles. Two such organisations were identified and the clinical managers were contacted using email. The email introduced the researcher and

gave a general outline of the focus of the study. After three weeks, having received no reply, follow up contact was made by telephone with the clinical manager of one of the centres. The manager expressed interest in the study, but explained that they would need approval from the organisation's board of management before contacting the therapists working for the centre to see if they would be interested in taking part. The manager requested a more detailed letter (see Appendix 1) to bring to the board, and said they hoped to have an answer in a week's time.

After a week, an email (see Appendix 2) was received that the proposal had been approved and all therapists working for the organisation would be contacted by email to see if they were interested in taking part in the study. After a further two weeks there was no response. On advice from the research supervisor a past student – who had undertaken a previous study relating to the conflict in Northern Ireland – was contacted. This person recommended contacting a psychotherapist who was a trauma specialist in Northern Ireland. An introductory email outlining the nature of the study was sent. The therapist responded positively, and a phone conversation ensued to organise dates and times for a face-to-face interview. To recruit further participants the author spoke with a lecturer in the college who had contacts with therapists working with trauma in Northern Ireland. This lecturer suggested a particular therapist who worked with traumatised clients in Northern Ireland using *Sensorimotor Psychotherapy*. This participant was contacted by email and a follow up phone call to arrange a date and time for a face-to-face interview.

As the early strategy of contacting the trauma centres proved to be less than satisfactory, the author utilised the *snowballing* process. This method of sample generation involves asking each interviewed subject if they can recommend another person who might fit the criteria of the sample (Patton, 2002). This proved successful as the first person interviewed recommended another psychotherapist with extensive trauma experience in Northern Ireland. Unfortunately this participant was unable to recommend another suitable therapist. This sampling method proved to be successful with the other recruited participant and three further trauma psychotherapists were suggested. Again each one was contacted by email and a follow up telephone call. As a result of using these two methods of sample gathering – recommendations from college faculty, and the *snowball* method – five trauma therapists were recruited.

Of the five psychotherapists that were recruited and interviewed for this study two were female and three male. The age profile was between forty-six and sixty years of age. All were originally from Northern Ireland. Two of the participants were ex RUC officers³. All but one had received their psychotherapeutic training in Northern Ireland, three in the Ulster University, one in Queens University Belfast and one in the Anna Freud Centre, University College London. All participants had attained a master's degree level in training. All of the Therapists were accredited, one with the Irish Association of Counsellors and Psychotherapist (IACP), three with the British Association of Counsellors and Psychotherapists (BACP) and one with the Irish Council for Psychotherapy (ICP) (see Table 1). In terms of clinical practice modalities, one

³ (RUC), Royal Ulster Constabulary the formerly named Northern Irish Police Service, now disbanded and replaced by the Police Service of Northern Ireland (PSNI) in 2001.

participant was Humanistic and Integrative psychotherapist, another was Integrative and used Eye Movement Desensitization and Reprocessing (EMDR), one was a Sensorimotor Psychotherapist, another was a psychoanalytic psychotherapist and the last one was a psychodynamic psychotherapist. Their experience of clinical practice ranged between eleven and twenty-six years. Their experience of working with trauma ranged from eight years to thirty-three years (one of the participants had worked as a social worker for seven years prior to qualifying as a Psychotherapist)(see Table1).

Table 1: Demographic chart

Participant Pseudonym	Age	Gender	Training	Therapeutic Orientation	Accreditation Body	Years In Practice	Practice Northern Ireland	Years working with Trauma
A. Mary	60	Female	Ulster University	Integrative	IACP	25	25	25
B. Danny	59	Male	Ulster University	Integrative EMDR	BACP	18	18	18
C. Gerry	58	Male	Ulster University	Sensorimotor Psychotherapy	BACP	11	11	8
D. Tim	59	Male	Queens University Belfast	Psychoanalytic	ICP	26	33 ⁴	33 ⁴
E. Alice	46	Female	Anna Freud Centre University College London	Psychodynamic	BACP	21	18	18

⁴ Worked for seven years as social worker

3.5 Data Collection

Data for this study was obtained using audio-recorded, face-to-face, semi-structured qualitative interviews. Two of the interviews took place using Skype – an Internet based live video conferencing software program. These Skype Interviews were conducted at a prearranged time and in a private secure environment. Both parties, prior to the interviews, agreed to this. The balance of the interviews took place face-to-face in the respective therapists therapy rooms. Each interview lasted between fifty to sixty minutes, and was pre agreed with each therapist. Additional information was gathered using a demographic questionnaire (see Appendix 6).

The structure of the interviews and the use of open-ended questions (see Appendix 3), allowed space for the participants to elaborate and were used loosely to collect data. McLeod (2003) suggests that this qualitative process of interview can allow for meaningful and detailed information to be collected. The objective of this interview style was to elicit an understanding of the lived experience of the sample group of psychotherapists and to understand the meaning they attribute to their experience (Seidman, 2006). The semi-structured interview format allowed for flexibility, which could facilitate the inclusion of topics and questions that were unforeseen when forming the original questions for the interviews, thus allowing for a richer quality and amount of data.

3.6 Data Analysis

A thematic analysis approach was used in this study, as the method of examining the data collected from the five interviews. Braun and Clarke (2006) suggest that as a result of ‘its theoretical freedom, thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex, account of data’ (p. 78). It has been used in this study to identify, analyse and offer patterns, which emerged from the data (Braun & Clarke, 2006). In the context of the analysis of the data, a theme is considered to be ‘something important about the data in relation to the overall research question and represents some level of patterned response or meaning within the data set’ (Braun & Clarke, 2006, p. 82). Thematic analysis in this research project has identified through the process of initial coding of the data, patterns that lead to specific themes (see appendix 7).

Coding resulted from the verbatim transcription of the five audio interviews. This time consuming process, of typing and listening, then reading and re-reading the individual transcriptions, facilitated an in-depth familiarity of the data. Emerging codes were numbered in five columns, A, B, C, D and E, (representing the five transcribed interviews) (see Table 2, and Appendix 7).

Each of the columns of codes was examined and common themes of the therapist’s experience relating to the overall research question were identified. As this process evolved, due diligence was maintained to ensure the emerging data was not being coloured by either personal bias or the information discovered in the review of the

relevant literature above. A large number of themes emerged and were refined down to three that spoke to the aim and objectives of the study.

Table 2: Sample of Coding

<i>A</i>	<i>B</i>	<i>C</i>	<i>D</i>	<i>E</i>
1. Personal traumatic experience 2. Personal journey therapy 3. Skills for working with trauma 4. Training 5. Body 6. Traumatized community	1. Reason for working with Trauma 2. Personal traumatic experience 3. Coping strategy in police 4. Hurt feelings Psychiatrist?	1. Reason became therapist 2. Early trauma work 3. Sensorimotor modality 4. RUC career helped 5. De sensitised? 6. Tribal language	1. Reason therapist 2. Social work practice 3. Psychoanalytic approach 4. Repeat to remember to change 5. Client example of trauma	1. Reason therapist 2. Reason trauma MA child psychotherapy 3. Resilience 4. Own childhood brushed under carpet 5. Psychodynamic therapy

3.7 Ethical Considerations

The ethical considerations for this study firstly involved approval from the Dublin Business School ethics committee. All of the five participants were informed of the nature and focus of this study. Each participant was given an information form that outlined the focus of the study (see Appendix 4). As practising psychotherapists in Northern Ireland they were not considered to be vulnerable participants. It was explained that participation was totally voluntary and they could withdraw at any time without reason. They were informed of the format and expected duration of the interviews. Anonymity was explained in detail, all identities or information pertaining to any

individuals would be anonymised, coded and kept in a locked file. All data collected – written and audio – would be again be coded and kept on a password protected computer. Once the audio interviews were transcribed the files were deleted. Two of the participants expressed concern about client identity due to the public nature of what had happened to them. Another interviewee expressed concern about the name of the organisation they worked for being mentioned in any way. They were reassured that all of that information would be anonymised.

Each of the participants was allocated a pseudonym and a code to assure anonymity. Names, locations and organisations were removed from the transcribed interviews. Consent forms (see Appendix 5) were provided and gone through with each participant. Each individual confirmed that they had read the information leaflet, understood the voluntary nature of the study and that they could withdraw at any time. They understood that their identity would remain anonymous at all times. They were made aware of the possible risks of the study. They were made aware that the interviews would be recorded and each person received a copy of the information leaflet and consent form for their own records.

3.8 Summary

In order to study the instance and transmission of intergenerational trauma in Northern Ireland, as experienced by psychotherapists working in the field of trauma, the methodology for this qualitative research utilised a thematic analyses approach. Five psychotherapists were recruited with extensive trauma therapy experience in Northern

Ireland. Semi-structured interviews were used to collect the relevant data. At all times in the process of working with the participants and the collected data proper ethical standards were applied and adhered too.

Chapter 4. Findings

4.1 Introduction

This chapter explores the findings from the semi-structured interviews used in this qualitative research study. Five accredited psychotherapists with extensive experience of working in the field of trauma in Northern Ireland were interviewed in this process. All of the five psychotherapists came from different modalities: humanistic integrative; integrative EMDR; sensorimotor psychotherapy; psychoanalytical psychotherapy and psychodynamic psychotherapy. Their range of experience and modality approaches brought a rich variety and depth of experience to this studies focus.

Four of the five interviewees spoke of having had personal traumatic experiences in their past which led them into working with Trauma. Mary spoke of witnessing her mother being shot through the window of their house – by a British Army soldier – when she was a young girl. Danny spoke of the terrible trauma of his wife completing suicide, he also mentioned that as an RUC officer he had been ‘blew up a few times and shot once’. Gerry spoke of the cumulative traumatising effect of working with terrorist atrocities during his time as an RUC officer. Tim explained that ‘a friend completed suicide at school’. He believes this experience unconsciously led him to volunteering with the Samaritans, which ultimately led him to train as a psychoanalytical psychotherapist and work with trauma victims. The participant Alice alluded to a childhood experience being ‘brushed under the carpet’ as a motivator in her choosing a career working with

traumatised people. They all differentiated between the work they had done with general trauma and trauma related to the Troubles in Northern Ireland.

The interviews with these participants were transcribed and codes were developed using the thematic analysis process. A number of themes emerged relating to their experiences of the instance and transmission of intergenerational trauma in Northern Ireland. These emerging topics were condensed into three themes:

1. The experience of working with trauma in Northern Ireland.
2. The experience of trauma pre/post the Good Friday Agreement.
3. The instance of intergenerational trauma in Northern Ireland.

4.2 Theme 1: The Experience of Working with Trauma in Northern Ireland

The theme of the psychotherapist's experience of working with clients experiencing trauma in Northern Ireland was apparent in all five of the interviews conducted in this study. Participants outlined their training, background, personal experience and understanding of working with trauma. They all described their initial training as inadequate and were ill prepared for what was to present in their practice. It was evident that each participant assumed the researcher had knowledge and an understanding of the pre-peace-process troubled landscape of Northern Ireland.

Mary outlined her personal journey of working with traumatised clients. She explained, ‘I went through a general training in therapy which lacked particular focus on trauma.’ She said, that she undertook a number of postgraduate trauma focused courses, as well as ‘a lot of personal therapy’ to deal with her own traumatic experiences. She said she likes to stay informed and reads lots of books and articles on the subject, she made specific reference to Bessel van der Kolk. She described her experience of working with trauma in Northern Ireland.

Mary: ‘What have I come in touch with? Awful things that I haven’t shared with my supervisor, because I felt they were too awful for me to describe. I didn’t want to traumatise him. People sharing about walking over parts of limbs after a bomb or during bombs! Those sorts of things, that are horrific’.

Mary recounted the impact of a traumatic event on her.

Mary: ‘I was invited to go to Omagh, to work with the people who were affected, I couldn’t, I was actually traumatised by it. I wouldn’t have been any help. I had to take a few months out to cleanse myself of that. I mean twenty years on, I still see people who come up from Omagh, who were traumatised by that experience, they are still trapped in the traumatic event.’

Danny in addressing his training for trauma work stated.

Danny: ‘Part of my foundation training, was two weeks of training on PTSD. That makes me a *trauma expert*; I’ve found that’s not a very wise way to think. I thought that was quite shocking, for those of us in the North given our history. I also did an MSc in psychological trauma management. ... There are six and a half million people on the island and only fifty of us have studied trauma at that higher level. One of the great things is that it forced you into reading - Bessel van der Kolk, Peter Levine, and Ogden.’

Tim gave an example of how he had worked with individuals who were traumatised in the Troubles. He stressed the importance of explaining that the PTSD symptoms they were experiencing were ‘normal’ considering the circumstances.

Tim: ‘I could meet someone for the first time and give them a list of what I would expect them to be going through, and at the end of it say, you are experiencing the

normal reaction to an abnormal event, and if that is all that people took away ... they might hopefully take an initial step from pathologizing their experience.'

Alice in dealing with the theme of trauma and traumatised clients spoke about her psychodynamic relational therapeutic approach.

Alice: 'Trauma, it's an injury to the self, the self has been fractured in an overwhelming way. The work we do is trying to restore a sense of identity ... You are generally easing that person into the present, in the relationships that are there. I've found, in all the people I've worked with, the main thing that moves them forward is the relationship.'

Danny explained his technique of working with traumatised clients using EMDR.

Danny: 'We were meeting people with chronic PTSD who'd been blown up several times, shot at, and subject to punishment beatings. ... Normal therapy wasn't working. My clinical supervisor said there's this thing called EMDR. With this protocol there is a thing called *blind to therapist* ... if you (client) can bring up a traumatic memory in your mind, and you can feel some kind of disturbance in your body - you don't need to tell me what it is. It's a much more compassionate way to work ... No re-traumatizing.'

In recounting his experience of working with trauma as a psychotherapist in Northern Ireland, Gerry stated that his previous career as a police officer helped him.

Gerry: 'My previous career was actually a huge bonus in the area. I was around the Troubles so much in my history. I was familiar with the nuances of paramilitary organisations and their structures. ... I have had a lot of experience of being around very difficult and traumatic situations. In fact there wasn't a lot, or very little, that would have shocked me - in the sense of somebody describing their traumatic experience to me.'

Alice expressed the importance of context regarding trauma and that trauma in Northern Ireland is multi layered and complex.

Alice: 'Lots of families live in areas where there would have been a lot of trauma in the home, and outside the home, violence and threats of violence - even today repeated media violence - They turn on the TV and there's something from 1970. Instantly they are back there - re-traumatized. There are so many layers of trauma here. It's a whole culture of violence that pervades everything, and perpetuates a culture of fear. In terms of moving on from trauma, that's incredibly hard. ... You have to take into account the whole context.'

4.3 Theme 2: The Experience of Trauma Pre/Post the Good Friday Agreement

In all five interviews the therapists shared their experience of trauma, both pre and post the Good Friday Agreement. A number of sub-themes emerged. All of the participants agreed that there was a noticeable increase in Troubles related trauma referrals for therapy. Some noted the paradox of peace and *held-trauma*. One participant posited that the increase might be related to increased resources and availability of therapy. The challenge of dealing with trauma Post the Good Friday agreement was also discussed. Another sub-theme highlighted the traumatising violence of punishment shootings. Intergenerational tribal culture and its traumatising impact on society, was mentioned by a number of interviewees.

All interviewees commented on the increase of trauma referrals to therapy.

Mary: ‘Things are different since the peace process there is a lot more trauma coming to light now.’

Tim: ‘When the bounds of conflict changed and social cohesion wasn’t either necessary or obvious trauma could start to express itself in some people’s lives, because they lived in fight or flight and they were able to function in particular ways and then poof, over a relatively short space of time their lives fell apart.’

Gerry: ‘In one way it was paradoxical, because we were supposedly in a much more settled environment but not really. People started to come out of the woodwork.’

Danny: ‘The numbers have gone up you know since the Good Friday Agreement, but I still believe we are only at the tip of the iceberg.’

Alice had a slightly different take on the increase in referrals for troubles related trauma.

Alice: ‘In terms of post Good Friday agreement, there are a lot more people accessing services. Possibly because there is a lot more funding available now, and a lot more services providing it. There’s still a lot of work to be done.’

A number of participants referred to the impact of the on-going traumatic violence in communities post the Good Friday agreement.

Tim: 'I was reading there you know that at least sixty people have been killed post Good Friday Agreement. A lot of that was paramilitary groups that were at war within themselves. ... It's not inter community. There also have been punishment shootings.'

Danny: 'I work with someone who was shot through the hips, knees and ankles ok, this gentleman was conscious when they started this. This was done to him three times. So three times the brutality of being shot through the knees, hips and ankles. His legs were a mess. He was in a wheelchair, and he was in constant pain. The people who did it to him lived in the same street as him. They would see him go up and down the street in his wheelchair and they laughed at him.'

Gerry: 'I have a number of clients, who are – here-and-now – in local paramilitary scenes, and they have been the subject of punishment shootings – all of that is still very active.'

The interviewees addressed the traumatic impact of the tribe and tribalism that is evident socially and culturally in Northern Ireland.

Mary: 'Our society is traumatised; it's a really sick society that we have had, and still have. I would imagine that everybody has been touched by trauma.'

Gerry discussed the societal impact of the window of tolerance regarding trauma.

Gerry: 'I took that window of tolerance model, and applied it to the Northern Ireland community. It's a really interesting reference point. There are times in recent history, about a year ago, there was a series of street protests that were connected to the flag issues. When something like that happens, this very visible demonstration of tribalism, connected with flags, our window of tolerance as a community narrows. There is such a fragile resilience in some of the communities. These things will bring people into therapy.'

Gerry went on to highlight the impact of traumatic architecture in parts of Northern Ireland.

Gerry: 'There are still lots of menacing murals around in these enclaves. There is still demarcation. The red white and blue paint on the end of footpaths, and the green white and gold on the ends of other streets marking out territories, big walls with razor wire dividing communities - is still the visual architecture in these areas. These are the things that remind you of who you are and where you are. So

there may not be the sound of gunfire or riots but it's still there visually, it's in the community, it's in the DNA.'

Gerry went on to discuss possible cultural changes post the Good Friday Agreement relating to dealing with trauma.

Gerry: 'The culture in the past in Northern Ireland has been a very closed one. The catholic community had been a lot more cohesive in how they dealt with their internal pain – they have a very strong sense of community. Now, that is somewhat fractured. A lot of the nationalist catholic community have gone into therapy, more than they would have in the past. In the past they would have sought solace through the church and religion. The protestant community has always been quite fragmented, and has always felt quite under threat. It is no surprise to me that they are now coming to therapy. So there are a lot of cultural nuances.

Gerry went on to elaborate on culture and community changes pre to post the Good Friday Agreement.

Gerry: 'As a community, the way of going was, just get on with it, keep your head down. There was the culture of - don't talk openly about politics or all of that stuff. Post Good Friday it's opened that up. I was amazed, at the ex-terrorist clients that I had. They were my most tender encounters - with these men who had committed some awful things. When you heard their history - some were given up by their family particularly in protestant paramilitaries. Families had to give up at least one son.

Alice discussed the challenges that change brought for traumatised individuals and communities post the Good Friday Agreement.

Alice: 'People had to hold it together, the polarisation in communities held it together. They had a sense that we must stay together; we must get through this together, like in survival mode. When you're in survival mode your mind focuses on one thing. Once things start to change, to open up, things are completely different. Your cognitive ability comes back online it changes. When this happens for people when a lot of the realizations happen, why did I believe that? Why did I get involved in that? What was I thinking of? But when they are in survival, fight/flight/freeze mode, it's totally different.

Alice: 'It's a very fragile place you know particularly in Northern Ireland. It's about having to separate out what you know and what you've been told by other people. It's an incredibly painful process - to ask yourself, your own questions,

rather than depending on the tribal answers. It's very difficult, very challenging and could provoke illness.'

4.4 Theme 3: The Instance of Intergenerational Trauma in Northern Ireland

In the interviews with the five psychotherapists, again a number of sub-themes emerged in relation to their experience of the instance of intergenerational trauma in Northern Ireland. Sub-themes that surfaced relating to the intergenerational transmission of trauma included the impact of attachment, community, culture and tribe in the susceptibility to trauma. And lastly, Alice and Tim broached the concept of repetition in relation to the intergenerational transmission of trauma.

Mary and Danny addressed the issue of attachment in relation to trauma and the implications for immediate family members and Tim and Danny addressed the conscious and unconscious tribal games.

Mary: 'I think people who have been traumatised, are locked into their own pain, they feel very isolated and marginalised from the community, they find it very difficult to make connections. Making attachments with their children, wives, husbands, or mothers is very problematic.'

Danny: 'Of course there would be attachment issues because the parents themselves were under such stress. How could they be otherwise? There were all the other games that went on for children growing up. Like what school did you go to, and all the other questions people would ask to find out what religion you were, what tribe you came from.'

Tim: 'The radar is there, it doesn't necessarily mean that its accurate, but you know, we will often consciously and unconsciously place people on the basis of words, or a look, a name, or location, or school or college.'

Mary continued with an example of her experience of intergenerational trauma in Northern Ireland.

Mary: 'a client, whose father was killed. He was killed when she was a very young child. He was never talked about since. *Don't talk about him he was a policeman.* So the shame of that, the, *don't say your dad's a policeman,* is the way they were brought up. The children in that family were brought up with secrecy, lies, and shame. That had a huge impact on her as an adult. The trauma was passed down through the shame.'

Danny shares his experience of working with the children of traumatised parents.

Danny: 'Now we are working more with the children of people who were in the actual traumatic events. I think it could be epigenetic. As a consequence of their early experience at home they develop hyper-vigilance.'

Danny: 'You know kids as well as I do, If you're feeling threatened or on edge you won't have to say anything, your kids will pick that up. That can be even more traumatizing for the kids. Children don't know why mummy and daddy are worried, they just pick up the signs from mummy and daddy.'

Danny continued by referencing a generation of clients who had not experienced an actual traumatic experience, but who were presenting with PTSD symptoms.

Danny: 'I think this is the elephant in the sitting room, and I only work with trauma. We're talking about a generation who didn't experience the actual violence but are now presenting with PTSD symptoms.'

Gerry offered his experience of the instance of intergenerational trauma post the Good Friday Agreement in his work in Northern Ireland.

Gerry: 'Yes very much so, and in a couple of ways directly noticing that from clients who had been involved in the Troubles you know as direct victims or protagonists. They generally bring fractured relationships, kids who have been damaged by what they (their parents) were involved in or what happened to them. The family environment is either dysfunctional or not very healthy. The parents have a limited capacity for nurturing and caring, which definitely impacts the children. And I see it from that generation who's mum or dad were caught up in the Troubles and they come with loads of stuff, and generally they don't associate it initially with Troubles related trauma.'

Tim spoke about how from his psychoanalytical perspective, tribalism in Northern Ireland is a conduit for intergenerational trauma – it is built into the unconscious.

Tim: ‘Because I work psychoanalytically somebody’s thoughts about me, and my world, is often my access point into the bits of their lives. They will be curious about me and my life, what it is, what it involves, what I think about things, my community allegiance – and people will be very curious about that, and they will wonder about that. That would be a classic psychoanalytical way of working with transference and countertransference. This is a key source of material. People will be curious about all sorts of bits about my life, but every July, [village] will be decorated with flags and bunting, and most of the people I would work with, would drive through the village to get here, so they will have driven through the flags and bunting, but not one person has ever allowed themselves to be curious about what I think of all that.’

Alice spoke about her understanding of intergenerational transmission of trauma in Northern Ireland.

Alice: ‘Here it’s definitely transgenerational. It’s how we cope with things that are passed down. In the sense that an overwhelming event has happened that we don’t talk about, we all know it’s there, and then their parents are coping in ways that are shaped by their trauma, and that’s really what the children pick up. In terms of the context, realistically if those parents were caught up in the conflict, and were still living in that environment, and you know there’s still a lot of the political side of that held onto. So obviously the children are locked into that environment. They (parents) are locked into being a victim or a perpetrator. The children are living the legacy of their parents chosen situation, or what they have been through that they didn’t choose. The children have not a lot of choice. It’s the family they were born into. So that’s the sort of complexity that we are dealing with from a transgenerational perspective.’

Alice continued explaining her understanding and experience.

Alice: ‘there are so many unspoken aspects of it. I know, I have heard people talk about witnessing horrendous things here in Northern Ireland, and just not being able to talk about it. Like physically, just not being able to talk about it, for fear, or terror. I think it had to do with the Omerta type situation that exists. It’s an environment of secrecy, silence, we don’t talk to anybody whichever part of the political situation. And of course you know innocent victims who witnessed terrible things, it has a huge impact on them and their families’

The sub-theme of repetition emerged from two of the interviewees, Tim and Alice – how repetition relates to the intergenerational nature of trauma in Northern Ireland. Tim spoke

of his psychoanalytical understanding of intergenerational trauma in Northern Ireland.

Alice gave an example of the Freudian concept of repetition as a catalyst for eventual change.

Tim: 'In terms of intergenerational trauma, I suppose I think of Freud and what I learned about the compulsion to repeat. Freud spoke about remembering, repeating, and working through. We repeat to remember. Basically what we don't speak about we repeat. That became a depressing thought when it was applied to here, in that I thought that's us screwed.'

Alice: 'You know what I said about children growing up in a home where you know there had been traumatic experiences, it's well documented how it travels down families. If you have been brought up in it, you're just going to repeat the pattern until finally, there is a point where they realise that there must be something different out there. They begin to question the norm of how they have been brought up, but not everyone lives like this. But you know people repeat what they have experienced. I think we're talking about Freud there, people keep repeating until the experience something different. You know, so that's the whole layer where trauma gets passed on. It gets handed down until somebody's willing to think there's something different.'

Chapter 5. Discussion and Conclusion

5.1 Introduction

This Chapter discusses the findings from the previous chapter in the light of the literature reviewed in chapter two. In the conclusion, the strengths and limitations of this study are explored and possible areas for further research are suggested.

The aim of this study was to explore the instance and transmission of intergenerational trauma in Northern Ireland, as experienced by psychotherapists working with trauma. The review of the literature indicated that intergenerational trauma is widely experienced in Northern Ireland (McNally, 2014), however it became apparent that there was a lack of research into the experience of psychotherapists working with trauma and intergenerational trauma in Northern Ireland.

As the result of using thematic analysis, three broad themes emerged from the interviews with the five Northern Irish trauma focused psychotherapists. Theme one dealt with the experience of working with trauma in Northern Ireland. A number of sub-themes were identified. The participants discussed their training, background, personal experience and understanding of working with trauma. Theme two addressed the experience of trauma pre and post the Good Friday Agreement. Sub-themes relating to the increase in trauma referrals post the Good Friday Agreement, the challenges of dealing with trauma and the impact of continuing violence post the Good Friday Agreement were identified. Theme

three focused on the instance of intergenerational trauma in Northern Ireland. Sub-themes that emerged included the impact of attachment on the transmission of trauma, the influences of community, culture and tribe, as factors in the susceptibility to intergenerational trauma. Repetition as a psychoanalytic concept was discussed in relation to the transmission of trauma.

5.2 Theme 1: The Experience of Working with Trauma in Northern Ireland

In describing trauma, Rothschild (2000) suggests that the root of trauma is stress. Trauma can be said to involve a powerful physical and or psychological damaging effect. Someone who has a direct traumatic incidence can be said to experience the fear of immanent annihilation (Rothschild, 2000; Burrows & Keenan, 2004b).

A traumatic experience has an impact on the body and mind, whether there has been an actual physical injury or not, it is a psychophysical experience. Trauma does not just entail the overwhelming experience of the event, it also imprints on the mind, body and brain as the result of the experience (Rothschild, 2000; van der Kolk, 2015). In the findings, four of the interviewees recounted personal traumatic incidents, which influenced their decisions to work in the field of trauma. One participant, Mary, described the traumatising impact of hearing clients share harrowing experiences. She also recounted her traumatic reaction to the Omagh bomb in 1998.

Post-traumatic stress and post-traumatic stress disorder (PTSD) occur where the distressing symptoms persist long after the traumatic event. With post-traumatic stress,

symptoms dissipate gradually, and the individual has the capacity to self-regulate, without experiencing any long lasting effects. PTSD on the other hand results when the individuals' fight-flight-freeze response does not return to equilibrium. The brains' smoke detector, the amygdala, gets stuck in the stress response. This results in a myriad of distressing and confusing symptoms for the individual (Herman, 2001; Levine, 1997; Rothschild, 2000; van der Kolk, 2015). Early PTSD symptoms can include, hyper-vigilance, intrusive thoughts, dissociation, flashbacks, nightmares, sudden mood swings, insomnia and an inability to deal with stress, to name a few (American Psychiatric Association, 2013; Burrows & Keenan, 2004b; Kring, Johnson, & Davidson, 2014; Levine, 1997; Ogden, Et al, 2007).

Three of the participants described their way of working with traumatised clients. Tim outlined the importance of reassuring the client experiencing distressing PTSD symptoms, that they were 'experiencing the normal reaction to an abnormal event'. He believed that by explaining this it helped reduce the possibility of further pathologizing their experience. Danny described the body-oriented approach of EMDR, which focuses on regulating the fight-flight-freeze response. He explained that in using this modality, the client is not required to recount traumatic details to the therapist, thus greatly reducing the risk of re-traumatizing the client (Levine, 1997).

Another participant, Alice, employs a psychodynamic relational approach to trauma. She understands trauma to be an overwhelming injury to the self. She suggests that the essence of the work is to restore a sense of identity through relationship in the here-and-

now. She highlighted the importance of context and cultural complexity, which she stressed is multi-layered, when working with trauma in Northern Ireland. From a psychodynamic perspective, a traumatic experience or event in a culture, community, or indeed a family may be unconsciously absorbed and passed on to the next generation (Burrows & Keenan, 2004a; Fargas-Malet & Dillenburg, 2016; Shabad, 1993).

5.3 Theme 2: The Experience of Trauma Pre /Post the Good Friday Agreement

In the political and sectarian violence that took place in Northern Ireland from 1969 until the Good Friday Agreement in 1998 over 3,600 people lost their lives and more than 40,000 were injured. This all took place in an ostensibly civilized society where (for the most part) daily life continued in spite of it (Fargas-Malet & Dillenburg, 2016; McKittrick, 2007). A 2010 survey reported that over thirty per cent of the population were directly affected by the violence of the Conflict. In the context of the population of Northern Ireland, it is highly likely that everyone knew someone who was personally affected by the Troubles (Bolton, 2017; Breen-Smyth, 2013).

It emerged from the findings that all of those interviewed recognised a marked increase in individuals accessing therapy for trauma related issues since the beginning of the peace process. It was noted, that it seemed paradoxical, that post the Good Friday Agreement there should be an increase in trauma referrals. One interviewee, Gerry, suggested it was held-trauma, which had been repressed until it was safe to let it surface. Another

participant, Alice, proposed the increase in accessing services might be related to the increased funding and availability of therapeutic services in the community.

Three interviewees referred to the on-going traumatic violence in certain communities – particularly “punishment shootings and beatings” – and how this was perpetuating and re-traumatising in these communities. Two participants suggested that society in Northern Ireland is traumatised as a result of the historical violence and by the on-going unresolved cultural issues that raise their heads from time to time. Gerry, using the example of the flag issue that arose in the past couple of years, applied Ogden’s (2007) Window of Tolerance model (see Figure 1). He suggested that this highly visible demonstration of tribalism had caused the communities’ Window of Tolerance to narrow. ‘This reduced resilience brings people into therapy’ (Ogden, Et al, 2007; Schore, 2012).

Gerry further highlighted the impact of traumatising architecture that is evident across Northern Ireland post the Good Friday Agreement, which is located primarily in disadvantaged urban areas. He referred to the dividing walls between communities, topped with razor wire, the menacing murals and the painted footpaths (red white and blue, and green white and gold) in both communities. He suggested that the riots and gunfire may be gone, but the violence is still there visually in the communities – ‘its in the DNA’. This is not surprising, considering that the majority of Conflict deaths occurred in these socially disadvantaged environments (Bolton, 2017; Fargas-Malet & Dillenburger, 2016).

Two of the participants referred to cultural shifts that have emerged in dealing with trauma in Northern Ireland, post the Good Friday Agreement. Gerry suggested, that in the past there was a very closed culture in Northern Ireland. He believed that during the Troubles, the nationalist catholic community were cohesive in dealing with pain. He suggested that this community is quite fractured now. In the past (pre the Good Friday Agreement) they depended on the church for support and solace. Presently, a lot of that community are accessing therapy. Gerry suggested that the protestant community have always been somewhat fragmented and felt under threat. He said they are also accessing therapy in bigger numbers. He stressed there are a lot of cultural nuances to be aware of in post the Good Friday Agreement.

Two participants suggested that for the most part the way communities dealt with trauma in the pre Good Friday Agreement period was to 'just get on with it' and 'keep your head down'. 'People had to hold it together,' they were in survival mode and in survival mode they had singular focus. There was a culture of silence. Gerry recounted being told by ex-loyalist-terrorists clients that in the protestant communities families had to give up at least one son to the cause.

Fonagy (1999), in an article discussing the traumatic effect of the Holocaust, posited that the enormous impact of it resulted in no small part from the fact that it occurred in a so-called civilised society. Daily life went on as 'normal', while a group of citizens were being persecuted and stripped of their humanity, safety, and dignity. To some extent, it can be argued, that in the pre Good Friday Agreement Northern Ireland, in some

communities, normal life – albeit in a ‘getting on with it’, the ‘keeping the head down’ way – carried on in the midst of terrible traumatising experiences.

According to Alice, once the peace process began and change started, peoples’ cognition came back on line. People started to ask questions, ‘Why did I believe that? Why did I get involved in that? What was I thinking of?’ Alice suggested that they had been in stress response, a state of fight-flight-freeze (Herman, 2001; van der Kolk, 2015). She stated, that post the Good Friday Agreement, Northern Ireland was a very fragile place. She suggested that it is a very painful process for individuals, to begin to make sense in relation to what they know, and what they were told to believe. She suggested that to break out of one’s tribal position is very challenging and difficult and can provoke illness.

5.3 Theme 3: The instance of Intergenerational Trauma in Northern Ireland

Primarily, the concept of intergenerational trauma has been researched in relation to the Holocaust. Studies have empirically demonstrated that the experience of holocaust survivors and what happened to them in their lives afterward, has impacted their children (Kaitz, Levy, Ebstein, Faraone, & Mankuta, 2009). Intergenerational trauma has been shown to occur through the parents’ style of adaptation (Danieli, 2016). Conversely, a study that focused on the intergenerational effects of trauma in midlife on the children of holocaust survivors proposed that in spite of the offspring having experienced the effects of their parents’ trauma, they had in fact taken on the resilience of their parents (Shrira, Palgi, Ben-Ezra, & Shmotkin, 2011).

In the discussion in theme two above, the loss of human life, and the suffering that resulted from the Conflict was referred to. In excess of thirty per cent of the population was directly affected, in a country with a population of just over 1.6 million, which had an enormous impact on society as a whole (Fargas-Malet & Dillenburg, 2016; McKittrick, 2007; Breen-Smyth, 2013). A study of the children of individuals, who had witnessed the shooting of 13 civilians in Derry on “Bloody Sunday” in 1972, found that there were clinical levels of PTSD evident (McGuigan & Shevlin, 2010 as cited by Fargas-Malet & Dillenburg, 2016; Hayes & Campbell, 2000). The Irish Peace Centre (2010), in a report, acknowledges the intergenerational experience of Conflict related trauma in Northern Ireland. It is also noted that both community and state organisations are aware of the intergenerational effects of the Troubles (Bolton, 2017).

A definition of intergenerational trauma suggests that it is the impact on a younger-generation family member of the trauma suffered by an older family member - whether or not the younger family member was exposed to the traumatic event. It is also described as the impact on the mental health of the offspring of the generation who experienced the traumatic occurrence. (Fargas-Malet & Dillenburg, 2016; Kaitz, Levy, Ebstein, Faraone, & Mankuta, 2009; Smith, 2012).

In terms of the participants’ experience of the instance and transmission of intergenerational trauma, two discussed their experience of attachment, and two discussed the impact of tribal awareness as a traumatising factor in Northern Ireland. Attachment theory proposes that healthy infants with good enough parents learn to

regulate their feelings of distress by being reassured and regulated by their primary carer (Wallin, 2007; Gerhardt, 2015). The nature of this attachment relationship, whether it's secure or insecure, will dictate how the infant will go on to deal with arousal throughout its lifetime (Gerhardt, 2015). The mothers' capacity to regulate the infants hyper or hypoaroused state – their fight-flight-freeze response – will dictate the depth of their Window of Tolerance (see table 3) (Bowlby, 1973; Ogden, Et al, 2007). Mary, one of the interviewees, stated that in her experience where a mother has experienced a traumatic event, her capacity for attachment with her children and family are very problematic. Danny: suggested 'how could there not be attachment issues, when the parents were experiencing such high degrees of stress'.

Three of the therapists referred to the tribal sensitivities, or the cultural “radar” of the communities involved, the conscious and unconscious checking out that is constantly on. Questioning who others were, what schools did they go to? How they looked, what their name was, did they belong to your tribe, all of this awareness involved being in hyperaroused state (Ogden, Et al, 2007; van der Kolk, 2015). One of the participants, Tim, who works psychoanalytically, explained that of all the things clients show transference curiosity about, they never allude to, or enquire about, his religious or political allegiance, in spite of the fact that he lives beside a village that in the summer months is quite clearly decked out in the flags and bunting associated with a particular culture.

From a neuroscientific perspective, the intergenerational transmission of attachment trauma occurs when the child is matching the mother's dysregulated arousal state (Ogden Et al, 2007; Schore, 2012). Also, overwhelming stress or trauma in early childhood has implications for brain development, as the capacity for self-stress regulation is imprinted in the developing brain (Schore, 2012; Howe, 2011).

According to Wallin (2007) disorganised parents were themselves trapped by unresolved childhood traumatic experiences. Two of the participants gave examples of working with children of individuals who were traumatised by events in the Conflict. Both explained that as a result of the child's early experience at home they had developed hyper-vigilance (Ogden, Et al, 2007). They continued, suggesting that children in any case are highly attuned to their parents' emotional state, so if a parent is traumatised the children will be pick up on that and internalise it. Gerry suggested that this was particularly true in the case of children whose parents had been actively involved in the Troubles. Another therapist Danny referred to a generation of clients who had never experienced an actual traumatic event but who non-the-less were presenting for therapy with symptoms of PTSD. He stated, 'I think this is the elephant in the sitting room'.

Continuing with the experience of intergenerational transmission of trauma in Northern Ireland, interviewee Alice suggested how people cope with things that are passed down is important to be aware of. She spoke about how often the overwhelming traumatic event is not spoken about. Parents cope with it in ways that are shaped by their experience of the trauma. That is what the children pick up on. It is connected to the style of attachment

in their primary relationships (Bowlby, 1973; Ogden, Et al, 2007). Alice went on to discuss the implications of living in a traumatised community: ‘Every day you are reminded of who you are, what tribe you belong to, and what has happened’. The children are locked into the environment of their parents. The parents are locked into being victims or perpetrators. ‘The children are living the legacy of their parents’ chosen situation’. There are little choices for these children, it’s the family and environment they have been born into. This is linked to the sub-theme in theme two above, the suggestion of how traumatic architecture and community culture can impact individuals and a community (Bolton, 2017; Fargas-Malet & Dillenburger, 2016). Alice described the situation as complex and layered in terms of the transmission of intergenerational trauma. It is both currently traumatising and intergenerationally traumatising. She continued by explaining that this trauma exists in the culture and the communities, which are steeped in fear and terror. It’s not just physical inability to talk about the horrendous things that have happened, it’s the culture of silence that exists (Burrows & Keenan, 2004a; Burrows & Keenan, 2004b).

The final sub-theme that emerged in this theme was the concept of repetition. Two of the participating therapists spoke about how the Freudian concept of repetition related to their understanding of intergenerational trauma. Shabad (1993) suggests that whatever issue or trauma hasn’t been worked through in one generation is passed on to the following generation. He offers the example of a parent being unpleasantly surprised and then ashamed at themselves, when they find they have repeated a hated behaviour of their own parents with their children. He suggests this is directly related, to the adults’ inability

to consciously connect to the grief of their childhood experience of their parents. He proposes that as a result, they are doomed to repeat the behaviour intergenerationally until it is worked through (Freud, 1914/2001).

Tim explained that for him, the intergenerational aspect was related to the Freudian concept of repeating, remembering, and working-through. He suggested that what we don't speak about we repeat. He felt this was a depressing thought in relation to intergenerational trauma in Northern Ireland (Freud, 1914/2001). The other therapist Alice offered the example of children growing up in a home that has experienced trauma. She suggested that if someone is brought up in that environment, the pattern is repeated until the realisation occurs that there must be another way. The norm of how they were brought up begins to be questioned. People repeat what they have experienced until they experience something different and that might take a number of generations. It gets handed down until somebody becomes willing to think there's something different (Freud, 1914/2001; Shabad, 1993).

5.5 Conclusion

The aim of this study was to explore the instance and transmission of intergenerational trauma in Northern Ireland through the lens of accredited psychotherapists specialising in the field of trauma. It identified and researched key terms, concepts and theories relating to trauma, PTSD, attachment theory and intergenerational trauma in the existing literature, with particular focus on its instance in Northern Ireland as a consequence of the Troubles/Conflict. Using a qualitative research approach and applying thematic

analysis to the data – which was collected from the five semi structured interviews with trauma focused Northern Irish psychotherapists – three themes were identified. These themes were:

- The experience of working with trauma in Northern Ireland.
- The experience of trauma pre and post the Good Friday Agreement.
- The instance of intergenerational trauma in Northern Ireland.

The findings in relation to the instance of intergenerational trauma in Northern Ireland supported the literature available in relation to trauma and its intergenerational transmission. The findings also supported the literature in relation to the link between difficulties with attachment and susceptibility to intergenerational trauma. Within the context of trauma and its intergenerational instance and transmission, two unexpected areas emerged from the findings. The first related to a seeming paradox of the peace process. Post the Good Friday Agreement – the findings from the interviews suggest – there was a relaxing of the social and mental constraints that had been in place. This resulted in a notable increase in the number of individuals accessing therapy for trauma related issues. However, one of the interviewees suggested that the large increase in client numbers accessing trauma therapy might be related to extra funding in the area of trauma and of increased availability of therapy services.

Another unexpected area that emerged was related to the complex layered nature of trauma and its transmission in Northern Ireland. The daily reminder and re-traumatising

nature of the architecture, the impact of historical media reports on the troubles, the on going displays of “tribal” culture in both communities, and the continued violence in some areas, when combined, create a complicated layered terrain in which intergenerational trauma is perhaps just one part of the trauma landscape.

Strengths

The sample group in this study represented a fair degree of gender balance, with two female and three male participants. They represented a broad sample of practice modalities and had a combined 102 years of trauma work experience. The semi-structured nature of the interviews, together with the experience of the therapists, worked well in facilitating an extensive discussion and understanding of intergenerational trauma, which brought to light some unexpected findings.

Limitations

A possible limitation in this study relates to the lack of qualitative and quantitative research into the area of intergenerational trauma and its implications in Northern Ireland. In terms of the sample recruited for this study – in so far as there was a broad level of experience within the sample – it possibly lacked balance from a public mental health services perspective. Another possible limitation could be the bias of five psychotherapists who work solely with trauma.

Recommendations

Following on from the above limitations, a study of the provision of public services for trauma in Northern Ireland could bring further information to light regarding the instance and implications for public mental health. As a result of interviewing the participants in this study, the author had questions about the instance and impact of vicarious trauma and the levels of compassion fatigue and the possible implications for the treatment of trauma in Northern Ireland.

Perhaps it is fitting that this study leaves the final words to one of the participants, Tim:

‘When the peace process started, decommissioning weapons was the big thing. I never viewed weapons as the problem. It was our desire to use them that was the problem. But decommissioning the human heart, I think takes many generations.’

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Appendices

Appendix 1. Sample of Contact Email

Hi [director],

As per our phone chat here is the information requested about my research project.

I am a final year Masters student in Psychotherapy at the Dublin Business School.

I am interested in talking to psychotherapists with experience of working with trauma in Northern Ireland.

If at all possible, but not essential, that they have been in practice pre Good Friday Agreement up to the present day.

The conversation should take no longer than one hour and will be recorded on a voice recorder.

All data and names of participants will be anonymised in line with best research practice.

I am happy to travel on a day and time that suits.

Ideally it would be great to have two interviews on the same day.

My mobile number [phone number] if you need any clarification please don't hesitate to call or email.

Can you acknowledge receipt of this email so I know I have the right address.

Thank you

Kind regards

Dermot Ronaldson

Appendix 2. Confirmation Email

Dermot

I apologise that it has taken me time to get back to you about this, I trust all is well with you.

I now have the go ahead to put it out to my clinical team, so I will get back to you when I know who is willing and available.

Thanks,

Warm Regards
[Director]

Appendix 3. Research Interview Questions

Topics	Questions
<p>Trauma/PTSD</p> <p>1.</p> <p>2.</p> <p>3.</p> <p>4.</p>	<p>Can you tell me what brought you to working with trauma?</p> <p>How long have you been working with traumatised clients?</p> <p>Can you tell me how trauma informs the way you work?</p> <p>Can you talk about your experience of the causes of trauma?</p>
<p>Culture/Attachment Northern Ireland</p> <p>5.</p> <p>6.</p>	<p>In your experience have you noticed any common factors that are specific to NI or Troubles?</p> <p>Follow on Question can you tell me about your experiences of cultural influences and attachment as a factor in your work experience with Trauma in NI?</p>
<p>Intergenerational</p> <p>6.</p> <p>7.</p> <p>8.</p> <p>9.</p>	<p>Have you noticed any changes in presenting symptoms over your time working in this area?</p> <p>Have you had or noticed any intergenerational connections post Good Friday agreement?</p> <p>What if any is you're sense or experience of trauma being transmitted through the generations?</p> <p>Is there anything you would like to add or something that struck you during this interview?</p>

Appendix 4. Information Form

INFORMATION FORM

My name is Dermot Ronaldson and I am currently undertaking an MA in Psychotherapy at Dublin Business School. I am inviting you to take part in my research project, which is concerned with trauma. I will be exploring the views of people like yourself who work as Psychotherapists in Northern Ireland.

What is involved?

You are invited to participate in this research along with a number of other people because you have been identified as being suitable, being a Psychotherapist working in Northern Ireland. If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience, which should take no longer than an hour to complete. During this I will ask you a series of questions relating to the research question and your own work. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

Confidentiality

All information obtained from you during the research will be kept confidential. Notes about the research and any form you may fill in will be coded and stored in a locked file. The key to the code numbers will be kept in a separate locked file. This means that all data kept on you will be de-identified. All data that has been collected will be kept in this confidential manner and in the event that it is used for future research, will be handled in the same way. Audio recordings and transcripts will be made of the interview but again these will be coded by number and kept in a secure location. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

DECLARATION

I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research. I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant (in block letters) _____

Signature _____

Date / /

Appendix 5. Consent Form

Consent Form

Trauma and the instance of intergenerational transmission in the context of Northern Irish psychotherapeutic practice.

Please tick appropriate answer.

I confirm that I have read and understood the information leaflet attached, and that I have had an ample opportunity to ask questions all of which have been satisfactorily answered.

Yes No

I understand that my participation in this study is entirely **voluntary** and that I may withdraw at any time, without giving reason.

Yes No

I understand that my identity will remain confidential at all times.

Yes No

I am aware of the possible risk of this research study.

Yes No

I am aware that audio recordings will be made of this session.

Yes No

I have been given a copy of the information leaflet and this consent form for my records.

Yes No

Participant _____

Signature and dated

Name in block capitals

To be completed by the Principal Investigator or his nominee.

I the undersigned, have taken the time to fully explain to the above participant the nature and purpose of this study in a manner that he/she could understand. We have discussed the risks involved, and have invited him/her to ask questions on any aspect of the study that concerned them.

Signature

Name in block capitals

Date

Appendix 6. Demographic Sheet

Demographic Sheet

Male

Female

Age

Where did you do your training

Psychotherapeutic orientation

Accreditation Body.....

Years in Clinical Practice

Years working in Northern Ireland

Years working with Trauma

