Counselling for Healthcare Harm

by

Linda Kenward

Counselling for Healthcare Harm

by Linda Kenward

2026

Ethics International Press, UK

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

ISBN (Hardback): 978-1-83711-640-9
ISBN (Ebook): 978-1-83711-641-6

Acknowledgements

Thanks go to my family, especially by long-suffering husband, for their support and their willingness to allow me to spend time in completing this book. This book could not have been written without them.

Thanks also to those who have listened to my thoughts, contributed, corrected and supported my thinking. Their enthusiasm in talking about what is a difficult topic is so much appreciated.

Thanks to my published for this support and patience, but most of all thanks to every person who has shared with me their experience, both good and not so good in healthcare.

For Gina with thanks

Table of Contents

Tables and Figures

Tables

Figures

Introduction

This book has been nearly two decades in the making and comes from my clinical experience as a therapist, my doctoral work and extensive knowledge of the health care system. This book is written ostensibly for therapists who already work in healthcare, who want to work in health care and those who want to better understand the impact of harm on those that access the services that are meant to care for them. Many therapists, in their work with clients, will come across those that have been harmed in healthcare, and this book is also a resource for them. It is also a useful and I hope thought provoking book for healthcare professionals who want to understand the impact of healthcare harm and why the responses of organisations and the people within them can on some occasions be so devastating. This book will suggest why this negative response occurs and how it develops. It will contextualise the need for principles that are about the recognition of harm and how to respond appropriately as well as what happens when that response lacks intentionality, becomes toxic or even deliberately destructive.

In the first part of the book, I look at developing the readers understanding of healthcare harm. Unless the therapist has a good understanding of the context and nature of the harm, they are unlikely to be able to connect with the client. Clients appreciate this understanding and this came out clearly in the findings of my doctoral study. I begin by setting out why this book is needed. We look at how harm in healthcare has been gradually recognised and understood and how specialised psychological support for those

affected has been largely absent or misunderstood. Using my research, I consider how the accounts of those harmed reveal not only injury but moral and relational wounds and significant trauma. I consider the term second harm and look more closely at what second harm looks and feels like. In exploring what happened, I move towards a clearer understanding of second harm, and a trajectory is suggested of how second harm develops in organisations and professionals. This suggested trajectory is not a single event but a trajectory that can unfold over time and is about the relationship or lack of it between the patient and the healthcare provider and how they maintain, enhance or destroy that relationship in the face of harm. The suggested trajectory can help healthcare professionals recognise the tipping point between normal irritation with a patient and how that might ultimately lead to destructive behaviour that may lead to additional harm.

Additionally, second harm as a relational response is explored and deconstructed to consider attitudes that lead to harm.

In the second part of the book the focus turns to the needs of the client who comes to counselling following an initial harm and second harm. We explore what clients need from counselling in this context, to have their story heard and believed, to experience safety and respect, to be supported in understanding what happened and what it has meant to them. In the later chapters we think about the need for justice and how people's voices are silenced or dismissed and how this creates deeper layers of harm that therapists will be required to work with. I consider the role of therapists not only as witnesses and companions in the healing process but as contributors to a wider cultural shift in healthcare and understanding the extent and impact of harm. Throughout the

book, I reiterate a trauma-informed approach that means holding what happened to clients in their full context, recognising that clients may carry both the trauma of the event and the trauma of how it was handled.

The final part of the book briefly looks at how therapists can maintain their practice in this area considering the implications for practice and suggesting future directions for research. This book gives language to what happened to clients and patients accounts that have too often been left unspoken, not recognised as important or simply treated as non-existent. To work with healthcare harm is to work with trauma, loss and injustice. I also include a lexicon of useful language at the end of the final chapter.

Part One

Understanding Healthcare Harm

Chapter 1
Why this book is needed

In the UK we have been rightly proud of our 'free at the point of care' health system. Daily thousands of safe, compassionate and effective interventions are delivered by committed competent staff in a diverse range of settings across the UK under enormous pressure and weight of need and expectation. For many years, I worked within the system and have cause to be grateful for the care it provides.

However, this is not the full picture. Not only do positive interventions happen in these settings, but people that access care can experience damaging, harmful and traumatic events and responses that impact their lives leaving them with long term psychological issues and changing their relationship with our healthcare system permanently. These are frequently evidenced in newspapers, documentaries and inquiry reports into shocking failures in care and management.

In 2024 NHS Resolution estimated that the annual cost of harm to the NHS for their schemes was £5.1 billion (p8 2024). This cost does not include any cost outside the NHS and does not take account of the personal, psychological and social cost of healthcare harm. Considerable research and intellectual effort are directed at reducing harm in healthcare, identifying factors around what has previously been called 'never events' and working towards quality healthcare that takes account of human factors, evidence-based quality improvement methodologies and the influence of cultures

(Yu *et al.* 2016). Research is translated into new and often innovative ideas, policies, initiatives and approaches that are introduced in the hope that harm can be reduced in some way. This is what the patient safety community in healthcare works towards.

There is wide recognition and acceptance that no matter how well trained staff are, how cognisant they are of factors impacting upon quality or how carefully staff practice, errors still occur (Ham *et al.* 2016). The recognition of this is what is now called human factors (Reason, 1995). Despite this recognition, the long-term psychological response to harm and support for those who have been harmed remains under researched and up until recently unrecognised. The patient safety arena includes a myriad of actors, even patients themselves but rarely until recently was the psychological care of people after harm included as a topic of discussion. However, in recent times, with the publication of a number of high-profile enquires, harm has begun to be acknowledged as an issue that impacts and changes the life of those who have lived with and through it, although even with this acknowledgement the discussion of solutions that might address this devastating impact has yet to become a coherent conversation or offer any solutions.

More recently evidence is beginning to emerge that additional harm referred to as second harm can be caused by the way a healthcare provider or clinician responds to people following an error (Ocloo 2010, Dyer 2014, Titcombe 2015, Vincent 2006 and Sokol-Hessner *et al.* 2015). The current evidence base in relation to patient safety for the most part fails to include second harm, which is not surprising considering that this topic has not been researched systematically. Any recognition or discussion of second

harm comprises anecdotal reports from patient organisations that have documented the impact of additional harm and significant patient accounts such as those from Action against Medical Accidents (AvMA). Recognition that people that access healthcare may suffer additional harm and require support following harm is an important step in the way forward for the development of appropriate systems and processes for support and for improved relationships between those who are harmed and those who may unintentionally harm them. Wu *et al.* (2012) suggest that such recognition may go some way to reducing additional harm. A report into the Learning from Deaths Review from the National Quality Board in 2018 gave guidance to NHS Trusts on dealing with families after bereavement following errors and mismanagement of care. This report recognised that systems and processes should be designed to mitigate any long-term impact for people and to regain trust in the healthcare services thus allowing those having been harmed to be confident in future engagement with services and to input into services as valued partners (National Quality Board, 2018). This guidance came out as the concept of trauma informed care, the relevance of which will be discussed later within this book, was coming into more mainstream thought in social care and education from the USA's Substance Abuse and Mental Health Services Administration (SAMHSA 2014). The health sector remained and still does remain considerably behind in being trauma informed and the implications of this will be explored later in the book.

Despite a growing recognition of harm, studies investigating the accounts of harm and the impact of harm and second harm are few and far between within the academic literature. Studies exploring the impact of harm from the perspective of those accessing care,

the therapy and support needs of clients following harm, exploring second harm specifically or the journey back to functionality for those that are harmed have been few, although this does seem to be changing. Conversely, the number of studies that have included research into the experiences of clinical staff as 'second victims' (those who have made errors and have suffered as a result) or as experiencing moral injury (having found themselves working in circumstances that run counter to their own personal values and beliefs) have burgeoned, particularly since the global pandemic of 2020 (Shale, 2020).

While areas of research that focus on harm and second harm to patients might not be the first concern of clinicians in the immediate aftermath of a harmful event, second harm should be a concern in relation to patient outcomes and future engagement with the health services (Vincent, 2006). Given the psychological impact of initial harm and second harm there is some evidence that suggests that people do want therapy following harm (Care Quality Commission, 2018). Once again evidence for interventions is absent in the academic literature despite anecdotal evidence that suggests people are accessing support for issues relating to harm and second harm. An evidence base that supports therapy for second harm as well as research into the long-term psychological impact, particularly of second harm remains absent. It is within this context that my own doctoral work was commenced in 2016 and completed in 2021.

Having worked in healthcare for several decades and having trained as a therapist who has an interest in health, I began to see patterns in the accounts of clients, the impact of both the harm and the devastating aftermath of second harm, something which I had

initially believed to be almost unique. Over time, sharing my observations with colleagues and friends, I began to hear that these accounts were by no means as unique as I had first thought and having read reports into cases of harm and the aftermath, I could see striking similarities in the narratives of clients that came for therapy after these events. Undertaking my therapy training, I never intended to specialise in this area of work but continuous exposure to those who had gone through harm, especially second harm, led to my interest in this area of work and a developing understanding.

Harm in healthcare

While the NHS is an organisation known for its caring practices and culture by the general public, there have always been cases of initial harm that are preventable (Kalra *et al*. 2013). More recently the harm caused within healthcare setting has become widely reported on, talked about and debated (Youngson, 2014). Preventable harm is unacceptable, should not happen and several high-profile reports since 2013 has seen the public become more aware, more vocal and more concerned in response to the poor care documented within these reports.

In 2013 four reports were published that acknowledged preventable failings within the UK Healthcare systems and the negative impact these failings had on individuals. Specifically these reports were; The Francis Report in to the Mid-Staffordshire NHS Foundation Trust failings (Francis, 2013), the Solihull Hospital Kennedy Breast Care Review on the work and professional behaviour of breast surgeon Ian Paterson (Kennedy, 2013), the Keogh review, which reviewed care quality and

identified 14 hospitals which has significant failings in care deliver (Keogh, 2013), and the Promise to Learn Report drafted by patient safety expert Don Berwick (Department of Health, 2013) in response to the Francis Report. These reports recognised that the culture of the organisations involved and, importantly the wider NHS and associated systems, could contribute to poor outcomes, negative experiences and distress to individuals accessing care.

In 2015 the Report into the Morecambe Bay Investigation (Kirkup, 2015) also highlighted the issue of culture, but went further in noting the mismanagement and deliberate deception that led to families not being able to fully have an understanding of what really happened to their relatives. This subtle change in recognition of a particular kind of organisational cultures and the negative impact of these kinds of cultures began to be seen in subsequent reports. In 2016,the Learning From Deaths: Care, Quality and Accountability report was published (Care Quality Commission, 2016) into failings at Southern Health NHS Foundation Trust and this report began to document the harm that a poor response to error and neglect had on people that accessed care and their relatives. Since 2016, the Learning From Deaths Final report (NHS England, 2017) and the One Year On report (NHS Improvement, 2018) recognised that a common culture of second harm may happen and that the response of an organisation should not further contribute to the distress of patients and families. The Inquiry into Hyponatraemia-related Deaths in Northern Ireland in 2018, supported this recognition and led to calls for the Duty of Candour, the legal duty of organisations to be open when something goes wrong, to be extended to that part of the UK (Hyponatraemia Inquiry Team, 2018). The recognition of second harm was further acknowledged in 2018. Three reports were

published acknowledging that second harm happened and recognising the impact of second harm including that perpetrated by regulatory bodies. In May 2018 the Professional Standards Authority investigation in to the Nursing and Midwifery Council's (NMC) response to the Morecambe Bay Families, was published (Cayton, 2018). The report concluded that the NMC had failed to take the concerns of families seriously and had, as a result failed in its statutory duty to protect the public in a timely manner and as a result further deaths had happened. Within a week the report into deaths at the Gosport War Memorial Hospital (Gosport Independent Panel, 2018) and Tawel Fan Hospital in Wales (Johnstone, 2018) highlighted the same systematic treatment by NHS Trusts of patients and relatives. In July 2018 the Guidance for NHS Trusts for Working with Bereaved Families was published and both recognised that second harm happens and that the impact of a poor response to error exacerbates the original harm (National Quality Board, 2018). Later reports such as the Ockenden Report (2020) the Cumberlege Report (2020) the Report into the Death of Elizabeth Dixon (Kirkup 2020) and the Inquiry into the East Kent Maternity Deaths Report (Kirkup 2022), highlighted the same poor treatment of people accessing care and their relatives documenting incidences of trauma and second harm encountered by those who raised concerns, had complained about poor care or had simply asked for explanations or apologies.

In England a Commissioner for Patient Safety began their role in September 2022. The Commissioner is independent of government and the healthcare system with the Commissioner's funding provided by the Department of Health and Social Care (DHSC). This new role predominantly came about due to the Cumberlege report, *First Do No Harm*: *The report of the Independent Medicines and*

Medical Devices Safety Review, which reported on the use of two medications; Primodos and Sodium Valproate, and the surgical use of pelvic mesh (2020). The harrowing accounts of what happened to people drew condemnation about the lack of acknowledgement of similar and thematic concerns that were consistently raised by patients over a long period of time resulting in no concerted action. The reports of not being listened to, of harm and distress being minimised and a lack of compassion shocked and saddened the public but came as little surprise to campaigners that raise concerns about patient harm.

The history of harm in healthcare is long, and not surprisingly, complex (Sharpe and Faden, 1998). Mistakes may be avoidable, but they happen in every area of society including healthcare. Anecdotally, people that access care seem to recognise that this is the case and that genuine mistakes do happen in such a complex environment. However, there is a considerable difference between errors that occur by genuine mistakes and are shared in a transparent way with those involved, and harm that is perpetuated by attitudes of denial, withholding information, policies and practices that fail to minimise that impact on patients, fail to mitigate risk and redress errors following mistakes. These kinds or harm nearly always cause additional distress, and it is this that people find additionally damaging. Similarly, a lack of trauma informed approaches that might minimise the chances of second harm makes the healthcare system a dangerous and distressing place for those that have already encountered harm, mental health issues, bereavement, disability, abuse, poor care, social deprivation or discrimination.

Psychological support for harm within healthcare

Current psychological support available via the NHS for those harmed within the healthcare system either exists at a local level, with the support of, for example specialist bereavement nurses or therapists, or though the Increasing Access to Psychological Therapies services. These interventions tend to be focused on the subject of the initial harm such as bereavement, disability and some services around birth trauma, but rarely recognise the second harm element of the harm and may not have training or expertise in second harm. As a result, there may be little understanding of the context, nuances of second harm and perspectives of those harmed in this way.

As far back as 2016 the Learning From Deaths Programme (National Quality Board, 2018) identified a number of areas of concern and aspirational practice in response to work with patients who had lost friends and relatives as a result of errors or poor care. This work focused on the responses, attitudes and actions of healthcare providers following avoidable deaths in the wider NHS and it made shocking reading. The clinical and often brutal nature of how families were dealt with by organisations after a loss was again a feature of this report. This mirrored the personal accounts of individuals in several high profile cases (Steane, 2007; Titcombe, 2015; Ryan, 2017). LeCraw *et al.*, (2018) and (Triggle, 2013) state that the organisational practice known as '*Deny, Delay and Defend*' (p1) is one that sums up these kinds of responses. These reports indicate that there is more than one level of interaction at which second harm occurs: both interpersonally and organisationally.

The approach is one that may often be adopted by healthcare providers at the point that an error is highlighted or a concern raised and a response is requested, often by a person that has accessed care or their relative. Whilst no figures have been compiled on this practice and it has not been researched, it is a commonly observed response that sees the provider ignore a concern, minimises the extent to which it is an issue or simply deny that it happened. Any investigation may play into this approach by presenting 'findings' that avoid the main issues, exclude key individuals, rush the investigation, fail to include the patient or simply elongate the process to delay the outcome. Investigations may be poorly carried out, and the outcome be defensive with no explanation of what happened or indeed any apology. If the incident is a major one that results in attempted litigation by the person accessing care, the deny, delay and defend process is often expertly practiced by a large legal team with significant resources and expertise again patients that have limited resource, lack understanding of the legal system, may be exhausted from pursuing litigation and may only really want an apology, explanation and information (Birks *et al,* 2018). While a range of different types of guidance to make any investigation fair exists, such as the Being Fair (NHS England, 2025), these are to ensure fairness to staff in investigations by attempting to minimise blame, reducing discrimination and taking a proportionate approach to mistakes. While this is right in ensuring that staff are treated fairly for any mistakes they make, given appropriate support to make changes to their practice and improve, this guidance is not there to ensure fairness to patients.

Should the complaint by a patient escalate to litigation, this route rarely, if ever, brings the desired outcome of apology and greater

understanding for patients. This is primarily because the focus of the legal process is not to elicit information or apology but to apportion responsibility with the requirement for financial redress. This is not necessarily the first and most important desired outcome according to Birks, Aspinal and Bloor's 2018 research, but may well be a necessary one if harm has been severe enough to cause financial hardship in the long- or short-term requiring replacement of lost income, costly housing modifications or long-term psychological support. What is clear, is that those people who feel that litigation is their only course of action to get the information they need can go through extreme distress and trauma in undertaking a process of litigation (Walsh 2018).

In 2017 ongoing discussions began within the sector about the cost of litigation, the limitation of compensation packages and the reduction of support for patients bringing litigation following error or harm (Wu, 2018). Alongside this discussion of the financial implications of harm came the consultation on 'Safe Spaces' undertaken in late 2016 (Walsh, 2018). The 'Safe Space' proposal, first suggested by Jeremy Hunt then Secretary of State for Health, sought to legally ensure that information provided by staff as part of a health service investigation would be kept confidential except where there is an immediate risk to patient safety, or where the High Court made an order permitting disclosure (Walsh, 2018). This proposal was suggested to allow healthcare professionals to feel comfortable about being honest and to be able to offer information without fear of litigation or further scrutiny especially by bereaved families and those that were harmed. However, the proposal drew considerable criticism from patient groups and advocates for the patient voice that feared that confidentiality might be used to deflect from significant failings and poor practice

by both individuals and organisations and thus exacerbate the second harm (Walsh 2018). Following lobbying by patient groups, the proposal was initially dropped. However, in 2023, for the first time, safety investigations undertaken by the newly established Health Services Investigations Body (HSIB) were granted a legal privilege, or 'safe space' which meant that findings of the HSIB's safety investigations would not be admissible evidence in legal proceedings (Weaver and Cameron, 2023). The rationale for this change was to minimise and avoid blame and the fear of raising concerns by professional staff. Along with the HSIB safe space came a change in focus with regards to patient engagement. HSIB, (since October 2023 called HSSIB) who previously engaged with families around investigations, no longer do so other than through focus groups or selected means of engagement. This is seen to minimise the chance of patients bypassing engagement with the healthcare provider, which is the systems preferred way of engagement and means to resolution. While this might seem a logical step, it fails to recognise or minimise trauma and distress thus forcing those who have been harmed to engage with the organisation that perpetrated that harm and may potentially causing more harm and retraumatisation. LeCraw *et al.* (2018) also draws attention to the fact that this practice of deny, delay and defend is not restricted to the UK alone and commonalities can be found in other countries. The news accounts and personal narratives of those whose relatives' death had at best, been poorly investigated and at worst, covered up, displayed consistent themes that resonated with the findings of the patient safety reports published more recently such as the report into the Maternity and Neonatal Services in East Kent by (Kirkup, 2022) and the report into Maternity services at Shrewsbury and Telford Hospital (Ockenden, 2022). It is important to note that active deliberate

harm by a healthcare professional is exceptionally rare. However, the impact on patients and families who access care if far reaching and it is always patients that suffer most in the aftermath.

In 2022 a new patient safety initiative, The Patient Safety Incident Response Framework (PSIRF), was launched to provide a consistent system wide approach to investigations of serious incidents in the NHS (NHS England, 2022). While PSIRF advocates that patients should be involved in incident responses and investigations, PSIRF fails to address the practice of attitudinal resistance in staff to involvement of those that access care or the issue of robust post incident psychological support that is independent of the system that caused the harm and is appropriate.

In 2025 the then Secretary of State for Health, Wes Streeting announced a rapid review into maternity services to be led by Baroness Valerie Amos, citing the very clear harm and second harm to families and individuals across maternity services often caused by individuals (Gov.UK, 2025). A week later the Health Service Safety Investigation Body (HSSIB) laid the responsibility for failings in maternity care and harm to systemic issues (Dresti, 2025). The system shapes the responses, attitudes and cultures of individuals including those whose responses contribute of harm and second harm, even if they remain unaware of it.

In 2025 The interim rapid report of the Investigation by Baroness Amos found that maternity services in England are failing too many women, babies and families, with problems that are systemic and long-standing. These included a culture of defensiveness and lack of transparency where families often face

denial, poor investigations, or even concealment of mistakes after harm or death as well as a failure to learn from the past reviews. This was clearly harming those who used the system (Amos 2025)

Despite such attention to harm within healthcare, the numerous reports of harm and the strategies to reduce harm, there remains no coherent policy that specifically supports people that have been subject to harm. It is only recently that second harm has even been acknowledged officially, with the Professional Standards Authority actually referring to second harm (Professional Standards Authority, 2022).

Interestingly, this sense of additional harm perpetrated by a poor response, or no response at all to an event is not confined to the healthcare sector. In 2017 a report was published that highlighted the impact of the lack of care, compassion and the 'patronising disposition of unaccountable power' that followed and continues to pervade the Hillsborough disaster. The Right Reverend James Jones says, in the report

> *'when in all innocence and with a good conscience they have asked questions of those in authority on behalf of those they love the institution has closed ranks, refused to disclose information, used public money to defend its interests and acted in a way that was both intimidating and oppressive'* (p2 James Jones KBE, 2017).

This description perfectly summarises the attitude of those who held the authority and the information. Ironically, this same description could be as applicable to some harm but is certainly applicable to second harm in healthcare.

In my research and therapy work I work closely with organisations and individuals that have supported patients and have had my own client base whose accounts of harm and second harm mirrors those within these reports. There is no doubt that most therapists will be able to work with clients that have undergone harm, but they may not be aware of the wider implications of the context, the trajectory of the journey and the damage that is done to those who have to take this road as unwilling travellers as well as the nuances of second harm.

A summary of my research

The scope and focus of therapy that might be needed for those who have suffered initial harm and second harm in healthcare is under researched with no empirical literature on the specific needs of people who report this specific type of harm. Consequently, the needs of those who attend therapy following healthcare harm have not been clear. My doctoral work commenced in 2015 and the objectives of the study which focused specifically on second harm were threefold.

i) to identify common needs of clients coming to therapy following second harm
ii) to identify key factors that are both common and novel in relation to that clients believe would be most helpful following second harm, and
iii) to establish clear recommendations for counselling that can be utilised by those working with clients that have gone through second harm.

Ethics

This study was reviewed by the regional Health Research Committee and the Ethics committee and University research ethics committee in 2018 and a favorable opinion was given by both. All participants were provided with details of the study, able to ask questions and gave written informed consent.

Methods

This study used **Q methodology**, a research method developed by William Stephenson (1902–1989) to explore people's viewpoints on a particular topic (Brown, 1993). The "Q" refers to the type of factor analysis used, which looks for patterns among participants rather than variables. Unlike the traditional "R method" that compares variables, Q methodology identifies shared perspectives by analysing how participants sort statements related to the topic. Participants rank these statements using a computer program or a manual grid. Q factor analysis then groups similar viewpoints into "factors," representing shared ways of thinking (Coogan & Herrington, 2011).

What makes Q methodology unique is its focus on **subjectivity**. It values personal opinions as data, allowing a blend of qualitative and quantitative approaches. It respects individual perspectives, ensures anonymity, and helps give voice to those who often feel unheard (Cross, 2005). In this study, Q was chosen specifically because it allows the voices of marginalized groups—such as patients and families—to be heard (Ocloo, 2010). It aligned well with the aim of amplifying the voices of those often overlooked in healthcare discussions.

Q Study Stages

The study followed the four key stages of a Q methodology project:

Stage 1: Generating the Q -sort pack

The first step involved creating a collection of statements known as the **Q set** (Watts & Stenner, 2012). These were drawn from the **concourse**—the full range of opinions and experiences on the topic. In this case, because "second harm" is not well-defined, the concourse was built from publicly available sources like newspapers, patient accounts, inquiry reports, books, and social media. Over 14 months, 80 written sources were reviewed, focusing on patient accounts of being harmed again when raising concerns about care. From this, 41 statements were selected. A panel of experts reviewed the list and added one more, making a total of 42 statements.

Stage 2: Administering the Q Sort

Participants were recruited using purposive sampling through social media, professional contacts, and word of mouth. Twenty people responded, and ten took part in the study. All participants had gone through second harm—meaning they felt harmed by how healthcare providers responded to their concerns or requests for apologies, information or support and this has had a significant and lasting impact.

Stage 3: Data Collection

Participants completed the Q sort online using a program called **Q SortWare**. They ranked the 42 statements in response to this guiding question (called the **condition of instruction**):

> *"Following the experience of second harm, what would be important to you in the relationship with your therapist?"*

After the sort, each participant was interviewed. The Q sort data was then prepared for analysis.

Stage 4: Factor Analysis and Interpretation

In the final stage, data from the Q sorts were analysed using a statistical tool called PQMethod. This software runs a centroid factor analysis to find patterns in how participants ranked the statements. It uses Eigen Values (EV) to group similar responses into factors—representing shared viewpoints among participants (Herrington & Coogan, 2011). Each factor is then interpreted as a distinct **viewpoint**, meaning a set of commonly held beliefs or preferences (Corr, 2001; Exel & Graaf, 2005).

Findings

The study found eight core needs relevant to this client's group. Some are clearly relevant to people coming to counselling for a range of issues and are expectations for a core counselling relationship, but others were specifically around second harm.

1. The need to acknowledge the trajectory of harm and second harm even if the journey was different.
2. Recognising the time perspective of clients

3. Core values as a mean to safety in the counselling work
4. Respect articulated as not being blamed.
5. Relational depth in the counselling relationship
6. Sitting with the client in their experience
7. The need to be able to access counselling that is trauma informed and focused on harm and second harm
8. Specific support to understand what happened and to process the events

    - Specific support to make meaning
    - Support to process and pass on meaning and learning on to others.
    - Support to manage the trauma of the complaints process.
    - Specific support to 'keep going' and get through life.
    - Specific support to explore emotions in order to maintain functionality

It is these findings that are the basis for the current approach to therapy for those who have been harmed in healthcare that is discussed in this book.

Additionally, I have sought to further define the nature of second harm continuing on from the work done during the study and to review the trajectory of interactions during second harm between healthcare professionals and patients. I have continued to work with those harmed in healthcare, including families involved in national investigations into healthcare harm as well as individuals and training organisations and teams in trauma-informed interventions.

Throughout this book I will refer to therapists to mean all of those that are registered as counsellors and psychotherapists on voluntary and statutory professional registers and provide psychological services to clients and patients. I will also refer to patients or service uses when discussing the healthcare setting and clients where referring to those that access therapy.

Chapter 2
Introduction to second harm

As the concept of second harm is not always recognised and is under researched, it is important to introduce and explore the concept, providing context before offering a potential definition in Chapter 3 as well as discussing the importance of language.

The importance of language and the defining of key terms

Within a healthcare settings people can be harmed by an illness, the treatment for that illness, an error in care or treatment, or indeed none of these (Berlinger, 2005). Harm caused by healthcare treatment has long been recognised and is called iatrogenic harm. Despite reports identifying harm within the provision of healthcare, there is a lack of an appropriate, consistent and adequate definition of related terms that can support the narrative of people who have been through harm and second harm.

In 2006 the patient Safety advocate Charles Vincent acknowledged in his book 'Patient Safety' that a '*second trauma*' (p175) may occur because of the response of the healthcare provider to a patient after an original harm, and that this may result in physical and/or emotional deterioration, long-term disability and psychological distress, including PTSD and anxiety disorders. Vincent used the word trauma to describe what he saw, but, as we will see, this is a contested and emotionally laden word to use, especially considering that Charles Vincent has a medical background. The