View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

provided by Roehampton University Research Repository

DOCTORAL THESIS

The Use of Coping Strategies by Psychologists to Prevent Vicarious Traumatisation

Tizzard, Christine

Award date:
2015

Awarding institution:
University of Roehampton

General rights
Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal ?

Take down policy
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Download date: 04. Feb. 2021

The Use of Coping Strategies by Psychologists to Prevent Vicarious Traumatisation

Christine Tizzard BSc, MSc

A thesis submitted in partial fulfilment of the Doctorate in Counselling Psychology

Department of Psychology

University of Roehampton

June 2015

Abstract

The purpose of this study was to investigate the coping strategies used by psychologists working within the demanding field of trauma psychology.

The research process seeks to investigate whether post session distress remains or whether it may be effectively processed. Are there strategies that psychologists use that stand out as major components in removing residue material?

Central to this study was the requirement to obtain a rich account of the participants' experiences in order to elucidate the depth of meaning behind their statements.

To achieve this aim the phenomenological method chosen was the van Kamm method adapted by Moustakas (1994). Following careful ethical preparation, five consultant psychologists were recruited for the semi-structured interview process.

The findings of the study indicate that the individuals concerned use a range of unconscious and conscious coping strategies to process traumatic material. These were either positive or negative. A variety of physical, emotional and cognitive strategies were used. The choice of therapeutic modality influenced processing strategy.

A major finding of the study was the use of peer supervision as a first line coping strategy. Participants reported that there were often inadequate resources allocated for this. Peer supervision is helpful because the shared experience of working with traumatic material provides a normalising function.

Traditional one to one supervision was generally viewed as unhelpful and often perceived as exacerbating the distress of participants.

Findings indicate that despite the use of coping strategies, residue material often remains. Participants did express positive effects of working with trauma but these

coexisted with lasting negative attribution changes. This research has implications for the training of psychologists, particularly in the development of coping strategies both within supervision and as a method of self-supervision. It also raises the question as to whether trauma work should be solely provided by teams.

Acknowledgement

I should like to express my appreciation and gratitude to my director of studies Professor Robert Edelmann for his advice, support and encouragement. I would also like to say thank you to my research supervisor Dr John Rae for his calm and supportive approach; his wide knowledge and enlightening enthusiasm for the field of phenomenology.

I convey special thanks to the participants who were willing to share sensitive material with me. I think we have increased each other's knowledge. I should also mention my clients, their tenacity and resilience is a source of inspiration.

A special word of thanks to my partner, Sho who has supported me on this journey. Your self-sacrificing attitude to supporting me and tolerating my occasional rage at technology has been appreciated.

Table of Contents

List of Tables & Figures

List of Appendices

Chapter 1 Introduction

1.1 Setting the Scene

This study investigates the strategies used by Chartered Psychologists to process residual traumatic material from their awareness.

It is established that working with traumatic material can have a profound effect on an individual's functioning. Over time of repeated exposure this may often escalate causing different degrees of distress in the individual (Saatvitne & Pearlman, 1993).

The dangers are amplified in circumstances where individuals are exposed to repeated injury from client material. Although a relatively new area of investigation, findings suggest that the effects of vicarious traumatisation (VT) can have a profound effect on the professional and private functioning of the individual. Saatvitne (1995) defines the phenomenon:-

> *"Vicarious traumatisation refers to the accumulative transformative effect upon the trauma therapist of working with survivors of traumatic life events. It is a process through which the therapist's inner experience is negatively transformed through empathetic engagement with client's trauma material."*

The American Psychiatric Association (2000) defines a traumatic incident as an event that has three principle conditions:-

1. *The individual was totally unaware of the likelihood of the event happening, therefore, as he had no anticipation of the event, he could take no preventative action however futile, to try to protect himself.*
2. *While the event was actually happening there was no opportunity for the individual to stop the process. Clients have often described this process, as a feeling of total powerlessness.*

3. *Following the event there is usually a belief or perception that the world has changed irretrievably. These changes are attributable to the incident that the individual was exposed to. The perception is that things will never be quite the same again. An individual will often believe during the incident he or certainly someone close to him will die.*

1.2 Reflective Practice

Throughout my career, I have worked extensively with many clients who have experienced both recent and historic exposure to horrific and violent situations. Most of these situations have involved either the loss of life or severe and debilitating injury.

My work in each of these varied situations shared a unifying theme. This theme was and continues to be listening to and making sense of, first witness descriptions of horrific material. This is material that is sometimes shocking and generally unpleasant. Descriptions of situations are frequently relayed in an extremely emotive fashion. This is unsurprising given both the nature of the material and the emotions it produces in those who encountered it. These types of narratives have been referred to elsewhere as having the capacity to produce flash bulb memories (Roff, 1989; van der Kolk, 1996).

A flash bulb memory is a particular memory imprint within the cognitive system of the individual that is associated with extreme horror and vivid representations. These kinds of memories are alleged to have the capacity to provide flashbacks in the individual. The events of September 11th 2002 are a very poignant reminder and all too real an example.

Examples of traumatic material from my past clients have included a Community Psychiatric Nurse who, in shock, recounted to me how when making a routine home visit she found a patient dead with gunshot wounds through the head.

Other examples include a railway worker who recounted retrieving the body of a decapitated passenger from under a train and the investment banker who witnessed the immediate aftermath of the 9/11 attack. I recall one PTSD victim describing his situation as "being a passenger in a highly speeding car, being in for the ride, unable to exit."

Contained in each of these examples is descriptive language, language that creates a picture but stops short of providing a full description of a scene in gory and graphic detail. The intention is not to inflict unpleasantness on the reader. During work with clients it is precisely these omitted details; the blood, the guts, the fear, descriptions of smells and sights that I had been receiving in my role as a Consultant Psychologist.

For example, an account of a road traffic accident in which four people died was conveyed as follows:-

> *"I was asked to attend an accident on the motorway; actually I was there to retrieve the mangled cars. As I approached the scene, there was carnage. Although most of the actual casualties had gone from the scene, I saw a policeman walking up to me along the road. As I looked closer I saw that he was carrying a severed head under his arm. It was as if it were a football he had just picked up. It took me a while to realise, my god that was a human head".*

The sense of shock in the recovery man's voice was palpable. His trembling was acute. Hearing this shocking information, to be empathic with the man's situation (although at an unconscious level), I needed to actually connect with that picture. Later that day and for weeks after, while driving past that described location, which was on my direct way home, the client, his strong emotion and his story popped into my mind.

In such circumstances any psychologist or mental health worker is potentially at risk of experiencing unpleasant reactions. These may occur either during the session or after it has finished. It is as if the material is not immediately capable of being understood and accommodated. As many in the field have stated, the material is immediately beyond comprehension. There is no frame of reference for it. There are no existing structures within memory where it can be coded and it hangs about uncomfortably. Listening to the account of the accident I was aware that I would hear about death, blood and carnage. However, I was not prepared for the shock of hearing about a severed head being carried by a policeman.

One might read such an account in a horror story and feel vaguely uncomfortable, but to have to listen closely and empathically to the account, accompanied by the strong emotions and shock of the client makes the story more real. Almost as if perhaps the practitioner was there too at the scene. Full attuned listening and empathic engagement transports the psychologist into the world of the client.

A significant component of therapy with a deeply traumatised client involves the retelling of the story. This is a therapeutic tool used to create a comprehendible narrative that minimizes the symptoms of distress in the client. It involves a piece by piece reconstruction of the minutiae of the details of the trauma. This time intensive intervention attempts to make sense of a situation that there is really no sense for and is a large component of the work. Expressed another way it is an attempt to normalise the abnormal and is a necessary part of this intervention. Paivio (1986) states it is possible that the clinician may experience alterations to the memory as a result of being involved in traumatic situations.

During clinical work a large component of the psychologist's role entails helping clients to reconstruct a congruent and meaningful narrative from situations

which initially have no meaning. The reconstruction process facilitates comprehension. This acquired understanding ameliorates some of the horror of clients' experiences. It becomes obvious that in facilitating positive change, practitioners too are left with many diverse and unpleasant stories.

It is reasonable to suggest that there would be a reluctance to talk about such material freely. While others may consider it natural to engage in conversation about the daily routine, it is probable that the trauma psychologist would need to edit a large extent of their experiences. The reasons for this would be two fold, ethical considerations and a desire not to shock others.

Practitioners have to find a method of dealing with this frequently disquieting material. In my own experience working as a supervisor, accumulated trauma stories often increase the risk of stress and depression in the practitioner. A failure to manage disquieting material runs the risk of our own frames of reference and attribution styles becoming adversely affected. It is correct to state that much of the healing work with trauma victims relies on the practitioner being empathic to their distress.

In my experience it is truly not possible to offer sincere empathy and at the same time to be emotionally detached or to remove oneself from the situation. So it would appear that providing empathy comes at a cost. At a cognitive level, being exposed to trauma often has a physical effect. Shock and fear are registered in the autonomic nervous system and within the limbic section of the brain. This is the part of the brain that responds to fear rather than reason. These reactions are driven as a result of changes within the hippocampus and amygdala, which influences the hormonal system of the individual (Wignal et al., 2004).

Following an incident in which an individual experiences feelings of a lack of autonomy and control, the cognitive system remains subject to hyperarousal, primed

for any possible future attack. Hyperarousal occurs even if the likelihood of the event reoccurring is minimal or even non-existent. The individual exposed to this kind of shock generally experiences anxiousness, agitation, insomnia, anger, hysteria, and hyperarousal following the exposure (van der Kolk & Saporta, 1991).

Many symptoms of vicarious traumatisation mirror those of post-traumatic stress disorder. It is not uncommon for therapists to suffer flashbacks of stories that they have heard (Bryant, 2010). Intrusive images often appear voluntarily and unbidden. They can occur during the day, in nightmares, during sex, or at other random times. They can be auditory or visual. They are frequently hard to talk about and always disturbing. The process often mirrors that of the victim. Without adequate supervision or personal processing, the therapist may at times take on the trauma of the client. This may then become locked within the individual and eat away at their physical and spiritual sense of self.

Current treatments employ methods that reduce symptoms of hyperarousal, lessen fear and increase an adaptation to and accommodation of the trauma. Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR) are the NHS National Institute for Clinical Excellence (NICE) advocated current methods of treatment. It should be noted that many patients report a reduction in symptomology through the use of other therapy modalities.

The rule of the psychologist is to assist the client process a life threatening event or serious shock without the experience being permanently stored as a distorted part memory within the memory store. Distorted and incomplete memories often become templates that the client uses as a working model to judge or conceive their world.

There is a distinct parallel in trauma work with the Freudian concept of Transference developed first in 1895 by Freud and Breuer. Transference may be defined as the carrying across of old patterns from the past into the present. Many of the clients who present at clinic following a trauma have been referred because of an inability to manage daily life. For instance, the man who was involved in the 9/11 attack would not enter an office building if it was made of glass. His perception was that buildings constructed of glass would shatter and people would be killed. He was therefore, using a previous experience to judge all others in the future. Having this perception had made life unmanageable, he was unable to work and his future was threatened.

Transference may be further defined as a process of viewing the future through the lens of the past. When this happens, there is a tendency to react as if the past is happening in the present. Often, the most distressing element of a traumatic incident is that one's exposure to horrific images remains in consciousness. This occurs despite attempts to construe some sense of meaning to the situation. Distressing images sometimes appear to circulate in the consciousness. In these circumstances it feels as if there is an absence of a pre-existing schema to imbed these experiences into. As a result, these images reverberate throughout the cognitive system often causing escalating levels of distress.

I became both interested and concerned about the potential of clients' narratives to affect the practitioner in a negative manner. I was personally aware that stories told and retold to me on a repeated basis sometimes caused distress and anxiety. Sometimes material 'hung around' after a session. On other occasions, the client's trauma story would 'pop into my head'. Frequently this was a result of an associated trigger. On other occasions I would need to 'root' out the trigger. Vicarious

traumatisation is a tangible and real risk to practitioners working within the helping professions. These concerns led me to consider, how I, as an individual dealt with traumatic material. In effect, how do I process traumatic material and are there methods I could use to do this more effectively?

It has always seemed difficult to process unpleasant and horrific images within a supervision framework. This is something that I have noticed both as a supervisee and as a supervisor. This is particularly emphasized within a group setting. There are several reasons why I speculate this may be the position. One obvious reason would be a wish not to cause harm to supervisors or colleagues. Another reason is a general reluctance not to discuss material that is normally kept below one's own consciousness. This avoidance has the function of reducing overall anxiety levels.

There appears to be a continuing yet subtle taboo in society regarding openly speaking of such things as death, mutilation and the specifics of atrocity unless one is a physician. These existential yet unpleasant events are often bracketed off creating an illusion of safety. In the supervisory contract there is a generally understood precept that supervision deals with process rather than content (Hawkins & Shohet, 2007). While this focus on process is helpful in the dyadic relationship between supervisor and therapist in general counselling matters, in trauma work it could be unhelpful. I tentatively speculate that during this type of supervision potential images and material that are distressing and therefore need release through transformation and accommodation remains hidden from others. The retaining of traumatic material may be considered a risk factor both to the professional and personal life of the practitioner.

1.3 Personal Reflection of Working with Trauma

It became important to me to develop a way of coping with the images and unpleasant material that I was receiving on a regular basis. Most of the material was

very unpleasant. Over a period of time I monitored my level of discomfort, recognising my own capacity to deal with this material was dependent on developing robust coping strategies. These strategies helped foster an acceptance of the unpleasant and downright horrific and facilitated meaning in many difficult situations.

I have personally found ways to deal with unpleasant material in a proactive manner. One key aspect that has been personally relevant to me is that the world appears to lose a little of its colour when my threshold of tolerance to unpleasant material is reaching its limit. I am no longer so enthused or conscious of the beauty that surrounds me. Living in an area of outstanding natural beauty, this is significant.

I have always used a metaphorical, image based method of dealing with material. The world losing colour to me is symbolic. It resonates with the approach of night, of darkness and depression. When I register this feeling, I immediately think of how I could bring back the light or at least restore subtle hues to the palette. On one occasion in which I had to provide therapy to several staff members who had witnessed a traumatic death, I could almost feel as if the light was going.

I think this was very pertinent because in the weeks before I had been called to a mental health unit where three patients had committed suicide by hanging within a two week framework. I wondered how I could reconnect with feelings of colour and of vibrancy. A solution for me was a flying lesson, high above the fields of the Sussex Downs. A combination of concentration and the hues of early summer brought back my positivity and allowed me to feel buoyant again.

This coping strategy enabled me to leave the images of hanging, ropes and distorted faces behind. These general processed and highly personal insights led me to consider how others might deal with similar material. How do my colleagues process traumatic material? What do they find difficult and how do they manage it? Further,

is it possible that all psychologists working with trauma report residue feelings that are distressing and that over time these have the capacity to cause attribution changes that while below the threshold for vicarious traumatisation impact significantly on daily life and decision making.

I wondered if the insight gained through asking colleagues about their experience might lead to the development of a self-help manual or supervision tool for dealing with traumatic material. Or indeed the development of a model for the supervision of trauma that qualified supervisors would find useful in working with their supervisees. My first step in formalizing my enquiries was to extend my knowledge of the literature.

As a chartered counselling psychologist existentialism underpins my therapeutic approach. I therefore, place a significant and rich emphasis on the meanings people ascribe to their situations and life events. Naturally, I am able to draw on and utilise other key approaches such as behavioural and psychodynamic orientations in my work with clients. My emphasis on an existential approach as a method of elucidating and distilling individual meaning resulted in the selection of a qualitative semi-structured phenomenological interview; a natural choice for this research study.

The process of utilising counselling skills to elucidate participant meaning ensured that there was a natural fluency in obtaining, clarifying and honing in closely in participant reality.

1.4 Purpose of This Study

This research study has the objective of examining the coping methods of a wider group of psychotherapists. The purpose of the research will be to gather insights and foster understanding. It is anticipated that these insights may promote further

investigation. It is hoped that the gained phenomenological insights may produce a synthesis of meaning that can inform the development of a supervision tool, a resource that may be used in trauma work. This may be used either in a formal supervisor setting or as a self-supervision method.

Tools and strategies that help reduce vicarious traumatisation are needed in psychology. Ultimately an extension of knowledge in this area is of paramount importance within the wider helping professions. It will also have utility with emergency personnel and the armed forces.

The supervision of trauma workers is a professional area which is currently under developed and little researched. Psychologists often feel unable to discuss events that have distressed them and have been unable to process them. As a result their distress has continued for extended periods.

The aims of this study are:-

1. To elucidate the strategies used by psychologists to manage trauma.
2. To produce rich data that will be able to be utilised in the development of both formal and self-supervision.
3. It is anticipated that the development of an extensive base of knowledge may be used in the training of the next generation of psychologists and lead to lower levels of vicarious traumatisation.
4. To improve the overall effectiveness of supervision and line management to psychologists working in the trauma field.

1.5 Research Question

What are the processes and coping strategies that psychologists use to process traumatic material and how effective are these?

Chapter 2 Literature Review

For psychologists working with trauma survivors the process can be a demanding and sometimes unpleasant experience. Vicarious traumatisation (VT) (McCann & Pearlman, 1995) is defined as the cumulative transformative effect on the helper of working with survivors of traumatic life events. Vicarious traumatisation is the transformation of the therapist's inner experience as a result of empathic engagement with survivor clients. Simply put, McCann and Pearlman believe that when we listen with open hearts to other people's stories of atrocity and horror our world view changes.

Lyotard (1979) devised the concept of metanarratives. These describe the values and beliefs that an individual holds. Metanarratives may be described as the big story or the meanings ascribed by a culture, system or process.

McCann and Pearlman (1999) identified seven major cognitive schemas that are prone to alteration through exposure to trauma through one's work.

1. *Frame of reference (*e.g. clinicians may question their professional or personal identity).
2. *Safety* (heightened sense of fear).
3. *Trust and dependency* (viewing significant others with suspicion).
4. *Esteem* (criticising and undervaluing the self).
5. *Independence* (loss of freedom as a result of feeling vulnerable).
6. *Power* (e.g. clinicians may feel overly responsible for their clients' recovery*)* and
7. *Intimacy* (e.g. loss of faith in humanity may cause clinicians to block against feelings of intimacy).

Finally, vicarious traumatisation may contribute to behaviours that promote emotional numbing including alcohol consumption, overeating, overspending and overworking (Tehrani, Cox & Cox, 2002).

Vicarious traumatisation is related to concepts such as 'compassion fatigue' (Figley, 1982) 'emotional exhaustion', 'burnout' and 'secondary traumatic stress' (Figley, 1983, 1985, 1989; Stamm 1995, 1997) and 'counter-transference'. Key differences exist between some of these concepts (Dunkley & Whelan, 2006). Vicarious traumatisation is often expressed as 'feeling heavy', or when the work (or an aspect of the work) 'gets inside you'. Others have referred to the process as a 'haunting'.

Professional burnout (PB) is typically caused by external factors of the work environment while vicarious traumatisation is caused by specific internal reactions (Maslach, Schaufeli & Leiter, 2001). Some psychologists appear to suffer little while working with the horror and atrocity of clients' lives while others, generally, over a period of time descend into a process of cynicism and experience changes to their attribution style (Tehrani, Cox & Cox, 2002; McCann & Pearlman, 1991). Others experience disruption to their cognitive processes with intrusive imagery and flashbacks often being experienced (Hesse, 2002). It was estimated in 2002 that 18% of mental health workers suffer from symptoms which meet the criteria for PTSD (Meldrum, King & Spooner, 2002).

Level of experience may also be relevant in predicting vicarious trauma, but existing research on this is contradictory. Providing sexual abuse treatment to survivors over a shorter length of time has been found to predict greater 'intrusive' symptoms in clinicians, but it is also suggested that clinicians most affected by trauma may leave the field prematurely and therefore they may not have been represented in

this study (Way, VanDeusen, Martin, Applegate, & Jandle, 2004). Case load was also found to be significant (Furlonger & Taylor 2013).

On the other hand, number of years' experience working in the field was found to be associated with more disruptive beliefs regarding intimacy with others (Bober & Regehr, 2006). These researchers suggest degree of exposure has an impact on intrusion and avoidance symptoms, but that altered beliefs do not appear to occur in the short term. Finally, some researchers suggest that symptoms may also be recognised to a lesser extent over time, becoming 'normalised' and so less noticed (Iliffe & Steed, 2000). Other studies suggest that supervision teaches coping strategies (Courtois & Ford, 2009; Adams & Riggs, 2008). Others assert that practitioners' on-going physical and emotional management may be within the individuals' control (Mathieu, 2012).

Time spent counselling trauma victims is the best predictor of trauma scores among counsellors (Bober & Regehr, 2006). Research has also found that counsellors with a higher percentage of sexual assault survivors in their caseload reported more disrupted beliefs, more PTSD symptoms, and more self-reported vicarious trauma (Schauben & Frazier, 1995). This has implications for preventing or addressing vicarious traumatisation. The role of empathy is important here. Empathy is a major resource for trauma workers, who use it to assess survivors' problems and work out a treatment approach (Campbell, 2002).

Empathising with survivors of rape helps workers understand their experience of being traumatised, although in the process, the professionals may be traumatised as well (Figley, 1985). Counsellors must personally endure repeated exposure to distress and use their own feelings of sorrow as tools for therapy. As such, it is impossible to

escape this kind of work without personal consequences (Campbell, 2002). Empathic engagement makes the therapist vulnerable (Sexton, 1999).

Recent research findings suggest that not all individuals experience negative change through their work. Researchers have found evidence of Post Traumatic Growth (PTG) defined as 'the experience of significant positive change arising from the struggle with a major life crisis' (Klaric et al., 2013; Chesler, 2003; Tedeschi & Calhoun, 1995). Indeed although not referred to as post traumatic growth, the concept has been described by others (Frankl, 1963; Maslow, 1970; Lieberman, 1991) as well as by poets, philosophers and authors throughout the centuries who have attempted to address the meaning of human suffering.

However, the widespread notion that trauma will result in disorder should not be replaced with the belief that growth is an inevitable result. Rather instead, continuing personal distress and growth often co-exist (Cadell, 2003). Paradoxes have been found to coexist; "I am more vulnerable, yet I am stronger". Individuals who experience traumatic life events perhaps unsurprisingly tend to report a heightened sense of vulnerability that is congruent with the experience in ways they have been unable to control. However, these same people frequently report an increased sense of their capacities to survive and prevail (Calhoun & Tedeschi, 1999). There is often an increase in the raising of existential questions of purpose and meaning.

However, post traumatic growth does not necessarily result in less distress. (Tedeschi & Calhoun, 2004). Most of the literature refers to individuals who have experienced a traumatic incident. There is a paucity of research to date regarding post traumatic growth in therapists.

A negative attribution style appears to be one phenomenon associated with vicarious traumatisation. Some studies suggest the onset of post traumatic stress

disorder is in part, associated with a less than robust coping style and link this to developmental issues (Terr, 2002). A recent research study concluded that vicarious traumatisation is determined by individual variables and that positive re-interpretation can buffer the impact of the work when it comes to emotional wellbeing (Cornelia & Turliuc, 2013). This stresses the importance of personality traits such as extraversion, neuroticism and conscientiousness as predictors of dysfunctional beliefs.

It is possible then to hypothesise that one's own attribution style prior to listening to stories of clients' distress may be a factor in the development of vicarious traumatisation. Others have concluded that coping with pain can significantly reduce the emotional energy and coping resources of professionals (Adams & Riggs, 2008).

A healthy attribution style may be a factor in preventing vicarious traumatisation. There is also a strong clinical argument for the use of a supervision tool that ameliorates distress before it becomes increasingly embedded in an already negative attribution style. A number of key studies have identified several potential moderators of vicarious post traumatic growth in therapists, including coherence and organisation support (Joseph, et al., 2005; Joseph & Linley, 2008). A sense of coherence describes the extent to which therapists are able to maintain a positive world view which in turn reduces stress levels (Antonovsky, 1987). Caseload, personal trauma history, professional trauma history, the perception of adequate training, peer supervision, social support, self-care and resilience were each viewed as crucial for maintaining a healthy functioning attribution style (Jordan, 2012).

It is also recognised that even the most healthy attribution system can be detrimentally affected by stories of extreme violence; therefore, it remains important to develop effective methods of processing the distress. This may involve constructing meaning from stories of horror or simply processing the somatic feelings that

therapists often experience. In my early years as a trauma psychologist I became aware, when supervising others, that certain supervisees seemed to be experiencing less residual side effects of distress after working with other's traumatic material.

A qualitative study (Tizzard, 2004) revealed that a cohort group of psychologists were indeed using processing strategies to rid themselves of traumatic material. They appeared to be processing trauma in three distinct modalities. The selected modality depended on the modality in which they received the trauma. Each of the psychologists was not consciously aware of the function their processing strategies solved.

This study will examine the coping methods of a wider group of psychologists. The purpose of the research will be to develop a supervision tool that may be used in trauma work. This may be used either in a formal supervisor setting or as a self-supervision method. This will be of paramount importance within the helping professions. It will have utility with emergency personnel and the armed forces.

Effective supervision is believed to be an important component in the prevention and healing of vicarious traumatisation. Responsible supervision creates a relationship in which a worker feels safe to express their fears, concerns and feelings of inadequacy. Some researchers argue that trauma continues to be ignored in the training of mental health professionals. While supervision is addressed in training unfortunately there is not much emphasis placed on how to provide quality or even adequate supervision. These two gaps create an unacceptable situation for trauma therapists (Bledsoe, 2012). There is an emerging belief that training in trauma supervision and self-supervision should begin in the classroom (Newman, 2011; Shannon et al., 2013).

Sometimes staff supervision will be combined with ensuring organisational accountability and staff evaluation. This can create a tension; a worker's concern about the evaluation of their work may make her or him reluctant to bring up something relevant to vicarious traumatisation. Because of this, some recommend that supervision and evaluation remain separate functions (Bell et al., 2003). In agencies where this is not possible, the use of external clinicians for trauma specific supervision is recommended. Certainly, all supervisory relationships need to be characterised by trust and transparency, set by a supportive workplace culture.

Trauma supervision training should model humaneness and facilitate an environment where practitioners are encouraged to reflect and talk about their experiences (Courtois & Gold, 2009). It is also worth noting that supervisors themselves need to be able to access effective supervisory support.

Given the prevalence of sexual assault, many workers in the field will also be primary victim/survivors, although it is worth noting that, while inconclusive, research does not suggest a higher proportion of abuse survivors among those in the 'helping' professions (Stevens & Higgins, 2002). Some research suggests an association between personal history of abuse and experiencing vicarious traumatisation. In one study of trauma therapists, counsellors with a personal trauma history showed greater disruptions (in, for example, their beliefs about themselves and the world) than those without such a history (Pearlman & Mac Ian, 1995).

However, other research has not found a personal history of abuse to be a relevant factor in predicting vicarious traumatisation. For example, Schauben and Frazier (1995) found that vicarious traumatisation 'symptomology' was not related to personal trauma history, including experience of sexual assault.

Another study found that personal histories of abuse were not associated with vicarious trauma, except in individuals who had sought treatment, which suggests that those who were distressed or unresolved about their personal histories were likely to seek appropriate assistance (Bober & Regher, 2006). Stevens and Higgins (2002) found that a personal history of maltreatment predicted current trauma symptoms, but not burnout. Thus, while personal experience of abuse may sometimes be salient to the experience of vicarious trauma and sometimes not, research also has found that it is traumatising within itself to be exposed to traumatic material.

It is related to concepts such as 'emotional exhaustion', 'burnout', 'compassion fatigue', 'secondary traumatisation' and 'counter-transference', but some key differences exist between some of these concepts (Dunkley & Whelan, 2006). It can also be expressed as 'feeling heavy', or when the work (or an aspect of the work) 'gets inside you'.

Whichever terms are used, the process of working with trauma is often a challenging task. There is a paucity of research that has sought to elucidate how psychologists continue to work in this area, or that has identified the strategies they use. While concepts such as vicarious traumatisation, compassion fatigue and secondary traumatic stress are unequivocally accepted phenomena, it is possible that simply working with trauma is sufficient to cause frame of reference changes over time.

Chapter 3 - Methodology

3.1 Selection of a Methodology

The selection of a methodology presents the researcher with a number of choices. The challenge is to choose which particular model is best suited to the research question. The question in this research study is to elucidate the coping strategies used by psychologists to prevent vicarious traumatisation. To achieve this it is crucial to be able to obtain first person accounts of experience. Historically, many areas of traditional academic research have utilized quantitative or empirical methods. There has traditionally been a focus of what is measurable and quantifiable (Gergen, 1995; King & Halling, 1989). While it is the case that quantitative studies have an unequivocal and crucial position in the research field; qualitative research methodologies continue to develop as a powerful tool to describe in details and to elucidate meaning. Specifically, qualitative research is concerned with reaching beyond prediction, control and measurement, and it aims at capturing the essence of experience.

In 1960 Speigelberg stated that 'The historical roots of phenomenology may be viewed as a movement rather than a discreet period of time'. This distinction is important because it reflects the view that phenomenology and hermeneutics and our understanding of them are not stationary, rather they are dynamic and subject to continuous evolvement (Laverty, 2003).

In reality there was a growing recognition of the limits of addressing many significant questions in the human realm within the requirements of empirical methods and its quest for inaudible truth (Polkingthorne, 1983). All qualitative approaches draw on German philosophy and attempt to understand and elucidate human experience as it is lived (Laverty, 2003) and reach similar end points in discussion

(Hein & Austin, 2001; Todres & Wheeler, 2001). A variety of research methodologies became popular, phenomenology, ethnography, grounded theory and hermeneutic phenomenology (Denzin & Lincoln, 2000) all secured a place in this type of research.

Two major approaches, hermeneutic phenomenology and transcendental phenomenology represent philosophical assumptions about lived experience and ways to organise phenomenological data. The two approaches are different in their historical perspectives (e.g. Heidegger or Husserl), methodological procedures (Laverty, 2003) and their current advocates (van Manen, 1990), for hermeneutic phenomenology and (Moustakas, 1994), for transcendental phenomenology of science, a design for acquiring and collecting data that explicates the essences of human experience. Hermeneutics require reflective interpretation of a text or a study in history. All understanding is connected to a given sense of foreclosure including one's own historicity that cannot be eliminated. Specifically, we bring our own understanding and values to any situation. These are preordained by our culture and history.

Husserl's transcendental phenomenology is based on the assumption that the meanings of the world exist out there, which is separate from human beings and human beings need to find the meanings of the world. Husserl's original work was in the area of mathematics. He developed an interest in philosophy eventually viewing phenomenology as objective and subjective. Finally, subjectivity dominated his approach which culminated in pure phenomenology (Cohen, 1987). Phenomenology is essentially the study of lived experience or the life world (van Manen, 1997). Its emphasis is on the world as lived by a person, not the world as distinct or separate from the person (Valle et al., 1989).

On the other hand, Heidegger's hermeneutic phenomenology is based on the assumption that the meanings of the world come to human beings through human

beings' interaction with the world. That is, Heidegger's hermeneutic phenomenology argues that the meanings of the world depend on the ways that human beings encounter the world. Moustakas has indicated that the steps of analysis in transcendental phenomenology use a more structured approach than the hermeneutic method.

The differences between phenomenology and heuristics are within ontological, (relating to being), epistemological (the study of a theory) and methodological realms (the underlying principles and rules of organisation of a philosophical system). The phenomenological approach seeks to bracket off one's assumptions at the outset of the research process, to be aware of that which the researcher is bringing in an attempt to remain impartial and to suspend judgments.

In hermeneutics assumptions are not put aside rather they are viewed as important components in understanding the material. The purpose of this study was to obtain as data rich material that could be analyzed for meaning from a fresh standpoint to see with new eyes.

The selection of phenomenology as a research method evolved as a natural choice. Within this area there were several choices of methodology available. Each was evaluated as a possible method.

Interpretative Phenomenological Analysis (IPA) was considered. IPA provides a theoretically informed framework for how research is conducted rather than just providing a method. IPA has a dual focus on the unique characteristics of individual participants (the idiographic focus) and on patterning across the participants. In contrast, thematic analysis focuses mainly on patterning of meaning across the participants (this does not imply that it is unable to capture difference and divergence). Overall, Interpretive Phenomenological Analysis proceedings assist the researcher to remain close to the data because codes and themes are developed for the data and focus

is on the unique characteristics of each participant. Codes are developed for each item in turn.

By contrast the procedures of Thematic Analysis help the researcher identify patterns across the complete data set. This was a crucial aspect in choosing the research method for this study. Additionally, while thematic analysis provided a framework its flexibility ensured it could be used across the epistemological and ontological spectrum. It offered the scope to analyse most types of qualitative data, interviews, vignettes, diaries etc.. It was also ideal for the semi-structured interview process.

A disadvantage to using IPA in this research study was that its methodology offered an entire framework that was too structured for this research.

Grounded Theory was also considered. The aim of Grounded Theory is to generate or discover a theory (Glaser & Strauss, 1967) and may be defined as 'the discovery of theory from data systemically obtained from social research'. Grounded Theory offered possibilities in terms of facilitating the use of open ended questions during in-depth interviews and the questions could be modified to reflect emerging theory. The main drawbacks to the use of this method in this research were:-

a) The limited time available. Grounded Theory is the process of data collection for generating theory whereby the analyst jointly collects, codes and analyses the data and decides what data to collect next and where to find them, in order to develop theory as it emerges. Charmaz (1990) suggests that theoretical sampling is most effectively employed after some key concepts have been discovered. Initial data collection is commenced with a 'fairly random' group of people who have experienced the phenomena under scrutiny to generate further concepts. Theoretical sampling is then used to generate further data as it emerges.

b) A second rationale against the using of Grounded Theory was that a full analysis is only achievable with a large research project (Burks & Mills, 2011).

The selected methodology provided an opportunity to undertake research with participants in a field that the researcher is very familiar with. Therefore there was a commonality between the researcher and the participants. The transcendental and heuristic phenomenological approach of Moustakas was fitting in this circumstance.

3.2 Final Selection of Methodology

The selection of a phenomenological approach for this research study arises out of the requirement to work directly with the participant psychologists' material. It was of the upmost importance to be able to gain material that was rich in meaning. In this study, the aim of the interviews was to gain access to the personal feelings of clinicians of listening to distressing material received from their clients during clinical practice. A primary consideration in the selection of methodology was the ethical responsibility to directly cause no harm to participants. It was crucial that during the investigation of the process, participants were not re-exposed directly to traumatic memories. Further exposure of the psychologists to traumatic material raised the risk of emotional harm occurring. A sensitive information gathering process was required and a process that gathered authentic data.

An aim central to this study was to produce research that was applicable to the field. To achieve this, the chosen research methodology needed to provide an opportunity to collaborate with participants by actively involving them in the research (Clandinin & Connelly, 2000).

As researchers gather stories from participants, they negotiate relationships, smooth junctures in the process and provide ways to be helpful to participants. In narrative research a key theme has been the focus on the relationship between the

researcher and the researched in which both parties will learn from it and change accordingly.

A qualitative research process was chosen in order to fulfil these specified procedural and ethical concerns and to achieve the objective to add as much depth, richness and diversity as possible. The method selected for this research is phenomenological qualitative research. It follows the philosophy of Moustakas (1994), Giorgi (1995) and Worthen and McNeill (1996). Moustakas (1994) developed a modification of the van Kaam method of phenomenological data.

This method is concerned with the elucidation of meaning, particularly the richness and diversity as experienced by the individual. This method of phenomenological research ensures that the core richness of a participant's descriptions is captured in the transcribing and analysis of their data.

The process allowed positive opportunities for classification of data and would allow an inductive process to occur. Worthen and McNeill (1996) state that phenomenological enquiry is very similar to the interviewing techniques central to the training of counselling psychologists and is a methodological extension of researchers' previous training experiences. The interview dialogue offers the opportunity for immediate clarification and further probing.

After consideration of these outlined factors it was decided that an in depth interview process was the most effective method for the purpose of this research project.

3.3 Method

The section that follows will outline the practical steps that were undertaken to produce results using the selected methodology.

3.3.1 Selection of Participants

Five psychologists of European ethnicity were interviewed for this study. Participant's age ranged from 35 years to 60 years of age. To ensure some variation in training experiences, participants were selected from three psychology disciplines. These were clinical psychology, forensic psychology and counselling psychology.

All the participants were registered with the British Psychological Society and held current Health Council Professionals Registration. Each psychologist had completed a Doctorate in Psychology. All participants had completed at least 5 years post qualification training professional practice. Most had completed in excess of 10 years practice. Each psychologist engaged in regular supervision. Supervisors were five women having 5 – 10 years of supervisory experience.

The criteria for participant's selection included a preparedness to participate in a tape recorded interview and willingness to participate in a follow-up interview as necessary. Participants were volunteers and were not paid for their involvement in the research.

The recruitment of the participants was an arduous and time consuming process. Despite using the following strategies to recruit participants:-

- Three advertisements for research participants being placed in the BPS Publication 'The Psychologist'
- Fifty letters addressed to individually named chartered psychologists
- Individual personalised letters addressed to a total of five clinical services specialising in the treatment of trauma.

Only five participants were able to be recruited.

The recruitment process involved a timeframe of nine months. At one point serious consideration was given to aborting the planned research investigation. There

was also consideration given to recruiting individuals from a broader therapeutic background.

A decision was made to recruit participant psychologists from the independent sector and eventually participants came forward. It is believed that participants would not have been recruited without the assistance of the chief psychologist who encouraged her staff to take part.

Reasons for a reluctance to participate were given as a fear of being, a) evaluated negatively if perceived as failing to cope, b) a fear of being judged as incompetent if negative reactions were disclosed and c) a reluctance to talk about traumatic material outside of the therapy situation.

The five subjects who did agree to take part in the study all voiced similar concerns. However, they were informed by their manager that the researcher was a practitioner in the trauma field. This appeared to allay to some extent fears regarding being considered incompetent or perceived as not coping if they disclosed that they struggled at times with the material.

Although the participant size was small the sample produced phenomenally rich data; data that could not have been collected through a larger of different methodology.

Table 1 – Participant Profiles

Identifier	**Age**	**Role**	**Years Service**
Participant 1 ‘D’	43	Forensic Psychologist	10
Participant 2 ‘T’	37	Clinical Psychologist	12
Participant 3 ‘L’	44	Forensic Psychologist	13
Participant 4 ‘A’	37	Counselling Psychologist	11
Participant 5 ‘M’	32	Counselling Psychologist	10

3.3.2 The Researcher

Christine Tizzard is of white European ethnicity and was completing her doctoral research in psychology. She had over 10 years' experience in clinical practice and had previously completed an MSc in psychology. Her current work includes providing clinical services to adults and children as well as providing psychology expert witness services to the criminal and family courts.

Christine Tizzard has had considerable experience of working in the field of psychological trauma and it is this area that prompted her to study the effects of working with traumatic material on psychologists. She has worked with survivors of both the 9/11 and 7/7 terrorist attacks as well as providing PTSD treatment to a number of police forces and the military. She is also a RAPP's registered supervisor.

3.3.3 Procedure

A research proposal was submitted to the ethics committee of the University. Approval was duly granted (Appendix 9). The ethical submission contained the full details of the participant consent form and details of the debriefing follow up process (Appendices 1, 2 & 3).

All research interviews were carried out by Christine Tizzard. Each participant was interviewed at their place of work. Participants were interviewed in a small private office. Each participant was provided time to read and sign an informed consent form before the process began. None of the participants declined to take the process further at this stage. All were keen to take part in the investigation.

During this process each participant was taken through a sequential process outlining the debriefing protocols in place that were available for them following the research interview. (Appendix 3.) It was anticipated that the psychologists could possibly experience some reawakening of past psychological trauma. Protocols were

developed to deal with this occurrence should it arise. The measures that participants were offered were a follow up telephone conversation with the researcher after 24 hours if they wished or that they agreed to make arrangements to visit their own supervisor.

A research question was formulated to guide the interview. The opening statement made to participants in the research study was: *"We all know that working with trauma is often an uncomfortable experience. I would like to learn from you what have been your experiences of working in this field".* The participants were then encouraged to elaborate on that comment. The interviewer's role was to facilitate and encourage a deeper and richer narration of the process involved in working with traumatic material.

During each of the interviews, basic counselling skills were used. These were prompting for further elaboration, clarifying, probing and summarising the processes given to the researcher. The use of active listening skills facilitated an elaboration on relevant points which contributed to a rounded and well covered interview.

The interviews ranged from between 30 – 50 minutes in length. There was no specific designated time frame. It was anticipated that by adopting an open ended interview approach participants would have sufficient time and space to articulate the personally relevant specifics of their experiences. The interview process drew to a close when the participants felt that they had expressed all relevant experiences.

A conscious attempt was made to make sure that questions did not lead the participants to specific or predetermined conclusions. Rather there was a logical and sequential flow to their spoken material that led to a phenomenological rich and diverse collection of data. The formal interviews concluded with the researcher asking participants if they felt that they had covered all aspects that they wished to include in

the data. After receiving confirmation that all information had been covered, the interview was concluded.

At the end of the interview the researcher reiterated the follow up process. This provided confirmation that the participants could contact the researcher after the process in the event that they were to experience any level of distress. It was noted that none of the participants took up this option. Each participant thanked the researcher for giving them the opportunity to take part in the process. All commented that the process had provided them 'food for thought'. Each stated that they had now gained a conscious awareness of their unconscious processes.

3.3.4 Materials Used

To record the process, a Dictaphone was used. A semi-structured interview prompt form was also used. The prompt was used as a focus and a tool to ensure that the semi–structured interview was adhered to.

3.3.5 Transcription

Each of the tapes were transcribed verbatim and checked for accuracy by a second individual. The second individual was an audio typist employed at the psychology practice.

3.3.6 Analytical Approach

The aim of a phenomenological reduction is to illuminate the totality of how varied events or human action can be perceived and described. To achieve this rich and varied account it was imperative that I engaged in a process that led to a bracketing off of my assumptions about the data. McLeod (1994) argues that using a phenomenological approach, the researcher should always be looking for new ways of seeing or understanding the object under enquiry.

Having obtained the rich and diverse data, it was important to select a method of analysis that could bring the richness of the participants' data to life. To achieve this, the researcher needs to immerse themselves in the material in a manner that enables them to access the experiences of the participant in an empathic way. A qualitative research analysis depends on the systematic application of fundamental ideas. These are emersion, categorisation, phenomenological reduction, triangulation and interpretation.

The method of phenomenological reduction chosen for the organisation of the data was that designed by Moustakas (1994); this method contains a procedure for studying the data. Moustakas' transcendental psychological phenomenology is focussed less on the researcher. It has the lens focused on the experience of the participant. This process concerns itself with *epoch* or bracketing off the researcher's assumptions as much as possible and seeing the material with fresh perspectives. Hence transcendental means seeing matters afresh. It is important to note that Moustakas emphasises that this is rarely achieved.

The phenomenological interview tends to be a lengthy process, concerned with meanings. Moustakas argues that the challenge facing the researcher is to describe things in themselves, to assist what is in front of one to enter consciousness and to be understood in its meaning and essences in the light of intuition and self-reflection. The process entails a form of blending of what is really present from the vantage point of possible meanings thus a unity of the real and the ideal.

Post-modern narrative writers such as Czarniawska (2004) add another concept to the analytical process. This is a process of a deconstruction of the participants' stories; an untangling of them by such analytic strategies as exposing

dichotomies, investigating silences and their meaning and attending to disruptions and contradictions.

The method chosen is Moustakas' adaptation of the van Kaam method of phenomenological analysis. It simultaneously draws from the work of Czarniawska in using a process of deconstruction in an attempt to investigate dichotomies, silences and their meanings.

The modification of the van Kaam method of analysis of phenomenological data involves a number of stages:

1. *Initial Grouping*

   The initial process involved in this form of phenomenological research is termed *horizontalisation.* That is the noting of each relevant expression, that a participant makes. Each expression is viewed as a related unit of experience. Each expression of meaning is given equal value. Central to the process of analysing each participant's material, each transcript was read and re-read again to gain full understanding of the text.

2. *Reduction and Elimination*

   The relevant phrases were then subject to reduction and elimination to determine the invariant constituents. The invariant constituents refer to the part of the rephrase that remained relevant to the research process. In order to do this the following processes were carried out:-

   a. The researcher considered each phrase as follows, the question was asked "does this phrase or sentence contain a moment of experience that is a necessary and sufficient constituent for understanding it."

   b. Is it possible to abstract and label it? If this is possible it is a *horizon of experience.* A horizon of experience is the understanding and interpretation

> of being in every circumstance, moment by moment. Each horizon of experience becomes a small component or aggregate in an individual's wider sense of meaning.

Expressions not meeting these criteria were eliminated. Overlapping or vague phrases were eliminated from the process. The horizons that were made were the invariant constitutes of the experience.

3. Clustering

The invariant constituents became the core themes of experience (Moustakas, 1994). After this process had been carried out the next stage involved clustering and organising, the invariant constitutes.

4. Final Identification of the Invariant Constituents

Each related concept was grouped into an emerging thematic level. At all stages of this process the data was rechecked to ensure that it remained a true representation of the participant's transcript and that the responses were correctly categorized.

5. Construction of Individual Textural Description

After this process was completed an *individual textural experience* was completed for each participant. The individual textural experience includes the situated examples from the transcribed interview that put the information into context.

6. Construction of Individual Structural Description

This process was followed by the construction of an *individual structural description* for each co-researcher based on the individual textural description and imaginative variation. For each participant, incorporated into the textural description is a structure that explained how the process occurred. As each

textural description was produced time was spent thinking of the factors that precipitated the experience of each psychologist. This process facilitated an understanding of how the experience occurred. Central to this process are the acts of judging, imagining and recollecting, these practises lead to an emergent structural meaning.

This process allows the researcher to gain a concrete understanding in more varied terms. The individual structural description provides a vivid account of the underlying dynamics of the experience, the themes and qualities relevant to the process. The structures are brought into the researcher's awareness through imaginative variation, reflection and analysis, beyond the appearance into the real meanings or essences of the experience underlined. To clarify, the textural description provides an account of direct or raw experiences while the structural descriptions provide a contextual setting, situatedness and back bone to experience.

7. Composite Textural Description

After both the individual textural experience and individual structural description for each researcher had been carried out the process then moved to the construction of a *composite textured experience*, this encompassed all the participants' experiences.

8. Composite Structural Description

The following stage involved the construction of a *composite structural description* for the group of participants. In this final stage the themes that emerged were common to all the participants and formed the basis for ongoing discussions about the research.

The final phase of the process resulted in the essence of psychologist's experience of working with traumatic material. This stage consisted of a refining the description into its most distilled and concise form. What actually occurred was that there was a range of concepts identified below that encapsulated individuals' experiences of working with trauma. These are identified, outlined and discussed in the following chapter.

3.3.7 Personal Reflections Regarding the Interview Process

I am of the opinion that my role as a researcher was enhanced by practitioner researcher background.

In the study I was clearly the researcher; I was not a co-respondent. However, my extensive experience of working with clients who have experienced trauma perhaps facilitated a deeper disclosure by the client group. Participants were able to speak about areas which they were aware would be understood. While it was not necessary to speak in detail about specific traumatic material, the sharing of a common narrative enabled a deeper level of disclosure.

I believe that there was a consensual and implicit understanding that each of us are often shocked by the traumatic suffering of others. This enabled a discourse to begin from a mutually understood foundation.

In being able to comprehend the actual lived phenomena of trauma, I was able to provide a containing and safe atmosphere that aided the collection of very genuine data.

The semi-structured interview process provided an effective tool to gain the trust of the participants. This was crucial in exploring this sensitive area of practice. There was an initial reticence on the part of the participants. The presence of the

researcher in the room allowed for a period of time to be spent establishing a working alliance and building a rapport. The process was analogous to supervision.

A further strength of the method selected was the ability to use basic counselling skills, such as paraphrasing, prompting and clarifying to aid the flow of information. Limited and well-timed self-disclosure by the researcher (who actively works with trauma) provided a safe environment for the participants.

I did not experience a particular weakness of this method as it fulfilled the specific aspect of gaining access to rich phenomenological data.

Chapter 4 - Results/Analysis

4.1 Personal Reflections Regarding Data Analysis

The van Kamm method as described by Moustakas (1994) was used for data analysis. I found the process both helpful and illuminating. The process provided an emergent theme of concepts that were able to be explored and clarified further using a process of deconstruction (Czarniawska, 2004). This method was particularly helpful in creating an environment where both researcher and participant could collaborate in the establishment of a working relationship that set the scene for safe disclosure. This was of specific assistance in elucidating and clarifying difficult and sensitive areas that could have implications for professional practice.

4.2 Participants' Experience of Working with Trauma

After reading the transcript several times and completing step 1 - listing and preliminary grouping and step 2 - reduction and elimination, step 3 was undertaken. The emergent themes were clustered into invariant constituents and defined the "core themes of experience" (Moustakas, 1994).

Box 4.1 - Participant 1 (D) Themes

Longevity of Traumatic Material

Unpleasant Residue Material

P2 Thinking beyond the material concept - creating pictures in the mind.

Trying to make sense of it/parallel process

P6 Replaying it, putting the self in the others shoes, entering their frame of reference.

Somatic Reactions

P14 "I get a headache."

Emotional Reactions

P17 Rumination – "On the mind for days – the specifics of the trauma."

P8 "Goes behind the professional mask and intrudes into one's own time."

P14 "Difficult to shut off."

Flashbacks/intrusions

P18 "It is intermittently on the mind – triggers will bring it back again – I'm not always aware what these are."

Desensitisation

P20 "You become desensitised to it – you become unshockable"

"Only one person died… tending to minimise trauma…..quantifying it."

Method of disclosure

P14 Immediacy, "…in a one to one session much more traumatic."

Burnout

Temporary

"Not working with severe trauma one's sensitivity comes back and you become shockable."

"Desensitisation is temporary."

P24 "Have had to retrain my sensitivity, not registering small crimes – less empathy – selective empathy."

P27 "Desensitisation is a natural phenomenon."

Coping Strategies

P30 "…couple of glasses of wine to relax… help to soften things."

Supervision

"It's good to talk."

"I miss the team work and talking and black humour – the normalising."

P32 "Working alone with trauma is hard."

Peer Supervision

P32 "Peer supervision was the most effective way of processing things."

Supervision failures

P38 To get the supervisor to understand "you almost have to tell them the details."

Supervision behaviours

P42 Editing what is said. Not necessary to edit in peer supervision, easier to abbreviate – peers share a common sense of reference.

P50 & 52 Compartmentalise trauma when working well.

P46 "The more you hear the more desensitised you get to protect yourself."

"Not hearing it regularly, the more it shocks you."

Peer Support/Peer Relationships - Positive Influences/Trauma Bond

P49 The support of colleagues – "unconscious communication makes it better with friends who do the same work."

Normalising

P50 Spending time with colleagues "because you can go out and have a meal, go bowling or go and do something fun, it's like they are okay. Yes, it is okay, I suppose that other people cope with this material, it is okay. So, again it normalises what I do."

"Because my colleagues are dealing with this stuff and surviving, I can too."

P52 "It's a part of my job."

P8 "To distance myself from it and to make a professional judgement about what is going on"

Changes to Frame of Reference

Awareness of changes to attribution. "Not always easy to elucidate the nature of these changes."

P54 "…it changed things when I had children…" "… more suspicious of…"

P56 See things other people don't.

P62 "I might have a skewed take on things but there is a reality. The risks are there."

P64 Need to check out thoughts with family and friends – support network vital.

Box 4.2 - Participant 1 (D) Textural Description

'D' often finds it hard to work with traumatic material, "I find myself thinking about it beyond the session." It often intrudes into her personal space "I find myself thinking about it afterwards and not always from a professional point of view." She thinks traumatic material "goes behind the professional mask and intrudes into one's own time." A rumination takes place.

'D' thought it was necessary "to distance myself from it and to make a professional judgement about what is going on."

She finds it very hard to "intellectually and emotionally shut off" after working with traumatic material. She often finds she was often left with a "headache." On some occasions the residue of working with trauma can go on or "be on my mind for several days." 'D' was unsure what the processes were that made the material remain with her. She stated that her unpleasant thoughts were "intermittent" and a response to triggers, many of which she was unaware.

'D' feels the worst aspect of working with trauma was "that you could become desensitised to some of it" and "you become unshakable." 'D' felt this had happened to her. 'D' notices that when she stops engaging in specialist trauma work her

sensitivity begins to return. She now notices that "I am more sensitive to a lower level of trauma or distressing material."

Working with trauma greatly affects her empathy levels, she found that for a period after working in forensic psychology "I had to retrain my levels of tolerance." She found initially she would discount offending behaviour because it was not to the previous level she had been accustomed to, "I would think it is only a punch, whereas actually a punch is a punch."

'D' uses strategies to "soften out." She stated that she was embarrassed to admit that she would regularly have a couple of glasses of wine to feel better. She also uses supervision as an outlet to "just tell someone" her distress. This was particularly useful when she was working independently.

She particularly likes working in a team where banter with colleagues helps to ease the pressure. It helps to be able to say "I had this case or that case" or to be able to engage in black humour. The black humour is a normalising experience.

'D' expresses that working alone in the trauma field was 'hard'. Peer supervision has a large advantage over generic supervision. "If the person that you are speaking to only has an intellectual ability to understand what you are saying, and remarks "guess that must have been hard", I think it made a barrier. I then think "you do not totally appreciate how I am feeling which is why I think peer supervision is brilliant because you get the sense that the other person has experienced the same kind of experience." Because peers understand it is easier to process the emotions, if somebody does not understand "you almost have to tell them everything without wanting to pass on the trauma."

"I think that if you do this kind of work you do have to shut it off or compartmentalise it. The more you work with it the easier it is to shut it off."

The support of peers is really useful, e.g., engaging in normal things with colleagues like "going bowling or having a meal, it's like they are ok – so it normalises what I do." Recognising that fellow colleagues are coping is important because it normalises trauma as an unpleasant but normal occurrence.

'D' feels that her own sense of reference has altered since working in the trauma field. This became more noticeable when she had children, it became hard to work with sex offenders, she found "the material became intrusive" and this negatively affects her view of the world.

She states that "you see things and situations that are only really visible to you because you have had a certain experience or heard certain material." Some time ago it became important for 'D' to make "sensible decisions about my children, I am more cautious than I may possibly have been."

She feels that her cautiousness may present as a problem as her children develop. She is concerned about how she will negotiate the process of giving them independence. Despite this she does not want to become "paranoid."

'D' appreciates she may "now hold a slightly skewed view of human nature." She balances this by checking out her assumptions with people she feels close to.

In summary, 'D' felt that working with traumatic material had certainly changed her perspective, she needs the support of a collegial team to maintain emotional stability and despite this feels that she has become more paranoid about her children's safety. She recognises that she may have a tendency to negatively over evaluate situations and relies on close associates and family members to check out the validity of her assumptions.

Box 4.3 - Participant 1 (D) Structural Description

For this participant working with trauma is sometimes difficult. She often experiences residual feelings that intrude into her consciousness. These feelings frequently slip behind her professional mask.

She is aware of the need to try to separate out or compartmentalise her own feelings from those of her client. Despite this awareness hearing traumatic stories directly from a client is often difficult. Sometimes coping strategies do not work and the material stays around for a few days.

She experiences the immediacy of client disclosures as difficult particularly when the client's trauma resonates with areas of her own frame of reference. For instance, now as a mother of young children she finds infant sexual abuse almost unbearable to listen to. Prior to becoming a mother, although unpleasant, such disclosure was viewed as a part of her role as a forensic psychologist.

This psychologist uses a number of conscious and unconscious strategies to manage her unpleasant feelings and sensations. She seeks out peer supervision. This is usually of an informal nature. She asserted that on occasions just being in the company of colleagues who work in a similar area is sufficient to ameliorate her distress.

She finds peer supervision useful because she does not feel she needs to edit the material in order to look after the supervisor. She stated there is often an unspoken connection between people who work with horror. Peers understand the material and its effects on the system. Therefore, it is often possible to feel better without having to divulge the actual horror. Colleagues will know without one having to be descriptive. Conversely, formal one to one supervision is not always helpful. This is particularly salient when a supervisor does not engage in this kind of work or worse, adopts a theoretical approach. The psychologist often felt that she was not understood and was

left with her distress. To gain relief during this type of supervision it would be necessary to fully divulge trauma and this felt unethical.

This participant misses working in a team. Being able to take part in the camaraderie and black humour help manage the conveyable aspects of trauma work. Being with others who work on similar cases provides effective modelling. She states that when she observes her colleagues coping and doing normal things despite the things they have to deal with she realises that she can cope too. She feels more vulnerable working alone.

In the past when working with a very complex group of clients she has found that she became desensitised and less empathic, small assaults did not seem worthy of being called trauma she would say things like, "it was just a punch" and nobody died. The more her work load increased the more prominent her attitude became.

She found that since working less extensively with trauma she has begun to feel her empathy returning. Smaller things affect her to a greater degree.

There have been profound changes to her own world attribution view. She is very aware that there are bad things that happen in the world, she struggles constantly to not over exaggerate risk or catastrophise everyday situations. She relies on friends and family to check out if her views are correct or if she is being paranoid. She is unsure how her changed world view will affect her parenting; she feels she could be overprotective in the future.

Her most effective strategy is to compartmentalise her feelings. This works well under normal situations but becomes less effective as her work load increases.

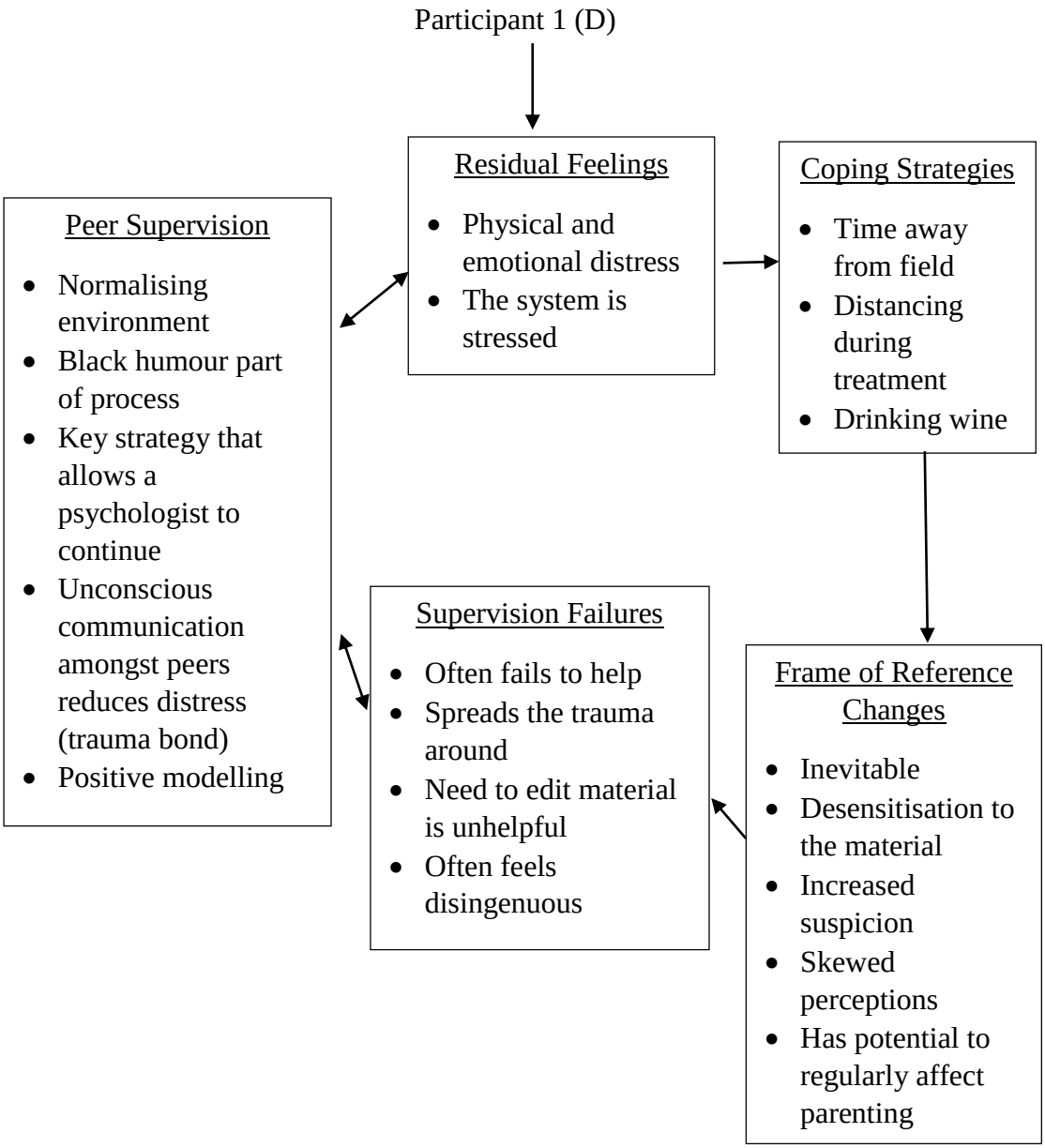


Figure 1 Thematic textural-structural representation of participant 1's experience of working with trauma.

Box 4.4 - Participant 2 (T) Themes

Residue of Trauma

When does it happen (circumstances?)

P2 Unexpected and unprepared for disclosure caused difficulties.

P2 When disclosed in a forceful manner.

P2 "When it resonates or parallels personal material."

Type of Residue

P4 Visual images

Strategies Used

Inactive Strategies

P6 "First wait a while, it takes time for these things to be processed."

Active Strategies

P6 Strategy talk to someone, either supervision or a colleague.

P6 Self-reflection trying to recognise what it was.

P8 Watchful waiting and acknowledging it has had an impact for discussion.

P10 CBT Based strategies to remove imagery – similar modality used as to treatment protocol.

Normalising

P12 Absence of concerns would worry. Concerned about burnout.

P12 Absence of burnout would mean less empathy, more defensiveness.

P14 "Feeling this way is a good indicator that I am coping OK and not burnt out."

Personal Similarities

P16 Traumatic material affects more as we develop. Finds it harder being a mother especially when dealing with childhood abuse. Would have found it easier earlier in career.

P22	Informal supervision as important as formal supervision where feelings can be openly discussed.
P24	Colleague support hugely important.
P24	Supervision from same background.

Shortcomings of one-to-one Formal Generic Supervision

P26	"Needing to hold onto the trauma feeling a responsibility not to re-traumatise others."
P26	"Feeling a responsibility to contain it."
P26	"I think I always deal sensitively because I suppose I have a concern that, like repeating material as it has been said to me causes further traumatisation. I suppose I kind of feel a responsibility to try and contain it to some degree. I think I find it a little bit easier to be more open with the nature of the material with colleagues in the service."

Box 4.5 - Participant 2 (T) Textural Description

For 'T' working with trauma sometimes affects her, "it is infrequent, but I am left with a residue of it. 'It is kind of sometimes, it is not a ratio of one to one."

'T' finds there are times when she is more susceptible to taking on board the trauma and consequently feeling a residue disquieting from it. These occasions are when it runs in parallel to her own life "when it has a resonance with my own life or experience."

When this parallel occurs it is often uncomfortable for 'T'. Trauma work is also difficult when she feels "unprepared" for a disclosure, or when material is presented in a "forceful way and when it is not expected." 'T' usually approaches trauma work in a structured way working towards a planned disclosure by her clients.

'T' is aware that when she does experience discomfort after working with survivors of trauma, she notices emotional intrusions following the work, "I suppose the thing I notice most is images." The process of listening to first person accounts is often problematic for her "I cannot help but visualise it." She is aware that she also registers trauma in other modalities but for her it is more commonly conveyed in images.

She manages her discomfort in what appears to be a sequential process, "my first strategy is just to wait a while", realising that it takes time to process material. She referred to this as a "watchful waiting" process analogous to the NICE guidelines recommended for working with patients who have been exposed to trauma.

If this is unhelpful she will seek out either formal supervision or peer supervision to try to "assess what it was about that material that made it stay with me." 'T' believes this second stage in her processing strategy is a cognitive approach in which she spends some time in a "different sort of mental space."

'T' considers that she often processes trauma residue in a cognitive manner. She is interested in the relationship between the treatment modality she uses with patients and her own personal manner of processing her residue distress.

'T' believes that working with trauma does not get any easier with experience. She states that "I do not think it gets easier, because if it is traumatic, then it is traumatic." She describes an acceptance of feeling perturbed by her client's stories at times. She argues that "I think it would worry me if I had a lesser response." She is concerned that were she no longer distressed at hearing traumatic stories, she would interpret a lack of discomfort as symptomatic of "an impending burnout." She asserts that a lack of feelings of discomfort would mean that she has become "more defensive or less empathic."

Particularly difficult feelings have been aroused for 'T' since she has given birth to her child. She states that "one of the things that has been really significant for me is having a child and you know that resonates with hearing about childhood experiences and abuse. I think it would be easier to listen to these things earlier in my career." She feels she is more easily and quickly distressed listening to clients' accounts.

For 'T' it has become much harder to be empathic to perpetrators of child abuse.

'T' feels it has become much harder to work with material that has strong connections to one's own frame of reference at particular times.

The distressing aspects of working with trauma have led 'T' to develop strategies to process her discomfort. Supervision is important. 'T' describes that "there are different ways and different levels of getting supervision." Formal supervision she thinks is really important in "having that protected time to discuss what is going on." However for 'T' it is important to have collegial support, "Equally important I think is the kind of more informal supervision of being able to kind of just talk to colleagues."

Knowing others had worked with similar material and had closely related experience helps, "I kind of feel it is really important to be able to be honest with colleagues about struggling with particular kinds of material." There seemed to be an imperfect fit between the process of formal supervision and 'T's needs. She stated, "My clinical supervisor works with women in forensic services. She is sort of aware of the material that can come up but her client group is a bit more mixed than mine. There is not quite so much trauma or traumatic material."

Working with traumatic material that 'T' knows her supervisor has not had experience of has led her to withhold information in supervision. She elaborated, "I suppose I have a concern that repeating material as it is said to me causes further traumatisation."

'T' is of the view that she should contain it, "I suppose I feel a kind of responsibility to try and contain it to a degree."

Informal supervision with colleagues is a different and positive experience, "I find it a little bit easier to be open with the actual nature of material with colleagues in this service."

Availability of colleagues was also a positive factor for 'T', "I have access to colleagues every day if I need to speak to them, and supervision is less frequent." She felt if something was really troubling her she could not disclose this during formal supervision. "I would not feel that I could say exactly what it was to my supervisor. I suppose I always feel the need to be sort of careful really."

'T' describes that working with trauma is hard. She is of the opinion that some aspects of people's trauma stay with her. "I think some things you hear are so extreme there is a slightly different process." The ability to tolerate material rather than process it is a key issue. 'T' described that she felt on some occasions, she "just tolerates the residual unpleasant feelings." She is aware that things come into her mind but "not usually with the same emotional impact as initially."

'T' also felt that working with traumatic material had changed her frame of reference, she was unhappy with the term 'evil' because of quasi-religious connotations but felt she had moved to a position of knowing that there are "really bad people in the world who do terrible things." Before engaging in this work it was a vague possibility that some people were really evil or bad.

'T' feels able to hold onto a balanced perspective and commented, "on the whole I believe there are nice people in the world, but there are a group of people who do awful things."

'T' described that she was more suspicious of people's motives and this has ramifications in her own life. She stated that she had found it particularly difficult to select a nursery for her son and was aware that the things she investigated would have been far from other parent's minds. She looked at what areas staff could be alone with children, what security systems were in place and what was the policy on taking photographs.

She does not believe she is paranoid about risk but rather "was alive to the possibilities." She felt one goal for her had been to live with the possibilities of risk. This was a new task for her.

'T' asserts that working with trauma had also increased her confidence, she described that knowing she has dealt with horrendous material has allowed her to increase her confidence in general therapeutic terms. She feels that she has acquired the skills of resilience and perspective through working in this field. 'T' commented it does not mean that things become unimportant but that there is a sense of perspective.

It also allows 'T' to recognise that she has been very fortunate in her own life, this led her to feelings of gratitude. She commented that although people's trauma stories often remain with you, their triumphs and frequent ability to negotiate profound change also remain and this was a positive factor.

Box 4.6 – Participant 2 'T' Structural Description

For 'T' working with traumatic material is often difficult. After sessions she is frequently left with a residue of material. This particularly occurs when material has been said to her that has parallels with her own life. It would appear that she finds managing a trauma workload much easier when material she is presented with does not contain any parallels with events that have occurred in her own life.

'T' asserts that trauma work is also extremely difficult when material is presented in a sudden and forceful way by clients. Planned disclosure appears to be a method that 'T' uses to prevent herself from experiencing symptoms that could contribute to vicarious traumatisation.

'T' is aware that on occasions when she is left with a residue of traumatic material this is manifest in her consciousness through pictorial images. She believes that she receives images in her head because of the constructions that she has made with clients.

'T' feels that on reflection she has developed a concrete strategy for dealing with her feelings of distress. This is generally a two-fold process. The first part of the process involves a stage of 'watchful waiting'. This is very similar to the process advocated in the NHS NICE Guidelines for victims of trauma. She believes that frequently a pause of watchful waiting allows traumatic residue to fade away after a couple of days.

On some occasions 'T' recognises that she is left with a residue of unpleasant material and at these times she would seek out supervision. Formal supervision is useful in that it allows a dedicated period of time to discuss a particular case. However, formal supervision is less effective in facilitating the processing of traumatic material for the following reasons. 'T' did not feel that it was right to divulge unpleasant pictures of trauma to supervisors who were then left with material that was particularly harrowing. She felt that this would be counter to her ethics and therefore she needed to contain her feelings.

'T' recognises that in these situations the benefits of peer supervision or just support from a colleague within the same team is crucial to her wellbeing. She stated that people in the team who engage in similar kinds of work are both readily and easily able to empathise with her feelings.

Interestingly, ‘T’ is of the opinion that sometimes the nature of the work is so traumatic that even with peer supervision it is impossible to ameliorate some of the images and stories that she hears. ‘T’ is of the opinion that it has become necessary for her to simply adjust and learn to live with the residue that remains. She is of the opinion that the process of working in this field never will become easier. She hopes that she will not become complacent to the horror that sometimes occurs. Rather she uses the negative experiences of feeling low as reinforcing and positive evidence that she is still functioning effectively. ‘T’ asserts that for her, feeling bad after working with trauma stories is clear evidence that she has not burnt out or succumbed to compassion fatigue. She experiences a general sense of welcoming and allowing the negative feelings that arise.

One of the greatest challenges in this field ‘T’ feels is the ability to develop a resilience in one’s personal emotional functioning. She is of the opinion that since engaging in this work she has seen an increase in her resilience and in her ability to manage difficult situations.

Despite this increase in resilience there is still an awareness of changes within her own personal frame of reference. She has found that since having children she is less able to engage with certain situations. She is far more suspicious and sceptical regarding people’s motives. She is of the opinion that once an individual gains an awareness of the possibilities of danger and violence occurring, one develops the practice of scanning situations for these possibilities. ‘T’ does not believe that this change of perspective has negatively influenced her judgement thus far. She is of the distinct opinion that it is necessary for her to become alive to the possibilities of danger and to remain vigilant to the need to appropriately check out perceived risk.

In general ‘T’ perceives that working with trauma has also resulted in positive changes to her frame of reference. Her confidence is increased as is her resilience. She experiences an increased sense of gratitude for the many positives she has in her own life. She is also thankful for the ability to recognise the profound changes in others that providing assistance in this field has achieved.

In summary, ‘T’ feels that she is left on occasions with a residue of traumatic material. She uses a two stage strategy to process these feelings. Occasionally despite strategies she is unable to remove the graphic images from her mind. These images remain in her consciousness and frequently cause intrusions. She asserts that she is generally able to deal with these intrusions through acceptance and resilience. She describes that working with trauma does not get easier as one’s career progresses. She stresses the importance of supervision as a tool for containing one’s feelings. She feels that collegial supervision was far more important to a practitioner than formal one to one supervision. She accepts her negative feelings, viewing personal feelings of negativity as evidence of her ability to remain empathic and to subsequently function as an effective psychologist. ‘T’ states that there have been positives since she has worked in this field. She experiences an increased level of confidence and perceives herself as more resilient. She is astounded at individuals’ own ability to be resilient in the face of trauma and she experiences a profound gratitude for her own benefits and nuclear family.

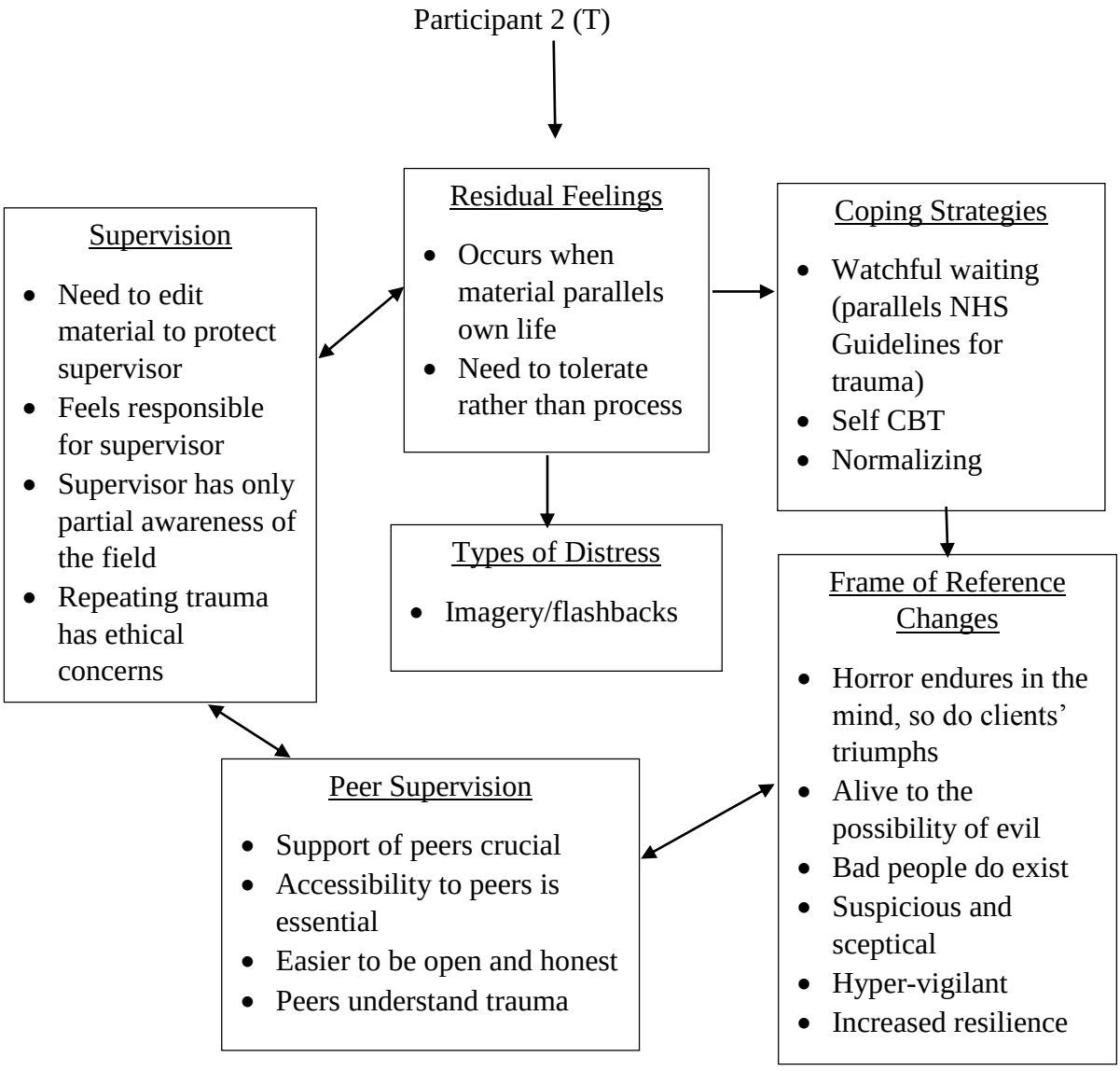


Figure 2 Thematic textural-structural representation of participant 2's experience of working with trauma.

Box 4.7 - Participant 3 (L) Themes

Longevity of trauma

P2 Residue of trauma remains.

P22 "It does not get any easier, need to shut it off."

P22 "It never stops being sad."

Strategies for dealing with traumatic material

Strategies were grouped as either conscious or overt or at a covert sub-conscious level.

Need for comfort

Bad Strategies

P6 Drinking wine.

P6 "Ordering takeaways."

P52 Quarrelling with partner.

Good Strategies

P4 & 8 "Taking the dog out for a walk to unwind."

P4 Looking after oneself outside of work.

P4 Appropriate case scheduling.

P4 Seeking team support.

Change of reference and attribution style

P28 "Mutual recognition of humanity."

P22 "Feeling desensitised and unshockable." Emotional processing takes longer.

P38 Loss of innocence. Need to check out assumptions.

P28 Heightened empathy.

Importance of therapeutic relationship

Need to establish safety for client and therapist.

Forceful disclosure shocks

Effect on psychologist's life

P52 Working in this field can lead to relationship conflict

P52 Feeling tired and drained.

Box 4.8 – Participant 3 (L) Textual Description

For 'L' working with trauma victims frequently leaves her with "material long after the session has finished." She is careful in her scheduling of the work as she feels the need to "look after herself." She described that she would schedule work with trauma victims at intervals during the week rather than "say three trauma victims one after the other."

She has found that in the past material has often "remained with her"; this has had a disquieting effect upon her and has resulted in her feeling drained. Her feelings of being drained has "led to fights with her partner." For 'L' trauma work is different to other clinical work and it is necessary to "shut it off before one can get on with one's personal life."

'L' finds her team supportive and is of the opinion that it helps to "have a debriefing after a session with a colleague." Despite this she often leaves with work unpleasant material in her head. Sometimes she has to force herself to adopt positive strategies to enable her to feel better. She has to force herself "to walk the dog and for a longer than usual walk." She keeps walking until she feels the material has gone and "it is safe to go home"; she knows when it is gone. She describes it being like walking on a treadmill, "when your mind's empty you can go home."

'L' thinks on reflection that she experiences the trauma in her body and needs to rid her system of it, the emotional processing "takes longer."

It is an effort because she feels drained and too strained to do this. She tends to think that she "generally wants to just reach for the bottle for a couple of glasses of wine." "Cooking a meal and washing up afterwards is a real chore" and a process "that she does not have the energy for." On occasions she states that she "comfort eats." She recalls when she is working with trauma she craves takeaways, she thinks it a kind of comfort habit.

'L' finds that even though she has been a psychologist for many years connecting with a patient's trauma "never stops being sad" or gets "easier to deal with."

She feels that she has stopped being shocked by peoples stories "the more you hear about peoples experiences the less it shocks you." Conversely, she is more shocked by an individual's attempts to minimise their own trauma. She does not think that it ever becomes easier not to experience the immediacy of an individual's pain.

She asserts that she is still able to be empathic with her patients but does not know what processes are allowing her to do so. She feels that connecting with a patient (developing a therapeutic relationship) before undertaking trauma work was probably helpful in this process.

Traumatic material particularly negatively affects 'L' when it is disclosed suddenly; the immediacy has the potential to shock. She states normally we are building in resilience for our clients and we are prepared for their disclosures. "If you can control aspects of it (trauma), aspects of the emotional experience, then that is much easier than everything feeling out of control."

'L' feels that working with trauma has had a large impact on her, "it's like your innocence has gone. You know that people are capable of the most horrific acts against humanity and that destroys your innocence and nativity…. If you saw two people,

grandparent and grandchild in a shop you would always have that thought in the back of your head, are they grandparent and grandchild?"

This work has an impact on 'L's' thinking, "it has changed my frame of reference." On balance 'L' believes this reference change could be quite helpful as long as she does not leap to conclusions. There is a constant need to check out her assumptions. She was convinced that working with trauma has changed her and believes the most prescient task for her was "trying to contain the emotional impact of the work."

Box 4.9 – Participant 3 (L) Structural Description

For 'L' working with trauma gives rise to multiple issues that she needs to resolve. She is aware of a marked haunting from listening to trauma material. She experiences a need to shut off these sensations.

She feels a residue of traumatic material in both her physical being and in her emotional responses. It is often necessary to attempt to process the distress she feels. 'L' has to do this before she can get on with her normal life. In the past, a failure to do this has led to difficulties in relationships. These difficulties have culminated in regular fights with her partner when she has felt low and on edge. She also reports frequent quarrels with her partner.

Over the years 'L' has developed techniques to process her distress. These strategies are both conscious and unconscious. For instance she often indulges in comfort eating or reaching for a few glasses of alcohol. She feels drained and reported that simple routines become too much of a chore.

The unconscious element only reached her awareness after exploring her processes. On a positive level she will often take the dog for longer walks, not returning until she feels her mind is clear. Strategies can also be coded as either negative or positive.

Negative strategies frequently offer an immediate short term feeling of separating the trauma from the self.

Another conscious coping strategy that 'L' uses is seeking out peer support. These resources are drawn from both her private and professional life. These are beneficial and usually assist her in keeping a realistic perspective about matters. She appreciates that her frame of reference has changed but regularly checks out her cognitions to ensure she still has a balance in her thinking.

Unconscious strategies are routinely used as a method of self-soothing. These include drinking too much alcohol and eating comfort foods. She experiences a need to feel soothed. Cooking and washing up are perceived as needing too much effort.

Peer supervision and the support of colleagues is vital in 'L's attempts to keep a perspective on matters. Traditional supervision has not been helpful to this psychologist. Informal supervision where sharing a common experience may be achieved is helpful.

Despite good peer support and informal supervision 'L' feels that working with patients' trauma has had a profound effect on her frame of reference. She mourns the loss of innocence that has occurred over time. One of the hardest aspects is the acquired knowledge that people are capable of real sadism and once this schema has been developed it cannot be unlearnt. One of the biggest challenges for this psychologist is to try and keep matters in perspective and not to over generalise.

She also believes that it is possible to become desensitised and is of the view that peer supervision helps maintain a balance in her thinking. 'L' is of the opinion that one of the most significant ways in which she protects herself from the effects of listening to stories of survivor's horror is in planning the patient's disclosure. On such occasions as this can be achieved her experience of residue material is lower.

On balance, 'L' thought that feeling distressed was a normal part of working with trauma and in one sense was a good thing. Feeling shocked and haunted was a sign that she had not lost the ability to show empathy. Her view was that if trauma stopped having a negative effect then that was an indication that she had burnt out.

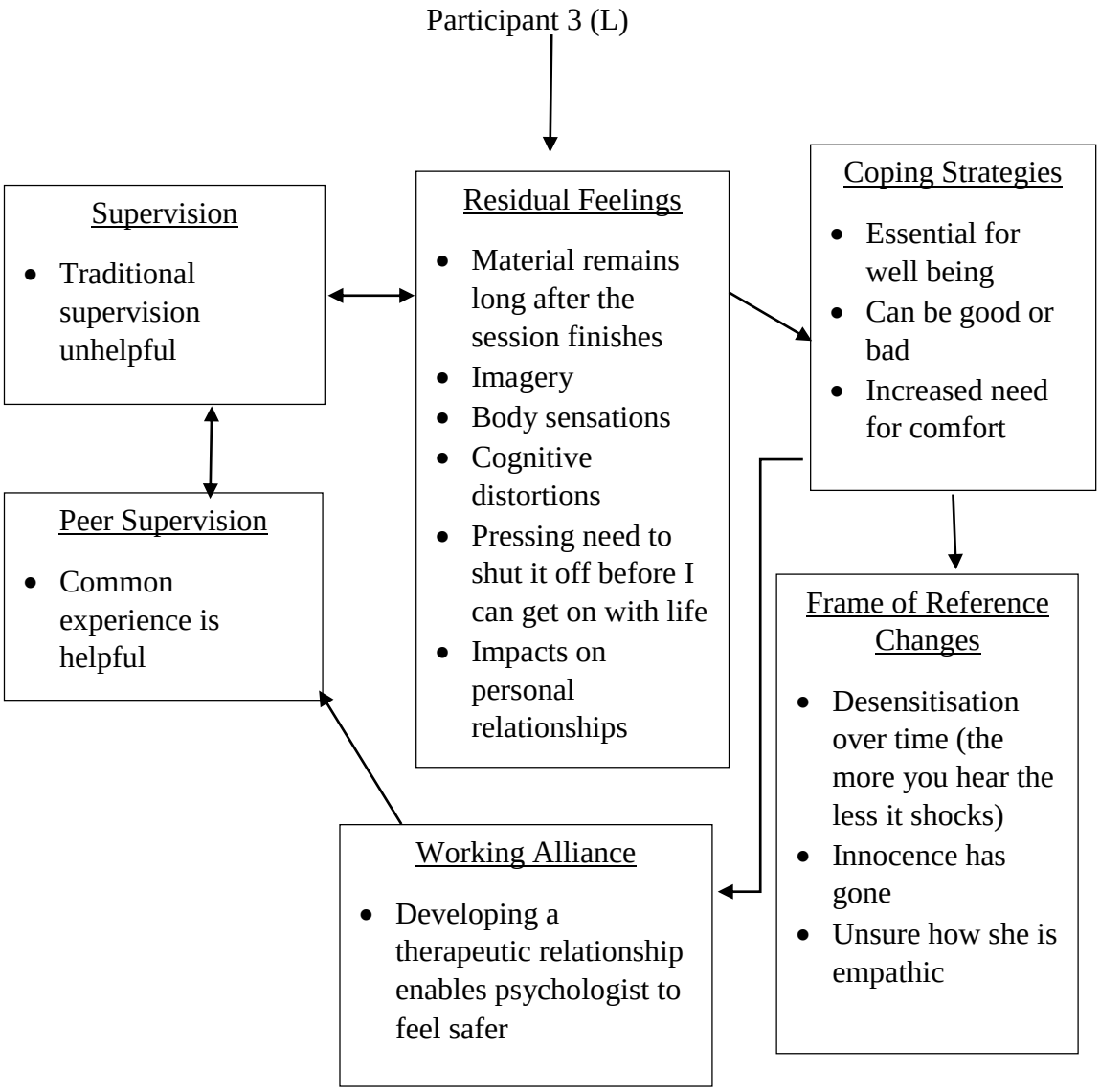


Figure 3 Thematic textural-structural representation of participant 3's experience of working with trauma.

Box 4.10 - Participant 4 (A) Themes

Residue of material

P3 & 4 Post session.

P6 "Post session processing time is often insufficient."

P8 "Need to speak to peers." "To share feelings, to clarify."

P8 & 10 Imagery (self manages), rumination.

P10 & 16 Need to make sense of, to contextualise, to reframe (normalising).

P10 & 14 Sadness and inadequacy.

P14 "Sitting with sadness (watchful waiting) managing, refining strategies, trying not to succumb to negativity."

P14 Career experience is a safeguarding factor.

Support

P20 Support as a coping strategy (collegial).

P44 Help with processing material.

Coping Strategies

P18 Unconscious.

P38 Conscious strategies evolve.

P18 & 38 Ability to self-care develops over career, trainees more vulnerable, causes intrusions and emotional unavailability (absorption in work).

P18 Early positive training/support increases resilience.

P16 Positive and negative strategies largely cognitive, inward reflection, transference, using self as instrument.

P16 "Residue feelings in therapist increase empathy."

P26 Psychologist world view affects response to client material.

P18 Support from colleagues, richness of eclectic experienced team.

P48	Talking about feelings, helpful throughout career.
P12	Processing imagery.
P12	Intrusive imagery.
P10	Contextualising trauma.
P14	Appreciation of the normalcy of difficult feelings.
P12	Modality of treatment influenced individual processing style. Cognitive and Humanistic approaches reflected in processing.
P28	Able to understand complexity/develop wisdom.
P34	Personal gratitude.
Peer Supervision	
P20	Value of experience of peers.
P20	Diverse team increases support.

Box 4.11 - Participant 4 'A' Textural Description

'A' described that working successfully with traumatic material was attributable to "contextualising patient's material."

She reports that uncomfortable residue feelings are to be "expected" given the subject matter of the client material. 'A' feels that she needs "support from peers." Working part time meant that there was often "not enough time for processing material."

She states she is able to "compartmentalise material." A process of normalisation in context occurs. Doing this prevents material entering her private life.

'A' feels it has taken time to develop this strategy, she is of the opinion that she was less proficient in managing distressed feelings during the time when she was a trainee.

In those days she would "ruminate a lot and material would eat away during her time off." She feels that she learnt to compartmentalise over time.

She described that her core treatment modality is cognitive behavioural therapy (CBT). She seemed a little surprised that she used reframing and cognitive restructuring as a way of managing trauma.

Unpleasant residue feelings are a process of her "empathic" engagement. She believes these feelings allow her to understand the client better and in a sense she welcomes them.

'A' perceives that there are occasions at home when unpleasant material "pops into" her head. She feels this is normal and actually assists her to gain a sense of her client's difficulties and often this allows her to develop ways of helping.

For 'A' time to process information is important but in actuality her reduced hours since returning from maternity leave, result in "less opportunity to process material." There is often not time for formal team supervision. In such instances she "manages her feelings by using her colleagues." Being part of a team is very important to 'A', even if contact is reduced to a "brief interaction."

'A' does not believe that working with trauma has affected her negatively. She perceives that through reframing situations, she is able to look after herself. She feels that she has become aware of the "resilience of human beings" and is humbled how people with very severe trauma are able to get up and carry on.

Box 4.12 - Participant 4 'A' Structural Description

'A' is of the opinion that working with traumatic material has become easier over a period of several years. She states that she now manages traumatic material differently to the time when she was a psychologist in training.

She is able to recall and reflect that during her earlier career, traumatic material remained in her head for a longer period. It also left a residue of unpleasant feelings.

For 'A', experience in the profession is one key to feeling safe and remaining positive. She is able to be very clear regarding the normalcy of unpleasant feelings that arise for her when working with trauma victims. She believes that these sensations are a valuable aid to understanding the client's presenting difficulties. This empathic engagement allows her to understand more fully the client's pain.

On rare occasions when intrusive imagery pops into her head she manages this through cognitive reframing and restructuring.

She appears to have developed a clear method of separating work material from her personal frame of reference. For 'A' the context of particular traumatic material seems to be an important concept in processing residue feelings of discomfort. She is able to contextualise her feelings and this appears to bracket off her work experiences.

'A' feels that the practice of cognitive restructuring is a very important part of her working role. It is vital to understanding clients. She is also of the opinion that any unpleasant symptoms were arising from the client's narration of events rather than from the therapist.

'A' believes it is of importance to be able to access good support. It would appear that for this participant support and supervision are distinct processes.

She believes that being a member of a team engaged in trauma work offered a very supportive environment. Being with people who were dealing with similar unpleasant and often harrowing stories produced an environment where trauma was automatically normalised. For 'A' the briefest interaction with a team member has the effect of making her feel better.

In summary, for 'A' to remain positive while working with trauma relies on three components. These are i) experience in the role, ii) ability to contextualise, reframe and compartmentalise material and iii) being part of a cohesive team.

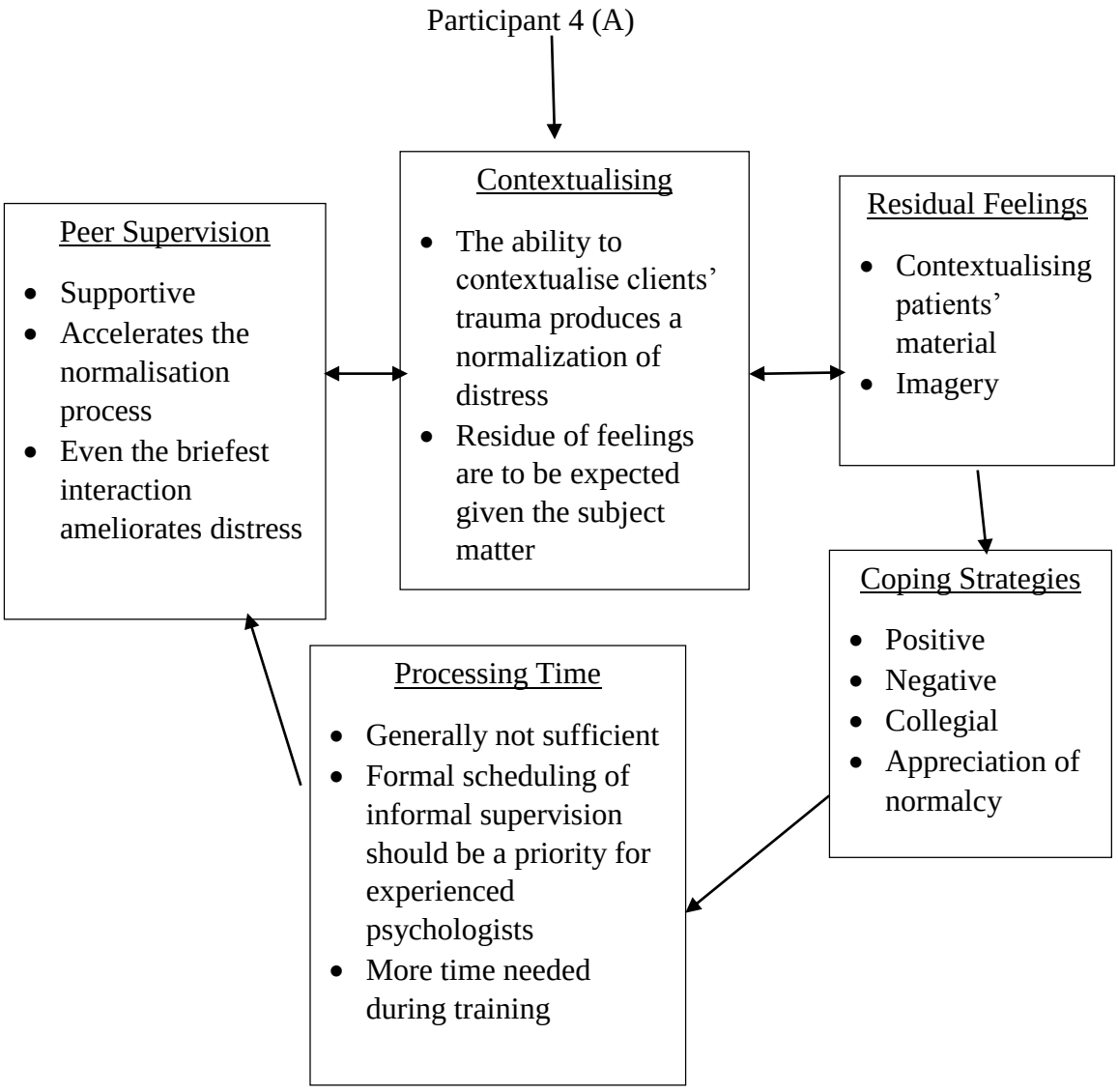


Figure 4 Thematic textural-structural representation of participant 4's experience of working with trauma.

Box 4.13 - Participant 5 (M) Themes

Residue Material

P2 "All the time."

P8 "Intensity varies in situation, time since trauma, trauma that is still ongoing worse, (safety issues). Distance from trauma important."

P16 Can become enmeshed.

Type of Trauma

P2 Childhood abuse.

Coping Strategies

P18 "Take a break/chill out/relax/practical issues/report ethical issues (mandatory and of personal use)."

P18 Careful scheduling of sessions. Pause between sessions/reflection. Any ethical issues.

Supervision

P18 & 22 "Immediacy needs. Important to have contact with team members who were around at the time of the session, off load feelings."

Physical effects

P30 Physical registering of the trauma – sad, upset, angry. Headaches, funny tummy

P36 & 32 Medication needed for pain. Has a chronic condition and feels it as pain, in her muscles, in her body.

P34 "Emotional response followed by physical response."

Cognitive effects

P38 Intrusive imagery.

Strategies

P42 Coping strategies - imagery as a stand-alone tool.

P44 Self-soothing – "not always successful."

Preparation – "Important to know the time lapse since the index incident" (How long ago did it happen?) Immediacy making it more acute and difficult to separate.

P46 & 48 Separating.

P48 "Need to drop it somewhere."

P50 "Visualise dropping it in the room with the patient."

P50 Collaboration with the client contains the trauma.

Resignation

P44 "Strategies do not always work."

Coping strategy - Supervision

P38 Early training can have lasting positive effects in managing material.

P56 & 64 "Quality of relationship with supervisor/need to not be judged/need to be honest."

P58 Lack of supervision while a trainee. Past trauma endures and has had a lasting impact.

P66 Anxiety about dumping it on the supervisor. "They are going to be left with it."

P72 Supervisor out of comfort zone – "prohibits practitioner from disclosure."

P74 Withholding material from supervisor afraid of being viewed as incompetent.

Practitioner as responsible for self-care

P78 "Recognising one's own vulnerability a big positive in protecting the self."

P42 Imagery as self-care/self-soothing.

P78 "Need to re-assess coping strategies at intervals" - self-preservation.

P84 "Taking care of the self and avoiding burnout."

P86 Not looking after the self until something bad happens. Illness seen as a positive time. Before viewed self as indestructible.

P126 Recognising that self-protective strategies may not continue to be useful and need to be reviewed and revised. "Tools don't always continue to work."

P126 Good to have time to reflect on strategies and in the reflecting the impact of the work becomes more visible and apparent.

P126 "Responsibility lies with the psychologist" for ensuring they look after themselves and seek out the appropriate support.

Skills needed for trauma work

P120 Accepting ambiguity.

Frame of reference changes

P96 & 98 "Loss of nativity/loss of illusion/entering a parallel universe."

P102 & 106 Negative and irreversible.

P106 Loneliness at carrying information other people never experience. A separateness from others.

P108 Depression and harder to cope.

Frame of reference - More positive awareness of self and others.

P110 "Self-actualisation." "Admiration for humanity." "Recognition of others."

P112 & 114 Personal resilience.

Box 4.14 - Participant 'M' Textural Description

'M' states that working with traumatic material leaves her with residual feelings, "all the time." This is especially so if the material she is working with contains reference to child abuse.

She described that in her last position she had worked in a refuge where "horrendous violence was occurring." She felt it was far more difficult for her to work with the "immediacy of trauma than it was listening to retrospective accounts of horror."

She asserts that "I was very much left with feelings because things were happening now; I was living it with them." In these instances she finds it hard to let go of feelings. For her the concept of "separation in time" is an important aspect of containing her feelings.

'M' believes that she consciously uses two initial strategies to contain traumatic material. These are "to have a break" and "not to rush straight into a session with somebody else."

A further strategy she uses is "to think if there is any kind of practical steps/things that I need to do with what I have just heard." She asserts that thinking about possible ethical disclosures served a necessary function of "alleviating my own burden." After an intense session she looks for collegial support. She describes that "I would see if any members of my team or people with whom I have a good relationship were around to kind of offload."

'M' is of the opinion that she often experiences traumatic material emotionally and somatically. She is of the view that she sometimes takes on the patients emotions and then has to attempt to process them.

She sometimes engages in a process where she has to decipher whether the feelings she experiences are actually hers or a 'taking on of the clients responses." She often experiences "headaches or a funny tummy."

'M' suffers with a chronic auto immune condition and often finds that after working with traumatic material she experiences stress in her muscles. She regularly copes with her distress which is often accentuated through her work by going to the gym. She

elaborated stating "not only does it help with pain management but it is also my transition time between work and home." This was clearly an important strategy for her. She also relies on imagery as a strategy for managing the trauma or compartmentalising it. She often uses these self-soothing strategies and sometimes instead of going to formal supervision. There are times though when they are not successful in removing her residue distress. She concludes by saying "I would not say that they always work."

She believes that the use of imagery is an important tool because on the occasions when it is successful, it facilitates a process of compartmentalisation. This compartmentalisation allows her to identify what is the clients influence on her feelings and which feelings are actually hers. She states in doing this "We are separating that (trauma) from your work and your personal life because otherwise it feeds in so much, so there needs to be a time when you offload it and drop it off somewhere."

Supervision is an important tool in managing traumatic material for 'M'. She asserts that the quality of the relationship with a supervisor is paramount in achieving a containment of the material. She was of the opinion that currently "I have a very good relationship with my supervisor where I can be completely honest." Historically, one to one supervision has not been as helpful, 'M' has felt unable to disclose her feelings to previous supervisors.

Formal supervision presents some difficulties for 'M'. She comments that "one to one supervision happens at a regular frequency and that might not be for another week." 'M' describes she "sometimes had an urgency to speak to somebody."

'M' describes that her past experiences of inadequate supervision have had a negative impact on her personal life. She states that "In the past there may have been no space

to talk about, actually how I feel about working with that person. Maybe this has made a difference because I have early experiences of working with trauma early in my training that still stays with me now, (ten years later), more than anything else I have ever worked with since."

'M' feels that good supervision where one can be open and honest and not feel judged was imperative. She is of the view that in the past she had refrained from disclosing material because she did not want to "dump it on the supervisor."

'M' states that this is a difficult field to work in and both psychologists and their supervisors could quite quickly feel out of their depth working with various materials. This can negatively influence the effectiveness of supervision because neither party feels comfortable about talking about a specific situation or incident. She describes that very often this is an uncomfortable process. A process in which both psychologist and supervisor feel incompetent but this is not a concept that is able to be discussed.

'M' asserts that to be able to continue with this work, she has had to admit that it was demanding and draining work and accordingly increase her self–care strategies.

"I had recently been very ill. I think that working in this area has had an impact on my physical health and I am now having to reassess what I was doing and whether I was taking care of myself well enough." "I know I was not (looking after the self) and I am now having to think a lot more about it if I am going to continue to work in this area." 'M' describes that her new awareness is a positive factor as it has facilitated a re-evaluation of her strategies. This is important in continuing her practice.

She feels that burn out is inevitable if professionals do not take care of their own needs. She has realised the hard way that professionals are not indestructible.

There have also been changes to 'M's frame of reference, she feels sad about this new realisation. She is more attuned to danger and risk factors. She describes that she had "lived in a bubble before engaging in this work."

For 'M' working with trauma has been experienced as entering a "parallel world", one in which others don't have access to. She feels it is probably safer not to know about her world. She added that "unfortunately, I stepped over."

She describes that "sometimes true ignorance is bliss." Working in this field is often lonely and it can separate one from others. "Nobody outside this work place has an idea of what is going on. Your idea of a hard day's work is very different to somebody else's." She describes that she has a significantly damaged perception of the world but for her "it was a true reality." It is hard to live with and inevitably leads to depression unless one really takes care of the self.

There are also positive aspects of working with trauma victims; these are respect for people's resilience and triumphs and some marvels seen in the human spirit.

This psychologist describes that on balance she wishes that she had not pursued this career path. Her wishes are attributable to the pain involved. She experiences changes to her frame of reference which are painful and irreversible. Despite her feelings and the very considerable negative factors experienced, she could not envisage herself doing anything else. 'M' felt that to be able to continue with this work necessitates both a balancing and normalising process.

'M' is also of the opinion that strategies that are developed to cope with trauma residue need to be regularly reviewed and re-evaluated and if necessary reworked. She states "Things worked for you a while ago but it does not necessarily mean that they are always going to work for you." There is a need to be constantly self-reflective and aware and to be proactive in recognising one's own needs.

Box 4.15 - Participant 5 'M' Structural Description

For 'M' the process of working with traumatic material is always difficult. She is constantly left with unpleasant residual feelings. This is particularly salient for her after listening to traumatic stories of childhood abuse from either the victims or the perpetrators. These experiences penetrate deeply to a place within her being.

She states that experiencing residual feelings is a regular occurrence. As if shock and horror are normal in the context.

She has developed strategies for working with this material. These are pro-active strategies that she has developed and refined over the years. These strategies have largely evolved a result of her developing a serious auto immune illness that has caused her to rethink her professional practices. Working with trauma is challenging and has the potential to affect biological and somatic processes in the body. She is aware of a primal need to protect her physical wellbeing. 'M' recognises that ultimately she is responsible for her self-care. The need to look after the self is as important as the concept of correct diet and sleep.

Her initial strategy is always to have a break following these types of sessions. She believes it is important to relax between sessions and create a physical space. One in which she is able to use reflective practice to consider any issues that are troubling her.

'M' is aware that ethical considerations feature largely in her conscious thinking. A part of her process is to consider whether indeed she needs to pass on any information to relevant authorities regarding the material. She states this ethical reasoning process also assists in helping her lose some of the physical heaviness that is associated with traumatic material. The need to act in an ethical manner is a crucial factor in her processing of the material. While ethical concerns are always important in terms of

effective practice, this participant feels that an ethical paradigm offers her containment in the sense that there is an established protocol she can follow. The following of protocol appears to slot into the concept of developing normalcy. Essentially, however traumatic the material, if there is an ethical process to follow, it means paradoxically, that although constituents of the trauma are 'unique' and 'harrowing' they may be managed in a prescribed manner. This may assist the processing of the material. It may also connect her with other participants who have also follow a given protocol.

A second established pattern that she uses is to actively seek out team members who are working on the unit at the time. This attempt to connect with peers may be a strategy to share experience with a group, thus producing a group normality.

She uses a second level of interventions, these include going to the gym on the way home in an attempt to put some distance between herself and the working environment. It is important that she is able to separate out the feelings of discomfort from her physical being. Otherwise she finds that these feelings are transferred into her private life. The connecting theme is a pressing desire not to 'hold on to the trauma'. 'M' clearly experiences that working with trauma has somatic consequences. She is frequently left with pain in her muscles and experiences these sensations acutely. Sometimes she requires medication to feel better.

One strategy that 'M' often uses with success is a practice of imagery. She adopted this process early in her training. She feels that when one receives graphic and horrific images during sessions, it is often necessary to remove them in the same modality. 'M' achieves this by consciously imagining different situations that act as a manipulator/transformer of the information she has been given. She experiences traumatic material as a burden that physically needs to be removed. She appears to be

saying that unless imagery is modified it remains as a part representation in short term memory that will not settle.

Although self-soothing strategies are often helpful for this participant there are times when strategies are not sufficient to remove traumatic material from the consciousness. Some material is too disquieting to process.

She often uses one to one formal supervision as a tool to cope with traumatic material. Often 'M' finds that this experience is not sufficient to fulfil the task. She states that she currently has a good relationship with her supervisor but reflected that sadly this has not been the situation in the past. She is of the opinion that her past supervisors were not really interested in process and this made it impossible for her to disclose her deeper feelings. 'M' feels that she has an ongoing trauma memory of events that occurred 10 years ago. She perceives this is due to an inability to process the material effectively due to inadequate supervision. Supervision is viewed by this participant as a central supportive concept that facilitates both effective therapy and helps to maintain psychologist wellbeing. She is not saying that it is the job of the supervisor to keep her safe, rather effective supervision is a proactive process that she needs to engage in but that at the point of delivery the facility should fulfil its purpose. The framework that surrounds the supervision process has two elements. It is the responsibility of the psychologist to seek out effective supervision but it is the responsibility of a supervisor to ensure that they are professionally and emotionally trained and able to deliver the service.

A second difficulty for 'M' in accessing supervision and one that she feels is often shared by psychologists is that supervision tends to have a regular time slot. Traumatic material presents a situation where there is an immediate need for release. Therefore this psychologist tends to turn to members of her team who all have similar

experiences and are able to talk through feelings with her in an open and honest way. 'M' is expressing the view that when she is distressed she needs to process it quickly rather than wait a week or two. The non-judgemental attitude of a supervisor is absolutely critical to good supervision for psychologist in the trauma field.

Another consideration about formal supervision with this practitioner was that generally a supervisor can become quickly out of their comfort zone working with traumatic material. This causes an uneasy and unspoken situation between the practitioner and supervisor and makes further disclosure impossible. The participant also felt that it was usual practice to withhold material from supervisors as there was a fear of being viewed as incompetent. This would suggest that for this participant a release of her distress is often not possible and may present a causal relationship with her feelings of poor health.

This participant feels that working with trauma is always a difficult process. She stated that sadly she has lost her naivety since working in this field. She mourns the loss of this innocence. She commented that it was impossible to unlearn information that one once had no awareness of. She seems to be saying that changes to frame of reference are to be expected. Information about the consequences of working with trauma would have allowed her to make an informed choice before embarking on her career.

She states that working with trauma is like entering a parallel universe and that this universe was one that she wished she had never entered. She feels her world and her professional and emotional outlook had been damaged irretrievably.

Notwithstanding these obvious consequences of working with trauma material, 'M' believes that there are some positives associated with working with this group of clients. She is stating that both negative and positive changes occur through working in the trauma field. There is the perception that these changes are both good and bad

and co-exist, rather than a process where the bad is transcended. In some aspects it appears that positive changes may be an afterthought and it is the negative aspects that are key.

She stated that she has learnt to respect people's resilience and abilities to recover from horrendous situations. She respects people's ability to forgive and carry on. She also feels that she is far more aware of her own personal resilience but is also very conscious of the need to look after herself if she is not to succumb to compassion fatigue. In some ways she wishes that she had never began to work in the trauma field but was unable to really imagine another form of employment that would be as rewarding.

One overwhelming factor that this participant identified is that working in the trauma field changes a practitioner's frame of reference irreversibly. She is aware that while one still appreciates the beauty of the world that we reside in there is still a sense that one has been damaged irreparably by working in this field. An image of the wounded healer clearly emerges.

For this participant the key to staying healthy is to be able to retain a balance and an accurate perception of the world around her. This participant felt that the only way one could retain an accurate sense of perception was to adopt regular reflective practices. Trauma changes people who work with it. The goal is to manage that change so that it does not destroy you.

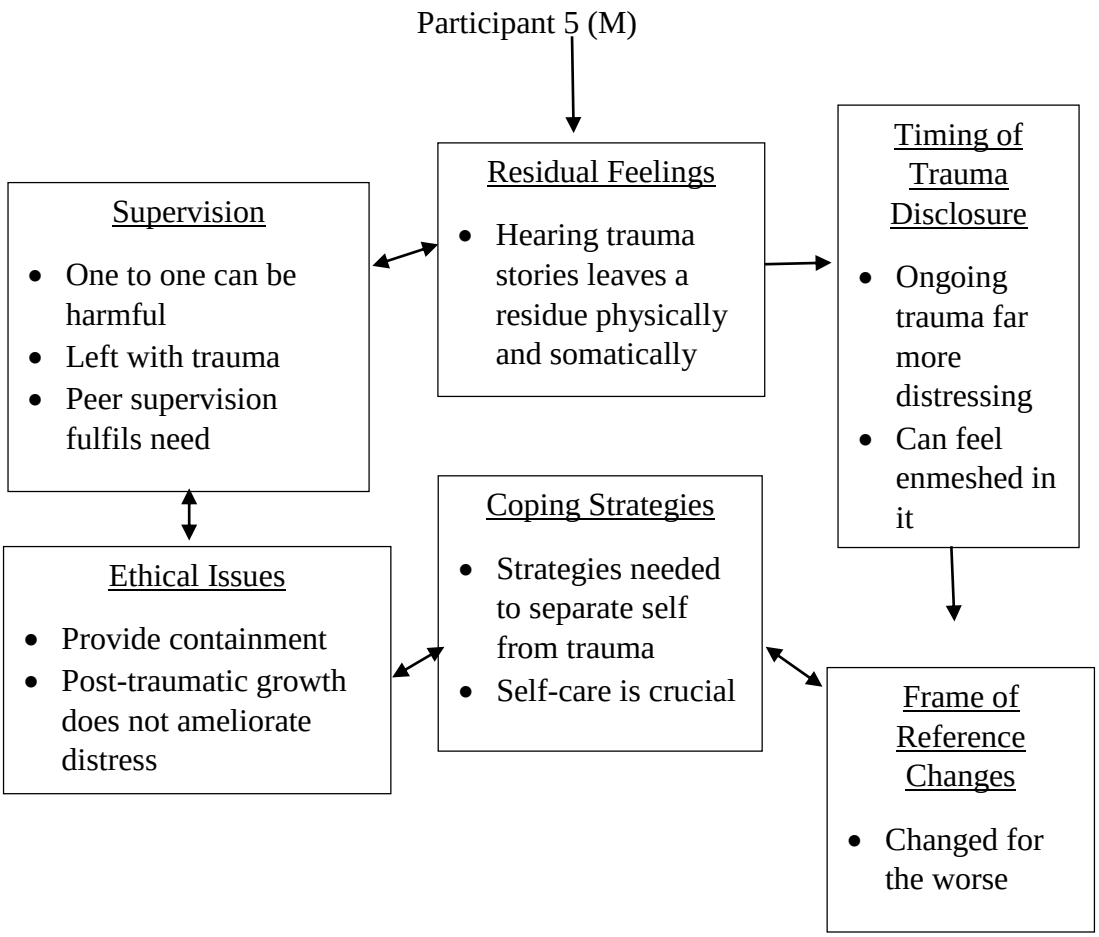


Figure 5 Thematic textural-structural representation of participant 5's experience of working with trauma.

The table illustrated below provides a synthesis of all of the participant emergent themes. These are the issues that were pertinent to them in their work within the trauma field.

Table 2 – Group Themes (Clusters)

Group Themes	**Participant**				
	1	**2**	**3**	**4**	**5**
Reactions after sessions	x	x	x	x	x
• Somatic reactions	x		x	x	x
• Cognitive reactions	x		x		x
• Emotional reactions	x	x	x	x	x
• Visual images	x	x		x	
Longevity of trauma after sessions	x	x	x	x	x
Trying to make sense of it/incomprehensibility	x	x	x	x	x
Needing to dump it					x
Use of coping strategies	x	x	x	x	x
• Active	x	x	x	x	x
• Inactive	x	x	x	x	x
• Positive	x	x	x	x	x
• Negative	x	x	x	x	x
Chosen therapeutic model as predictor of coping strategy				x	
Trauma residue differs on different occasions	x	x			x
• Personal similarities		x			
• Disclosure method	x	x			x
Supervision	x	x	x	x	x
• Need for peer supervision	x	x	x	x	x
• Need for good supervision	x	x	x	x	x
• Experience of supervision failures	x	x	x	x	x
• Supervision behaviours/need to edit content	x	x	x	x	x
Support of peers	x	x	x	x	x
• Trauma bond among peers					x
• Need for peer support	x	x	x	x	x
• Immediacy of peer support	x	x	x	x	x
Frame of reference changes	x	x	x	x	x
• Positive	x		x	x	x
• Negative			x		x
Consequence to the self	x	x	x	x	x
• Importance of self-care					x
• Relationship problems					x
• Parenting worries	x	x	x		
• Burnout	x	x	x	x	x
• Draining			x		x

4.3 Composite Textural Description

The composite textural description is a synthesis of the individual textural descriptions.

4.3.1 Group - textural descriptions

The process of working with trauma is often difficult, rumination often persists after sessions have finished. “Traumatic material goes beyond the professional mask and intrudes into one’s own time” (P1). For the participants, unpleasant feelings remained for extended periods, there is often a “haunting, long after the session has finished” (P1). One participant felt unpleasant residue occurred at different times, “It is infrequent but I am left with a residue” (P2).

Rumination is a common experience after working with trauma clients, one participant described the process as one in which she would “…ruminate a lot and material would eat away at the time off” (P4). She stated, “I have got better with time at compartmentalising it.”

The process of being left with a residue of material is an unpleasant phenomena. It is important to contain and separate these difficult feelings, “It is necessary to distance myself from it and to make a professional judgement about what is going on” (P1).

While a residue of material causes distress it is viewed by many of the participants as a sign that they are able to be helpful to their clients - to make a difference. Unpleasant feelings are considered by some as a process that results from empathic engagement (P4). After a session it is necessary for the participants to cleanse themselves of unpleasant feelings .This includes “…a process of restructuring thoughts”, (P4), or “…softening things…” out (P1).

One aspect and a concern expressed about working with trauma was "that you could become desensitised to some of it and you become unshockable" (P1). This appeared to increase with time, "The more you hear about peoples' experiences the less it shocks you" (P3).

An important aspect of working with clients' trauma stories is the need to look after oneself. Care of the self is evidenced through a range of diverse coping strategies. Some of these strategies appear positive while others have a negative effect. Positive approaches include exercise, walking off the material and walking "…until it is safe to go home" (P3), going to the gym (P5) and "…needing to run it off" (P4).

The need for personal comfort or to "soften out" is evidenced by more negative strategies, (P1), "a couple of glasses of wine to feel better" (P1), "reaching for a bottle of wine" (P3) and "ordering takeaways" (P3).

Some of the participants use coping methods which involve cognitive approaches, giving the material time to filter out. This was referred to as a process of "watchful waiting" (P2). Release was achieved "through reframing a situation" (P4) this led to feeling of being able to "look after myself" (P4). This is action that parallels the NHS guidelines for managing trauma.

Other strategies revealed the need for personal comfort or a softening out. There is a tendency to seek a quick release from distress, "a couple of glasses of wine" (P1). Despite strategies that are both conscious and unconscious residue feeling sometimes remain. Discomfort can lead to relationship problems, "quarrelling with partners" (P3). It led to physical feelings of distress. These feelings are experienced in many ways by the participants.

Each of the participants use different strategies for managing the residue feelings that were experienced. Some view difficult feelings as a sign that they are

able to engage with their clients. Distress may sometimes be normalised as resulting from empathic engagement (P2). To no longer be distressed would be a sign of an "impending burnout" (P2).

Residue is often managed by taking "time to process information" (P4). This is important but in reality there is "less opportunity to process material" than is required. There was frequently not time for "formal supervision. In these instances a brief interaction with a colleague helped" (P3). She felt that she had become "aware of the resilience of human beings" and was "humbled how people with very severe trauma are able to get up and carry on."

Peer supervision is experienced as a very important strategy for managing the effects of trauma. The supportive function of peer supervision is perceived as crucial to well-being. Peers understand the nature of the work. The team is viewed as supportive and it "helps to have a debriefing session with a colleague" (P3) and being with people who were dealing with similar unpleasant and often harrowing stories produced "an environment where trauma was automatically normalised" (P4).

Peer supervision has a large advantage over formal supervision (P1). "If the person you are speaking to only has an intellectual ability to understand what you are saying and remarks superficially, that makes a barrier" (P1).

Traditional one to one supervision was experienced as problematic by the participants in the past and on many occasions has been less than helpful. One to one supervision is experienced as increasing feelings of being alone with trauma. The frequency of one to one supervision is not enough, often there is an "urgency to speak to someone and supervision might not be for another week" (P5).

Participants feel that they have an ethical duty not to traumatise their supervisor. Some refrain from sharing information that is distressing them. There is

an anxiety about "dumping it on the supervisor as they are going to be left with this" (P5), a fear of "passing the trauma on" (P1) and a "responsibility to contain it" (P2). Formal supervision is not sufficient to enable participants to get rid of traumatic material, whereas peer supervision is helpful (P1). The team is experienced as supportive and it "helps to have a debriefing session with a colleague."

Because peers understand it is easier to process the emotions, if somebody does not understand "you almost have to tell them everything without wanting to pass on the trauma" (P1). Peer supervision facilitated an ability to be "open and honest" (P2). Just being with peers can be useful "like going bowling or having a meal together." Seeing peers function well also provides a form of positive modelling. "Seeing my colleagues dealing with this stuff means I can too" (P1).

Despite peer supervision, participants may on occasion leave work with unpleasant material and need to use strategies in order to feel better. For some, residue feelings occurred "all the time" (P4). At these times it is important to "have a break" and "not to rush into a session with somebody else" (P4). This is also the time when participants draw upon their coping strategies, negative and positive ones. Responses include going to the gym (P5), walking until it is safe to go home (P3), using watchful waiting and cognitive restructuring (P2), reaching for a couple of glasses of wine (P1) and using imagery to compartmentalise trauma (P5).

The participant's choice of strategy varies depending on the intensity of feeling. Sometimes participants "feel too tired and drained" (P3) to be proactive in managing their feelings. Feeling tired and drained is often associated with difficult relationship interactions. At these times "quarrels" with partners may occur.

On occasions working with trauma impacts on many different areas of the participants' lives, including their ability to maintain a healthy diet. Feeling "too drained to cook and tending to comfort eat" (P3) was described by one participant.

Participants frequently feel that they take on their clients' material. This is felt in vague terms and may be experienced as a "headache or a funny tummy" (P4). This is particularly pertinent at various times. For example, when client stories feel close to home or share a frame of reference, "one of the things that is difficult is having a child and that resonates when hearing stories of childhood trauma" (P2), material can then feel intrusive (P1). When trauma stories are relayed in a "forceful way" (P2), participants felt an increased residue after sessions.

It is also difficult to separate oneself from trauma while it is still continuing. There is a sense of being caught in the process and "living it with them" (P4). On some occasions and despite concentrated attempts to employ strategies participants were unsuccessful in removing residue. They asserted strategies would not always work (P4).

Participants were of the opinion that working with trauma changes the individual. Before engaging in this work, there had been an idyllic period where one "lived in a bubble." (P5). Working with trauma results in entering "a parallel universe" (P5), "one that others do not have access to", "people outside of this building have no idea what is going on" (P5). There is a knowledge that "there are bad people in the world who do terrible things" (P2).

There is now a need to "check out assumptions" (P1), an awareness that one may hold "slightly skewed assumptions" (P1), and it's like "your innocence has gone" (P3). There is a belief that "true ignorance is bliss." (P5). Conversely, having negative assumptions is experienced as possibly being helpful providing one does not leap to

conclusions (P3) and rather relies on close associates and friends to check out the validity of assumptions (P1).

Over a period of time the participants' frame of reference has changed. Since having children "the work has become intrusive" (P1). "I see things and situations that are only visible to me because I have had a certain experience or heard certain material." "If you saw two people, a grandchild and grandparent in a shop, you would always have that thought in your head, are they grandparent and grandchild?" (P3). Participants express concerns about the impact of trauma work on their parenting. It has implications on parenting, "It has made me look at areas where staff could be alone with children" (P2) and "I want to be able to make sensible decisions about my children" (P1), "It has changed my frame of reference" (P3).

Participants describe negative lasting changes to frame of reference but there are also positive aspects such as an increase in "confidence in general therapeutic terms", gratitude for the fact of having been "fortunate in one's own life" (P2), an awareness of the resilience of human beings (P4) and respect for this resilience (P5).

Table 3 Textural – structural representation of participant group experiences of working with trauma

Themes	Participant semantic descriptions
Residual Feelings	*Are an integral and unpleasant part of working with trauma* *The ability to manage are central to working in the trauma field* *May be somatic, physical or emotional* *Can intrude into personal life causing difficulties in intimate, personal and parenting relationships*
Coping Strategies	*Are used by all participants* *Essentially to maintain resilience* *Conscious and unconscious* *Active and pro-active* *Ethical framework provides opportunity to contextualise material* *Peer supervision*
Frame of Reference	*Generally negative changes occur* *Negative attribution* *Post traumatic growth does occur but co-exists with negative schema change* *Regret at changed world view*
Supervision	*Generally inadequate* *Leaves participants struggling*
Peer Supervision	*Normalises environment* *Protective factor* *Can be an abbreviated process* *Promotes resilience* *Feels genuine* *Creates positive trauma bond*

4.4 Structural Description for all Participants

Working with trauma is uncomfortable. It leaves a residue that often continues to resonate within the cognitive and emotional systems of the participants. These feelings are integral to working with the material.

Traumatic material causes a disruption that is often felt as a disquieting or a feeling of material being held in the body. There is a primary need to remove this material. It causes a haunting and a rumination. Participants need to get rid of these feelings before life can be resumed, before things can return to normal. Trauma does not make sense and it cannot be easily processed. The self needs help to achieve this.

Participants use two distinct types of coping strategies in an attempt to shrink, distance and remove material. Separating oneself from distress is crucial and a fundamental human need. There is usually an active processing of the material assisted by strategies that parallel clients' own processes. Despite these efforts which often involve considerable commitment; feelings of vulnerability, of being weighed down and feeling unwell often remain in the system. Varying degrees of residue appear to persist.

Working with complex trauma is more uncomfortable. It becomes amplified when material resonates with the psychologists' own frame of reference. Their ability to empathise at a deep level allows an easy development of imagination. Through rumination they create situations in their head where they and their families become victims. The narratives they are witness to provide an unwelcome knowledge that atrocities occur in ways previously unimagined. Despite a core urge and distinct motivation to protect themselves from these feelings, distress pierces their usual professional skin.

There lies a constant and uncomfortable tension between trying to protect the integrity of the self and the desire to be helpful to clients. Strategies can help to varying degrees on different occasions. Working with trauma is often experienced in a way similar to those who are involved or caught up in the original situation. Coping with trauma is hard and it is always a challenge.

A number of proactive positive coping methods offer some protection. Carefully scheduling appointments that are identified as potentially difficult helps to buffer against distress. It is not always possible to prepare though. Case-loads are often high and it is impossible to guard against a sudden harrowing disclosure. Such material frequently remains in the cognitive system for hours, weeks and sometimes indefinitely. Feeling vulnerable and overwhelmed by material is associated with more negative strategies as the self seeks to find the comfort that is necessary to restore homeostasis and quickly.

At the onset of this work and as one continues to work with material, the need for support is crucial. The need to dissolve the isolation; to connect with others in a parallel universe and to be able to cope, becomes an indivertible urge and an instinctual drive. Peers understand, there is a commonality of experience, a deep phenomenological understanding.

The process of sharing or simply being with others who really understand provides a cathartic element. This offers a partial panacea normalising the toxic environment of trauma. Sadly, peer support is not often factored in organisational schedules. Its true value is not immediately recognisable. The process of being managed in formal supervision increased the experience of helplessness. There are feelings of vulnerability, of being exposed and viewed as incompetent. These feelings add to the weight to the already present burden. There is also anger experienced at

needing to explain the inexplicable to a person who does not understand. This increases perceptions of isolation.

Formal supervision is often unhelpful, there is often a perceived and prescient need to edit material and to contain it. It is this very material that paradoxically becomes locked in the psyche of the participants. The very essence that needs to be removed.

Peers understand, relief comes in sharing, in abbreviating the trauma, there is no fear of traumatising peers and no requirement to spill the gory bits. Peers inhabit a similar universe. They understand the language and landscape of trauma. Inhabiting a similar universe, represents normality however skewed. It can more easily be understood. Peer supervision meets a need to discharge material quickly. Release cannot want to wait for regular scheduling. There is often a team member around. Just their presence helps. It breaks the isolation.

Despite an active intention to protect the self, each of the participants reported differing levels of distress. These distressing feelings were ameliorated through positive and negative strategies. After work, a range of conscious strategies help. Exercise, leisure, yoga and timeout all help to provide a vessel in which to dump residue.

Despite good intentions, sometimes the need for a quick fix takes priority. Tension needs release and quickly. Pain is often masked by a few drinks or comfort eating. Self-care is vital and self-soothing is a habit. The extent of uncomfortable feelings decides whether a strategy at a given time is positive or negative.

Over time the process of working with trauma becomes a larger burden. Coping strategies become like ineffectual and worn out tools. Consciousness facilitates a searching for new methods and updating models that maintain the frame

of reference relatively intact. Despite this, attribution change is inevitable, one's change of perspective is felt as an acute loss, as grief. There is no going back to the start.

Relationships and parenting both are viewed as fragile, not as clear as before. The loss of innocence and growth of suspicion causes doubt. Doubt about one's ability to make good choices. As rumination grows, it needs pruning to ensure it does not take over and cause a high and rambling level of anxiety and doubt. Feelings of doubt and isolation have the potential to spreads into decision making, thoughts about family safety prevail. Working in a close team helps clarify and then partially ameliorate these fears. Positive relationships allow a sharing of fear and confusion. They provide a mirror. Good decision making is possible, choices remain effective. Sharing one's concerns, provides an opportunity for clarification. Clarification produces anchoring. Anchoring results in a perception of safety.

There are benefits to working with trauma and there is post traumatic growth. This is not experienced as a hallelujah concept or self-actualisation. Post traumatic growth emerges from the distorted shape of one's new attribution style. It coexists. It does not transcend the distress and costs of trauma work. It does not ameliorate the pain. Rather, there are positive strengths that emerge that one may recognise; confidence, humility, gratitude and strength. These concepts do not ameliorate what has been lost. Growth coexists with pain. It is a duality.

Chapter 5 - Discussion

5.1 Discussion

The investigative research process found various themes emerging from working within the trauma field. While there were certainly positive outcomes associated with engaging in this specialised type of work, there was an emergent pattern of negative results and long lasting consequences.

The most profound change found across the investigative process was the concept of significant alterations to participants frame of reference or their own personal 'metanarratives' and life stories (Lyotard, 1979).

These alterations to the psychologists' attribution style, more simply expressed as changes to their individual life scripts or personal meanings were of a notably negative occurrence. These changes involve disruptions in the cognitive schemas of counsellors' identity, memory and belief systems (Pearlman & Saakvitne, 1995b). In this study coexisting with the concept of negativity was a sense of deepening, a ripening and the development of the concepts of acceptance and wisdom. It should be emphasised that the concept of an emergent wisdom did not mitigate the negative consequences of working with trauma. Rather participants experienced a coexistence of positive and negative effects.

The metaphor of alchemy is of some assistance in describing the practice of processing trauma material. Initially following trauma work, the therapist is often left with an unpleasant residue, the Prima Material (Jung, 1957). In this context the Prima Material may essentially be viewed as a crude deposit of information. The after effects are often experienced as a 'weight' a 'heaviness' or 'residue' by participants. The Alchemists believed that lead could be turned into gold through intensive labouring. To achieve this state, the material needed to undergo a transmutation process. In

everyday terms the metaphor simply translates as 'The soul could be freed from troubling material'. In terms more comprehendible to academic and cognitive psychology the distressing information needs to be assimilated, understood and eventually accommodated. Trauma does not make sense and is not easily comprehended and assimilated by cognitive structures.

The psychologist often enters into a process of confusion and unsettlement. This distressing phase is analogous to a dark night of the soul and its associated state of *nigredo* (Moore, 2004). In this phase all previously held attributions are tested and need to be re-appraised. If this phase is successfully negotiated, there lies the possibility of the emergence of the development of new and potentially positive schemas. These new schemas viewed adversity and horror as conditions that could lead to self-growth, appreciation of self and others and a general level of wisdom.

For post traumatic growth (PTG) to occur adequate processing of trauma needed to take place. Noticeably all of the participant psychologists in the study reported positive changes. However, all of the participants experienced negative lasting change. Previous studies have produced findings that suggest that finding meaning in client's trauma can help mitigate the effects of vicarious traumatisation (Astin, 1977).

This study suggests that although positive growth does occur, its presence does not ameliorate negative schema change. The findings derived from the participants in the study strongly indicate the development of a changed attribution system that participants constantly struggle to manage. The results suggest that post traumatic growth is not an end product of successfully processing material, (Joseph & Linley, 2008) rather post traumatic growth can be present in the face of persisting negative

feelings and negative schema changes. This view supports the research of Cadell (2003) whose findings were that personal distress and growth often coexist.

This concept has marked implications and should impact and influence the training of mental health practitioners who envisage working in the trauma field. While an acquired wisdom may be a positive outcome from trauma work, the negative and lasting changes to personal schemas raise ethical issues. Essentially, practitioners need to be fully aware of the potential consequences of the work and be more effectively prepared to manage their responses.

5.2 Changes to Attribution Style

An individual's personal attribution system may be likened to a programmed machine. This is a machine that operates in a manner specific to the individual. Once these individual patterns or programmes have developed, typically, they remain as key influencers throughout the lifespan.

Attribution systems start to develop in childhood, beginning initially during our symbiotic relationship with early caregivers (Gerhardt, 2004). These primitive thought processes are extended and reinforced over the lengthy period of development. This occurs through interactions with parents, caregivers and peers. In usual circumstances individuals build upon particular thinking processes continually refining them throughout the lifespan. These thought processes become our primary schemas (Beck, 1980; Padeski, 1990).

These ways of thinking in turn influence all subsequent behaviours, emotions and decision making. Individuals who have developed positive attribution styles frequently report greater positivity and levels of happiness. Individuals having a history of cyclical depression often hold negative scripts and pessimistic automatic thinking. Participants in this study all reported positive schemas prior to engaging in

trauma work. This baseline positivity appears to be significant in their ability to continue to undertake this work. Previous research highlights the importance of a larger sense of meaning as being fundamental in protecting against vicarious traumatisation (Pearlman & Mac Ian, 1993).

It involves a great deal of conscious effort to bring these primary schemas to awareness. Generally they are governed by automatic assumptions. Once an individual gains an awareness of their negative schemas, there is an opportunity for change to occur. This process usually involves a great deal of ongoing practice and refinement. Cognitive behavioural therapy is a clear example of a conscious process designed to address maladaptive schemas.

For all participants working with trauma, a change to their attribution system was an unfortunate result of working in the trauma field. Awareness of these changes was not immediately accessible to all of the participants. During reflection and through speaking about their experiences participants showed a growing awareness of the changes that had occurred. Schema change was not a concept that was anticipated or planned for.

This understandable failure to recognise schema change meant there were no strategies put in place to ameliorate the cognitive and emotional distortions that occurred. The findings of this study suggest that mental health workers need to be educated early in their training regarding the importance of self-reflective practices, strategies and support as conditions that are crucial to working in the trauma field. It should be evident that a lack of awareness of one's negative inner processes may render the practitioner unfit to continue to work in this important arena and cause reverberations in their personal life.

It was also a noteworthy finding that each of the participants seemed to experience these marked schema changes relatively early in their career. They each spoke of significant change, of entering a parallel universe or feeling a bubble had been burst. Some participants experienced resentment that change had occurred. As stated these reported feelings have implications for the training of trauma practitioners. It should be considered important that trainee psychologists are educated about the changes that are likely to occur during trauma work. This is an ongoing ethical consideration that needs to be adequately addressed.

Once change had occurred all of the participants felt that they were then programmed to think in a negative manner. Their perception was that these thoughts became automatic thoughts. Once present they experienced these automatic negative thoughts on a regular basis and in innocent and innocuous situations. Countertransference and vicarious traumatisation although distinct in conceptualisation, are related to one another. As a practitioner experiences increasing levels of vicarious traumatisation, the related disruptions in cognitive schemas become part of the counsellor's unconscious personal material that may then result in countertransference towards the client (Saakvitne & Pearlman, 1996).

The research participants talked of imagining the worst scenario in a situation rather than recognising a potential positive outcome. It is correct to state that the psychologists did remain able to hold positive thoughts about situations. However, positivity was only recognised and registered after a full appraisal of an event had occurred. Each had coached themselves to think in a positive manner to address negative automatic assumptions. This ability to address negative automatic assumptions seemed to be a process that occurred over time spent in post. It was also a strategy that was regularly refined.

5.3 Feelings of Helplessness Early in Career

An emergent theme in the research was of significant changes to frame of reference. While these changes continued to occur throughout the career, the most negative changes occurred early in the professional role. These alterations to schemas continue to impact on thought processes and emotions, in some cases after many years. Such changes have very large implications for the training of trauma practitioners. Issues such as preparation of the practitioner, case loading and supervision become very important.

Preparing the practitioner for the inevitable changes to frame of reference is crucial. The findings of this study concur with the work of Curtis and Gold (2009) who argue for the need for inclusion of psychological trauma in the professional curriculum. A lack of preparation for the work raises very serious ethical concerns. An awareness of the inevitability of personal frame of reference change during formal training allows a potential practitioner to make an informed choice of whether to pursue a career in this particular field of psychology.

It is a researched area that practitioners who work primarily with trauma survivors experience a greater level of vicarious trauma than counsellors who work in general practice who may see only a few trauma survivors (Brady, Guy, Polestra & Brokaw, 1997; Chrestman, 1995; Cunningham, 1999; Kassam-Adams, 1995; Pearlman & Mac Ian 1993; Schauben & Fraser 1995).

The participants in this study seemed to have developed thought processes whereby seemingly innocent situations would be judged initially as negative or risky. This was followed by a process of cognitive restructuring to achieve a balanced thought. An example of this was the participant who when seeing a grandfather and small child alone together automatically assumed the older man was a paedophile.

These attribution systems also brought feelings of guilt to the psychologist who accused herself of being judgemental. She justified her thoughts by stating that in her working life it was people who were sex offenders that she encountered. Working with dysfunction was her reality. Her attribution system was normal under the circumstances.

A similar process was echoed by another psychologist who stated that working with trauma is like working in a parallel universe. This suggests that individuals who work with trauma need to become proficient in adapting to parallel realities. An awareness of this duality could be a protective function and something that could be introduced into formal training.

The rhetoric seemed to be that working with trauma is an experience outside of the realm of most peoples' understanding. The content of the material is often bizarre and frequently horrendous. Psychologists are regularly subject to stories and narratives that are beyond the conceptualisation of many fictional writers. Hearing these stories, sometimes on a daily basis, altered the participant's way of thinking and responding. It was if they had been immersed in an unreal word. Embedded in this experience was a perception of having crossed a line and of increasing isolation and loneliness.

The emerging theme among all psychologists who took part in the study was a changed attribution system. These changes raised the potential for difficult interactions and missed opportunities for connection with other individuals. Loneliness and isolation is a side effect of this type of work. Participants found communication became difficult both within public and private domains. Pearlman and Saatvitne (1995) described consequences of disruptions in this area as feelings of

emptiness when alone, difficulty enjoying time alone and avoidance and withdrawal from others.

The research findings in this study strongly indicate that being left with varying degrees of residue of material is a normal consequence of working within the trauma field. Residue feelings are always unpleasant. It may be postulated that residue feelings are a normal consequence and distinct from vicarious traumatisation and compassion fatigue. If viewed in this manner, an educative process that assists all practitioners to manage these feelings more effectively and teaches resilience would in the longer term be expected to reduce the occurrence of vicarious traumatisation.

Currently, there is frequently a perception that the display of negative emotion is a symptom of vicarious traumatisation. While this in many cases is correct, an acceptance of the normalcy of unpleasant residue should lead to methods that help process and facilitate a catharsis of such feelings. This may be viewed in a similar vein to the detoxification process firefighters use after exposure to hazardous substances. It would be preposterous to view the physical decontamination ritual used by firefighters as a weakness. This study suggests a parallel process is needed to reduce the toxicity of trauma from the cognitive and emotional systems of practitioners.

5.4 Reframing Cognitions as Coping Strategies

A powerful coping strategy emerged during the study across the participants. The psychologists needed to consistently monitor their automatic assumptions and personal metanarratives. This was necessary in order to live without varying degrees of conflict in their interactions with others. There was a potential for many misunderstandings and failed communications. These difficulties occurred, even with intimate partners. Furthermore, on many occasions participants felt it difficult to talk

about their work for fear of shocking another. This heightened their perception of isolation.

Most of the participants described the need to reframe everyday situations as a continuous theme. It is a process that they engage in privately. They only felt able to share their thoughts with colleagues, as they feared being perceived as weird and negative. This highlights again the value of peer supervision and the normalcy that such a process facilitates. Peer supervision has been found to decrease isolation, increase practitioner objectivity, empathy and compassion (Lyon, 1993; Bledsoe, 2012). Peer supervision emerges as a key protective factor.

Each of the psychologists reported negative changes within their attribution system. They needed to continually monitor, evaluate and reconstruct their negative thought processes. Feelings of guilt and shame for having these thoughts were common and this in turn negatively affected their self-worth. Peer supervision appeared crucial for a balancing of thoughts to occur.

5.5 Trauma Work and its Impact on Relationships and Parenting

The largest changes within the psychologists' attribution system were felt in their personal relationships and especially within the parental relationship. Participants felt they experienced a tendency to be overly protective of their children. They became hyper vigilant to the risk of harm. The effects of working with trauma on parenting style is an under researched area and needs further investigation.

Participants were of the opinion that if they did not constantly monitor their thoughts there was a perceived risk to their own children's development and the likely formation of negative attribution systems in their off spring. They were asserting that unchallenged negative assumptions could affect their responsiveness as parents with serious repercussions for their children's mental health. They appeared to be

suggesting that unresolved distress or vicarious traumatisation could become an intergenerational issue. There is existing research that suggests unresolved PTSD could be passed down to successive generations. Obviously in the event that attribution style is negatively transformed this would be a possibility. This theory has direct correlations with the work of Gerhardt (2004).

The participant psychologists were each of the opinion that it was a constant and conscious process to appraise their thinking. In this context the need for regular supervision from colleagues was imperative to their continued wellbeing.

When in a positive frame of mind and reflecting about their thought processes, all of the practitioners believed that their altered thinking systems were part of being human and a natural process. Specifically, if horror becomes a daily and normal event then one would anticipate schema change. Despite having a cognitive awareness of the inevitability of schema change, on an emotional level this was difficult.

5.6 Physical Effects on the Psychologist

A marked and repeated theme reported by the participants was the occurrence of being left with residue material. This finding has been reported extensively in previous studies by Pearlman and Mac Ian (1993) and Schauben and Frazier (1995).

5.7 Proximity of Trauma

An emergent theme in this study was that troubling symptoms were more likely to be reported if the trauma had occurred recently (the proximity of trauma) or was still continuing. This finding supports the work of Palm (2013) who studied the occurrence of vicarious traumatisation in rescue workers who were involved in the aftermath of the September 11th terrorist attack. One of the participants in this current study reported feeling as if she was involved in the trauma when the situation was ongoing for her client. This concept was echoed by another participant who described

that the tone and force in which stories are relayed affects the psychologist often in a negative manner.

Being able to gain information regarding the time frame of an incident before seeing a client permitted proactive strategies to be put in place, e.g., scheduling a lighter diary on the day that a particularly difficult case history was expected.

5.8 Coping Strategies

Each of the participants had developed a range of coping strategies to minimise the residue feelings they were left with. The strategies employed correlated closely with the modality of treatment used by the participant. The participants reported registering trauma in ways that mirrored their selected therapeutic approach.

Participants whose core discipline was cognitive behavioural therapy indicated a clear predisposition towards using cognitive restructuring as a coping strategy. This was contrasted by participants whose chosen model was humanistic or existential who displayed a tendency to remove trauma through physical exercise and movement. This knowledge is important in developing supervision models that are effective for trauma practitioners.

5.9 Positive Coping Strategies

The coping strategies used by participants were both conscious and unconscious processes. Conscious processes included physical exercise, cognitive reframing, watchful waiting and connecting with peers.

5.10 Negative Coping Strategies

Negative coping strategies were largely unconscious strategies that became apparent through a process of self-reflection and self-analysis. Participants reported a range of strategies that were undertaken to achieve feelings of comfort. These included comfort eating which translated as making decisions to eat poor nutritional food,

drinking alcohol or venting unpleasant feelings through being quarrelsome towards partners.

5.11 Being Part of a Team

An emergent theme that presented in the first research interview and was repeated by each participant was the positive and protective effect of being part of a cohesive team.

Being part of a team for one participant was a stand-alone concept in feeling supported irrespective of whether peer supervision was available. Simply being an integral part of a shared environment provided a normalcy for this participant. Identification with others appeared to offer a protection (Trypanny, 2004). Even the briefest interaction with a fellow team member was viewed as helpful.

Each of the participants talked about the support that being part of a team offered. Peer supervision was a crucial factor for all of the participants. What was important to the psychologists was that a colleague or peer was also available within a team environment. In a previous study Pearlman and Mac Ian (1993) found that 85% of trauma counsellors used peer supervision as their preferred coping strategy.

The need to connect with peers would often occur in between periods of allocated peer supervision. Just being able to connect with a colleague who might not understand the actual material but was experienced in listening to stories of horror and atrocity seemed to soothe the spirit. There was a knowing between professionals that content often did not need to be verbalised. As one participant explained, a peer environment allows a short cut process to occur. Oliveri and Waterman (1993); Bober, Regehr and Zhou (2006) in previous studies identified the benefits to counsellors of being able to talk to peers or simply vent their feelings. These participants appeared to

be extending these findings by stating that actually just being with other professionals who understood was helpful. This need to seek and receive peer support is crucial.

Most of the participants welcomed peer supervision and it would appear that there were often occasions when treatment units were busy and the supervision process could not occur.

While participants tended to seek out peers and/or use their own coping strategies, findings did suggest that on the occasions when peers were not available they did experience more rumination. Catherall (1995) identified the helpful role of peer supervision in reducing cognitive disruptions in trauma practitioners. Being able to share sensitive material reduces feelings of isolation and helplessness (Lyon, 1993). There was also the emergent theme of a trauma bond between practitioners and this created reality was seen as a protective factor. Experiencing empathy from colleagues lessened the burden.

5.12 Traditional Supervision

Traditional dyadic supervision was a process that was engaged in by the psychologists. This was reported as being not as useful as peer supervision. In some instances the participants felt that traditional supervision was unhelpful and punitive. On occasions dyadic supervision made it more difficult to get rid of material. This was because participants felt the need to provide a context and process to the narrative.

One striking response was the assertion made by several of the psychologists that in order to really be useful in a supervisory capacity, a supervisor must fully understand the reality of the trauma world. An intellectual understanding was experienced as inauthentic and on occasion prevented disclosure. Yassen (1995) stated it is important that caregivers have a variety of peer supervision to allow easy access to share with others the burden of being witness to traumatic events. Participants spoke

of the need for genuine empathy and expressed the feelings that empathy in trauma work must arise from shared experiences.

This raises a very pertinent question. Should supervisors who work with psychologists in the trauma field be recruited from a pool of trauma practitioners rather than be selected simply because they are registered supervisors? This question continues to gather momentum when one considers the role of modelling that supervisors play.

5.13 Modelling Role of Peer Supervision

It is interesting that several participants felt that simply being with peers helped them at an informal level. They experienced a catharsis of residue material in these circumstances. It was possible to abbreviate their disquieting stories but despite shortcutting their narratives they felt be understood (Dyregrov & Mitchell, 1996).

Participants found it was useful just being able to connect with someone who understood. This would prevent participants from having to enter into great depth about the material. It was suggested that colleagues would only require very basic information to be able to understand the full picture.

Two factors are pertinent here. Abbreviating trauma stories could prevent less cognitive rehearsal and in turn may reduce the formation of permanent unpleasant memory structures. A further benefit may arise from witnessing one's peers coping with difficult material. This research showed a relationship between modelling and the normalising of experience. The positive modelling and normalising aspect would be expected to be reduced during supervision with a supervisor who was not familiar with trauma work.

The most helpful element of supervision reported by the participants was being able to talk to somebody who actually understood trauma. There was an admission

that the world of trauma can produce an altered reality. To be effective supervisors must be able to genuinely understand that world. Good trauma supervision appears to be based on a synthesis of shared reality rather than compassionate and professional empathy. This function is perceived as more useful than case management in supervision.

During traditional dyadic supervision participants felt unable to reveal information for fear of traumatising the supervisor. There was also the fear that if a supervisor had no understanding of the field there could be a possibility that the psychologist might be seen as not coping if they shared feelings of distress. For participants, being viewed as not coping raised issues about their own competency. The power imbalances between the supervisor and supervisee would be expected to accentuate the participants' concerns.

5.14 Positive Changes – A Duality

5.14.1 Post traumatic growth

The concept of post traumatic growth arising from vicarious traumatisation produced tentative findings which require further research investigation.

All of the participants in the study were able to describe positive growth as a result of their work. However, the concept of positive growth was secondary to the perception of lasting and negative change and alterations to world view. Previous studies have in the main identified post traumatic growth as a potential positive of trauma work. The notion that post traumatic growth occurs and exists together with negative schema change is a less researched area. This study produced a tentative hypothesis that negative attribution systems and post traumatic growth may be concepts simultaneously experienced by the practitioner rather than mutually exclusive concepts that are experienced in a linear manner. To return to the familiar

alchemical metaphor, a hypothesis offered is that a change of base metals is partial. There are streaks of gold in the lead rather than a full change or transmutation of material per se.

Specifically all of the psychologists felt that their cognitive metaschemas had become subject to a process of maladaptation. Existing belief systems were shattered, intrusive imagery and strong emotions were experienced (Barrington & Shakespeare Finch, 2013).

Participants reported acquired automatic thinking. Assumptions needed to be appraised regularly for legitimacy. Among the cohort, cognitive schema appraisal became a process of both self and peer supervision. The participants positioned the opinion that there were positive factors associated with trauma work. However, these beneficial aspects did not in any sense reduce, remove or obviate the harm caused to the cognitive and emotional system through working in this field. Despite these negative aspects each reported developing new relationships, increased self-understanding and a greater understanding of life (Barrington & Shakespeare Finch, 2013).

Overall, participants reported a level of being pleased to be able to help others despite the obvious cost to themselves. This view concurs with the research of Stamm (2005) who developed the term ‘compassion satisfaction’ to describe the feelings experienced by those who work in the trauma field. It also concurs with the work of Ohaeri (2003) who described the benefits of providing support to others.

The use of coping strategies was vital in ensuring negative automatic assumptions were identified and subject to cognitive restructuring. This process needed to be maintained.

Moss and Shaefer (1993) postulated that coping resources were found in individuals having stable emotional and personal regulation. This correlates with the findings of Howard and Goelitz (2004) who argued that self-care was an important factor in the continued wellbeing of clinicians.

Interestingly, a recurrent theme throughout the phenomenological research process was the need to talk about material with individuals who understood. It was a recognised position that formal supervision was not particularly useful in facilitating the removal of trauma material. A self-care strategy was practised in seeking out peers to talk to usually informally.

This investigation suggested that coping strategies in the participating psychologists were regularly updated and were always in flux. The participants all expressed sadness and regret that working in this field had changed their metascripts of the world and in a negative way. They reported a loss of innocence that they felt was unable to be restored. This led to cynicism. The benefit of compassion satisfaction was expressly related to their personal relationships and families, although even in these intensely intimate areas doubts about ones self-efficacy were often expressed. Similar findings were made in a previous research study (Bober & Regehr, 2006).

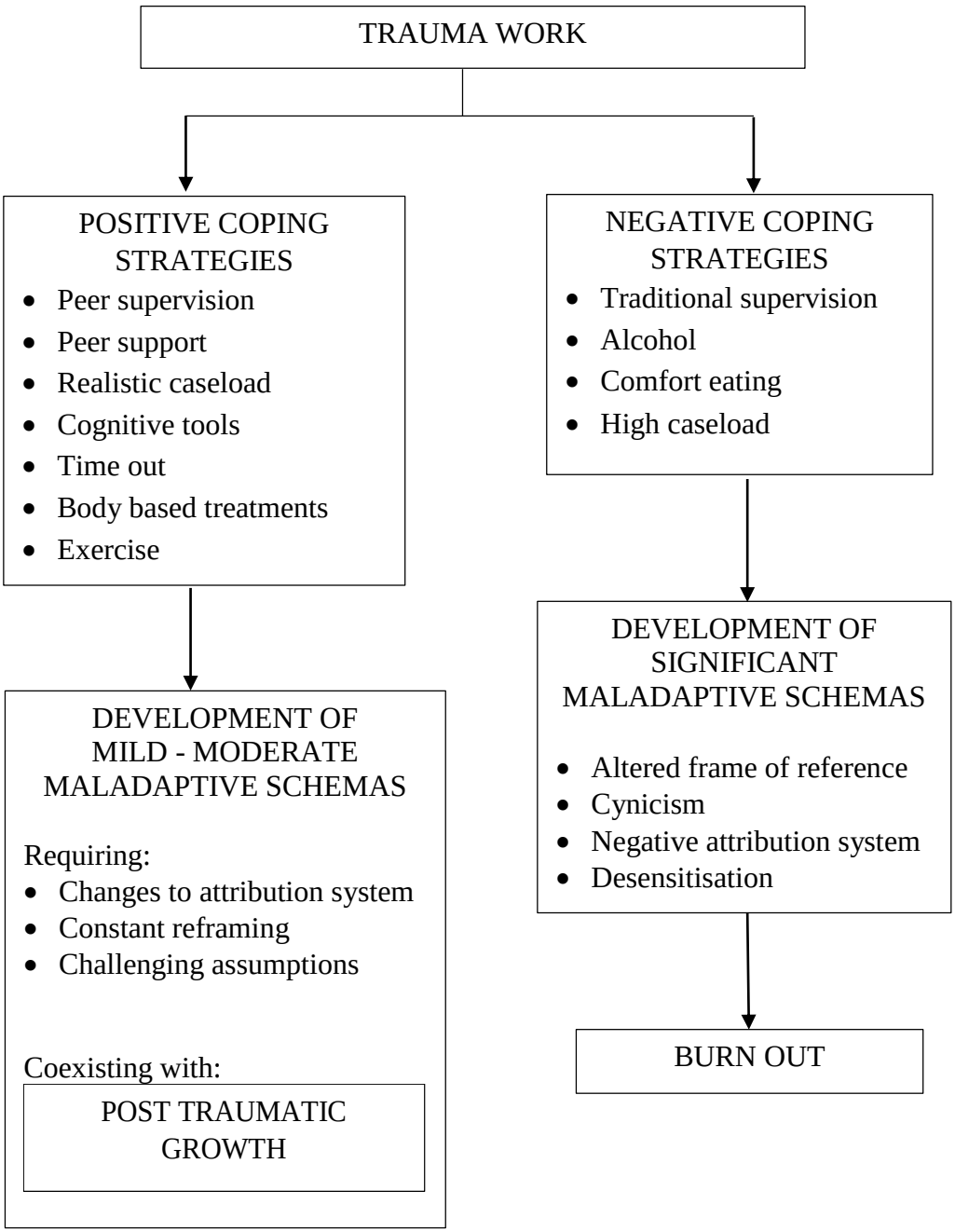
5.14.2 Negative Changes

A common concept reported by all the participants was of lasting change to their attribution styles. All the participants spoke in different terms about a loss of innocence. There was a shared consensus among the participants of seeing danger where others saw none. This equated to an opinion shared by all participants that in their work they enter a parallel universe, a universe that others do not have general access to.

5.14.3 Desensitisation

Of particular concern was a feeling of desensitisation. One participant spoke of a gradual loss of empathy and a growing tolerance of violence. She stated that she had reached a point where she felt herself thinking, 'It was a slap. Nobody died'. Clearly schemas of this type raise concern and represent marked challenges to continued empathic and ethical practice. Structures need to be developed to reduce the incidence of this type.

Figure 6 - Summary of Coping Strategies Used by Participants



5.15 Conclusions

This study has clearly established a relationship between trauma work and the development of negative attribution styles in each of the psychologists notwithstanding the use of coping strategies. While it can be hypothesised that in some cases a negative attribution style develops over time and is related to the amount of exposure a psychologist has, it is also the case that several participant's experienced significant schema change early in their career. This is consistent with other research (Adams & Riggs, 2008).

The findings of this study suggest that individuals who are engaged in trauma work may be at risk of schema change at any point in their career. Significant negative schema change could have a very marked effect on both the professional and private life of the psychologist.

One theme that emerged was the feeling of a lack of empathy towards victims. These feelings of desensitisation towards trauma victims could be expected to weaken the working alliance between therapist and patient. Significant research throughout the decades has highlighted the importance of a genuine and firm working alliance as the foundation to successful therapy (Clarkson, 1995).

A further emergent fact is the strong value that is placed on peer supervision. This study indicated that on many occasions, peer supervision enabled participants to continue with this work. Not only did it facilitate a continuance of the work, it appeared to provide a protective function to the participants. It is of concern that peer supervision is at times an ad hoc occurrence. There is a need for structured time to be built into the working diary of practitioners for this process.

The training of psychologists who wish to work in the trauma field is another area where further and specific input is needed. Psychologists need to gain an

awareness of the inevitable changes to attribution and frame of reference that are likely to occur. This is an emerging ethical issue. Further research is needed into the use of coping strategies and how these may be developed into a practitioner supervision model.

A particular interesting area of further research is the manner in which psychologists of different disciplines are left with haunting material. The results of this study and a previous study (Tizzard, 2005) suggest that the modality of therapy used has a correlation in the type of residue material experienced by practitioners.

Further research in this area is advocated to develop modality specific self and peer supervision techniques that will provide increased protection to personnel working with trauma. The overall disposition of the psychologist prior to engaging in trauma work also appears of significance.

A further area of immediate concern arises and this is one pertinent to many psychologists in private practice. Many of these experienced psychologists provide occasional ad hoc trauma interventions to individuals and organisations through employer assistance programs. Many more provide trauma reduction services to the emergency services often working in isolation. Their supervision is frequently provided by their regular supervisor who offers a generic supervision to their usual client base.

While these supervisors are often highly skilled, empathic and a source of knowledge, their ability to provide the type of support needed to trauma practitioners must be called into question. The research highlights the need for specialised, trauma specific supervision to enable practitioners to continue to live authentic well balanced lives.

A very pertinent question arises out of this research and asks should trauma psychology be provided solely through dedicated teams or individuals that have evidenced access to supervisors who are specialised in the trauma field.

5.16 Summary, Implications and Outcomes

In bringing this research to a conclusion it is appropriate to consider the findings in terms of what is known. This study has reviewed the existing literature as a means of positioning the research and validating the existence of a need.

Having completed both a comprehensive search of the literature and a scrutiny of the topic relevant to this area, and having compared the findings of my own investigation to those in the literature, I believe the textural and structural descriptions provided by the participants add unique and significant extensions to existing knowledge.

This research captures a descriptive and phenomenological understanding of the coping strategies used by psychologists working with the trauma field. The investigation produced material that extended beyond the coping strategies used by psychologists and yielded rich data contextualising their reported schema alterations. These were both negative and positive.

This study produced interesting material regarding the positive value of peer supervision as a key coping strategy. This type of support emerged as being a central element in the prevention of vicarious traumatisation. The process of peer supervision appears to offer a rich ground for further hypothesis building and testing. The findings of my previous study were replicated. This previous study investigated a correlation between the psychologist's therapeutic stance and the manner in which trauma residue is registered and retained.

Furthermore, while certain themes and issues that focus on the experience of working with trauma and its after effects can be gleaned from existing literature, no previous studies brings together the situational with the experiential and synthesizes the experiences that reflects the totality of practitioner experience.

The process of conducting this research has been enlightening. It has been a process that will remain with me for a considerable period. It has been affirming to learn that the feelings and sensations that I have experienced at times during my career are shared by my colleagues. This knowledge is normalising. It is also a comforting thought that I may draw on during some of the darker periods of trauma work in the future. I believe that the discussions that have taken place during this process and which are evidenced by the transcripts will have a therapeutic benefit to the participants.

I have arrived at a deeper understanding and acceptance that working with trauma is costly. The process may inevitably change one's personal schemas. It will involve considerable effort to remain healthy and optimistic if one chooses to remain working in this area. One must continue to be proactive in caring for the self. Caring for the self must also include self-care strategies that assist the individual to recognise when the cost of caring has become too high.

On a personal level, I recognised that I was unable to continue to work in the trauma field shortly after a very close family member died in a horrendous incident. At that point I felt unable to be helpful to clients who were dealing with traumas. I needed to recover; to take time out, including time away from this research (two years). Similar to the experiences of my colleagues when our clients' trauma is in close proximity to our own it is difficult to continue to be empathic. It is a painful process. I fully recognise the assertions made by my colleagues on a professional and personal

level. Central to this is the need to talk about traumatic material. This is essential. The need to really be heard is crucial.

However, the insights and I hope, learning from my experiences has made me a more empathic, thoughtful and in some ways stronger person. I am also of the opinion that this strength is recognised by clients in ways that are unable to be articulated.

Coexisting with the negative changes and perceptions that may to some degree be inevitable in trauma work emerges a true valuing of one's life, one's family, acts of love, beauty and the resilience of the spirit. For me, working with trauma has taught me simply that life is what it is, both positive and negative experiences are part of our time alive. The negative experiences need understanding and processing. Despite this residue material remains. The phenomenological material that has emerged from this study clearly illustrates this reality.

Word Count: 29,849

References

Adams, S.A., & Riggs. S.A. (2008). An exploratory study of vicarious trauma among therapist trainees. *Journal of Training and Education in Professional Psychology*, 2. (1), 26-34.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (4th ed., text revision).* Washington, DC: Author.

Astin, M. C. (1997). Traumatic therapy: How helping rape victims affects me as a therapist. In M. Hill (Ed.), *More than a mirror: How clients influence therapists' lives.* 101-109. Binghamton, NY: Haworth.

Antonovsky, A. (1987). *Unveiling the mystery of health: How people manage stress and stay well*. Jossey Bass. San Francisco, CA.

Barrington, A., Shakespeare-Finch, J. (2013). Posttraumatic Growth and Posttraumatic Depreciation as Predictors of Psychological Adjustment. *Journal of Loss and Trauma, Volume 18, Number 5,* 429-443(15).

Beck, A.T., Rush, A.J., Shaw, B.F., & Emery. G. (1979) *Cognitive Therapy for Depression.* Guilford Press. New York.

Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society, 84(4),* 463-470.

Bledsoe, D. E. (2012). Trauma and supervision. In L. Lopez Levers (Ed.), *Trauma counseling: Theories and interventions.* 569-578. New York, NY US: Springer Publishing Co.

Bober, T., Regehr, C., & Zhou, R. (2006). Development of the coping strategies inventory for trauma counsellors. *Journal of Trauma and Loss 11,* 71-83.

Brady, J. L., Guy, J. D., Poelstra, P. L., & Brokaw, B. F. (1997). Vicarious traumatisation, spirituality and the treatment of adult and child survivors of

sexual abuse. A national survey of women psychotherapists. *Professional Psychology: Research and Practice 30,* 386–393.

Bryant. R. A. (2010). Acute stress disorder as a predictor of post-traumatic stress disorder: a systemic review. *Journal of Clinical Psychology 2010.*

Cadell, S., Regehr, C., & Hemsworth D. (2003). Factors contributing to post traumatic growth: A proposed structural equation model. *American Journal of Orthopsychiatry. Vol 73, issue 3,* 270-287.

Calhoun, L. G., & Tedeschi, R.G. (1999). *Facilitating post traumatic growth: A clinician's guide.* Mahwah NJ: Lawrence Erlbaum Associates Publishers.

Campbell, R. (2002). Emotionally involved: The impact of researching rape. New York, NY: Routledge

Catherall, D. R. (1995). Coping with secondary traumatic stress: The importance of the therapist's professional peer group. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators.* 80–94. Lutherville, MD: Sidran.

Charmaz, K. (1990). 'Discovering' chronic illness: Using grounded theory. *Social Science and Medicine 30(11):*1161-1172

Chesler, M. and Ungerleider, S. (2003). Post-traumatic growth: Understanding a new field of research. *The Prevention Researcher, 10,* Suppl., December, 2003.

Chrestman, K. R. (1995). Secondary exposure to trauma and self-reported distress among therapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators.* 80-94. Lutherville, MD: Sidran.

Clandinin, D. J., & Connelly, F. M. (2000). *Narrative inquiry: Experience and story in qualitative research.* San Francisco: Jossey-Bass.

Clandinin, D. J., & Connelly, F. M. (2000). *Handbook of narrative enquiry: Mapping a methodology.* Thousand Oaks, CA. Sage.

Clarkson, P. (1995). *The therapeutic relationship.* London. Whurr Publishers.

Cohen, K., Collens, P. (2013). The impact of trauma on trauma workers. A metasynthesis on vicarious trauma and vicarious post traumatic growth. *Journal of psychological trauma, theory and research practice and policy. Vol (5), no 6,* 570–580.

Cohen, M. (1987). A historical overview of the phenomenologic movement. *Journal of Nursing Scholarship, 19(1),* 31-34.

Cornelia, M., & Turliuc, M. N. (2013). Predictors of vicarious trauma beliefs. *Journal of loss and trauma. Vol:18,* 414- 428.

Courtois, C. A., Ford, J. D., & Cloitre, M. (2009). Best practices in psychotherapy for adults. In C.A., Courtois and J.D. Ford (Eds.). *Treating complex stress disorders: An evidence based guide*. 220-224. Guilford Press. New York.

Courtois, C. A., & Gold, S.N. (2009). The need for inclusion of psychological trauma in the professional curriculum. A call to action. Psychological trauma: Theory, research practice and policy, 1(1), 3 -23.

Cunningham, M. (1999). The impact of sexual abuse treatment on the social work clinician. *Child and Adolescent Social Work Journal. 16,* 277-290.

Czarniawska, B. (2004). *Narratives in social science research.* London. Sage.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2000). *Handbook of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Dunkley, J., & Whelan, T. (2006). Vicarious Traumatisation: Current status and future directions. *British Journal of Guidance and Counseling, 34(1),* 107-116.

Dyregrov, A., & Mitchell, J. T. (1996). Work with traumatized children: Psychological effects and coping strategies. *Journal of Traumatic Stress, 5*, 5–17.

Figley, C.R. (1982, February). Traumatization and comfort: Close relationships may be hazardous to your health. Keynote presentation, *Families and close relationships: Individuals in social interaction.* Conference held at Texas Tech University, Lubbock.

Figley, C. R. (1983a) Catastrophe: An overview of family reactions. In C.R. Figley & H. I. McCubbin (Eds), *Stress and the family: Vol.2. Coping with catastrophe. 3-2.* New York Brunner/Mazel.

Figley, C. R. (1985a). From victim to survivor: Social responsibility in the wake of catastrophe. In C. R. Figley (Ed.), *Trauma and its wake: The study and treatment of post-traumatic stress disorder.* 398-415. New York: Brunner/Mazel.

Figley, C. R. (1989). *Helping traumatised families.* San Francisco: Jossey-Bass

Figley, C. R. (1992a). Post traumatic stress disorder, Part 1: Empirically based conceptualisation and symptom profile. *Violence Update, 2 (7), 1, 8-11.*

Figley, C. R. (1992b) Post Traumatic Stress Disorder, Part 1V: Generic treatment and prevention approaches. *Violence Update 3(3).*

Figley, C. R. (1993a February). Compassion stress and the family therapist. *Family Therapy News. 1-8.*

Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-Care Issues for Clinicians, Researchers, and Educators. 3–28*. Lutherville, MD: Sidran.

Frankl, V.E. (1963). *Man's search for meaning.* New York. Pocket Books

Freud, S., (1957). Mourning and melancholia (J. Riviere, Trans). In J.D. Sutherland (Ed.), *Collected papers. Vol 4, 152-170*. London. Hogarth Press (Original work published 1917).

Furlonger, Brett. (2013). Institute of human development and counselling, Faculty of Education, Monash University, Melbourne, VIC, Australia, Australian *Journal of Guidance and Counselling. Vol 23(1), Jun, 2013.* 82-94.

Furlonger, B. E., Taylor, W., (2013). Supervision and the management of vicarious traumatisation among Australian telephone and online counsellors. *Australian Journal of Guidance and Counselling [E], Vol 23, issue 1*, 82-94 Cambridge University Press, UK.

Gergen, K. J. (1995). Social construction and the educational process. Constructivism in Education. 17-39.

Gerhardt, S. (2004). *Why love matters: How affection shapes a baby's brain.* Routledge, Hove.

Giorgi, A. (1995). Phenomenological psychology. In J.A. Smith, R. Harre & L. van Langenhove (Eds.), *Rethinking psychology.* 22–42 Sage. London.

Glaser, B.G., Strauss, A.L., (1967). *The discovery of grounded theory: Strategies for qualitative research* New York: Aldine de Gruyter.

Greenberger, D., & Padeski, C. A. (1995), *Mind over mood: Changing how you feel by changing how you think.* Guilford Press, New York.

Hawkins, P., & Shohet, R. (2007). *Supervision in the helping professions*. Open University Press.

Hein, S. F., & Austin, W.J. (2001). Empirical and hermeneutic approaches to *phenomenological research in psychology: a Comparison. Psychological Methods*, *6*, 3-17.

Hesse, A. R. (2002). Secondary Trauma: How affecting with trauma survivors affects therapists. *Clinical Social Work Journal.* 30(3), 293-308.

Howard, J. M., & Goelitz, A. (2004). Psychoeducation as a response to community disaster. *Brief Treatment and Crisis Intervention, 4,* 1-10.

Iliffe, G., & Steed, L. (2000). Exploring counselors experiences of working with perpetuators and survivors on domestic violence. *Journal of Interpersonal Violence 15.* 393–412.

Johnson, K. (2012). Vicarious trauma. *Journal of Family Psychotherapy. Vol 21, (Eds4).*

Jordan, K. (2010). Vicarious trauma: Proposed factors that impact clinicians. *Journal of Family Psychotherapy, 21(4),* 225-234.

Joseph, S., & Linley, P. A. (2005). Positive Adjustment to threatening events: An organismic valuing theory of growth through adversity. *Review of general psychology. 9,* 262-280.

Joseph, S., & Linley, P. A. Psychological assessment of growth following adversity: A review. In: Joseph, S., & Linley, P.A. (Eds.), (2008). *Trauma, Recovery, and Growth: Positive psychological perspectives on post-traumatic stress.* 21-38. Hoboken.

Jung, C. G. (1958-1967). *Psyche and symbol*. (R. F. C. Hull, Trans.). Princeton, New Jersey: Princeton University Press. (Published 1991).

Kassan–Adams, N. (1995). The risks of treating sexual trauma: Stress and secondary trauma in psychotherapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care Issues for clinicians, researchers and educators.* 37-48. Lutherville MD: Sidram.

Klaric M., Franciskovic, T., Stevanovic, A. (2011). Marital quality and relationship satisfaction in war veterans and their wives in Bosnia and Herzegovina. *European Journal of Psychotraumatology 2:* 8077.

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. A comparison of historical and methodological considerations. *International Journal of Qualitative Methods, 2(3),* 21–35.

Lieberman, P. (1991). *Uniquely human: The evolution of speech, thought and selfless behaviour.* Harvard University Press. Cambridge, Mass

Lyon, E. (1993). Hospital staff reactions to accounts by survivors of childhood abuse. *American Journal of Orthopsychiatry, 63,* 410–416.

Lyotard, J. F. (1989). *The Post modern condition: A report on knowledge.* Manchester: Manchester University Press

Maslach, C., Schaufeli, W.B., & Leiter M. P. (2001). *Job Burnout:* Annual Review of Psychology Vol 52:397-422.

Maslow, H. (1970), *Motivation and personality.* Harper. New York.

Mathieu, F. (2012). *The compassion fatigue workbook: Creative tools for transforming compassion fatigue and VT.* Routledge, New York.

McCann, I. L., & Pearlman, L.A. (1990a). Vicarious traumatisation. A framework for the psychological effects of working with victims. *Journal of Traumatic Stress. 3(1),* 131-149.

McCann, I. L., & Pearlman, L.A. (1990b). *Psychological trauma and the adult survivor, theory, therapy and transformation.* Bruner/Mazel. New York

Meldrum, L., King, R., & Spooner, D. (2002). Secondary traumatic stress in case managers working in community mental health services. In C. R. Figley (Ed.), *Treating compassion fatigue.* 85-106. New York, NY US: Brunner-Routledge.

McLeod, J. (1994). *Doing counselling research*. Sage. London.

Moore, T. (2004). Dark night of the soul: A guide to finding your way through life's ordeals. New York: Penguin Group.

Moos R. H., Schaefer J.A., (1993). Coping resources and processes: Current concepts and measures. In: Goldberger L, Breznitz S, editors. Handbook of stress: Theoretical and clinical aspects. 2. New York: Free Press. 234–257.

Moustakas, C. (1994). *Phenomenological Research Methods.* Sage Publications. London.

Ohaeri, J. U. (2003). The burden of caregiving in families with a mental illness: a review of 2002. *Current Opinion in Psychiatry*, *16,* 457-465.

Oliveri, M. K., & Waterman, J. (1993). Impact on therapists. In J. Waterman, R. J. Kelly, M. K. Oliveri, & J. McCord (Eds.), *Behind the playground walls: Sexual abuse in preschools.* 190–202. New York: Guilford.

Paivio, A. (1986). Mental representations. New York: Oxford University Press

Palm, K. M., Polusny, M. A., & Folette. V. M. (2013). Vicarious traumatisation: Potential hazards and interventions for disaster and trauma workers. *Prehospital and Disaster Medicine Vol 19: No1.*

Pearlman, L. A. (1995). Self-care for trauma therapists: Ameliorating vicarious traumatization. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators.* 51–64. Lutherville, MD: Sidran.

Pearlman, L. A., & Mac Ian, P. S. (1993). Vicarious traumatization among trauma therapists: Empirical findings on self-care. *Traumatic Stress Points: News for the International Society for Traumatic Stress Studies. 7*(3), 5.

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26,* 558–565.

Pearlman, L. A., & Saakvitne, K. W. (1995a). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: Norton.

Pearlman, L. A., & Saakvitne, K. W. (1995b). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* 150–177. Bristol, PA: Brunner/Mazel.

Rubin, D.C., Boals, A., Berntsen, D. (2008). Memory in posttraumatic stress disorder: Properties of voluntary and involuntary, traumatic and non-traumatic autobiographical memories in people with and without PTSD symptoms. *Journal of Experimental Psychology: General.* 137:591–614.

Samuels, A. (1985). *Jung and the post-jungians*. Routledge. ISBN 0-203-35929-1

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counsellors of working with female sexual violence survivors. *Psychology of women quarterly*, *19,* 49 – 64.

Sexton, L. (1999). Vicarious traumatisation of counsellors and effects on their work place. *British Journal of Guidance Counsellors, Vol 27, (3).*

Shannon, P. J., Simmelink, J., Im, H., Becher, E., & Crook-Lyon, R. E. (2013). Exploring the experiences of survivor students in a course on trauma

treatment. Psychological trauma: theory, research, practice, and policy, doi:10.1037/a0032715

Speigelberg, H. (1960). *The phenomenological movement: A historical introduction* (2nd ed.).The Hague. The Netherlands: Nijhoff.

Stamm, B. H. (ed.) (1995). Secondary traumatic stress. *Self-care issues for clinicians, researchers and educators,* Lutherville, MD: Sidran press.

Stamm, B. H. (1997, Spring). Work-related secondary traumatic stress. *PTSD Research Quarterly, 8.* Available from http://www.ncptsd.org/research/rq/rqpdf/V8N2.PDF

Stevens, M., & Higgins, D. J. (2002). The influence of risk and protective factors on burnout experienced by those who work with maltreated children. *Child Abuse Review, 11(5),* 313-331.

Tedeschi, R. G., & Calhoun, L.G. (1996). *Trauma and transformation: Growing in the aftermath of suffering.* Thousand Oaks, CA: Sage.

Tedeschi, R.G., & Calhoun, L.G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15*, 1-18

Tehrani, N., Cox, T. and Cox, S. (2002). Assessing the impact of traumatic incidents: the development of an extended impact of events scale, *Counselling Psychology Quarterly, 15(2):* 191-200.

Terr, L. (1994). *Unchained Memories.* Basic. New York.

Todres, L., & Wheeler, S. (2001). The complementarity of phenomenology, hermeneutics and existentialism as a philosophical perspective for nursing research. *International Journal of Nursing Students. 38*(1), 1-8.

Trippany, R.L., White Kress,V.E., & Allen Wilcoxon, S. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of counselling and development. Vol (82).*

Valle, R., King, M., & Halling, S. (1989). An introduction to existential-phenomenological thought in psychology. In R. Valle & S. Halling (Eds.), *Existential-phenomenoligical perspective in psychology* 3-16. New York: Plenum Press.

van der Kolk, B. A., & Saporta. J. (1991). The biological responses to psychological trauma – Mechanisms and treatment of intrusions and numbing. *Anxiety research UK. Vol: (4)* 1992-212.

van der Kolk B. A. (1996). Trauma and memory. In: van der Kolk B. A., McFarlane A. C., Weisaeth, L., editors. *Traumatic stress: The effects of overwhelming experience on mind, body and society*. New York, NY, USA: The Guilford Press 279–302.

van Kamm, A. (1966). Application of the phenomenological method. In A. van Kamm, *Existential foundations of psychology*. Lanham, MD: University Press of America.

van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy* (2nd Ed.). London, Canada: The Althouse Press.

Way, I., VanDeusen, K. M., Martin, G. Applegate, B., & Jandle D. (2004). Vicarious trauma: A comparison of clinicians who treat survivors of sexual abuse and sexual offenders. *Journal of Interpersonal Violence, 19(1),* 49 -71.

Wignal, E. L., Dickson, J. M, Vaugham, P., Farrow, T.F., Wilkinson, I.D., Hunter, M.D., & Woofruff P. W. (2004). Smaller hippocampal volume in patients with

recent onset post traumatic stress disorder. Biological Psychiatry Vol: 56 (11) 832-6.

Worthern, B., & McNeill, B.W (1996). A phenomenological investigation of good supervision events. *Journal of Counselling Psychology, Vol: 43(1), Jan 1996,* 25-34.

Yassen, J. (1995). Preventing secondary traumatic stress disorder. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* 178–208. Bristol, PA: Brunner/Mazel.

Yoder, P. (1990). Guilt, the feeling and the force: A phenomenological study of the experience of feeling guilty. (Doctoral dissertation, The Union Institute, 1989). *Dissertation Abstracts International, 50, 5341B*

Appendix 1

Recruitment Notice/Letter to be placed in <u>The Psychologist</u>

The use of coping strategies by psychologists to prevent vicarious traumatisation

Listening to, and working with clients' reports of trauma and atrocity can be disturbing.
I'm carrying out a study researching the strategies that psychologists use to address unpleasant feelings that might arise following working with client's trauma. I am conducting this study for a PsychD at Roehampton University.
If you are a practising psychologist who regularly works with clients' stories of trauma and are prepared to complete some psychological scales and a qualitative interview then I would very much like to hear from you.

Christine Tizzard C.Psychol
Sheehan Brooke Psychological Consultants
Manor Farm Barns
Donnington
Chichester
West Sussex
PO20 8PS
Tel 01243 775055 email: chrissietizzard@btinternet.com

Appendix 2

Roehampton University London

ETHICS BOARD

PARTICIPANT CONSENT FORM

Title of Research Project: The use of coping strategies by psychologists to prevent vicarious traumatisation.

Researcher details
Name: C Tizzard, School of Human and Life Sciences, Whitelands College, Holybourne Lane, London SW15 4JD
Email: ctizzard@sheehanbrooke.org
Telephone 0208392 3611

Brief Description of Research Project:

This research aims to investigate the coping strategies that psychologists use when working with clients' trauma material. Trauma work is often dirty work and listening to clients stories of horror and atrocity over time can sometimes lead to changes in practitioners' frame of reference.

This research seeks to explore whether the use of coping strategies amongst psychologists leads to lower levels of residual distress. Specifically, do psychologists who use specific coping strategies experience lower levels of vicarious traumatisation?

By agreeing to take part in this research project it is possible that you will access memories of your work with certain clients. It is possible also that this may cause you some distress. The process will consist of a semi- structured open interview and you will be asked to complete three psychometric tests during the process.

It is important to understand that by taking part in this process you have understood the duty you have to yourself to only discuss issues that you feel comfortable with. It is possible that you may need to use the coping strategies that you may have developed to close the memories that you may access while talking about an event.

If you feel uneasy at any stage before or during the process it is your responsibility to decline to take further part in the process. Obviously all care will be taken not to cause distress to participants who take part in the study. It is a normal part of our work that we become privy to people's stories of horror and this in turn often has an effect on the practitioner, it is recommended that you do not discuss your feelings about a client's trauma material that you are currently processing. It is recommended that you think in general terms about the subject area.

I am offering to telephone participants 48 hours after the qualitative interview to offer a debriefing process. The purpose of this process is to help ameliorate any feelings

that may have surfaced during the process. Please indicate on the form if this is something you would find helpful. Alternatively, if you wish to discuss any feelings that may arise but do not wish to talk to me then it is recommended you either talk to your supervisor or access the normal professional support system you have in place. In the unlikely event that you experience any serious emotional symptoms, it is recommended that you speak to your health practitioner as soon as possible.

The interview process is confidential. However, if you disclose any information that suggests that BPS ethical practice has been breached and by implication clients are at potential risk, the researcher will have a duty to pass this information to the relevant bodies. You are also reminded that the same confidentiality applies as in Supervision and therefore you must not disclose any details that may identify an individual client.

Please ensure you have read the consent form fully before signing, if you have further questions please contact me at the address or email below.

Right to withdraw

Participants have the right to withdraw their data from the study at any time. In order to do this, participants should quote the individual participant number found on the top right hand corner of the questionnaires and debriefing letter in order to facilitate the return of their data. This number will also apply to the audio tape and transcript of the process.
It is important to note that data may still be published in an aggregate form.

Consent Statement:

I agree to take part in this research, and am aware that I am free to withdraw at any point. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings.

Name …….

Signature ……

Date ……

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School or the Director of Studies.

Director of Studies Contact Details:
Prof. Robert Edelmann
School of Human and Life Sciences
Whitelands College,
Roehampton University
Holybourne Lane,
London SW15 4JD
Email: r.edelmann@roehampton.co.uk
Telephone: 0208323619

Dean of School Contact Details:
Michael Barham
School of Human and Life Sciences
Whitelands College
Roehampton University
Holybourne Lane
London SW 15 4JD
Email: MBarham@roehampton.co.uk
Telephone: 0208323617

Appendix 3

Roehampton University London

ETHICS BOARD

PARTICIPANT DEBRIEFING FORM

Title of Research Project: The use of Coping Strategies by psychologists to prevent vicarious traumatisation.

Researcher details
Name: C Tizzard, School of Human and Life Sciences, Whitelands College, Holybourne Lane, London. SW15 4JD
Email: ctizzard@sheehanbrooke.org
Telephone 0208392 3611

Brief Description of Research Project:

This research aims to investigate the coping strategies that psychologists use when working with clients' trauma material.

Debriefing follow up

If you have indicated on the consent form that you would like to receive a follow up telephone call after the process you will receive a phone call approximately 48 hours after the qualitative interview to offer a debriefing process. The purpose of this process is to help ameliorate any feelings that may have surfaced during the process. The time you have agreed with the researcher is –- O' clock on ---------. Please be ready for the call 5 minutes before the specified time.

Alternatively, you may wish to discuss any feelings that may arise with your supervisor or access the normal professional support system you have in place. In the very unlikely event that you experience any serious emotional symptoms then it is recommended that you speak to your health practitioner as soon as possible.

Right to withdraw

Participants have the right to withdraw their data from the study at any time. In order to do this, participants should quote the individual participant number found on the top right hand corner of the questionnaires and debriefing letter in order to facilitate the return of their data. This number will also apply to the audio tape and transcript of the process.
It is important to note that data may still be published in an aggregate form.

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to

contact an independent party please contact the Dean of School or the Director of Studies.

Director of Studies Contact Details:
Details:
Prof. Robert Edelmann
School of Human & Life Sciences
Sciences
Roehampton University
Whitelands College,
Holybourne Lane,
London SW15 4JD

Email: r.edelmann@roehampton.co.uk
MBarham@roehampton.co.uk
Telephone: 0208323619

Dean of School Contact

Michael Barham
School of Human and Life

Roehampton University
Whitelands College
Holybourne Lane
London SW 15 4JD

Email:

Telephone: 0208323617

Appendix 4
Interview Transcript of Participant 1

Para		Notes
1	**Interviewer**: Thank you very much for coming along to talk to me. As we have spoken about the researches investigating the coping strategies used by psychologists working on trauma, I think it is a well-established area that most us who are listening to horrific material often experience some aftereffects of that process, and I would like in a minute to ask you what your experiences working with this kind of material has been. I need to say first that my intention in doing this interview is not to bring you into contact with any direct trauma. Obviously, that is not my intention, but to think more in a generalised way that the kinds of experience that you had in working in this area and again, of course, I need to caution you that afterwards it may possibly bring up some material for you, but I have given you a debriefing form to take away that says that I am asking you if you feel uncomfortable to talk, to give me a call within the next 24 or 48 hours so that we can talk through it, and there is also a full set of instructions and ideas of what to do if we do find anything that we talk about traumatic, but as I have said my intention is really to look at process right now rather than content. So, really, yes, I would like to ask you what are your experiences of working with trauma?	
2	**Participant**: I think I have to separate it into two different types, I think. One to do with social services work and the assessment work and some	

	of the cases that you come into contact with, I find myself thinking about kind of beyond the assessment [1], and some of the material is quite difficult [2]. And also my background in forensic psychology means that I have again had a lot of case details that have been quite difficult to listen to and then to work with the client.	C [1] - rumination C [2] - distressing
3	**Interviewer**: In terms of trauma, you are talking about clear traumatic material that comes under the DSM category of that.	
4	**Participant**: Yes, traumatic material, and I think that is..... And along with that, I suppose that, you know, working in, again, forensic settings, particularly the psychiatric settings, being involved in cases where there is suicides and things like that is difficult, or self-harm, and if you are very involved with the case and then somebody is acting out in n experiences I've had specifically to me.	
5	**Interviewer**: Do you find that in the processing of that material, the disquieting effect of the material stays with you for a while?	
6	**Participant**: Yes, as I said, I think I found myself thinking about it afterwards and not only from a professional point of view but also from an even empathic point of view [1] and, you know, the cases of social services for example imagine how you feel to be mum and in that situation, and I find that emotion is a quite traumatic emotion.	C [1] - intrudes into personal frame of reference
7	**Interviewer**: So, what you are saying to me, if I am understanding you correctly, is it goes beyond the professional mask sometimes, that you feel it with real empathy as a mother.	

8	**Participant**: Yes, which means that you have to, I think, be aware of it [1] and then be able to distance yourself to make a professional judgment [2] about what is going on. So, yeah, and that is also true in a forensic setting because you get, obviously, access to information; you have to separate information from the client and somehow process the information, remain objective, to be able to treat the individual [3].	C [1] – positive coping strategy C [2] – positive coping strategy C [3] - compartmentalising
9	**Interviewer**: So, you are talking almost about a distillation of what is professional and what is an overlap, and getting a separation in between the two.	
10	**Participant**: Yes, yes. Does that answer your question?	
11	**Interviewer**: That answers my question. Yes, but moving slightly on from that, are there sort of any physical symptoms in any sense that you would experience after a session if you've heard something that you find particularly traumatic? Are you left with any residue; I think, some people would have referred to it before as a kind of a haunting for a while...not haunting in the sense of the supernatural, but a sense of...	
12	**Participant**: An echo of it.	
13	**Interviewer**: Yes.	
14	**Participant**: I think sometimes it is difficult to intellectually and emotionally shut off after you have been working with traumatic material [1]. So, yeah, would find myself in my evenings thinking about a session [1] that I had earlier in the day, whereas, had there not been that material, I would not... drift into my own time. Physical	C [1] - intrusions C[2] - physical symptoms

	sensations...have got a headache [2], I suppose sometimes, if something has been very intense. I guess you have to concentrate harder on whatever makes the process easier, usually it comes up in a session, becomes much more real if you can read information about somebody, which is traumatic, but then when you put to face and a context to it... it may take a different way really.	
15	**Interviewer**: Okay, but do you feel ever in a way that perhaps some information you have been told or some story that you have heard from a client in a way colours your day?	
16	**Participant**: Yes, definitely.	C - mood changing
17	**Interviewer**: Yeah... and could it ever be the case that that would go on for a few days that, for instance, it would be on your mind, the specifics.	
18	**Participant**: It would come and go; so, I do not think... I can't think of an example where something has stayed with me several days intensely, but it would come and go [1]; so, something might remind me of something and then I will go back and think I am thinking about that case again and or that piece of information about the patient and...	C [1] - triggers
19	**Interviewer**: So, it sounds to me you've got a very sort of heightened conscious awareness of knowing that you are being almost taken into that material and therefore you can separate it.	
20	**Participant**: Yes, I think I can fairly well because I have worked in forensics for such a long time. I think what I have found the worst thing about that is you become desensitised to some of it [1], which is on the opposite. So, you become unshockable [2].	C [1] – desensitisation C [2] – unshockable

	So, when things in real life happen, your reaction is not the same [3] as it might be. So, I have noticed since I am no longer working in a forensic setting, I am more sensitive to a lower level of trauma or distressing material [4].	C [3] – changes you C [4] – desensitisation may be temporary
21	**Interviewer**: Okay, so can I clarify then with you are you saying that since you are no longer in the unit, your sensitivity is returning.	
22	**Participant**: Yes.	
23	**Interviewer**: Alright, that is interesting.	
24	**Participant**: Yes...that's definitely true. So, having worked in high security and seen some very distressing, you know, almost the extreme end of details of crimes and things like that to then work in a community setting where you are dealing with much lower levels. For a while I wasn't, it used to affect my clinical work a little bit because I would sort of call it 'it was only a punch' whereas actually a punch is a punch. So, one has had to retrain my levels of tolerance [1, 2 & 3].	C [1] – desensitisation C [2] – change to frame of reference C [3] – acceptance of violence
25	**Interviewer**: It is an interesting area you are speaking about. So, it is almost saying that to be in the high sort of forensic unit area, you have got to become a little bit desensitised, but that process is not forever so to speak... that you mellow out again, bad choice of English, when the area is less intense.	
26	**Participant**: Yes...I think that's true.	
27	**Interviewer**: Okay, so that is interesting. So, that would suggest then that we do not lose our empathy. It's just these times when we need to	

	become a little bit more desensitised to actually cope.	
28	**Participant**: Yeah, I would agree with that.	
29	**Interviewer**: Okay, so, now that you are in a less intense environment and something, you know, does sort of get past your personal armour so to speak, are you conscious of any strategies that you would use either very overtly and consciously or, when you think about it, are the, perhaps, behaviours that you might engage in that enable you to feel better quickly?	
30	**Participant**: Yep, this is probably unhealthy behaviours [1], if I am honest, which would be a couple of glasses of wine to relax and that probably would help to soft things [2] and I do have supervision so that helps me a lot because it is a space just to tell somebody [3], particularly again working independently, you do not have the kind of banter with your colleagues [4], which in some ways is kind of, again normalises what you've experienced [5 & 6], saying things like, "oh, I had this case and or I had a kind of ...."	C [1] – negative coping strategies C [2] – comfort C [3] – supervision C [4] – collegial support C [5] – need to disclose C [6] - normalise
31	**Interviewer**: Almost the old black humour [1].	C [1] - clarification
32	**Participant**: Yes, absolutely, to get through it and when you are on your own without other colleagues and you are working on similar material, I think that is hard [1]. I think I've found that hard [2]. So, supervision helps, yeah, but I think peer supervision with people in the same field would be better [3]. Going back to when I was working in an in-patient setting, peer supervision was the most effective way of processing things [4]...	C [1] – isolation C [2] – isolation is hard C [3] – peer supervision people understand C [4] – peer supervision best

33	**Interviewer**: And this is a theme that comes again and again that a formal supervision on a one-to-one basis with a supervisor, especially when they do not work in the trauma field is a really frustrating experience for most practitioners and most professionals.	
34	**Participant**: Yeah, I'd agree with that [1].	C [1] – one-to-one supervision frustration
35	**Interviewer**: Okay, was there any element of that when you were having supervisions on a one-to-one basis that was particularly frustrating?	
36	**Participant**: I think probably in the sense of... certainly if the person that you are speaking to has only an intellectual ability to understand what you are saying, guess that must have been very difficult... I think it made a barrier [1] as well, you do not totally appreciate kind of how am I feeling [2] about, which is why I think, you know, again peer supervision is brilliant because you've got the sense of, you know that the other person has experienced the same sort of situation [3 & 4].	C [1] – empathy is crucial C [2] – supervisor's understanding is crucial C [3] – peer support C [4] - understanding
37	**Interviewer**: So, you mean you can speak in a sort of shorthand, abbreviated way because you know that they understand what you are really talking about.	
38	**Participant**: Yes, and I think then more time can be spent processing the emotions [1] that go there as opposed to passing on the facts that you like, because there is a sense of somebody does not actually know what is it that you are talking about [2], you almost have to tell them the details because it is almost without wanting to traumatise	C [1] – peer supervision better processing C [2] – formal supervision failure C [3] – fear of traumatising

	somebody else [3], but you have to almost say this is what it is that, you know.	
39	**Interviewer**: Yeah, so, in a sense you could be, please don't think I am putting words in your month, you have to edit perhaps the most important bits of the trauma that is troubling you for fear of traumatising the supervisor.	
40	**Participant**: Yes, which you know people working in the same field is easier [1], but...	C [1] – peer supervision useful
41	**Interviewer**: So, you still don't have to go into actual content or specific nitty-gritty necessarily because you know they will understand that themselves.	
42	**Participant**: Yeah, and if somebody has worked in the same field, of course, they have probably come across it in their own practice [1]. So, again, yeah, at the moment, I have a supervisor who is not working the field that I am working in and has never worked in the field that I am working; so, her experience is very different... a lot different, and so [2]...	C [1] – commonality C [2] – supervisors need to be active in field to understand
43	**Interviewer**: So, going back to what you were saying about, you know, either sort of using peer supervision, or supervision over a couple of glasses of wine, are there any other strategies that you've developed yourself to refrain the experience?	
44	**Participant**: I do not know that I have really. I think I have become over the years disciplined enough to shut off [1].	C [1] – coping strategies improve with practice
45	**Interviewer**: Okay so, you are able to, I suppose as we'd say compartmentalising in a sense.	

46	**Participant**: Yes, so, if you hear enough traumatic material, you do, I think, have to shut off to some degree [1]. It becomes... the more you hear, the less traumatising it becomes [2]. So, if your patient self-harms every day, it is not as difficult the first time they do it and I think it becomes a bit like that. So, in the past, I was working with this stuff every day, so, I think I learned mostly to shut off generally. Now, I think it is harder sometimes, for the reasons I said really, because I am isolated [3], and you come across things less often; it is not daily, it's monthly or whatever that you come across something.	C [1] – need for strategy C [2] – desensitisation C [3] - isolated
47	**Interviewer**: So, what I think I am really picking up in what you are saying is that it is the support network works for you that is key to keeping you sort of vital and able to do this work.	
48	**Participant**: Yeah, definitely...yes and I sort of think professionally, but also I have been lucky to have friendships with people who have worked in the same area [1]; so, even though you do not talk about work, when you are out of work, if you like, there is a sense of, you kind of know there is a support there [2], there is a common experience that you have had or you have and... it makes your friendship closer in way without having to say [3]...	C [1] – Support network C [2] – support network C [3] – trauma bond
49	**Interviewer**: Bonding in a sense because of your friendship and you both have that element of knowledge.	
50	**Participant**: Yes, and almost that you can go, ...that sounds very strange, because you can go out and have a meal, go bowling or go and do something fun, it's like they are okay [1]. Yes, it is	C [1] – modelling

	okay, I suppose. You know that other people cope with this material, it is okay [2]. So, again it normalises what I do. And yes, it's okay, it is just work.	C [2] - modelling
51	**Interviewer**: No, I think what you are saying is really in essential saying it's not that traumatic because it's an occurrence that is happening to other of my colleagues and they are surviving; so, therefore, though it is horrible, it is got to be okay, and it is a part of life.	
52	**Participant**: Yes, it is a part of my job [1].	C [1] - normalising
53	**Interviewer**: Yes, so, it is a part of your job; so, again, you are clearly compartmentalising and it feels as if you are able to say, well okay, yeah, all that is happening, but it is happening in work. So, that leads on to kind of a really sort of next question. Would you it has altered your own personal frame of reference to any significant degree? You know many of us when we start this job we're quite idealistic and hopeful and think that the world's okay whereas a few people later on, their perspective changes completely.	C [1] - compartmentalising
54	**Participant**: I think it has changed my view [1]. I think I noticed that it changed things when I had children [2] because my specialism I suppose was working with sex offenders and prior to having children, that was copable with, I could deal with it, it was our work and that was that. I think having had children, suddenly the traumatic material becomes more intrusive [3] into your own life. So, thinking about things more carefully. Who you might leave your children with and more suspicious of. [4]	C [1] – schema change C [2] – too close to home C [3] – frame of reference changes since having children C [4] – heightened reactions and suspicion

55	**Interviewer**: So, it becomes a problem when the trauma comes into your own frame of reference and it becomes personal.	
56	**Participant**: Yes. So whenever you see things and in situations which really are only visible to you [1 & 2] because you have this experience or heard this material or you know that, whatever.	C [1] – changed world view C [2] - isolation
57	**Interviewer**: So, how do you deal with that? Again, in a way, is that again on your ability to compartmentalise.	
58	**Participant**: Yes, definitely. I think that is work. I think with some of information you think, I will make sensible decisions about my children, maybe more cautious than possibly I might otherwise have been [1], and at the moment, they are quite young, so, when they get older and more independent I do not know whether that will be an issue to me as a mum just how much freedom they get, you know, like, how paranoid I feel [2] and because I know the kind of people that are out there and...	C [1] – parenting decisions take longer C [2] – doubting parenting skills as result of experience
59	**Interviewer**: It is interesting word you said, paranoid. Do you feel paranoid?	
60	**Participant**: I feel, no, just a feel a bit over...	
61	**Interviewer**: And that sounds though from what you are saying as if almost that that is healthy because you used the word you feel and you are already acknowledging that you may feel that way, but at some level you know that that is not fact, which kind of feels that is really being in touch with yourself.	
62	**Participant**: Yes, or at least I know that might not be fact, so, I might have a skewed take on things [1],	C [1] – altered perception

	but there is a reality. The risks are there. They are just not as prominent as I might feel they are [2]. If you work with it every day, you see it everywhere [3].	C [2] – exaggerated perception C [3] – negative schemas
63	**Interviewer**: So, what I am interested in from what you say then is how do you get that point of being able to have that, you know, I am not trying to be judgmental here, but having that level perspective of being able to then, you know, have those feels to check it out. What is it that has enabled you to get that point?	
64	**Participant**: I think again it is the contact with others [1], family and also other people in and out of the work, you know, and use that as a point of reference. I have checked out with my mum before, you know, I wanted to let my daughter do this, that is okay. So, it is a sort of, I am not, you know, am I being responsible or am I being too much of a... [2]	C [1] – support C [2] – Checking out perceptions
65	**Interviewer**: So, openness and ability to communicate to others honestly what is going on is perhaps the key as well.	
66	**Participant**: Yes, very much, yeah.	
67	**Interviewer**: Okay, I think you have really sort of told me all that I needed to know, and is there anything that you would like to add to that?	
68	**Participant**: I do not think so. No, I think that is pretty much how I deal with it. I think, or try to deal with it [1].	C [1] – strategies do not always work
69	**Interviewer**: Just to recap what I have understood you to say is that initially, you were seeing lots of what would be categorised as more severe trauma histories, which led to desensitise [1] yourself a little	Distillation C [1] – desensitise

	bit to avoid getting hurt, which possibly resulted in a loss of empathy [2], but when you went into a less intensive area, it was not that necessary to protect yourself and you found your empathy coming back [3]. So, peer supervision [4] has been the key to staying safe and talking to family and friends around you, and keeping open and checking out your perspectives.	C [2] – loss of empathy C [3] – loss of empathy temporary C [4] – peer supervision
70	**Participant**: Yes... that summarises that pretty well.	
71	**Interviewer**: Thank you very much.	
72	**Participant**: Thank you.	
73	**Interviewer**: That is really brilliant	

Appendix 5
Interview Transcript of Participant 2

Para		Notes
1	**Interviewer:** Thank you very much for coming along to talk to me today and specifically thanks for agreeing to take part in this study. As I have outlined, the studies are looking to investigate the coping strategies that psychologists use when dealing with listening to patients' traumatic stories. We all know the concept of vicarious traumatisation and equally we know that it can be a painful process for ourselves listening to the material. Perhaps we are not ready for it, on the day we found it particularly horrendous, etc. and you know I would like to ask you firstly are you ever left with a residue after working with clients' traumatic stories?	
2	**Participant:** Yeah, definitely. I think so perhaps not, considering the frequency with which I hear traumatic material; not perhaps, you know, it is infrequent, but I am left with residue of it [1]. It is kind of what I'm trying to say, it is not a ratio of one to one. It does not always leave that impression on me, but I suppose there are times perhaps when the material has some kind of resonance with my own life [2] or experience when that is kind of difficult and also I guess when it kind of takes you more unprepared [3]. Because we work with a lot of, well in fact all of the women in the service have got a history of trauma. It is kind of expected that at some point in working with someone you will be working with traumatic material in relation to that person and usually that is kind of quite well prepared for and there is a kind	C [1] – residue sometimes C [2] – personal resonance C [3] – sudden disclosure

	of period of working up to that but then sometimes in the way that memories are occurring, flashbacks and things, you know it can be that you know particular memories presented itself in a forceful way [4], and that comes up in therapy perhaps when it is not expected.	C [4] – forceful disclosure effects
3	**Interviewer:** So, that is sudden almost parallel process catching you unawares and unprepared for it. Okay, and when that happens, are you – it's going to sound daft thing to say to you, but are you aware of registering that after the session in any particular modality yourself?	
4	**Participant:** I suppose the thing that I notice most is visual images [1]. Because I think in hearing about the traumatic experience in detail, I cannot help but visualize it [2]. I think a lot of the, kind of, richness of trauma memories is often in other sensory modalities, but I think if you haven't actually had that experience, it doesn't have the same sort of connection. So, yeah, usually it is kind of, it is visual images.	C [1] – visual images C [2] – automatic visual images happen
5	**Interviewer:** Okay, and are the strategies that you would use if they are, you know, if they hang around, if those images hang around for a bit longer than you would wish. Say after a session, are there techniques that you use or do you wait for them till they gradually go?	
6	**Participant:** I suppose my first strategy is just to wait a while [1 & 2] because I think in the same way that obviously the people we are working with are trying to process those experiences, I think you know it takes some while as a therapist to process these experiences as well. But I think if that does	C [1] – positive strategy C [2] – strategy wait a while C [3] – active strategy

	not work then I will try and do something more active about it [3] and that would sort of be kind of either formal supervision [4] or talking about in reflective practice or discussing with a colleague [5]. You know I am trying to kind of understand perhaps particularly what it was about that material that was that meant that it kind of stayed with me [6].	C [4] – formal supervision C [5] - peer support C [6]- trying to understand (self-reflection)
7	**Interviewer:** Okay. So, if I am understanding you correctly, you would adopt basically a cognitive approach to dealing with it in that you go to formal supervision and identify what it was.	
8	**Participant:** Yeah. I guess that would be a kind of second strategy really. I mean obviously I would talk about the work in an ongoing way in supervision but if it was something in particular about the work that had particularly bothered me or stayed with me, I guess my initial way of coping with it would just be you know what they call in their, NICE guidelines, watchful waiting, you know [1]. But I am just kind of acknowledging that it has had an impact on me. So, trying to think myself about what that might be and also just giving it some time and probably using other strategies like distraction [2] initially so you know if it is possible to just kind of spend some time in a different sort of mental space.	C [1] – watchful waiting C [2] - distraction
9	**Interviewer:** So, kind of it would appear to me then that essentially you work with clients a good deal of the time in a cognitive way. So, you use perhaps similar strategies of managing it yourself. So, I am mindful of talking in an earlier study talking to a group of counselling psychologists whose strategies appear to be very different in that they use	

	their own strategies of perhaps – I can recall one person saying that they used imagery to a huge degree to change the imagery that they already had of a particular trauma. And I wonder if it is sort of an area where people who work more cognitively actually process the trauma in a more cognitive manner.	
10	**Participant:** Yeah, I think that is probably true and definitely my treatment approach to trauma is the CBT one [1].	C [1] – same processing as treatment modality
11	**Interviewer:** Right, have you noticed that over your career that you have got better or dare I say worse, at processing trauma, is it something that gets easier?	
12	**Participant:** I do not think it gets easier because you know if it is traumatic then it is traumatic [1], and actually I think it would worry me if I had a lesser response [2]. Because I would kind of probably see that as impending burnout [3] because – and I don't mean that in terms of like every single traumatic incidence that I discussed with you because I do not have that sort of response to every single trauma that is discussed with me, but I think if I felt that I was never having that response anymore I'd be actually worried about it rather than thinking that I had got better at dealing with it [4]. I think I would think that I have become more defensive or less empathic [5].	C [1] – trauma work remains hard C [2] – residue is experienced as normal C [3] – lack of symptoms indicative of burnout C [4] – indicative of burnout C [5] – symptomology part of being present
13	**Interviewer**: So, in a paradoxical way feeling that simple yuckiness is a good self-measure that actually I am still okay and I am still feeling.	
14	**Participant:** Yeah, I would definitely think about it in that way.	

15	**Interviewer:** And then supervision on top of that.	
16	**Participant:** Yeah, I think in terms of have I got better at dealing with trauma or worse, I think different aspects of trauma affect me more readily now than they did earlier in my career [1]. And I think one of the things that has been really significant for me is that actually having a child and you know how that resonates with hearing about childhood experiences and abuse [2]. And I don't know that I would have said that it would have been easier to listen to these things earlier in my career, but I think it has a more immediate emotional impact on me [3] perhaps then than prior to having a child.	C [1] – more vulnerable C [2] - since having children vulnerability has increased C [3] - heightened sensitivity
17	**Interviewer:** I think I can identify that completely. In my younger days, certainly before children, my strategy would be much more thinking about what happened to that person to make them behave in that way, what is their history and being able to separate more easily the person from the crime whereas now, perhaps now as grandmother, I have to pull myself very much into order because my first response is not as empathic to particular clients as it was and maybe that is something that changes.	
18	**Participant:** I definitely think it is actually. I know it kind of affected me from earlier on in my career. I mean I guess it is perhaps important to say that most of the people that I work with now have been victims of childhood abuse. Some have gone on to perpetrate kind of various sort of types of criminal behaviour and a very small proportion have gone on to offend sexually. But I guess what I am listening to mainly is kind of the people being victims of	

	childhood abuse, but thinking back to earlier in my career, I found it probably hardest to work with rapists of adult women, and I think these days I would find it much, much more difficult to work with childhood or child sex offenders than adult or people that are victims [1].	C [1] – trauma is harder to work with when it mirrors personal experience
19	**Interviewer:** So, in a way, it becomes more traumatic possibly when one is dealing with a client group presenting material that has very strong connections to your own internal frame of reference at the moment and current time.	
20	**Participant:** Yeah, I think so.	
21	**Interviewer:** Okay, and in terms of managing trauma, how important to you is supervision?	
22	**Participant:** I think it is extremely important. I think there are different ways and different levels of getting that sort of supervision, that sort of formal supervision which I think is really important [1] in you know having that protected time to discuss what is happening with your case load [2] instead of you know, difficulties that you are having. But equally important I think is the kind of more informal supervision of being able to just kind of talk to colleagues about the difficulties [3] of hearing about particular experiences or working with a particular person and also reflective practice which is not supervision exactly but I think fulfils some of the same functions and I kind of find it really important to be able to be honest with colleagues [4] about struggling with particular kinds of material.	C [1] – formal supervision is important C [2] – provides protected time for case management C [3] – peer supervision allows time to talk and reflect C [4] – peer supervision allows honesty
23	**Interviewer:** Okay, so, would it be correct in a way to deduce that collegial supervision with this particular client group or with traumatic material	

	per se is perhaps more important than the more formal one-to-one supervision with, dare I say it, in some cases of a supervisor who does not really understand the ins and outs of that client group.	
24	**Participant:** Yeah, I think kind of talking to colleagues who know the client group and know what you are experiencing is hugely important [1]. I mean, I think it is obviously much better if your clinical supervisor can be from a similar background in terms of working with the same sort of client group [2]. My clinical supervisor kind of is and kind of isn't. You know she works with women in forensic services. So, she is sort of aware of the sorts of material that can come up, but her client group is a bit more mixed than ours so there is not quite so much trauma or traumatic material that she is dealing with.	C [1] – colleagues understand context C [2] – supervisors need experience in the field to be helpful
25	**Interviewer:** So, would that have an impact on you at all that you might have to edit sometimes what you said for fear of being really understood or misunderstood.	
26	**Participant:** I think I always do edit a bit what I say [1] because I suppose I have a concern that like repeating material as it has been said to me causes further traumatisation [2]. I suppose I kind of feel a sort of sense of responsibility to try and contain it [3] to some degree. I think I find it a little bit easier to be more open with the kind of the actual nature of the material with kind of colleagues in the service [4].	C [1] – edit material in supervision C [2] – fear of re-traumatising supervisor C [3] – responsibility to contain C [4] – easier to be open with peers
27	**Interviewer:** Because that again is a theme that seems to come up over and over again is the fact that psychologists often feel the need to edit in formal supervision and the bit or the bits of the	

	trauma perhaps is troubling them and giving them the greatest residue is the bit that they can't get rid of. But it feels what you're saying to me is that is not necessarily so because you can do that with your colleagues.	
28	**Participant:** And I think it is kind of something also about the frequency like we have reflective practice each week [1] and you know I have access to colleagues everyday [2] if I need to speak to them about it but supervision is kind of less frequent [3] and yeah… I would not feel that if something is really bothering me, I would not feel that I could not say exactly what it was to my supervisor [4]. I suppose I always feel like I need to sort of be careful really.	C [1] – reflective practice C [2] – availability of peer support C [3] – formal supervision is not often available when needed C [4] – cannot be open with supervisor
29	**Interviewer:** And also the duty to look after them because it was distressing or has the potential to be.	
30	**Participant:** Yeah, because I also had the experience of being the supervisor to people working with trauma and therefore kind of one or two things that I have been told in supervision that have stayed with me, and I suppose I do feel that there is a kind of duty to be careful with that sort of material [1].	C [1] – duty of care
31	**Interviewer:** Yeah, and I suppose that is when it comes back to the central question is, well okay a person has been to supervision that you know but is still left with that kind of vague residue. Then where does that go in the end?	
32	**Participant:** Well, I think that is a kind of difficult question to answer because I think it stays. You know it stays, aspects of it kind of stay with me [1]. I think some things you hear are so extreme that you know there is perhaps a slightly different process	C [1] – longevity of trauma

	about those very small sub-sample of experiences or things that you listen to. Most of the things that I found kind of particularly distressing at a time when I have discussed them with somebody and I think they do not stay with me afterwards it is kind of like really quite a very small sub-sample that do, and I suppose I just kind of tolerate them [2]. You know I kind of, I am aware that they are there. Occasionally you know they come into my mind and not usually with the same kind of emotional impact that may be they had initially, but they're still there [3].	C [2] – ability to tolerate is key C [3] – trauma remains but varies in intensity
33	**Interviewer:** And how do you sort of reconcile that then within your own frame of references? What sort of narrative do you tell yourself about that? I mean is it that the world is a crap place or, just as an example, or that it's part of being human, it's good and bad. I mean it is changes to frames of references that I am interested in.	
34	**Participant:** I suppose it is, okay, I think it is a really interesting question because that is something that came up in reflective practice. A couple of weeks ago, I was talking to a colleague who has obviously been working with sort of very traumatised people for a long time and we were talking about the kind of mind and something that she had to talk to me about and even my colleague said that prior to coming to work here she had really believed in the existence of evil [1] as such and that the work that she has done in the time that she has been here has kind of changed her frame of reference [2] and she believes that, you know, there genuinely are evil people in the world. And I am not sure that I would use that word because I think the	C [1] – changed schemas C [2] – reference to attribution style changes

	concept of evil has some kind of semi-religious overtones. But I suppose what happens inside my own mind is that I acknowledge that there are people that do awful and very extreme things and I guess having worked for forensic services in my whole kind of career in a way that is sort of not news [3]. But I guess prior to working here, I did more work with perpetrators than victims and you know, the perpetrators usually have been victimised in their own history as well. So, it is not kind of completely one or other, but I suppose I have done a lot more work around being victim here than being a perpetrator, which is a kind of swap really from the focus in previous jobs. Yes, I guess I just acknowledge that there are people who do awful things [4].	C [3] – loss of illusion C [4] – acceptance of co-existence
35	**Interviewer:** And in you saying that it sounds as if, you know, in a way, you are compartmentalising that. You are not saying everybody does evil things, you still have got a kind of balanced perspective of humanity.	
36	**Participant:** Yeah, I mean on the whole, I still think that most people are decent, but there are group of people who do awful things [1].	C [1] – integration of reality and acceptance of dualism
37	**Interviewer:** And has it made you any more or less protective of your own family or about the same?	
38	**Participant:** Oh no, definitely more. It has made me very suspicious, particularly of people who work with children [1]. And I went on some training towards the end of last year. The sex offender treatment programme facilitated this training and one of the trainers kind of just asked about kind of, you know, how much people indulge in paedo	C [1] – suspicion

	spotting and you know everybody laughed because I think it does inevitably change your view of certain groups of people and you know I am very aware that you know some people who have a sexual interest in children specifically choose to work with children because they may have much more access. And I am suspicious of people who choose to work with children in whatever way [2]. It does not mean that I assume that they are all like that but I suppose it just makes me very alive to the possibility that you know, those things can happen [3] and some of the people that I meet seem perfectly nice might actually have those kinds of interests.	C [2] – judgemental, jumping to conclusions & reference changes C [3] – heightened response
39	**Interviewer:** I suppose it is similar to a trauma. Once something has happened you do not go around assuming this is going to happen with 100% certainty but once your eyes have been opened, you cannot really close them again or if you did, you would be stupid to do that. So, it is perspective you are saying in a way, but recognising you have had your awareness brought to an area that you would not have done before.	
40	**Participant:** Yeah, definitely.	
41	**Interviewer:** And being able to live with that.	
42	**Participant:** Yeah, but finding it difficult sometimes. I find it really hard to choose the nursery for my son because you know what I was interested in is kind of the risk issues [1, 2 & 3]. You know, kind of like what areas are there in the nursery where, you know, kind of an individual member of staff could be alone with a child without any observation and you know, what are the security systems in the nurseries and you what	C [1] – heightened awareness of risk C [2] – difficult decision making C [3] – distress

	happens to photographs and things like that that are taken there. There were all sorts of those things. It makes some things quite uncomfortable, but you know as you said, it does not kind of colour my perception of everything but it does make some things kind of more difficult [4].	C [4] - distress
43	**Interviewer:** So, do you have to then in essence check yourself to make sure that you are not going over the top. Is that sort of side effect to the job, full stop?	
44	**Participant:** Yeah, I think it is. I think particularly in relation to children, yeah, and again I think that relates back to the kind of change in perspective in sort of becoming a mother [1 & 2]. You know, you have the knowledge prior to that but you have the knowledge without the kind of sense of duty to protect a specific person.	C [1] – perspective changes C [2] – motherhood is seen as a large reference change
45	**Interviewer:** That is really helpful, you know, your answers have kind of really given me some clarity in perspective, but kind of in, you know, finishing the interview, do you think there has also been huge pluses; do you see posttraumatic growth as it were occurring from this kind of work?	
46	**Participant:** Yes I do, yeah. I think in a way that trauma survivors learn that they survive [1]. I think as a therapist you learn they survive. Because I think the extreme nature of the kind of material that I have worked with particularly since working here has kind of given me a sense of confidence [2] that there is really kind of not much more in therapy that you know I could experience in terms of, you know I have been able to work with people who have been sort of horribly traumatised and you know, seen	C [1] – resilience of clients C [2] – sense of personal efficacy

	them kind of coming through in therapy and making significant progress and recovering from that trauma. And I suppose it has given me a sort of sense of confidence that you know, that there really isn't anything that I could not handle in therapy [3], and I do not mean that in terms of you know, I feel… yeah, it is not I think kind of like you know I am the most brilliantly skilled therapist. It is not about actually kind of that sort of work in therapy but the ability to be with somebody who has been through awful experiences and actually hear about them, and it is sort of an inner sense of confidence, but I think that is really helpful in terms of you know going forward and working with people in the future.	C [3] – belief in own professionalism
47	**Interviewer:** You recognise your own ability and also you have resilience in all of this.	
48	**Participant:** Yeah, I think resilience is really a good way of describing it [1]. I think that is what I was sort of trying to say really.	C [1] - resilience
49	**Interviewer:** Okay, can that come outside of the professional sphere into your home life?	
50	**Participant:** I think it definitely does. Yeah. You know I kind of, I see it with friends and family. I think people you know that I care about kind of feel able to talk to me about really difficult things because they have a sort of sense that I am unshockable [1], and you know it has meant that I have kind been able to support people through difficult times and we have had a friend recently who is diagnosed with HIV, and I think kind of knowing about the sort of work that I do you know	C [1] – could be positive or negative

	both enabled him to sort of perhaps talk about that with me in a way that he….	
51	**Interviewer:** Okay.	
52	**Participant:** Yeah, and I think it gives you a sort of sense of perspective on kind of everyday trials and tribulations. It does not mean to say that they are not as important, but there is a sort of sense of perspective [1].	C [1] – trauma is a paradox (perspective and lack of perspective)
53	**Interviewer:** So, that is quite interesting to hear you say a sense of perspective rather than small things don't matter. You clearly seem to be talking about a scale and being able to sort of check things out against that.	
54	**Participant:** Yeah. I think it does… it also kind of, I suppose allows me to feel very fortunate in my life [1] as well that I have not had those kinds of experiences myself. So, I think it does make me grateful for the kind of life that I have had and do have. So, I think that there are positive elements in my personal life related to doing this kind of work [2], and also, you know, that it is quite hugely satisfying to see people who have been you know, sort of suffering day in, day out terribly from the after effects of their trauma and to see those kind of changes in them over time and I think in the same way that sometimes the trauma stays with you, that stays with you as well [3 & 4]. You know the sort of sense that you have seen really profound positive changes in other people.	C [1] – gratitude C [2] – positives C [3] – negatives C [4] – trauma has positives and costs
55	**Interviewer:** And that is a really interesting point that you see the positivity that comes rather than centring on the bad stuff that you have heard as well.	

56	**Participant:** I think yeah, I think it can be hard sometimes you know, but I think it is a perspective that helps to put some of the material that does stay with you in context [1].	C [1] – contextualising and perspective are key
57	**Interviewer:** Okay, thank you very much. That was really helpful.	

Appendix 6
Interview Transcript of Participant 3

Para		Notes
1	**Interviewer**: Thank you very much for agreeing to take part in this research. I have explained to you the debriefing process and a little bit about the research in general, but essentially, I would like to explore with you some of the coping strategies perhaps we all use when working with stories of patients' trauma and in this context I mean trauma that is out of the everyday experience generally, according to the DSM criteria, of trauma and you know what we all know that is listening to the client's stories sometimes is unpleasant and on other occasions can be really horrible for us. So, I am really asking you if you have ever had experiences where you have been left with material after a session.	
2	**Participant**: Yeah. I have. I mean I suppose the kind of, I think about a range of different patients that I have and listening to their offences can be traumatic in the same way as listening to their traumatic experiences can. So, hearing them talk about what the trauma they have inflicted upon others as well as the trauma they have had inflicted upon them. I think both of those are equally traumatic to listen to and <u>leave you with the material long after the session is finished</u> [1].	C [1] - longevity
3	**Interviewer**: So, would there be strategies that you would either consciously or perhaps unconsciously because it has not really been sort of clarified by yourself or with anybody else. Are	

	there strategies that you are aware of that you use to limit the damage of some these sessions?	
4	**Participant**: I think one of things I do is trying to ensure that my case load is spread over the week [1] so that I do not have too many patients with similar work coming up [2]. So, if it is offence focused work, I would not have three patients all doing offence focused work on the one day, and I would not be doing trauma work with two or three patients in the one day. I will try and spread it across the week [3]; so, it feels more manageable. So, I guess that is something that I do inside work. I think we are a very supportive team [4]. So, I think just debriefing after a session about how difficult the session has been can be very helpful [5] and supervision when you do feel able to use that space to reflect [6] on how difficult a week has been. And then I think I always just try and make sure that I look after myself outside of work [7]. So, even if I don't feel like it [8], coming home from work and taking the dog for a walk that is probably longer than usual until I really feel that it is kind of left out of my system and left behind [9].	C [1]- case load scheduling C [2] – limiting similar traumatic material (self-care) C [3] – case load scheduling C [4] – peer support C [5] – debriefing C [6] – reflection C [7] – self-care C [8] - reluctance C [9] – coping strategy - exercise
5	**Interviewer**: So, that is a conscious strategy that you go out with the dog?	
6	**Participant**: Yeah, even though generally you probably just want to reach for a bottle of wine [1], or glass of wine at least, and yeah, you know emotional eating [2] as well, is a terrible one; like, the kind of, I remember always wanting to get a take away [3], and it wasn't a conscious decision to get a take away [4], it's more a kind of filling a need [5] that was just about kind of horribly... can't be	C [1] – negative coping strategy (alcohol) C [2] – negative strategy C [3] – negative strategy C [4] – unconscious strategy C [5] – feeling drained

	bothered to cook because you feel so drained... can't be bothered to do a lot washing up [6] that comes with cooking, so, kind of making life a bit simpler for you. But probably emotional eating, an element of that in there.	C [6] - exhausted
7	**Interviewer**: So, a bit of comfort is needed?	
8	**Participant**: Yeah. So, I think that is probably looking back on that work that I reflected on, how frequently I would do that on a day when I had particular patients. What else would I do? Yeah, I am not really an exercise person, but walking the dog [1] is kind of really……I am interested in it....	C [1] – physical exercise (outdoors) strategy
9	**Interviewer**: You said about walking the dog until you knew that you had walked long enough. So, was there a point where you could recognise that something has sort of almost qualitatively changed in you or in your head?	
10	**Participant**: Yeah, I think it is, you are kind of, you are thinking about the tape, it stays with you and you kind of just, yeah, you are walking out a bit like someone who goes on a treadmill and runs until their mind is empty [1], it is that kind of feeling, that you are walking until you think, you know what, I can go home and I am not going to be thinking about work.	C [1] – needing to process with physical exercise
11	**Interviewer**: So, it is gone then, it doesn't…?	
12	**Participant**: Yeah.	
13	**Interviewer**: Okay. So, it kind of feels in a way that what you are saying it's a physical processing of it with you.	
14	**Participant**: Yeah.	
15	**Interviewer**: Okay.	

16	**Participant**: I think that is probably the more…that is the immediate…you know the emotional processing of the impact probably is over a longer period of time [1], but there is something that is….yeah, something physical that is required to do after a difficult day of hearing that material.	C [1] – residue, emotions remain Physical is removed quicker
17	**Interviewer**: That is interesting. And then you can go home and sleep, do whatever you want to do?	
18	**Participant**: Yeah. There is something different about working with trauma [1] and needing to shut off from the day…Leave that work behind [2].	C [1] – trauma is different C [2] - compartmentalise
19	**Interviewer**: And it is interesting that one of the things that people have often said to me, you know, exercise, yes, is a big component of it and another thing is some kind of imagery that some people tend to use to compartmentalise as it were, the experiences. So, that it kind of feels almost at times bizarrely whichever modality the person receives it in, it is always the modality they use to get rid of it. So….	
20	**Participant**: And I think, right, and I think some of my patients are very avoidant, emotionally avoidant. I wonder if that determines then how you process that material [1 & 2]. Yeah, that is an interesting kind of reflection.	C [1] – taking on client's material C [2] – method of client disclosure affects therapist
21	**Interviewer**: Do you feel it is easier to process as you develop in your career or is it something of a blanket statement that actually trauma is still trauma and it hurts whenever, or is it something that one gets more skilled at?	
22	**Participant**: I think it is always something that feels very sad to connect with someone who has	

	had these really traumatic experiences. It never stops being sad [1]. I think it is possible to become desensitised [2] to the nature of the trauma, like you are not shocked anymore. The more you hear about people's experiences, the less it shocks you [3] and actually probably what shocks me more is people that minimise their trauma by saying it is not as bad. What I experienced is not as bad as someone else's because I was not sexually abused, I was just physically beaten every day, and they minimise it because they are on a ward with people who they know have had, in their view, much more traumatic experiences. But I think when you connect with their experiences [4] and you feel in that session you feel their helplessness and their overwhelming sadness. I don't think that gets any easier [5].	C [1] – working with trauma has emotional cost C [2] – desensitisation C [3] – desensitisation C [4] – empathy costs C [5] – always hard
23	**Interviewer**: Okay. So, if I have understood you correctly what you are saying is you become virtually unshockable but you are still able to empathise as you go on.	
24	**Participant**: Yes.	
25	**Interviewer**: Okay, and what would you say is the most helpful process in allowing you to continue to be empathic?	
26	**Participant:** I think it is about allowing yourself to connect emotionally to your patients [1] and I guess that comes with working with them over a period of time before you actually get to the traumatic material. Yeah, I don't know what enables me to stay empathic. Yeah, I don't know, I am not really sure what it is.	C [1] – establishing positive alliance with clients helps before disclosure

27	**Interviewer**: But there must be something perhaps that you are doing that is allowing you to kind of not feel, if completely jaded and burnt out by what you have experienced.	
28	**Participant**: Yes. I think our patients' histories are so traumatic. And you know you really cannot fix it, but maybe it is doing something that is helpful. Maybe it's, I think, with a lot of our patients, you are the person that they are doing that work with and they are at that point where they haven't done that work before. So, they are putting their trust in you that you will listen to them; that you will believe them; that you will understand what those experiences they have been through have been like. And there is a certain respect that you have, the sharing of that experience with you [1].	C [1] - empathy
29	**Interviewer**: And that kind of real sort of…well that humanity in it is that then what protects you from the kind of crap that they're bringing from sticking to you.	
30	**Participant**: Yes, I guess so.	
31	**Interviewer**: It sounds like it's a complex relationship.	
32	**Participant**: Yes, definitely because nearly always with our patients, you are doing other work before you do trauma work. None of our patients are just referred for trauma work. You are always doing other work that they need; the coping skills and the resilience building. So, you are building their resilience before they can do that work because they don't come into our service able to undertake trauma focussed therapy [1 & 2].	C [1] – importance of therapeutic relationship C [2] – planned disclosure lessens therapist's distress

33	**Interviewer**: Okay, what I am picking up on too is this sounds as if there is a planned element that you will address when it is the right time; rather than having it suddenly opened up or expelled everywhere and you are shocked at what you are hearing.	
34	**Participant**: Yes, that's not to say that patients don't ever suddenly disclose things that, you know, their trauma, but more often than not it is done in a planned and in a contained way [1], and I guess that helpful to us as well. We know that it is coming. We are preparing our patients and ourselves for that [1].	C [1] – preparatory work protects the therapist
35	**Interviewer**: So, there's a kind of sense of preparation.	
36	**Participant**: Yeah, and I suppose it is the same strategies that they use. If you can control aspects of it, aspects of the emotional experience then that is much easier than everything feeling completely out of control [1], which I guess is how our patients generally feel. They need to have a plan for it, and we need to know that they have got the coping skills to manage that, that difficult work.	C [1] – therapeutic need for control makes it manageable
37	**Interviewer**: So, over time do you feel that you know working in this way has changed your own frame of reference or not?	
38	**Participant**: It is difficult to separate out the trauma from offending because I think offending, the forensic aspects of the work definitely change and you become much less naive and much less…..it is like your innocence is kind of gone [1] when you have heard these….you know people who are capable of the most sadistic acts [2] against	C [1] – loss of innocence C [2] – loss of naivety

	humanity and that destroys your sense of innocence or your naivety. But I guess the forensic aspects probably overshadow and never look at.... for example, if you work with sex offenders then looking at interaction between a granddad and a grandchild is never going to…you always going to have, you know, <u>if you just saw two people, granddad and grandchild in a shop, you always have that thought in the back of your head, are they grandchild and grandfather</u> [3 & 4].	C [3] – jumping to conclusions, C [4] - need to check out perception
39	**Interviewer**: Yeah, so, it is profound change of reference.	
40	**Participant**: Yes.	
41	**Interviewer**: Nothing is just as it is anymore or as it might be.	
42	**Participant**: Yeah, and I think the forensic aspects probably overshadow….I think the <u>forensic work changes your frame of reference</u> [1]. You know the people are capable of real sadism because you have heard it. You know, you have seen…..	C [1] – change to frame of reference
43	**Interviewer**: Yeah, so that is, in the sense that you are speaking about it, then that's a sensible frame of reference, isn't it? Would you see that as a positive rather than something that has been negative or would you, something has been taken away from you?	
44	**Participant**: <u>I think it can be quite helpful as long as, I mean I guess if you kind of run up to those people and say oh my god you are a paedophile then yeah that is not very adaptive</u> [1]. If it is alerting you to potential risk or concern then yeah have those concerns, have your eyes open to what	C [1] – realism can be helpful as long as it is checked out, perspectives may be wrong

	goes on in the world, but do not let it affect every aspect of your life [2].	C [2] – importance of balance
45	**Interviewer**: And that is a tricky question. I guess can you do that at all times or are there times when the world would look blacker than it is?	
46	**Participant**: Yes. I think it is shocking sometimes that you have that thought that you see what could be an entirely innocent interaction. You see an old man on a bench at a park and you think what is he doing there? [1]	C [1] – over-generalisation
47	**Interviewer**: And it is a double take where perhaps there wasn't before?	
48	**Participant**: Yeah, I guess that is the perpetrators of trauma rather than the victims of trauma and the perpetrator seems to overshadow in terms of the frame of changing your view of the world.	
49	**Interviewer**: Are there any positives, real positives in terms of, there's been a lot bandied about, post-traumatic growth? But would you say that working with trauma does have that effect as well or not?	
50	**Participant**: I think it does. I am sure it does change the way that you view things when you know what experiences people have had and you have listened to that material. I am sure it does change you [1]. It is trying to contain the emotional impact of that work [2].	C [1] – reference changes C [2] – need to contain
51	**Interviewer**: Yeah, and that's the big thing that keeps coming up is the emotional containment or the reframing of it or the restructuring of it, those words come back again and again.	
52	**Participant:** Yeah, and I think that is probably what you try and do…. I mean people have all	

	sorts of emotional reactions to trauma, kind of immediate and maybe more long-term [1] don't they? It's kind of, there's an immediate reaction to the material that is coming out of the session and feeling emotionally very drained [2]. And then there's the long-term impact of doing this work over a period of time and how much that changes you as a person [3]. Yeah, picking fights with your partner [4] because you are just feeling frustrated or full of emotion that you can't really express. You find, you know, having a glass of wine when you get home from work and there being direct connection with listening to traumatic material and trying to find a way to cope with it and thinking, okay I am not going to take it out on my partner or my friends or you know and I need to do something to just kind of put work away [4].	C [1] – trauma reactions are immediate and long lasting C [2] – physical are more immediate C [3] – attribution changes C [4] – potential for relationship problems
53	**Interviewer**: And it is almost, it can almost become a reflex action where one comes home, into the kitchen, opens the fridge and gets a bottle of wine for a couple of glasses, without really knowing why, but then when you reflect about it, oh yeah, it was a rough day today...	
54	**Participant**: Yes.	
55	**Interviewer**: So, there's kind of subtle effects that may be not always a great big obvious factors of working with trauma but the smaller factors that if you really look at them, they are there.	
56	**Participant**: Yeah, and maybe we don't stop enough to look at them, maybe we don't stop enough to say what is the impact of doing this work because you just do it, you get on and you	C [1] – need for time out

	do it [1] you know one patient moves on and another patient comes in and you are preparing to do that work again. I don't think any of our patients don't have a trauma history.... it would be quite remarkable if the patient didn't have a trauma history. So, you are always preparing at some point to do that work [2] before they go and maybe that is where we are at in the system that in order for our patients to move on, chances are they are going to have to do that work because that is the work that underpins all of their difficulties, all of their ways of coping.	C [2] – trauma work is repeated
57	**Interviewer**: So, you are anticipating it?	
58	**Participant**: Yeah.	
59	**Interviewer**: And almost planning for it maybe at a sort of a, well, at a very conscious and unconscious level and that perhaps is some kind of protection. Whereas the independent psychologist working out in the field, somebody suddenly comes in and dumps their..... they perhaps are more shocked because ...no I am not used to this, I am usually dealing with a little bit of anxiety or something and….	
60	**Participant**: Although I think actually as therapists and as qualified psychologists, our patients always seem to choose someone unqualified, like they'll choose to talk to an assistant psychologist in the moment that they are experiencing flashbacks, if someone who is there is not trained in dealing with that material. So, I guess, yeah, the impact of that work, ours is always very planned [1]. We don't tend to have the unplanned disclosures of abuse that would happen	C [1] – work needs to be planned

	to someone on the ward that would feel probably very ill equipped to deal with it.	
61	**Interviewer**: So, there is a big difference then in what you are saying in being able to plan for disclosure; organise your work diary essentially so that you are not overloaded and then also doing your strategies afterwards.	
62	**Participant**: I also think there is a lot of self-doubt that comes with this work as well. Unless it is in a planned way, what do you say to someone who is spilling details of their abuse or their trauma. There's something about protecting yourself [1] by having it planned and in a place in the therapy when they are ready for it and when you are ready for it.	C [1] – lack of control and feelings of powerlessness
63	**Interviewer**: Yeah, just kind of mopping it up and containing it in a kind of receptacle.	
64	**Participant**: Yeah, it kind of make sense for it to be like that because abuse is so uncontained and the limits of confidentiality are there in your therapy and you know you are not holding secrets. There is nothing abusive then about that work. It is done when you and your patient are ready to do that work together.	
65	**Interviewer**: So, it might be far more traumatic if you were just walking off the ward and somebody collars you and discloses something or expresses something then when you are totally unprepared for that.	
66	**Participant**: Yeah. And I suppose it is about our patients' needs and the need to collaborate with them [1] about when you do that work and give them a sense of ownership and control over when	C [1] – handing control to client protects both

	that work is done. Always explaining what the reasons are for doing the work at the point at which you are doing the work and why it is not done before because lots of our patients know that that is what's led them on their path to being here and that is what they want to talk about and until they talk about it, they know that they are probably not going to be leaving here [2]. So, they want to do it much sooner than they are ready to do it.	C [2] – process is important
67	**Interviewer**: So, there seems to be some kind of a parallel process operating with the word control.	
68	**Participant**: Yes.	
69	**Interviewer**: It almost makes it possible to work with such horrendous material.	
70	**Participant**: Yeah, about control and about containment, I suppose therapeutic control. It is a control that is therapeutic and collaborative rather than what one is doing to another. That experience of not having any control, giving them a sense of control over their experience in a way that they have not had before.	
71	**Interviewer**: And do you find that supervision is valuable or supervision more valuable with peers? Or is there a difference?	
72	**Participant**: I think it is more of the informal supervision actually that is probably more helpful [1] than sitting in a room and talking about the impact of the work. It's all the shared jokes about that's a tough day [2], I really fancy a glass of wine, or what are the coping strategies that we use as psychologists and being able to say yeah wine, chocolate all of those.....yep we would like to be	C [1] – informal supervision C [2] – shared humour

	able to do more exercise, but who has the time.... so all of that informal stuff and just yeah… [3]	C [3] – informal contact with peers
73	**Interviewer**: A lot of people have said that just knowing that their colleagues have gone through exactly the same process have heard the same kind of material means that they do not have to go into the long-hand explanation of what they have heard because they just know they are understood about saying it.	
74	**Participant**: Yes.	
75	**Interviewer**: And that it can feel quite comforting and grounding.	
76	**Participant**: And actually don't need to share the details of what someone has experienced, to be able to convey the emotional experience that they've had. It is not what was done to them, it is more about how they felt when whatever was being done was being done and the feelings that that leaves you with and being able to share that. Your sadness at their sadness [1], yeah, how you stay hopeful and cheerlead [2] someone who is completely hopeless.	C [1] – sadness C [2] – resilience
77	**Interviewer**: Just having that connection, a supportive team or friends or colleagues can make.	
78	**Participant**: And I think you know your partner or your friends aren't really, you know, forensic work, they are interested in the forensic aspects [1] and not quite so interested in actual, you know, knowing that all of our patients have got extremely traumatic histories. People don't want to know that. They don't want to empathise with	C [1] – isolation & parallel universe

	or sympathise with someone who has killed someone or…..	
79	**Interviewer**: It is only the shocking factors they are interested in, not any deeper than that. And that kind of brings on the concept that really this work even when one is in a relationship, there are aspects of it that makes it quite a lonely process or separates oneself out from others in the field.	
80	**Participant**: Yeah. I think so.	
81	**Interviewer**: So, it kind of feels that we have sort of covered that quite well. Any other strategies that you know you can think of or I think we've covered them all?	
82	**Participant**: No, I think probably most of them are just probably more unconscious than conscious [1] you seek out other people who you know are going to understand [2] when you say you have had a bad day, that aren't going to judge you for reaching out for a glass of wine in the evening [3] and….	C [1] – unconscious strategies C [2] – seek out people who will understand C [3] – coping strategy (alcohol)
83	**Interviewer**: Rather than, is that your second, or how many is that?	
84	**Participant**: I think there is a kind of dark humour as well that sometimes goes with it [1]. But mainly that is the forensic aspects of the work as you never make a joke about someone's traumatic experiences [2], but there is a kind of dehumanising of our patients [3] sometimes that can happen.	C [1] – black humour C [2] – respect for clients C [3] – dehumanising as a strategy
85	**Interviewer**: The same as the emergency professions.	
86	**Participant**: Yeah, so, you would not make jokes on or become light hearted about their	C [1] – respect

	actual experiences [1]. But you know we talk about self-harm as if it's an everyday occurrence [2] and it is not outside of here. We minimise that.	C [2] – black humour
87	**Interviewer**: But almost minimising too kind of makes it almost acceptable in an unacceptable forum, doesn't it? In the sense it normalises the experiences.	
88	**Participant**: Yes, and it is the conversations that you would have with your colleagues that you would not have with anyone else [1]. With colleagues that know you, they know the work that you are doing.	C [1] – colleagues as container
89	**Interviewer**: Yeah, it is such a commonality isn't it really?	
90	**Participant**: Yeah. So, yeah, I guess kind of just that seeking out of other people for that informal kind of [1]...this is tough work, isn't it?	C [1] – informal support of peers
91	**Interviewer**: And would you do it again if you had the chance, sort of you know you choose a career again, would it be as a psychologist?	
92	**Participant**: I think so, yeah, probably forensic. It is difficult, really different but yeah, I think our patients are remarkable [1] when you hear what they have been through and in fact they are still alive and they are still fighting for a life out there, I think that is quite remarkable and you have to have respect [2] because I would have given up a long time ago, I think, if I might have been through what some of them had been through, I think I would have struggled to find….	C [1] – privileged to work with clients C [2] – humanity and empathy keep participant in the field
93	**Interviewer**: It is respecting their resilience and their will to carry on living.	
94	**Participant**: Yeah.	

95	**Interviewer**: Okay, thank you very much.	
96	**Participant**: Thank you.	

Appendix 7
Interview Transcript of Participant 4

Para		Notes
1	**Interviewer**: Thank you very much for agreeing to take part and help me with this onerous project. We are going to spend some time together in a roughly semi-structured interview talking about your experiences of work with trauma. Now, we all know that sometimes listening to client material can be particularly traumatic and I suppose it is important for me to say firstly that my intention is not to put you in contact with any specific trauma but rather to look at processing sense rather than content because the last thing I want to do is send you away feeling horrible. So, firstly, I would ask you; are you ever left with any feels after working with clients who tell you distressing stories?	
2	**Participant**: Yes, sometimes it does happen.	
3	**Interviewer**: So, you would say at times there is some kind of a residue [1].	C [1] - residue
	Participant: Hmm… yes [1].	C [1] - residue
5	**Interviewer**: Okay. And are you aware of any particular methods that you might use to rid your of that? Some people are conscious of it, other people aren't.	
6	**Participant**: Sometimes, it does actual boil down to kind of the amount of time I have within kind of work time [1], and I currently work part time. Obviously my case load is reduced as a result of that, but nevertheless, there are times	C [1] – time to process needed

	when that does leave less opportunity kind of in the working day to perhaps try and process some of that kind of when I would ideally want to kind of manage [2], but certainly using my, kind of, colleagues' support [3] is something I do when I feel kind of the need to …	C [2] - insufficient time C [3] – coping strategy, colleague support
7	**Interviewer**: So, you would turn to your colleagues and actually talk to them about the process or about, say, specific feelings or imagery that you have.	
8	**Participant**: Yeah, I guess it would be probably more about, kind of, combination of how I was feeling [1] coupled with, kind of, not so much of the content [2], but some of the difficulties that might have, kind of, been brought up in the session [3] and probably near, probably less so about, kind of, my imagery [4] but yeah more feelings just as a way of, kind of, verbalising it. Not always; I mean sometimes it is something I kind of, yeah process in my own way [5].	C [1] – feeling C [2] – content C [3] – things emerge that need clarifying C [4] – imagery does happen C [5] – process in own way
9	**Interviewer**: I mean in the processing on your own, are you conscious of any particular strategies that you find yourself doing or are you conscious in perhaps how you receive that. Some people call it a haunting feeling or a leftover feeling. Are there areas that kind of resonate with you?	
10	**Participant**: I mean I guess what I do sometimes is to try and kind of put that in the context [1] of the actual work that is being done with the client. So, kind of, trying to, I guess, see it as something that is, because it can be so	C [1] – need to make sense of

	horrendous experiences that they share with you, it is a natural reaction to be taken aback [2] sometimes and to have feelings of, kind of, sadness [3] and even sometimes feeling quite sort of unsure about how can I help that person [4], you know, how can we move forward. So, I guess while I find it helpful to try and kind of reframe [5] in that term, this is quite natural to kind of have a reaction and to have a response [1 & 2] and it can also to some extent help me understand the client a little bit better in some situations, potentially, but I guess I try to kind of reframe it in those terms [5].	C [2] – normalising in context C [3] – feeling sadness C [4] – inadequacy C [5] – reframe strategy
11	**Interviewer**: Okay, so far if I have understood you correctly, you kind of would work normally in a cognitive behavioural way [1] anyway. So, you would reframe your own distress kind of in that modality to have sense of it.	C [1] – CBT strategies
12	**Participant**: Yeah, I think that is kind of just sort of, reflecting on you right now [1], I think that is kind of what I, not necessarily kind of every time, but thinking about times when perhaps something has helped me to kind of manage those emotions that have been kind of left over and there have been times when I am kind of, you know, after work hours I am kind of you know at home and then just something kind of just pops into my head [2 & 3] and then that has been helpful just to kind of try and frame it in those terms and….	C [1] – CBT strategies C [2] – imagery C [3] - rumination
13	**Interviewer**: So, it is a clear kind of compartmentalisation in keeping it in that box as it were.	

14	**Participant**: Yeah, as I said kind of not always. I mean I think sometimes I do, I just feel immense sadness [1] and am kind of…and sometimes I just kind of stay with that feeling for a little bit [2] I guess ,just thinking; you know, thinking about it now that it is sad that people have to endure some really traumatic experiences and I think thinking back to kind of when I started working and I had started working with the prison population, I was working with people who had committed crimes, but in many cases they had experiences of being victims as well as perpetrators and I think over the years I feel I have become better able at kind of not kind of dwelling on those feelings, but actually kind of acknowledging, accepting, in some cases reframing [3 & 4] and then, kind of, not letting that, kind of, take over [5], so to speak.	C [1] – sadness C [2] – acceptance, watchful waiting C [3] – coping strategies develop over time, harder early in career C [4] – managing C [5] – trying not to succumb to negativity
15	**Interviewer**: That is a very interesting proposition. In such as I understand you, what you are saying is with developing practice and more skill, if that's the right word, you learn to treat it as more of an everyday part of your professional life, although it is sad and horrendous. Does that result in any loss of empathy in your view or not?	
16	**Participant**: I do not know actually to what extent that….because I am sure at some level I feel I need to depend how I kind of frame it, whether it is more about kind of focussing on, whether the focus is more on me and how I am experiencing those emotions [1] or whether I kind of frame it more in the context of that individual	C [1] – coping strategy reflection

	that I am working with [2] and their experiences, and in the sense that can help me to kind of actually get a better sense I think of the enormity of those experiences [3] and the impact that that had on that individual and I think sometimes actually the kind of residual kind of feelings can be really a useful reminder of actually why that individual is continuously struggling and why they are currently struggling [4], why they are struggling to see meaning in life or why it is so difficult for them to carry on with life and why it is such a kind of day-to-day battle. So, I think overall I feel that it can help me to kind of….because I do not share those experiences [5]; I mean, yeah, obviously we all have our difficult experiences but I think on some level it helps me to get some sense of the enormity of those experiences for that individual. The kind of emotions that brings out in me.	C [2] – coping strategy normalising C [3] – trying to comprehend C [4] – residue feelings help imagine clients' struggle and produce better understanding C [5] - empathy
17	**Interviewer**: Okay, so far from actually shutting off, you are actually saying that you are using your empathy and your own humanity to actually feel what that person is feeling or similar to what that person is feeling, but you are able to compartmentalise that; so, it does not, for want of a better word, bleed all over the place and into your personal life.	
18	**Participant**: Yes. I think that will be sort of a good way of capturing…..and again I think this is just kind of thinking about it now [1], this has been a process for me kind of, you know, within my, kind of, professional, sort of, career and that certainly when I think back, it was more difficult	C [1] – strategies may be unconscious

	to do that [2] and I think my focus....I spent probably less time acknowledging how I was feeling [3], which could then result in of a build up, you know, of kind of difficult emotions and again [3] using kind of… I have been very lucky throughout my kind of psychology through the years in working with very good teams [5]. So, that is you know as a trainee, as a sort of early into my kind of work, I have had good support networks [6]. So, that….	C [2] – strategies take time to evolve C [3] – less reflection early in career C [4] – need to manage trauma C [5] – importance of team as peers C [6] – early positive training increases resilience
19	**Interviewer**: So, what I am picking up clearly it is the good support network, the strong team that you can share similar circumstances or similar stories with; that makes it okay [1]?	C [1] – teamwork, support, sharing, work setting
20	**Participant**: Yeah, absolutely, I can guess, that has been very valuable for me [1] and also working with people with more experience [2] and perhaps the work setting, we were quite varied group of psychologists and psychotherapists, and so different approaches and different experiences and sort of hearing different people's experience has been helpful as well [3].	C [1] – teamwork, support, sharing, work setting C [2] – value of experience in peers C [3] – diverse team increases support
21	**Interviewer**: Good, so, I have asked you earlier about the positive coping strategies. Any negative ones that you have noticed, that you might use to get rid of sort of something that might be a little bit residue.	
22	**Participant**: I guess I am just trying to think, I think that sort of, I'm going to use the word classic sort of strategy of, you know, having an extra glass of wine [1] or something in the evening,	C – acceptance of negative coping strategies

	which does happen not for some time actually but just.... and never to pour over work. I felt that that is….	
23	**Interviewer**: But that leads to gently unwind.	
24	**Participant**: Yeah, just sort of, that kind of reliance on something [1], sort of that helps to just sort of relax [2] and, but I think nothing and just sort of thinking back to when I was sort of newer into this area of work that it never got to a stage where…I mean I guess what I did do more is perhaps ruminate and think more about it [3]. So, I did bring things home with me [4] more I guess.	C [1] – need to self-soothe C [2] – to rid self of material C [3] – ruminate C [4] – spills over
25	**Interviewer**: That was when you were newer in the profession.	
26	**Participant**: Yes, so that is kind of what I did do then more than I would do now and not being as able to just sort of leave some of that kind of behind, and again it is, yeah, we're obviously human as well as kind psychologists [1], so we will obviously be bringing things [2], you know, it's not as kind of straightforward as just leaving work at work, but I certainly feel I have reached a better balance [3] you know, kind of putting it that way ….	C [1] – vulnerability of self C [2] – psychologist's schemas influence their distress C [3] – strategies take time to improve
27	**Interviewer**: Balance. Okay. So, do you find in a sense that your frame of reference has changed since you started this job or would you say that basically your outlook on life, on people, on humanity is roughly as it was when you started?	
28	**Participant**: I think, I guess certainly in my current role, I started off working more with perpetrators of crime and now I predominantly	

	work with victims of crime, but again the clients do also have experiences of perpetrating crimes here, but certainly before we tend to do any sort of offence focussed work here, we generally have to address kind of individual struggles and difficulties. So, it could be some time before they start addressing their kind of antisocial and offending behaviour towards other people. So, I think this job has certainly given me the opportunity to have a different perspective on what it's like to be on the receiving end of kind of, well, certainly abuse and which obviously would come under kind of offending sort of context. <u>So I think it has helped me to kind of see the wider picture in that respect, but also kind of realise how complex</u> [1 & 2]. It is not straightforward just putting people kind of in groups and sort of giving them labels, sort of offenders or victims….it is kind of there is a lot to kind of unpick and try and understand. <u>So, I think, I think certainly I have kind of gained more understanding and knowledge</u> [3], so I guess in that respect I have changed my perspective.	C [1] – contextualise/perspective C [2] - complexity C [3] – acquired wisdom
29	**Interviewer**: I mean in terms of personal growth, do you think that working in this area has enabled that or made you think all humanity is horrible?	
30	**Participant**: Yeah, I mean I think because I started off kind of wanting to work with people perpetrate crimes. So, I have kind of started off working with this sort of perpetrators as opposed to the victims using those kind of…groupings, labels, I still have that interest in working with	

	that client group and it is not kind of…I do not feel that my beliefs have become anymore sort of extreme or black or white [1] in that respect, I think I am still able to work with that group as well.	C [1] – denies polarisation
31	**Interviewer**: Just trying to think. Yes, I think….	
32	**Participant**: Sorry, actually yeah, could you repeat the question again. I am just trying to....	
33	**Interviewer**: Really, has your overall perspective on humanity changed. Can you still view the world positively or is it slightly greyer than it was.	
34	**Participant**: No, I think in some ways, I think, if anything, it just really highlights how lucky I am [1] in so many different ways and I think that is something I do kind of quite frequently reflect on actually when I ... just kind of snippets of kind of sessions with clients and you sort of walk away thinking well….yeah, I mean life in some ways seems so unfair [2] and so, you know, you start thinking well some people were not given any fair chance [3] you know from their childhood. You know the life is really difficult from day one for them and I think what it has also done is actually I have been quite amazed how resilient and how strong people are [4] and what they do go through and that they can still get up in the morning and they do get on with things and that is quite…	C [1] – personal gratitude C [2] – sadness C [3] – increased awareness of sadness in self/inequality C [4] – noticing resilience
35	**Interviewer**: So, that is really interesting. So, what you are saying is you have actually become much more aware of the resilience of the people rather than their deficits as it were? So, that is	

	the kind of an almost, loathe as I am to use the word, sort of post traumatic growth area, perhaps, isn't it?	
36	**Participant**: Yeah. I mean I still ... and in terms of how I sort of relate to people and how I guess how I am able to kind of enjoy life and I do not feel that that has had a negative impact [1]. I do not feel that I have sort of compromised my kind of time because of it. I think it is, yeah not that I can kind of think….yeah I do not think it has had that kind of impact on me [2].	C [1 & 2] – does not believe negative assumptions have occurred
37	**Interviewer**: Okay, so it seems very, very key that one of your key skills has been that you have been able to compartmentalise and use it if you like cognitive skills to reframe some of the information that you have been party to so that you have been able to keep it that professional sphere, but that does not mean you have not felt it, but it has not leaked out, leak is probably the best word.	
38	**Participant**: I mean not to the extent where it had sort of a detrimental impact I feel kind of on me or my kind of close sort of relationships and, yeah, again when I started off, it took me a lot more time [1]; so, it would kind of eat into my weekend [2] and I would kind of be a bit a more sort of absorbed by the work I had done during the week [3] and I guess that was the time I was using all sorts of kind of process some of those experiences with a client I was working with at that time [4]. So, that did have an impact in the sense that I was more preoccupied and kind of quite consciously thinking about the material on	C [1] – harder in beginning of career C [2] – intrude C [3] – emotional unavailability C [4] – coping strategies necessary to process

	some of the client sessions that I had had that were particularly difficult. I guess that was also within the context of me kind of learning and being sort of still relatively new into that area [1]. So, part of that process was sort of a reflecting as part of my kind of learning and development, but looking back, I can kind of see how I actually, you know, did at times take up too much of my .... yeah both kind of in terms of my thoughts and I guess just feeling a bit weighted down by it at the time [5].	C [5] - residue
39	**Interviewer**: So, I think I am picking up again with you know that the central role of importance of peer supervision or team supervision that has enabled you to do that or facilitated you to do that for a while.	
40	**Participant**: Yeah, and I think to feel that it encouraged and it is okay to talk about and that it is actually necessary to talk about it [1]. So, that is something that is quite key. I mean interestingly enough at the moment I have individual supervision, but because I am part-time, the team reflects a practice that we have falls on a day that I don't work.	C [1] – need to talk, permission to talk
41	**Interviewer**: Right.	
42	**Participant**: So, I have not actually had that since August last year when I came back from maternity leave. So, again I have kind of had to use [1]. I mean, I would say I had my individual supervision and just, yeah, talking with my colleagues a little bit impromptu [2] perhaps a	C [1] – individual supervision not as effective C [2] – missing team supervision

	little bit more than I would have before, possibly more.	
43	**Interviewer**: Because a theme that has come up with other participants has always been the need for supervision, but there has been a problem around supervision that many people have found it an unrewarding experience when the supervisor is not directly in the same field that there has been a tendency to, if you like, edit information for fear of shocking the supervisor, but were the supervisor worked in the same field and it is okay to share their experiences that much better or with colleagues in the same team. So, it seems to be quite central that part of the ability to do this job well and to, if the right word is enjoy doing ones work, is good supervision.	
44	**Participant**: Yeah, I would agree with that. I think that is really key... just feeling that you are part of a team, yeah in this type of work [1], that has been, even if you do not always perhaps have as much time ideally as you would like to kind of utilise the support that you have [2] around you, but kind of knowing that you are part of that team and even just sort of the odd kind of brief interaction, I think that does help [3].	C [1] – team belonging C [2] – team supervision C [3] – informal interaction helpful
45	**Interviewer**: It's almost like a possible diffusion of not necessarily having to say what's on your mind, but that commonality of being a team member.	
46	**Participant**: Absolutely...that's been helpful.	
47	**Interviewer**: Thank you very much. I think you gave me some really interesting responses there.	

	Is there anything else that you would like to say to me or does that kind of sum it up?	
48	**Participant**: Yeah, it has been really interesting for me I think to kind of have these questions put to me as well and just again my at kind of space and time to reflect [1] on what is it that I actually did and how, what is it that does help and an opportunity to kind of perhaps reflect on what has changed [2] and what is…..	C [1] – reflection is helpful C [2] - self-evaluation helpful and necessary
49	**Interviewer**: It is interesting because it does sound as if you are talking about a linear kind of process where things are subtly changing as you develop. Okay, thank you very much.	
50	**Participant**: Yeah, you are welcome.	

Appendix 8
Interview Transcript of Participant 5

Para		Notes
1	**Interviewer**: Thank you very much for coming along and for taking part in the study. As I have outlined to you, the research is looking at the coping strategies that psychologists use to prevent vicarious traumatisation or reduce the likelihood of getting vicarious traumatisation, and mainly I would like to ask you about your experiences of working with trauma and specifically if you were ever left with a residue of material, feelings or sensation after a session with a client has ended.	
2	**Participant**: All the time, probably, you're kind of left thinking about some of the things that you've heard [1], specifically, probably if they are related to childhood abuse.	C [1] – residue, continual
3	**Interviewer**: So, for you, it would be that sort of area of childhood abuse would be…	
4	**Participant**: I think that is probably the stuff that I am most left with [1].	C [1] - residue
5	**Interviewer**: And being left with that on some occasions, I am thinking of other of people's experiences; it can often be a hard process to get rid of it. It kind of hangs around like a bad smell, pardon the analogy.	
6	**Participant**: Yeah...	
7	**Interviewer**: Are there particular strategies that you are aware of consciously that you use to get rid of it after a session?	

8	**Participant**: Yeah, I think I have it very much less in this work place than I used to, [1] where I used to work for a Refuge. So, I worked with women and children and lots of domestic violence and it was very much in the present [2]. So, I was very much left with feelings because things were happening now and I was living it with them [3].	C [1] – situation where disclosure happens C [2] – context C [3] - method and time of disclosure/time since trauma
9	**Interviewer**: Okay.	
10	**Participant**: Very different here now because I suppose you know that it is in the past.[1]	C [1] - safety
11	**Interviewer**: So, there is a separation in time.	
12	**Participant**: Yeah, so, the separation in time definitely, seems to be in my head [1] and be a way that I deal with things and a lot more [2].	C [1] – separation C [2] – time/distance
13	**Interviewer**: As if looking down the telescope the wrong way, it's further back.	C - clarifying
14	**Participant**: Yeah.	
15	**Interviewer**: Okay.	
16	**Participant**: So, it is very different to when I was actually living it with them. I found it very hard to separate myself after sessions [1].	C [1] – enmeshment with trauma
17	**Interviewer**: So, what kind of things would you do if you are consciously aware of it, to try and separate yourself after a session?	
18	**Participant**: Have a break [1], or just kind of go away [2], have time out, not rush into a session [3] with somebody else, think about the things you have heard, think about if there is any kind of practical things that I need to do with what I have just heard [4]. Almost as though to kind of alleviate my own burden, you know, there is something that I need to do ethically [5]...	C [1] – strategies – pause C [2] – remove self C [3] – reflective C [4] - is action needed C [5] – ethical issues

19	**Interviewer**: Okay, it is almost, do I need to pass this on somewhere, do I need to disclose something that then can almost be cathartic at the same time.	
20	**Participant**: Yeah, probably, supervision [1], any members of my team that were around at the time [2].	C [1] – supervision C [2] – immediacy of peer supervision
21	**Interviewer**: So, it's interesting. What I pick up with members of your team that were around.	
22	**Participant**: Yeah, or people that I have good relationships with here at the moment [1] that I'd be able to just kind of offload,[2] perhaps, say how I was feeling.	C [1] – strategy relationship people who are trusted C [2] – need to offload
23	**Interviewer**: Would that be more important to you than formal one-to-one supervision or would it take the same priority?	
24	**Participant**: I think sometimes with formal one-to-one supervision, if it is happening at a regular slot and that's not for another week... you sometimes have that urgency that you need to speak to somebody [1].	C [1] – immediacy of supervision
25	**Interviewer**: That is really interesting. So, there is an immediacy at some times of needing to get rid of it.	
26	**Participant**: To get rid of it....yeah, definitely [1].	C [1] – need to remove
27	**Interviewer**: Good, and do you ever feel that trauma somatically or in the brain or is there ways that you might register it within your own being?	
28	**Participant**: Yes.	
29	**Interviewer**: That's a bizarre question, I know...	
30	**Participant**: No, it doesn't at all. I think you feel it very much physiologically [1]. Emotionally can	C [1] – residue/physical symptoms

	feel very sad and upset, angry, all of those feelings [2] and then you have to think about processing them on [3]. Are they my feelings, do they belong to me or are they the patient's. So, generally go through that kind of processing after a session. Physiologically, feeling headaches, funny tummy [4]. You kind of feel your stomach. I have a chronic condition which means that I experience quite a lot of pain and I feel that talking can actually have that reaction quite quickly.	C [2] – residue/emotions C [3] – need to process C [4] – headache/funny tummy
31	**Interviewer**: So, actually it makes it worse, more stressful...	
32	**Participant**: Yeah, I get a lot of chronic pain, pelvic pain, and that is very much connected to feeling stressed [1]. When I am feeling quite anxious or when I have been listening to something very traumatic. So, I actually very much feel it in my muscles, in my body [2].	C [1] – stress increases with work load C [2] – somatic response
33	**Interviewer**: So, that is horrible but also interesting. So, you seem to be saying that you register it both emotionally and then you cognitively deal with it. You look at where it is coming from. Is it your material or is it what the client has brought to you. But then you also have a physiological response within your system.	
34	**Participant**: Yeah, and then I become very aware of the physiological response [1].	C [1] – cognitive strategies do not always remove physical symptoms
35	**Interviewer**: So, are there strategies that you can use to rid the pain level, I mean, apart from taking medication to stop it getting to that level or….	

36	**Participant**: Sometimes, it is about taking painkillers [1].	C [1] – acute distress/self-care
37	**Interviewer**: Right.	
38	**Participant**: So, it is about taking medication, yeah, at that time. And sometimes it is about, I have always used to be very good after work, having my coping strategies [1], going to the gym [2], which is very good, a pain management technique for me, but it was also my transition time between work and home to stop me from taking it home. So, it was almost like a period of dropping it off on the way [3]. I remember when I was in therapy myself and through my training as a counsellor, I was given the imagery of not taking your hat and your coat off as you walk through the front door and putting it on the coat stand [4], and I still use that ten years on [5].	C- positive coping strategies C [2] – going to the gym C [3] – getting rid of/dropping off C [4] – imagery helps as a strategy C [5] – training can be preventative
39	**Interviewer**: Interesting. So, you definitely use imagery?	
40	**Participant**: Very much use that feeling and mind very much connected to being on the treadmill and running it off [1].	C [1] – imagery as a strategy
41	**Interviewer**: Right, okay. So, really they sound like powerful strategies that are useful as well as supervision or you could use instead of supervision if you did not have that available?	
42	**Participant**: I use them instead of supervision sometimes.[1]	C [1] – imagery as a method of self-care
43	**Interviewer**: So, it is a self-supervision technique?	
44	**Participant**: Yeah, self-soothing I suppose, as well, technique [1]. Not always particularly	C [1] – self-care crucial/taking responsibility for self

	successful but they're there in their attempt, but... I would not say that they always work [2].	C [2] – self-care does not always work
45	**Interviewer**: I mean I picked up, you said a few sentences ago about almost dropping it off, and it gives that sort of concept of almost like a heavy burden or a great big parcel, or something undesirable that you've got to get rid of. Is that what you meant?	
46	**Participant**: Because you need to separate yourself [1]	C [1] - separation
47	**Interviewer**: Yeah.	
48	**Participant**: From what's yours and what belongs to somebody else [1]. And you know it is also about, okay, we are separating that from your work life and your personal life because otherwise it feeds in so much [2]. So, there needs to be a time when you offload it and drop it [3] somewhere.	C [1] – processing feelings C [2] – containing C [3] - separating
49	**Interviewer**: Absolutely.	
50	**Participant**: Whether you visualise dropping it in the room with the patient[1] and that they do the same when you say, you know, we are going to leave this here[2] until we come back next week, that is not always easy. It does and you sometimes need to take it outside the room.	C [1] – contextualising/using imagery C [2] – collaboration with client
51	**Interviewer**: Yeah, I mean, in fact, it is a very clear coping strategy that has emerged previously, the use of imagery and especially with trauma. This seems to be a very powerful way to work with oneself. Do you use any other strategies or would you be more sort of, you know, image-based and more processing-based	

	rather than say adopting a cognitive behavioural approach or is it part and parcel?	
52	**Participant**: Kind of think, kind of be aware of what I do. I mean they're very behavioural things [1]. Maybe, I am more behavioural than cognitive, I am not sure, not sure until you know you asking me that question. I use supervision a lot.[2] I had supervision weekly.	C [1] - strategy/behavioural C [2] - supervision
53	**Interviewer**: And that was a peer, colleague or on-to-one?	
54	**Participant:** That is a one-to-one supervision. I am a counselling psychologist; so we believe very strongly in reflective supervision.[1] I know that some of my forensic colleagues that are happy to have that once a month, and especially from being in a placement at refuge where I worked with trauma and I did not have it at all.	C [1] – modality effects coping strategies
55	**Interviewer**: And that is one of the things I am actually interested in, is the quality of supervision for us psychologists who work with trauma because one of the themes that has come up time and time again is that the 'process' rather than 'content' in supervisions. Sometimes, psychologists have said that when working with trauma that it does not work because very often it is something that somebody has said to you or an image that you have got that you cannot get rid of, but people have often stated that they feel uncomfortable divulging that to a supervisor for fear of whatever she or he might make of it.	
56	**Participant**: Yeah, I suppose here it makes a difference to your relationship with your	C [1] – relationship with supervisor

	supervisor [1]. I have a very good relationship with my supervisor here where I can be completely honest [2] and say I am not dealing with this or I actually feel really anxious going into a room with this patient because of what I might hear and am really able to speak about the impact that that patient has on me. I have had supervisors in the past that had been very absent [3] or I have not been able to speak about my feelings [4] too. And it has been more about them, what they would have done and well, you know, more about….	C [2] – need to be honest C [3] – supervisor can be absent C [4] – not being heard in supervision is a stressor
57	**Interviewer**: And missing you somewhere in the dialogue?	
58	**Participant**: Yeah, and there may have been no space to be able to talk about actually how I feel [1] about working with this person and maybe that has had a big difference because I have quite early experiences of working with trauma early in my training that still stay with me now more than anything else I have ever worked with since [2].	C [1] – processing is necessary with supervisor C [2] – inadequacy of supervision has lasting negative effects
59	**Interviewer**: And are still there.	
60	**Participant**: Yeah.	
61	**Interviewer**: And how long ago would that be?	
62	**Participant**: Well, I am what, 32 now and I have worked with that patient here, I can still even specifically remember when I was 25 to 26 and then she came back so then probably the last contact with her was at 27. I am 32 now. So, you're looking at five years and I can still probably remember her as the most traumatic [1], yeah.	C [1] – longevity of residue

63	**Interviewer**: So, the importance of good supervision is really key?	
64	**Participant**: Yeah, <u>good supervision where you can be open and honest</u>[1] and <u>feel that you are going to be negatively judged</u>[2] for you know what they could think of me for saying I am not coping with this.	C [1] – permission to be honest C [2] – supervisor needs to be non-judgemental
65	**Interviewer**: Yeah, and it often seems that you know that trauma supervision has followed the normal supervision models which does not always allow enough space for the counselling psychologist to actually be there in the immediacy of the situation, not saying that very well. But yeah, I mean, I think what I am picking up from here is the importance of supervision in being able to get rid of and process the feeling that you are left with.	
66	**Participant**: Yeah, and maybe there's partly nerves as well. <u>I certainly know I felt in the past I've not wanted to dump it on somebody else because then they are going to be left with it</u>.[1 & 2]	C [1] – ethical issue prevents disclosure C [2] – don't want to spread it around
67	**Interviewer**: Yes.	
68	**Participant**: And always having a supervisor that said to me you know what … they have probably heard a lot worse than that. And by the time it gets to them it's fed down the line three people. <u>They are dumping it on the next person</u>,[1] it is getting less and less real.	C [1] – concerns about dumping it
69	**Interviewer**: But it is always that sense of responsibility, I can't do that.	
70	**Participant**: Yeah.	
71	**Interviewer**: And I guess it leads, some of us, to sort of proposing and saying well should people	

	that have not or should professionals who don't specifically work with trauma, should they be providing supervision within that area because it seems to be such a sensitive area.	
72	**Participant**: I think it is quite a difficult area to work in and also a difficult area for people to talk about because I think sometimes it can go beyond people's…what's the word I am looking for…..it is quite a scary area to think about working in.[1] It has a lot of expectation upon you and you can quite easily feel out of your comfort zone [2] and so, I think that can affect supervision and supervisor's feeling oh this is something that I am not really feeling comfortable working and talking about.[3]	C [1] – difficult to talk about/lack of shared reality C [2] – out of comfort zone C [3] – supervisors can be overwhelmed
73	**Interviewer**: Yeah, and it is almost picked up by each party at some level or non-verbally.	
74	**Participant**: It's something that's very unsaid because both people can feel very incompetent in working in that area. So, it becomes something you don't talk about because they might see you as, you know, yeah, incompetent.[1]	C [1] – withholding material/fear of being judged in supervision
75	**Interviewer**: Yeah, I think that sounds really reasonable explanation; (a) we might traumatise and (b) we might be seen as being incompetent. So, it is nonstarter really on some occasions. Okay, so, since kind of actually working though in this area, are there any changes to your frame of reference that you've noticed? Maybe subtle, maybe not at all?	
76	**Participant**: I am learning at the moment to think more about myself [1] than I ever used to before.	C [1] – need for self-care/strategy evolving in self-awareness

77	**Interviewer**: So, self-care is a prominent theme.	
78	**Participant**: I do not know. That is because I had been recently very ill. I think that working in this area has had an impact on my physical health [1] and I am now having to reassess what I was doing and whether I was taking care of myself well enough.[2] And I wasn't, and now having to think a lot more about if I am going to continue to work in this area, how do I take care of myself and preserve myself?[3 & 4]	C [1] – stress impact on self C [2] – need to reassess strategies C [3] – reframe self-care values to continue C [4] – recognising one's vulnerability
79	**Interviewer**: So, then how do you develop warrior skills to survive if you choose to carry on in this area? So, is that a positive in a way or was it a negative?	
80	**Participant**: Yes, positive.	
81	**Interviewer**: So, it is a positive that you, I guess, without sounding corny, defining your own self-worth and looking to identify what you need to sustain and allow yourself to carry on.	
82	**Participant**: Yeah, because if you do not take care of yourself, you can't take care of anyone else [1].	C [1] – need to self-care
83	**Interviewer**: So, burnout would be in your mind?	
84	**Participant**: Yeah, and it is something very real in this setting. People burn out very quickly, very fast and if you are not taking care of yourself then you will be a victim of that quite quickly.[1 & 2]	C [1] – burnout C [2] – self-care
85	**Interviewer**: That sounds scary.	

86	**Participant**: Yeah, and I have learned the hard way [1] and having a chronic condition, that I have to control. I am not, you know, indestructible.[2]	C [1] – learning the hard way C [2] - vulnerability
87	**Interviewer**: Okay, so rather, it has actually shown you your own vulnerability and your own limits. Whereas I think a lot of us who have worked in this field tend, until something really bad happens, to think of ourselves as indestructible.	
88	**Participant**: Yeah, perhaps toughened to it.	
89	**Interviewer**: Yeah, all those sort of things that aren't true.	
90	**Participant**: Yeah.	
91	**Interviewer**: Okay, and your frame of reference to the world, how do you view the world now? Has that changed in any way?	
92	**Participant**: Very much, yes, sadly [1].	C [1] – negative reference change
93	**Interviewer**: Not for better then.	
94	**Participant**: Not for better. No, you unfortunately see that the world isn't always a safe place.[1]	C [1] – negative reference change
95	**Interviewer**: I notice you said always, not always, that sounds like there is a little bit of, a dare I say, realism there.	
96	**Participant**: Yeah, but I think before I worked here and in Refuge before that, maybe perhaps I had a slightly unreal image of the world. Coming from very much a stable background and you know maybe slightly in a bubble,[1] all of a sudden the world is, you know, can be a very dangerous place.[2] I think specifically working	C [1] – loss of illusion C [2] – sudden awareness of danger

	here, we always talk very much about almost there being a parallel dimension [3] and when you step into the building here, you have entered a different world to the world outside that other people don't know exists.[4] And sometimes actually it is better to know it doesn't exist than knowing that it does.[5]	C [3] – altered dimension C [4] – isolation in a crazy world C [5] – regrets loss of illusion
97	**Interviewer**: Yeah, because you cannot ever get that state of not knowing back again.	
98	**Participant**: Yes, sometimes it is true, feeling ignorance is bliss I think.[1]	C [1] – regrets loss of illusion
99	**Interviewer**: Do you find that separates you out from the people outside of the four walls of this place?	
100	**Participant**: Very much, unfortunately, and I see that as a bad thing sometimes as well because nobody outside of this workplace really knows what you are going through [1]or what you are experiencing on a day-to-day basis. Your idea of a difficult day at work is very different to somebody else.[2]	C [1] – isolation C [2] – isolation and separateness
101	**Interviewer**: Yeah, so, it is almost like a parallel universe I should say.	
102	**Participant**: Yeah, and that feels a very damaged perception of the world. Although it is a real one, for me, it feels like it has been damaged in a sense.[1]	C [1] – sadness, loss of illusion, regret
103	**Interviewer**: Yeah, irreparably.	
104	**Participant**: I hope that makes sense.	
105	**Interviewer**: That makes perfect sense. You have got, from what you are saying a kind of…,;you have got a realistic perspective of	

	another side of the world that really in some sense you wish you didn't have.	
106	**Participant**: Yeah, and which some people never have. Some people go through the whole of their life not knowing that and maybe I could have gone through the whole of my life not knowing that, but unfortunately, I stepped over.[1]	C [1] – regret, sadness
107	**Interviewer**: Could you say that that actually can make living, and do not let me try to imply that you are depressed or something like that, but having that knowledge can make life harder to live?	
108	**Participant**: Definitely, yeah, and I think it can make you depressed if you are not careful [1 & 2].	C [1] – need for self-care C [2] – trauma is dangerous work
109	**Interviewer**: Yeah, so, are there positives to this work, real positives or are they more negative?	
110	**Participant**: Sometimes, it is so rewarding [1] and so wonderful when you see results and the people that you work with here, the staff, some of the most amazing people I have ever worked with in my life and some of the nicest people I have ever met in my life [2] and the patients and their experiences and what they have gone through are just, you just have to admire them for the things that they have lived through and…. [3]	C [1] – rewarding C [2] – positive relationship with staff C [3] – admiration of resilience
111	**Interviewer**: So, you still see the good and something marvellous in humanity.	
112	**Participant**: Yeah, and that we know that we can go through experiences like that and come out the other side….. [1]	C [1] – resilience and humility
113	**Interviewer**: So, resilience again ...	

114	**Participant**: And find a life that is worth living. So, it is, there are the positives as well as there being lots of negatives as well.[1]	C [1] - positive and negative coexist
115	**Interviewer**: And I guess almost, what I'm picking up is some sadness entering this, is the word slip-stream or something that you did not know existed and you cannot come back down the yellow brick road again once you have done it. And does that then sort of go into your own private life as well rather than being able to sort of lock it up here dump your bag and off we go....	
116	**Participant**: Yeah.	
117	**Interviewer**: So, if you had, on a more sort of like casual note, if you had your chance to study and you know do the journey again that you had done, would you do it or would your career be something different?	
118	**Participant**: I often say no, I wouldn't. If I know what I know now, [1] I wouldn't have done it. But actually when I really think about it, I can't see me ever being satisfied and happy doing anything else [2] than being a psychologist.	C [1] – preparation for this work essential C [2] - vocation
119	**Interviewer**: Okay, so what you are saying then in a way is although it is extremely painful at times, it's really shitty and all the rest of it, there are massive leaps that people make and it is very rewarding. But you are kind of saying on balance, you almost accept that ambiguity that goes with it. [1]	C [1] – Clarifying/paraphrasing
120	**Participant**: Yeah.	C - ambiguity
121	**Interviewer**: So, it is a kind of balancing and a normalizing. I think that is what I am picking up.	

122	**Participant**: I think so. Yeah.	C - coexistence
123	**Interviewer**: Okay, that is really, really helpful. Is there anything else that you know you would like to add?	
124	**Participant**: No, this has actually been really insightful. It's kind of making me really recognise the impact of my area of work on me. There is parts of it that I already obviously knew, you know, put things in place and that it's actually kind of good to have time to sit down and really think about it. [1]	C [1] – reflective process useful
125	**Interviewer**: What I am picking up from people I have interviewed is, you know all seemed to be functioning really well. Is there something about putting things into place and being proactive?	
126	**Participant**: Yes, and you have to recognise you know that nobody can do this job without having things in place to look after themselves [1]. And actually sometimes you know before things that used to work for you just like we say to our patients, run their course. They worked for you a while ago, but it doesn't necessarily mean that they are always going to work for you. So, there are times in your life when those things stop working and you need to reassess and find other things that work for you.	C [1] – clear coping strategies necessary
127	**Interviewer**: So, it's a sense of self-enquiry about what can I do now to make myself feel better.	
128	**Participant**: Yeah.	
129	**Interviewer:** Okay, thank you very much. That is really helpful.	

Appendix 9

The research for this project was submitted for ethics consideration under the reference PT/008/005 in the Department of Psychology on 8th March 2009 and was approved under the procedures of the University of Roehampton's Ethics Committee on 22nd June 2009.