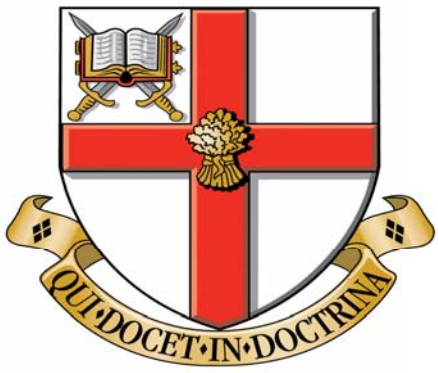

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A QUALITATIVE STUDY OF THE IMPACT ON THE COUNSELLOR OF ENGAGEMENT IN LONG TERM EMPATHIC RELATIONSHIPS WITH SURVIVORS OF CHILDHOOD SEXUAL ABUSE

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Dissertation submitted to the University of Liverpool for the Degree of Master of Arts (Counselling Studies) in part fulfilment of the Modular Programme in Counselling Studies

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ABSTRACT

This dissertation is a qualitative study of the impact on the counsellor of engagement in long term relationship with survivors of childhood sexual abuse. Five counsellors, experienced in working with adult survivors, were interviewed. Discussion focused on questioning their training and preparation for working with the particular needs of adult clients seriously damaged by traumatic child abuse; the counsellor's experiencing of long term empathic engagement; the quality and availability of supervision and other means of supporting the counsellor; the impact on counsellors exceeding their emotional and physical limitations; and changes caused by the nature of this work in the counsellor's perceptions of the world, their feelings, and the impact on their domestic, social and spiritual life. The study examines the particular nature of childhood abuse and the circumstances that arise working with survivors which may put the counsellor at risk. The results of the study indicate that careful preparation and appropriate training are required for counsellors who wish to be involved in this work, and that constant awareness of the potential dangers combined with self-care and experienced support will help the counsellor to avoid or lessen the risks involved.

DECLARATION

This work is original and has not been submitted previously in support of any qualification or course.

Howard Ernest Watkin

October 2004

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List of abbreviations

APA: American Psychiatric Association.

BACP: British Association for Counselling and Psychotherapy.

CCM: Constant Comparative Method of Data Analysis.

CSA: Childhood Sexual Abuse.

DID: Dissociative Identity Disorder.

DSM: Diagnostic and Statistical Manual.

Ed: Editor.

ed: Edition.

NHS: National Health Service.

PTSD: Post Traumatic Stress Disorder.

RMN: Registered Mental Nurse.

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A QUALITATIVE STUDY OF THE IMPACT ON THE COUNSELLOR OF ENGAGEMENT IN LONG TERM EMPATHIC RELATIONSHIPS WITH SURVIVORS OF CHILDHOOD SEXUAL ABUSE

Chapter One

INTRODUCTION

Counselling and psychotherapy provide a service that is unavoidably stressful for the therapist. It seems possible that there may be especially onerous circumstances that need to be considered that could affect the well-being and health of the therapist when dealing with the survivors of child abuse, and perhaps particularly when that abuse is sexual.

In my work as a practitioner for the mental illness charity MIND, a substantial percentage of my clients have disclosed at some stage that they have been abused sexually, psychologically, or physically brutalised. It is perhaps of interest that none of them presented initially disclosing their abuse. It is also significant that each client suffered abuse during childhood. The counselling relationships have been intense, stressful, and of considerable length. It was of some personal interest therefore that during my studies about child abuse, I searched for references on the needs and coping mechanisms of practitioners working with these severely traumatised clients. Despite a diligent search I found a paucity both in the literature and available research. My work with abuse survivors has caused me to reflect on the impact and outcome of this process on the therapist.

My research proposal contained the results of a preliminary reading of the background literature. The first stage of this study suggested two possibilities. One course would begin by concentrating on an intensive study of the literature. This would be needed in any event. The alternative was to start with the research process. The second route was chosen so as to avoid any bias that might possibly arise from the literature study that could influence either

the interviews or the outcomes.

Five very experienced and qualified therapists were invited to participate in research into their experiencing of the general preparation, specific training, empathic relationships, and the quality of the support they had received. The context and environment of their work was examined together with the various ways this had impacted on their feelings about themselves, their beliefs, and how these experiences had changed their attitudes to social and domestic situations as the progressive outcome of working with survivors of childhood sexual abuse. The client relationships referred to by them were of variable length, and substantially in excess of what we would understand by the term 'brief counselling'.

In my consideration of the impact on the therapist of working with clients who have suffered an 'extreme emotional assault' such as child sexual abuse it seemed important to understand more clearly the nature and consequences of the trauma as it affects the child, and subsequently the adult survivor.

This study examines important aspects of the traumatic nature of child sexual abuse; it will consider the impact on the counsellor of the empathic content of the relationship; the extent to which the client's trauma can contaminate the therapist; and investigates the needs and various self-care issues that are essential to the protection, safety, health, and well-being of the counsellor.

In asking myself the question, what is the nature of long term therapeutic relationships with survivors which demand of the therapist such extremes of skill, sensitivity, empathic understanding, and much more, all combined with emotional and physical endurance, I reflected on the comments of Moira Walker (1992, p.3) who says: "*In working with abuse survivors, helpers encounter the most intolerable and sickening aspects of human behaviour, in whatever way they are labelled.*".

The Penguin Dictionary of Psychology (2nd ed., 1995) has defined 'Trauma' as a description used *"either for physical injury caused by some direct external force or for psychological injury caused be some extreme emotional assault."* Andreasen (1985) describes the denominator that is common to victims of psychological trauma as having a feeling of intense fear, helplessness, loss of control, and threat of annihilation. Herman (2001. p.34) argues that traumatic reactions occur when action is of no avail and when resistance and escape are not possible. She says *"the human system of self-defence becomes overwhelmed and disorganised."* She goes on to state that such events produce profound and lasting changes in physiological arousal, emotion, cognition, and memory. The trauma tears apart a complex system of self-protection that normally functions in an integrated fashion.

The nature of the traumatic experience and the social and cultural context are described by Everett and Gallop (2001) as being factors that mediate impact, but they are outside the child's personal sphere of influence. Everett and Gallop (2001, p.22) make this statement:

> *Trauma that begins early in life interrupts developmental tasks and subjects young children to overwhelming emotional and physiological stimuli before they are able to understand what is happening and before they have the verbal capacity to communicate their pain. Their distress is heightened in proportion to the amount of violence used and to the invasive nature of the assaults sexual, physical, or psychological: (Elliott & Briere, 1995;Finkelhor, 1979; Herman, Russell,& Trocki, 1986; Russell, 1986).*

This statement focuses on the essential difference between childhood abuse trauma and other traumatic experiences, drawing attention to the effect of abuse trauma on young, immature, dependent and unprotected children causing psychological damage, the effects of which can continue for long periods of time. Children who learn to distrust adults find considerable difficulty later as adults in forming meaningful relationships. While there may be aspects of the abuse trauma which seem to have similarities, each survivor's experience is their unique experience.

The British Association for Counselling and Psychotherapy (2002) draws attention to the

need for counsellor self-care in its guidelines on good practice. Paragraph 56 states:

> *Practitioners have a responsibility to themselves to ensure that their work does not become detrimental to their health or well-being by ensuring that the way that they undertake their work is as safe as possible and that they seek appropriate professional support and services as the need arises.* (p. 10).

Everett and Gallop (2001. p.309), summarising a discussion on personal and professional self-care for those working with survivors of child abuse, underline the importance of this attitude when commenting that our own well being is one of our most important professional assets. They say that while the "*work is rewarding, it can be emotionally, physically, and even spiritually dangerous.*"

In chapter two, in reviewing the literature, my focus will be on the distinctive characteristics of psychological trauma, particularly in relation to child abuse; the use of empathy as an essential ingredient in entering the clients reality; and understanding the complexity of the impact of using empathy on the therapist. I will also examine various approaches to self-care which have been proposed in order to lessen or avoid the potentially damaging aspects of this work. Chapter three will set out the basis of the research design and methodology. It will give my analysis of the two principal research paradigms, and my reasons for choosing the qualitative approach. My use of the Constant Comparative Method of Data Analysis will be described. In chapter four I will present the data derived from the interviews which will lead into the statement of five outcome propositions which have emerged from the research. This will be followed by chapter five which analyses the data and comments on the implications of the research. Finally in chapter six I attempt to bring together the various interlinked themes and the conclusions I have reached.

Chapter Two

REVIEW OF BACKGROUND LITERATURE

Introduction

The study begins with a brief reference to the background of the recent history of the study of psychological trauma, and moves on to examine the contribution of scientific research by Freud and Breuer concerning incest and child abuse. The importance of Freud's work and the beginnings of psychoanalytic theories and practice are critically reviewed in conjunction with more recent developments in the psychodynamic approach. Humanistic and other forms of therapy are considered particularly in relation to their emphasis on the relationship between client and therapist, and the use of empathy. Attention is given to the nature and process of abuse trauma, especially aspects involved with professional and counsellor self-care.

Recent History of Public Awareness of Psychological Trauma

In describing the study of psychological trauma, Herman (2001, p.7) says that it is *'to come face to face both with human vulnerability in the natural world and with the capacity for evil in human nature.'* She draws attention to the fact that during the previous century a particular form of psychological trauma had surfaced into public consciousness on three separate occasions. The first to emerge late in the nineteenth century concerned the psychological disorder of women known then as hysteria. Micale (1989) described hysteria as a dramatic medical metaphor for everything that men found mysterious or unmanageable in the opposite sex. In the late nineteenth century it was believed by most physicians to be a disease proper to women and which originated in the uterus.

The slaughter of over eight million men during the four years of the First World War focused attention on the unremitting exposure to the horrors of trench warfare which resulted in the psychological disintegration of huge numbers of soldiers. Many soldiers

began to act in a way similar to hysterical women. Kardiner (1941) studied what he called *The Traumatic Neuroses of War*. His clinical and theoretical research showed a close similarity to the formulations advanced by Janet (1889) in recognising that war neuroses represented a type of hysteria. The study of shell shock/combat neurosis reached a peak after the Vietnam War. The American Veteran's Administration commissioned systematic psychiatric research which produced a five volume study on the legacies of the Vietnam War and delineated the syndrome of post traumatic stress disorder (PTSD). Hermon (2001, p.27) comments that this demonstrated beyond any reasonable doubt its direct relationship to combat exposure and is fully documented in the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders,* 3rd ed. (DSM lll), (1980). She goes on to argue that with the legitimisation of the concept of post traumatic stress disorder it became clear that the psychological syndrome seen in survivors of war was essentially the same as the syndrome seen in survivors of rape, domestic battery, and incest. (See appendix for copy of DSM IV PTSD, and proposed new formulation Complex PTSD.)

Danieli (1984, 1988), Kulka, Schlenger, Fairbank et al. (1990) and many others have written about the human suffering of the victims of the Nazi Holocaust and the impact of war trauma on the veterans of Vietnam. Especially moving is the personal experience of Dr Viktor Frankl (1959) who survived to describe his life in Nazi concentration camps.

The third and most recent example of trauma to engage public awareness is the psycho-logical, physical and spiritual distress caused to victims of sexual and domestic violence. Hermon (2001, p.33) powerfully describes the moment of trauma when the victim is rendered helpless by overwhelming force. In the context of domestic and sexual violence she says that human beings are confronted with the extremities of helplessness and terror evoking the responses of catastrophe. She goes on to quote the *Comprehensive Textbook of Psychiatry* (1985) which defines the common denominator of psychological trauma as a

feeling of "*intense fear, helplessness, loss of control, and threat of annihilation.*" She asserts that *"our contemporary understanding of psychological trauma is built upon a synthesis of these three separate lines of investigation."* (p. 9).

The Beginnings of the Scientific Study of Psychological Trauma

The Studies in Hysteria carried out by Freud and Breuer (1895) comprised some of the earliest scientific researches into the psychological effects of traumatic experiences, and in particular in relation to incest and child abuse. Dale (1999, p.9) comments that the Freudian notion that awareness of unbearable instincts or traumatic experiences can be blocked out and placed in an unconscious compartment by using a process Freud called 'repression', has had an enormous influence on psychotherapy. He goes on to say that this is particularly controversial in relation to the belief that extensive and severe sexual abuse is especially likely to result in massive repression; and that 'repressed memories' need to be 'recovered' as part of the process of healing and recovery. Freud discovered the unconscious process of 'transference' whereby aspects of a client's relationship with significant others, particularly parents, can become built into their perception of, and relationship with, the therapist.

Hermon (2001.p.13) draws attention to a statement recorded in Freud's report on eighteen case studies, entitled *The Aetiology of Hysteria,* that

> *at the bottom of every case of hysteria there are one or more occurrences of premature sexual experience, occurrences which belong to the earliest years of childhood, but which can be reproduced through the work of psycho-analysis in spite of the intervening decades.* (Freud, 1962)

Hermon describes these findings as brilliant, compassionate, eloquently argued, and a closely reasoned document. In summarising the case study of Katherina, Freud states his finding that

> *In every analysis of a case of hysteria based on sexual traumas we find that from the pre-sexual period impressions which produced no effect on the child attain a traumatic power at a later date as memories, when the girl or married woman has acquired an understanding of sexual life.* (Freud & Breuer, 1991. p.200)

Freud subsequently renounced his initial seduction theory. In his *'New Introductory Lectures on Psychoanalysis'* (1991, p.154) he asserted that almost all of his women patients had told him that they had been seduced by their father. He went on to state that he was driven to recognise in the end that these reports of hysterical symptoms were untrue, and that they were derived from fantasies and not real occurrences.

Sanderson (1995, p.33) challenges the validity of the psychoanalytic model in this respect and refers to recent research which demonstrates that incest and child sexual abuse is much more prevalent than was previously recognised (Los Angeles Times Survey; 1985, Russell, 1983). This view is supported by Draucker (1992, p.5) who refers to research by Peters, Wyatt and Finkelhor (1986), who in reviewing childhood sexual abuse prevalence studies carried out in North America found figures ranging from 6 percent to 62 per cent for female samples, and from 3 percent to 31 percent for male samples. Mendel (1995, p.5) makes the interesting comment that *"a basic tenet of postmodernism is that what we observe is influenced by what we think"*. He argues that for much of this century psychoanalytic therapists have probably mistaken indications of abuse as fantasised rather than actual childhood abuse.

The case study of Breuer's patient Anna O (Freud,1991, pp 73-102) led Freud to formulate the hypothesis that there existed a part of the mind containing intentionally repressed memories which were not accessible to the conscious mind of an individual, and which he called *the unconscious.* This case study describes the use of hypnotic suggestion to assist the patient to release traumatic material which had been repressed into her unconscious region. Although Freud was later to cease the use of hypnotism, these early studies enabled him to understand the reasons why patients 'blocked out' unbearable thoughts and feelings and were unable, or at times unwilling, to share their experiences and co-operate in their own cure. He used the term "resistance" to describe this mental process.

Freud discovered that tension and anxiety caused by repressed memories, wishes, and feelings associated with traumatic events, could be abreacted by the bringing into consciousness the original tension producing experience. He found that the use of language served as a substitute for cathartic reaction by the patient using words to fully describe the memory of the trauma.

The published results of Freud's research exposing the sexual exploitation of children exceeded the limits of social credibility of his time, and resulted in isolation and ostracism within his profession. These professional and social pressures caused Freud to recant with the result that the scientific study of psychological trauma came to a halt (Hermon, 2001, p.18).

This is a greatly condensed review of some aspects of Freud's contribution to our present understanding of the processes of the human mind, and from which has developed much of the clinical and empirical research into child abuse (Freud & Breuer, 1991, pp.35-65).

The evolving of the psychodynamic approach from its roots in psychoanalysis has seen substantial changes from Freudian attitudes and practice. Jacobs (1988, p.9) describes it as a long way from early Freudian ideas of the child as a bundle of mainly sexual instincts, waiting to be satisfied. He goes on to say that the psychodynamic approach includes the powerful feelings in relationships, both between people, parent and child, husband and wife, within a family or a group. Jacobs states that the term 'relationship' is more significant than might be apparent from reading early Freudian literature.

Current research and clinical studies have drawn attention to a number of limitations in the psychoanalytic/psychodynamic approach. Sanderson (1995, p.33) notes that the formulation has an explanation for the occurrence of father/daughter incest but has failed to explain other intra and extra familial abusive relationships such as father/son, mother/son,

mother/daughter, sibling, uncle or grandfather incest, or sexual assaults committed by neighbours, teachers or family friends. She goes on to comment that wider social and cultural issues are ignored, in particular that sexual abuse is primarily committed by men. Sanderson quotes Finkelhor (1984) that male abusers account for 95 percent of sexual assaults on girls and 80 percent of assaults against boys.

In referring to the psychoanalytic model placing responsibility for abuse on the unconscious desires of the 'seductive' child, or the collusive mother, Sanderson (1995, p33) argues that this exonerates the abuser, and comments that this has caused several writers to attempt to re-define Freud's *Oedipal Complex* theory (Chodorow,1978; Hermon,1981; Miller,1985). These writers acknowledge the *"power and status that males have"*, and contend that this interpretation allows for a shift in responsibility for the abuse from child to the adult.

The Development of Humanistic and other Alternative Forms of Therapy

The theoretical approach within the humanistic tradition attempts to describe the conditions which will facilitate the client's growth towards self-healing and fulfilment. An example of this is person-centred therapy, a form of non-directive and reflective psychotherapy developed by Dr Carl Rogers. He wrote (1957, pp.95-103)

For constructive personality change to occur, it is necessary that these conditions exist and continue over a period of time:

1. *Two persons are in psychological contact.*
2. *The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.*
3. *The second person, whom we shall term the therapist, is congruent or integrated in the relationship.*
4. *The therapist experiences unconditional positive regard for the client.*
5. *The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.*
6. *The communication to the client of the therapist's empathetic understanding and unconditional positive regard is to a minimal degree achieved.*

The person-centred approach provides a survivor with an opportunity to talk about their experiences in an accepting and non-judgemental atmosphere. The building of a deep, safe,

and trusting relationship between the client and the therapist is fundamentally important to the therapeutic process in which the former is able to narrate their experiences however painful and distressing. The facilitative use of empathic understanding is described by Rogers (1980, 1995, p. 116) as *"sensing accurately the feelings and personal meanings that the client is experiencing and communicating this understanding to the client".*

Pearlman and Saakvitne (1995, pp.296-7) comment that *"As therapists, one of our most valuable tools is our capacity to enter empathically into the experience of our clients."* They go on to say that therapist's empathy is an essential part of the process of creating a therapeutic relationship in which the sexual abuse survivor can recover (McCann & Colletti, 1994; Wilson & Lindy, 1994a). They continue with a warning that empathy also puts us at risk for vicarious traumatisation, and in particular a specific type of empathic connection which can heighten this. Pearlman and Saakvitne (1995) suggest the connection between vicarious traumatisation and empathy. They describe two types of empathy. The first, which they call 'cognitive empathy', focuses on "*what happened, what the client says she experienced, how it came about , what it meant to her, her narrative account of the abuse and the aftermath".* (p. 296)

They describe the second type of empathy as 'affective', and say

> *We can feel some of the client's pain, her fear, her rage, the range of intense emotions connected with her experience. When we sense her experience at a feeling level, this is affective empathy.* (p.296)

Both aspects are seen in different time frames, what took place in childhood, and also later as an adult. It is suggested that the affective empathy with the client as a child is the stage in which we are most vulnerable to vicarious traumatisation. It is then that our connection to

> *and experience of the overwhelming feelings of a child being abused affects us most deeply as therapists and human beings, and may change our fundamental experience of ourselves and the world. While it could be argued that avoiding such empathic connection would protect the therapist, it is however a crucial aspect of the therapy. It is only through the therapist's empathic connection, that the client herself can come to connect with and understand the truth of her experience in its developmental context.* (p.297)

Everett and Gallop (2001, p.45) describe dissociation as a *"compartmentalization of experience"*. Quoting from the Diagnostic and Statistical Manual of Mental Disorders [DSM-IV], American Psychiatric Association, 1994, p. 484, they state that there is *"a failure to integrate various aspects of identity, memory, or consciousness"*. They go on to say that elements of experience are not integrated into a unitary whole but are stored in memory as isolated fragments consisting of sensory perceptions or affective states. They comment that theorists hypothesize that dissociation may help a child cope during the traumatic event by building a defence against overwhelming emotion (Allen, 1993; Briere, 1992). Van der Kolk, Van der Hart and Marmar (1996, p. 306-8) describe dissociation *"as a way of organising information"*. They go on to quote from van der Kolk & Fisler (1995)

> *Many children and adults, when confronted with overwhelming threat, are unable to integrate the totality of what is happening into consciousness. Sensory and emotional elements of the event may not be integrated on to personal memory and identity, and remain isolated from ordinary consciousness; the experience is split into its isolated somatosensory elements, without integration into a personal narrative. This fragmentation is accompanied by ego states that are distinct from the normal state of consciousness. This condition, "primary dissociation," is characteristic of PTSD, in which the most dramatic symptoms are expressions of dissociated traumatic memories-intensely upsetting intrusive recollections, nightmares, and flashbacks.* (van der Kolk et al., 1996, p.307)

Dissociation occurs when the brain simply cannot handle the stimuli it is receiving and reality splits from consciousness in order to deal with the overload (van der Kolk et al., 1996).

Recent person-centred research at the Chicago Counselling Center with clients experiencing dissociative identity disorder (DID) and various other trauma-related dissociative states has shown that those who had worked through these experiences all came to remember sexual or physical trauma before the age of seven. Warner (2000. p.160-171) suggests that

> *Faced with overwhelming trauma and lacking the more complex ways of coping with experiences available to older children, our clients seem to have stumbled on dissociation as a solution.*

The abused child, according to Pearlman and Saakvitne (1995, p.59), *"does what he can and must do to survive"*. They comment that *"Adaptation for victims of childhood sexual abuse often includes dissociation"*.

Working with Survivors of Trauma, Particularly of Childhood Sexual Abuse

The crucial importance of the relationship between client and therapist has been the subject of an increasing amount of research. Clarkson (1995,p.4) refers to studies (Luborsky *et al.*, 1983; O'Malley *et al.*, 1983; Bergin and Lambert, 1978; Hill, 1989) and states that these *"demonstrate that it is the relationship between the client and psychotherapist, more than any other factor, which determines the effectiveness of psychotherapy"*. The results of research *"demonstrate negligible differences in the effects produced by different therapy types"* (Smith and Glass, 1977: 760).

Recent research, reported by Selwyn Black, Pauline Irvine, and Peter Weinreich (2000) has been exploring the individual responses of counsellors to their work with traumatised clients, who were survivors of the Omagh bomb in County Tyrone. This study has reached the conclusion that the construct 'vicarious traumatisation' goes beyond the notion that working with trauma survivors is difficult and sometimes distressing. It goes on to state that such trauma assaults the counsellor's self- protective beliefs about safety, control, trust, predictability and attachment. Changes in the inner experience of the therapist are the result of empathic engagement with client's traumatic material.

The trauma of abuse in childhood can cause deep psychological damage. These experiences are referred to by Draucker (1992, p.6) who comments that both clinicians and researchers have maintained that childhood sexual abuse often results in long term damage to the client including sexual dysfunction; depression, suicidality, and guilt; isolation and disturbed interpersonal relationships; post-traumatic stress symptomatology; physical, sexual, or emotional victimization; substance abuse and other self-destructive behaviour; and various

somatic complaints (Benward & Densen-Gerber, 1975; Britcher, 1986; Forward & Buck, 1978; Gordy, 1983; Gross et al.,1980; Tsai & Wagner, 1978; Van Buskirk & Cole, 1983). Some writers have suggested that some of these changes could be triggered in the therapist as a result of long term empathic engagement with trauma abuse clients.

Hermon (2001. pp141-154) takes us further. She argues that *"Repeated exposure to stories of human rapacity and cruelty inevitably challenges the therapist's basic faith."* In addition to heightened feelings of personal vulnerability, there may be increased feelings of distrust, even in close relationships, as well as fear of other people in general. The use of empathy enables the therapist to share the client's experience of helplessness, but this may lead to an underestimation of the value of the counsellor's own knowledge and skills. Hermon describes the temptation to assume the role of rescuer and the disempowerment this could cause would do harm to the client. Another aspect might be through empathic identification; the therapist may become aware of the depths of the client' rage, and adopt a placatory approach.

Pearlman and Saakvitne (1995, pp.298-300) identify three aspects of trauma therapy which they believe contribute directly to vicarious traumatisation: first, exposure to graphic trauma material, exposure to the realities of people's cruelty to one another, and observation of and participation in traumatic re-enactments. The graphic descriptions of rape and sadism that many survivors need to share with their therapist in order to heal can horrify, at times overwhelm, and haunt the therapist. The imagery used by the survivor giving specific details of smells, sounds, and bodily pain is often vivid and can shock or disgust the therapist. The repeated stories of horrific abuse, neglect, and the vulnerability of children unable to protect themselves in the control of untrustworthy adults who injure, molest, and systematically dehumanise them can cause the therapist to question *"views of others as well-intentioned, of childhood as a time of innocence and joy, and of families as supportive and loving"*

(Pearlman and Saakvitne, 1995, p.298).

Pearlman and Saakvitne (1995, p.299) comment on those survivors who become involved in re-enactments of their trauma outside the therapeutic relationship. This could expose the client to danger. They state that revictimization as a sequel to childhood sexual abuse is well documented (Chu, 1992; van der Kolk, 1989). They add that some clients are in a current battering relationship, while others might be approached by their former perpetrators, others may continue to re-enact abuse on themselves. Therapists hearing about a client's current abuse can be put repeatedly into the role of helpless witness, and can be affected in other important ways such as suicidal thoughts, their spiritual beliefs and by draining physical, emotional and somatic matters.

Warner (2000.pp.144-171) recognises the severe problems that *"some clients have in moderating the felt intensity of their experience, dealing with internal reactions of self-criticism and shame or controlling destructive impulses"*. She says that some clients experience dissociative shifts into 'parts', which is a process in which personified clusters of experience may exist within a personality either partially or totally unaware of each other's presence. She goes on to state that these parts seem to have been created in early childhood as a defence to keep the person from being overwhelmed by experiences of incest or other abuse. In considering how the movement towards actualisation is fostered, Warner refers to person-centred theoretical models developed by Gendlin (1964, 1968, 1974) Rice (1974) and Wexler (1974). She says that this natural tendency to process experience tends to work under optimal circumstances.

> *During processing, related, but previously unattended memories, thoughts, feelings and images emerge and transform themselves into more clearly understood forms... ... When emotions are evoked in the process they often intensify, go through transformations and ultimately resolve themselves into experiences of much less intensity (as when sadness becomes grief and sobbing and ultimately resolves into a feeling of peace.* (p.146)

Therapists dealing with the more extreme aspects of abuse trauma may find their client has

flashbacks or may reveal the presence of different personalities. It seems possible that there could be a risk of contamination although I have been unable to find any research that suggests this.

The Nature and Process of Psychological Trauma Therapy

Counsellors, psychotherapists, psychiatrists and other professionals who work with the survivors of childhood sexual abuse listen empathically and try to understand their distress and despair. Hermon (2001.p.140) makes this powerful statement:

> *Trauma is contagious. In the role of witness to disaster or atrocity, the therapist at times is emotionally overwhelmed. She experiences to a lesser degree, terror, rage, and despair as the patient. This phenomenon is known as 'traumatic counter-transference' or 'vicarious traumatisation'. The therapist may begin to experience symptoms of post-traumatic stress disorder.*

Pearlman and Saakvitne (1995,p.299) describing the process of the trauma therapy, comment *"repeated exposure to trauma material in the context of empathic connection with the survivor client, creates vicarious traumatisation"*. These very intense and intimate therapies are frequently terrifying for the client. They state that the powerful and often distressing affects aroused by this material can put the therapist at risk from vicarious traumatisation.

The experiencing by survivors of uncontrolled emotional pain is often described as worse than physical pain (Van der Kolk, 1996a, 1996b). Sometimes, under conditions of stress, Everett and Gallop (2001, p.71) argue *"that survivors regress and enter childlike emotional states that can last for a considerable period of time"*. They go on to describe a number of emotional indicators including fear and anxiety, anger, panic attacks, despair, hopelessness, and feelings of spiritual abandonment. Relational reactions often lead to some giving up and isolating themselves as much as possible from fellow human beings. Survivors who are the victims of sexual abuse may be repulsed by any possibility of sexual activity and adopt celibacy as their way of life. Everett and Gallop comment that the *"fear of sex, loss of enjoyment or interest in sex, and compulsive sexual behaviours have been well documented"*

(Craine et al., 1988; Lobel, 1992). Coppenhall (1995, p.29) comments that sexuality is experienced as a core part of our identity, and says that this core is touched time and again when working with survivors. She argues

> *Perhaps more than in any other field, counsellors of survivors have to have a greater honesty about their own sexuality and be clearer about their own boundaries when working with clients whose boundaries have been destroyed by abuse.*

Professional and Personal Self-Care Attitudes and Systems

Self-care has been described as a professional responsibility for all counsellors and psychotherapists. Horton (1997) in his introductory chapter describing the needs of counsellors and psychotherapists, comments that

> *although numerous books have been published on almost every aspect of counselling and psychotherapy, surprisingly little has been written about the needs of counsellors and psychotherapists themselves.*

Horton discusses various aspects of the term 'needs' which are both interesting and important. In the context of the therapeutic relationship are matters such as training requirements, and the *"need to establish healthy patterns of personal and professional self-care early in their career"*. He comments that in this way dealing constructively with the inevitable stress of psychotherapeutic work is learned and burn-out prevented.

Hermon (2001, p.141) writes about the risks to the therapist's health through involvement in trauma work, and their need for ongoing support systems to deal with the resulting intense reactions. She observes that: *"Traumatic countertransference includes the entire range of the therapist's emotional reactions to the survivor and to the traumatic event itself"*.

Sanderson (1995, pp. 235-255) describes a number of important matters that the therapist requires for protection of health and well-being. Ensuring that there is a support network that can be turned to provides opportunities for discussing and evaluating work. She suggests that in addition to a personal counsellor, that the supervisor should have experience in child

sexual abuse and its effects. She emphasises the importance of regular meetings, weekly or every other week, to clarify material that has surfaced, and which is also an opportunity for the counsellor to relieve the emotional effects the material has had on them.

Many trauma therapists work long hours and may not set adequate self-protective limits on their availability and stamina (Pearlman and Saakvitne, 1995). The results of this practice could lead to burn-out.

For those therapists whose work-load with survivors is particularly heavy and sustained the workbook on vicarious traumatisation entitled 'Transforming the Pain' written by Saakvitne and Pearlman (1996) assisted by doctoral staff from the Traumatic Stress Institute Center for Adult & Adolescent Psychotherapy contains valuable insights and exercises. These describe the recognition and contributory factors identified with vicarious traumatisation, and make practical suggestions about therapist self-care, including both at work and personal matters.

The need to understand psychological trauma and its effects on the therapist working with child abuse, and especially sexual abuse, is of considerable importance. It should be of concern that so little has been researched and written about the impact of this on the therapist. Pearlman and Saakvitne (1995, p.281) comment that from a theoretical perspective vicarious traumatisation is inevitable. The effects are widespread and its costs immeasurable. *"It changes the self of therapist and will inevitably affect all of our relationships – therapeutic, collegial, and personal"*. They go on to say that as well as leaving the therapist serious, cynical, and sad, it can affect his/her ability to live fully, to love, to work, play and create. If not addressed the therapist may leave the field either because of the likelihood of burnout, or through feelings of lost identity as an effective worker (Horner,1993). Pearlman and Saakvitne conclude by expressing their belief that the effects are modifiable when actively addressed .

Chapter Three

RESEARCH DESIGN AND METHODOLOGY

Introduction

Maykut and Morehouse (1994) emphasise the necessity to explore the philosophic assumptions underlying the quantitative and qualitative paradigms. They assert that positivism and phenomenology are the two overarching perspectives that shape our understanding of research. McLeod (2001,p.3) comments that qualitative research *"is a process of careful, rigorous inquiry into aspects of the social world"*. He adds that this approach can produce new forms of knowing. Such knowledge is generated by taking a category of person who is of interest to a professional group, *"and seeks to describe, analyse and interpret the world view, experiences and language of a sample of people who represent that category"*. Walsh (1995) argues that a qualitative researcher does not merely apply a method, but works from within an approach.

The traditional approach of the positivists has been defined as follows: *"all knowledge is contained within the boundaries of science and only those questions answerable from the application of the scientific method can be approached"*. (Penguin Dictionary of Psychology, 1995). According to Maykut and Morehouse (1994) this has come to mean objective enquiry based on measurable variables and provable propositions. McLeod (1998) describes quantitative research as involving careful measurement of variables with the researcher taking a detached objective role. This approach uses tests, rating scales and self-report questionnaires and subjects the data to statistical analysis. Maykut and Morehouse (1994) describe the traditional paradigm as having an emphasis on objective enquiry, numbers, measurable variables, statistics and provable propositions. Reference is also made to Polanyi (1958) who has stated that the avowed purpose of the positivist sciences is to establish complete control over experience in terms of precise rules.

By contrast the qualitative approach is characterized in a completely different way by a close

and careful analysis of what persons say, what they do, and what is written by them, in order to discern patterns of meaning which emerge from this data. The phenomenological approach described by Maykut and Morehouse (1994) concentrates on the meaning events have for the persons being studied (Patton, 1991). They state that the phenomenological position sees the individual and his or her world as co-constituted, and quote Valle and King (1978) *"In the truest sense, the person is viewed as having no existence apart from the world, and the world as having no existence apart from the person"*. McLeod (1994) emphasises the holistic perspective in the reciprocal inter-relationships between phenomena and keeping the larger picture in view. He suggests a set of interlocking themes, strategies and values from the work of key writers such as Lincoln and Guba (1985), Patton (1990), and Stiles (1993), which he states are characteristic of most qualitative research. I will refer briefly to some of those which were consistent with my sense of openness regarding whatever emerges.

Katz (1987) refers to a process called *Epoche* which sums up this important aspect:

> *Epoche helps the researcher to investigate the phenomenon from a fresh and open view without prejudgement or imposing meaning too soon. This suspension of judgement is critical in phenomenological investigation and requires the setting aside of the researcher's personal viewpoint in order to see the experience for itself.* (36/7)

This concept feels compatible with the *"posture of indwelling"* advocated by Maykut and Morehouse (1994, p.25) who say that this means literally *"to live between, and within"*. They suggest that it is like walking a mile in the other person's shoes, or attempting to understand that person's viewpoint from an empathic rather than sympathetic position. Bogden and Taylor (1975, pp.13-14) describe empathy as the ability to reproduce in one's own mind the feeling, motives, and the thoughts behind the actions of others.

The positioning of qualitative researchers ensures that in trying to understand the subject and/or situation being studied they are not outside the process as impartial observers. Lincoln and Guba (1985, p.187) comment that *"Such a contextual inquiry demands a human instrument"*. They go on to say:

that the human instrument builds upon his or her tacit knowledge as much as if not more than upon propositional knowledge, and uses methods that are appropriate to humanly implemented inquiry; interviews, observations, document analysis, unobtrusive clues and the like.

The phenomenological philosophy contained within this approach to research emphasises the importance of conclusions emerging from an inductive process. Lincoln and Guba remark on the similarities of inductive data analysis to *'content analysis'*, a process which attempts to uncover embedded information and make it explicit. The two essential sub-processes, which they term *"unitizing"* and *"categorizing"*, will be discussed later.

Having looked carefully at both quantitative and qualitative paradigms it seemed clear that the latter would be the most appropriate, both from the philosophical and practical aspects for my purposes. The outcomes from my research depend on the participation of five counsellors being interviewed in depth, the focus being upon the impact on them of their experiences, and the discovery of patterns of meaning that have emerged that are as close as possible to the participants' original experiencing.

Research Sample

Care is needed in qualitative research in selecting participants based on the possibility that each will expand the variability of the sample. This is emphasised by Maykut and Morehouse (1994, p.45) who argue that purposive sampling increases the likelihood that variability, common in any social phenomenon, will be represented in the data. This is in contrast to random sampling which attempts to achieve variation by using large sample size. I selected purposive sampling as the most suitable method having regard to the content, size and focus of the study.

To provide meaningful variability from a relatively small, specialised, and highly sensitive area of counselling activity I believed I needed to find counsellors who were qualified to Diploma level and having at least three years post diploma experience. They would need to have a practice background of working with survivors suffering with mental illness arising

from abuse. I hoped to locate at least five female and two male counsellors from differing working environments from whom to select four or perhaps five participants. In setting these basic requirements I relied on my own experience of the intensive nature and length of time such relationships seemed to require.

Very important also was the need to meet the ethical requirements of confidentiality, personal safety by the availability of professional counselling support, if needed, and supervision. Ethical matters such as informed consent, confidentiality, trust, support and safety were discussed in detail with each participant. (See appendix).

Access

Being conscious of the constraints on personal time, domestic and financial limitations when planning the how, when and where of my research programme, I searched for participants in my adjacent counties of Cheshire, Staffordshire, Derbyshire and Lancashire, and also in North Wales. This proved to be sufficient. My need was to gain access to the widest possible range of experience within a small sample. I wrote to the management of the General Psychological Services departments of an NHS Primary Care Trust and two teaching hospitals, and to four well established charities who either specialised in counselling survivors or who worked with clients having problems of mental illness frequently resulting from sexual abuse in childhood. I asked if they would co-operate by requesting expressions of interest from suitably qualified and experienced counsellors on their staff, and I enclosed a small poster setting out the purpose of my research. I wrote to each volunteer giving more details and enclosed a brief questionnaire asking for basic information about training and experience, and asking whether the counsellor was willing to be interviewed. I was exceedingly fortunate in receiving offers of help from five very experienced counsellors and was able to make a final selection. Unfortunately I was unable to find a male volunteer. (Copies of typical letters and the poster are included in the appendices.)

Data Collection

Blaxter, Hughes and Tight (2001, p.42-3) make the suggestion of using a pilot interview to try out the methods the researcher has in mind. I found this exercise of considerable benefit both from the point of view of timing, and most particularly of my own participation. I was assisted in this by a very experienced and wise counsellor who had at one time been my supervisor. Amongst several gems of advice she told me that I said too much, and to let my interviewees do the talking! I made a number of amendments to my guide, and was able with advantage, to tighten up my approach.

Each of the five counsellors was contacted by telephone, and after discussing matters such as informed consent and the general format of the interview, we arranged a convenient time and place for meeting together. I indicated that I wished to use a semi-structured approach and intended providing a simple guide to enable me to keep our discussion reasonably within the research focus. The guide would be discussed briefly before the recording started in order to provide the interviewee with some understanding of the focus and content of the process. The interviews were intended to last about one hour, and would be preceded by a short exchange of personal information in order to feel at ease and get to know one another. I mentioned that the interviews would be recorded and transcribed as quickly as possible afterwards, and of my intention to send the participant a copy of the transcription in order that any mistakes on my part could be rectified, and thus the authenticity of the transcription could be verified.

Each interview started as planned with a short period of informality and explanation. Before starting the recording I produced a form of consent which was discussed and signed by both of us. This was acknowledged at the start of each interview on the tape. The consent form confirmed details of the study, gave my personal details, named my research supervisor, and made clear that the interviewee could withdraw at any time. (A copy is attached in appendix

letter).

The first stage of each discussion covered aspects of training and general experience. The nature of the subject of the research was illustrated by very painful and stressful disclosures. Each counsellor was extremely open and honest in recalling, without in any way breaching client confidentiality, powerful examples , taken from different stages of their careers, of the traumas suffered by their clients. We were able to discuss how these experiences had affected their self-awareness, their conceptualisation of their role as counsellors, and the longer term impact on their personal beliefs. Important matters were disclosed affecting feelings about their self-care, and personal security, and safety in their domestic and social activities.

All of the interviews exceeded the time limits I had cautiously set. The depth of the subject matter and my own empathic responses engendered feelings in me, which were fully confirmed after the recordings finished, that it was very important to complete the reliving of these experiences. The cathartic effect was a release of and a relief from strong tensions. After each recording had finished I attempted to express my gratitude. Each counsellor thanked me for providing what was variously described as a rare opportunity to share some almost unspeakable experiences, and to talk in an atmosphere of safety about deeply hidden emotions.

It was important that sufficient time was allowed between interviews to complete the process of transcription outlined above. Thus began the more detailed process of immersing myself in what was now my raw data and using the experience to advantage in succeeding interviews.

Data Analysis

I have used the *Constant Comparative Method* of data analysis, as described by Maykut and Morehouse (1994, pp.126-147), and Strauss and Corbin (1998, 2nd ed, pp.78, 93-9) to provide a rigorous basis for developing propositional statements derived inductively from and

grounded in the data. This approach was first developed in the 1960s by the American sociologists Glaser and Strauss (1967), and important aspects dealing with procedural details were later suggested by Lincoln and Guba (1985). This method of data analysis is illustrated by Maykut and Morehouse (1994, p. 135) as follows:

Inductive category coding and
simultaneous comparing of units of meaning
across categories
1

Refinement of categories
1

Exploration of relationships and patterns
across categories
1

Integration of data yielding an understanding of
people and settings being studied

Each interview was transcribed on completion and a copy sent to the counsellor concerned requesting verification of its accuracy. There were a few places on each tape when either voice levels dropped, or the speed of the words briefly but rapidly increased. I drew attention to this and welcomed any corrections thought necessary. The five corrected transcriptions then became my raw data. I decided to make three copies of each transcription of which one copy was printed on coloured paper. This copy was to be used for dissection at a later stage.

Lincoln and Guba (1985, pp.344-6) describe the next step as unitising, by which they mean the identification of *"units of information that will, sooner or later , serve as the basis for defining categories"*. At this stage it was most important to keep the focus of the research clearly and constantly in mind. Strauss and Corbin (1998, p.110) stress the importance of opening up the text to *"expose the thoughts, ideas, and meanings contained therein"*. This required me to immerse myself in the data. To do this I carefully read through the coloured copy of each transcription and drew lines across each page indicating the separation between differing units of meaning. Coffey and Atkinson (1996, p.26) advise that in order to organise,

manage, and retrieve the most meaningful parts of my data it is necessary at this point to ensure that each unit is appropriately coded. They go on to say that codes form an important link between locations in the data, and sets of concepts or ideas. Seidel and Kelle (1995, p.52) are quoted as stating:

> *codes represent the decisive link between the original 'raw data', that is , the textual material such as interview transcripts or field notes, on the one hand and the researcher's theoretical concepts on the other.*

The different colour of the paper used for individual transcripts gave a visual identity, and a capital letter signifying the participant was added together with a page number. This would enable me to find the data source quite quickly at a later stage if, for example, I needed to refer to the context of the unit.

Each transcription was cut apart and classified into discrete units of meaning. These were examined, compared with other units, and those appearing to have a conceptual similarity or with related properties and dimensions, were labelled and grouped together into provisional categories and sub-categories. This process produced a large number of pieces of paper of differing sizes. By putting the discrete elements into A4 punched pockets I was able to maintain some semblance of order. I used the system of 8"x 5" index cards recommended by Maykut and Morehouse (1994, p. 129) to describe in a word or short sentence the substance of the contents of the grouping, and put the card inside the appropriate pocket.

Lincoln and Guba (1985, p.347) describe the tasks of categorizing in this way:

> *to bring together into provisional categories those cards that apparently relate to the same content; to devise rules that describe category properties and that can, ultimately, be used to justify the inclusion of each card that remains to the category as well as provide a basis for later tests of replicability; and to render the category set internally consistent.*

The process of 'bringing together' required me to engross myself in further comparison and reading of the raw data. Strauss and Corbin (1988) accept that conceptualising data requires some degree of interpretation, and is a form of deduction. They make this important comment:

> *whenever we conceptualize data... we are interpreting to some degree. To us, an interpretation is a form of deduction. We are deducing what is going on based on data but also based on our reading of that data along with our assumptions about the nature of life, the literature that we carry in our heads, and the discussions that we have with our colleagues* (p.136-7).

Strauss and Corbin (1988, p.137) *"recognize the human element in analysis and the potential for possible distortion of meaning.* They suggest that the validation of interpretations should be through *"constantly comparing one piece of data to another."* From this process of comparison, and by having regard to the context of the data, a conceptual name or label was given to each card. Cards that appeared to have a similar conceptual relationship were brought together forming various discrete groupings of data. From my preliminary analysis of these groupings there emerged the provisional categories and sub-categories which were analysed under the following labels:

- **Counsellors' experience of empathic working.**
- **Changes in personal feelings and attitudes resulting from their work.**
- **The impact on counsellors of exceeding their emotional and physical limitations.**
- **Counsellors' need of support.**
- **Counsellors' preparation.**
- **Miscellaneous.**

Validity and Trustworthiness of the Research

McLeod (2001) comments that the 'findings' of a qualitative study are the result of the active personal engagement of the researcher with the phenomena of interest. He argues that what is produced will be influenced to some extent by the researcher's approach, and that the experience and identity of the researcher always influence the 'findings' that are produced. I acknowledge that during the interviews there were occasions when what I was hearing resonated with aspects of my own experiences. On reflection, I believe that this is an important part of my process and direct involvement in the qualitative research paradigm.

McLeods' (2001, p.72) recommendation, which I have followed, is that

> *3. The researcher does not make any attempt to review the literature in advance of collecting data. The aim is to approach the phenomenon with an open mind, so that themes and categories 'emerge' from it rather than being imposed on it.*

At the stage when I had completed the amended transcriptions I immersed myself in an intensive study of the background literature. This considerably enhanced my understanding of the implications of what the counsellors were telling me in addition to being an enriching experience. Although I was at times stimulated to compare the interviewee's experiences with my own I feel that any limitation thus caused has been more than offset by a deeper comprehension of the phenomena. I believe also that it has helped me to reflect closely in my propositions the outcomes from the data.

Although small in scale, the study has examined the impact on the counsellor of important aspects of counselling which could affect them when working with severely distressed, emotionally damaged, and often traumatised clients. My interest in this subject arose naturally from my professional work with the mental health charity MIND, where a substantial proportion of my clients had underlying problems stemming from abuse in childhood. I have endeavoured to bring transparency to my research, while trying at all times to keep my counselling experience to the back of my mind. I acknowledge that it is possible that some bias could have crept in, for example in the wording of a question.

I have attempted to produce a logical and straight forward audit trail. This document is included in the appendix. While it can be accepted that replication of the method and process of another project, set up in a similar way, might arrive at similar conclusions, it will be appreciated that this study is dependent on data provided by five counsellors, all uniquely different, and at a particular point in time. It seems relevant, in this context, to mention that the research design used here is emergent and the outcomes rely on this data.

Ethical Considerations

The British Association for Counselling and Psychotherapy (2002) requires *"rigorous attentiveness to the quality and integrity"* of research and of the dissemination of the results. The rights of all research participants should be carefully considered and protected, and research methods used should comply with standards of good practice.

The research ethics relating to the counselling process described by McLeod (1994, p.165) are derived from *"the much larger field of moral philosophy."* He comments that writers discussing applied disciplines such as medicine and counselling (Beauchamp and Childress, 1979; Kitchener, 1984) have tended to focus on a small set of basic ethical principles such as beneficence, nonmaleficence, autonomy, and fidelity.

McLeod (1999, p.82) draws attention to what he describes as the *"main procedures that are used to ensure ethical standards"*. These are informed consent, confidentiality, and avoidance of harm. The purpose of the study was explained in detail to each participant and formalised. The form of consent included the right of the participant to withdraw at any time, and provided my personal details and the name and location of my research supervisor. At the commencement of each recording the counsellor was asked if she was satisfied with the form of consent, and their confirmation of their signed agreement recorded. Confidentiality and the use and disposal of data was described on the form, together with the verification of the transcript. This has been strictly adhered to.

Care was taken to ensure the safety of the interviewees by seeking their assurances that they had access to professional supervision and the availability of personal counselling if needed.

At the stage of selecting participants I was satisfied that each was suitably qualified and experienced for the purposes of the study. The identity of the counsellors providing data has been disguised to protect them and their environmental context.

Limitations of the Study

McLeod (1999, p.86) makes the significant comment that *"No research study ever proves anything in itself. The best that can be done is to add another fragment to the mosaic of previous research on the topic".*

This is a small scale study examining a sensitive and difficult area of counselling. It has been necessary to work within my personal limitations of time, expense, and domestic situation. I accept that the study is also limited by the methods I have used and the size and variability of the sample I have chosen to research. I have found a paucity of research covering the subject of this study. I have been able to make insightful connections with the impact of trauma on therapists in other unrelated spheres, for example the research by Black, Irving, and Weinreich (2000) into the effects of vicarious traumatisation on counsellors working with survivors of the Omagh bomb.

The study does not set out to propound new theories. It examines the impact of counselling practices on a small number of experienced therapists exposed to lengthy engagements with severely distressed and emotionally damaged victims, survivors of childhood sexual abuse. In the process of this examination a number of significant lessons have emerged for me which may have meaning for other professionals working in this field.

Chapter Four

PRESENTATION OF DATA

This chapter will identify important comments made by the counsellors and included in the data which link into the appropriate category labels used in the previous chapter. It will describe the process leading to the formulation of the outcome propositions.

All participants will be referred to by a pseudonym. Details of their statements may have been modified in some instances to protect confidentiality.

Counsellors' Experience of Empathic Working

The empathic approach to victims of traumatic experiences requires the therapist to engage at a very deep level in understanding the client's reality. Sensitive observation and understanding of the client's emotions, feelings and meanings, during the course of lengthy and very distressing narrations of traumatic and almost unspeakable childhood experiences can provide the counsellor with a deep insight into the lived experience. Sally commented that *"what I've learned over the years is that it is very important to be able to experience the trauma as though it's at first hand, because actually it is a direct experience of their experiences and their result, the exact experience that the client has relived. It's also really important for me to be able to hold on to me to see that, to be able to be there as well for the client, rather than to be so caught up in the client's experience that I'm unable to take the whole thing in hand and help her safely over it."* Sally admitted that at an earlier stage she was probably *"over empathic and that caused me to lose myself. I hang on to myself now by using far more cognizance and reason. Maybe stopping the client if their material is overwhelming, and congruently feeding back that what they are saying is overwhelming. Now I realise that that can help the client to identify their own feelings of being overwhelmed."*

Joan put her experience rather differently. She described empathy as *"particularly difficult."* She said *"I think we offer various levels of empathy. I think when we are whole, good, and*

strong we are probably much more empathic than if we are slightly damaged ourselves. At times we are very empathic with somebody, but we are not the client and not in that place. So I can be working with somebody and be very intense, it's like everything else has gone, this is our world, these two people in this room with a strong connection. But I can walk out of that room, and while it may take me some time, especially if the session has been very distressing, but I can let go of it, and I can go back to the next client and my life and let go."

Bess commented *"When I have really engaged empathically... especially in that form of working, because it's about trust and safety, once that process is really there, then the vicarious traumatisation or the impact is felt. I think that there are lots of things to be aware of."*

Sally spoke movingly about a client she had worked with for over two years, who *"had been horrifically abused physically, sexually and emotionally.* She thought it was the most extreme case she had ever counselled, with lots of issues about attachment, and horrific situations that he was exposed to that played havoc with his capacity to function. She described her reliance on the core conditions and her conclusion that empathy, and certainly deep empathy is not always the most appropriate way to go. When her client needed to revert *"to go back and back and back, he would actively regress... I was able to stay with him, and talk to him, say something back to him. But the more empathic I was with him, and certainly the more empathic I was in his regressed state, the more it encouraged him to remain regressed and keep going back to that regressed place."*

Changes in Personal Feelings and Attitudes Resulting From Their Work

It was clear from the comments of the participants that the impact on their lives of working in the ways described above had both positive and negative implications. Joan described the positive side of her work *"as very satisfying. There are thrilling moments, and there are exciting moments. Being able to watch damaged women grow from very low self-esteem to*

regaining control of their lives is an amazing thing to be part of. I think we have to value that ourselves, otherwise we are not going to be any good to ourselves or anybody else for that matter." She said she has a lot of support from home and has developed other interests completely different from her work.

Sally felt that the impact of her work *"strengthened who I was as a person. Perhaps the biggest influence it has had on me is that I no longer feel that I have any right to judge anyone under any circumstances, and I feel that has made me so much more effective. . There's a huge debt of gratitude to my clients, and to this client in particular, who did take me to the edge and helped me to look at myself, and without whom there is no way I could function in the way I am now.*

Joan remarked on a negative aspect that was very distressing for her *"that we've known about child abuse and violence towards women now for a lot of years, and the process of change is very , very slow."* She mentioned the difficulties with clients who can overwhelm. She said "if *we have one client who is overwhelming we can cope. If we have two or three clients that are overwhelming then it starts to become difficult because they absorb so much of our resources and drain your energy tremendously.* She made another important point, *"about the impact on some therapist's sexuality and their sexual lives when you are continually hearing about damaging sexual contact. How do you feel about your own sexual contact, in your relationships, with your children, how frightened are you for your children when they are young, how will they be when they start their own sexual relationships?"*

Carol was certain that her work had made her *"a very protective mother."* When her children were out playing *"I would always know where they were, and was horrified with other parents who didn't know. The kids thought I was being over protective, although they wouldn't say that now. I wanted to know exactly where they were going and what time they would be back."* She had driven miles as a 'taxi' to save them walking home late. This still

goes on. *"My daughter 's eighteen, if it's late she knows she needs to keep me informed to keep me from worrying. I don't watch sex, particularly sexual violence on TV. At night the last thing I do is to walk the dog. I take my alarm and mobile phone, I wouldn't go out without them."*

Sally, commenting on the negative side said: "*The other big impact is that I've been made to feel really unsafe.* Turning to a different point she said " *So I think there is a definite limit to the cases I take, and I think if I exceeded that limit I might fall short at times of what I need to provide."*

The Impact on Counsellors of Exceeding Their Emotional and Physical Limitations

During the course of my research interviews I listened to many horrific examples of therapists' experiences and the impact this had on them. Space permits reference to only a few examples. Carol describes how she *"hit the point of burn-out."* It is fair to say that this situation occurred over ten years ago when there was an increasing awareness of the urgent need to deal with survivors of childhood sexual abuse. It was also a time when there were far fewer trained and experienced therapists capable of dealing with survivors. Carol, a Registered Mental Nurse, had reached a position where others were passing abuse referrals to her, and management was questioning her case load. On one occasion a very senior manager *"came to see me and said that we've had social services on the phone, can you go out and see someone, they are absolutely desperate, and I'm saying I can't do any more. I was exhausted. The case was awful, a dreadful case,"* Carol eventually agreed to try. She went on *" It was a Thursday night and I got home quite exhausted... I phoned this lady to say really sorry but I can't come till tomorrow. She just burst into tears on the phone and sobbed and said "but they have taken my sons away, they have locked my husband up, I'm here on my own, I don't know what's going on in my life this is absolutely dreadful."* Carol just said OK. I'll see you in an hour.

Next morning when presenting the state of her case load to her services manager she *"fell to pieces and sobbed and sobbed for hours."* Her organisation took responsibility for what had happened to her providing specialist supervision and holiday time away. They acknowledged that it had taken her breakdown to make them realise the amount of abuse she was dealing with and the amount of pressure that was putting on her. Carol said she had been *"taught a really big lesson about how many referrals you can see in a day, how many new referrals you see in a week actually."* Drawing attention to her experience she said that *"it wasn't the story, it was the first story that counts because with that one you get the emotion, and the next time you see someone you are going to get the further story as before but you are ready for it."*

Sally was quoted above referring to a client she had worked with for over two years. She reached a point when she was unable to continue. Describing her mental state she said *"But in your mind are the experiences that I was having with him, the experience of intense fear and actual terror. It was too much. I wasn't able to hold on to myself. I clearly remember once, because it was on a Friday evening, of being on my own (and there were a number of occasions) when I was putting the milk bottles out, and I would be afraid that he would be on the road. That was one of the things that he did in his life, not to stalk, but to be around. I was afraid lots of the time, and I did have dreams which involved him hurting me. So it wasn't his material particularly. I guess I had so identified with his stuff that it was about me not him. I took it to supervision and I felt unheard in supervision. I think that's part of the process because I wasn't unheard. What was being unheard was that he might kill me. I wasn't afraid of him hurting me, but that he would kill me."* Sally spoke to a psychiatrist who said that he felt she was in grave danger. She went on to say *"that business of the danger being confirmed, it was hugely important to me, the fact that that was the reality of the situation. The importance of saying yes when we are at risk is just enormous."* Sally felt that she was "*hugely supported.*" Her supervisor made sure that she was always in the building

when seeing this client, and on occasions would position herself quite close to the door. Sally had extra supervision, and if she needed supervision immediately after a session it was available to her. By agreement with her client she *"took time out"* and he agreed that he would take time out as well.

Sally stressed that *"for me it's about the relationship with the client. In this case it's about me and this client. What's happening to me is part of my process with this client. It was really important for this client that I suffered in that way. Not that he wanted to hurt me, that was his only way of communicating. But I don't see vicarious traumatisation as being something that sits on me as a counsellor. It feels like it's an integral part of that process."*

Counsellors' Need of Support

The importance of support was stressed by all the interviewees. Support came in many ways and particularly in the management of case-loads. Mary acknowledged that at times *"we didn't have enough counsellors."* She felt very pressured and uncomfortable *"that anybody should be waiting, because whatever the issue is, when you reach a point when you are ready to talk about it you need to then. This is even more so with abuse because of the shame and embarrassment and all that goes with it that doesn't necessarily go with other issues that people bring."* Mary was encouraged to space clients better, and provide more time between sessions. She commented that to talk to her colleague allowed just enough of a safety valve.

Joan and the other interviewees used the term "dumping" for the facility for therapists to share their feelings with a supervisor or other trusted and experienced counsellor after a particularly stressful and painful session with a client. Joan said that within her organisation *"there has always been a culture of supporting one another in addition to supervision, and aware of confidentiality obviously, sharing with colleagues sometimes about dreadful things. Sometimes it's something good that you really want to share with somebody, and that's equally important, that sharing of movement, of something wonderful that's happened."*

All the counsellors had regular supervision. Several organisations provided group supervision in addition. Carol made the point that at times she *"might like to discuss an issue with her supervisor, but to be honest by the time I see him, unless something's happened in the last twenty four hours then it's dealt with. The philosophy here is that you deal with it now, don't go home with it. A number of people can be contacted.* Carol went on to describe one of many dreadful experiences when she needed to 'dump'. On this occasion she was unable to find anyone to talk with. She said *"I sat in a lay-bye and had a cry. My supervisor said "thank God, you are still human if you can do that", but yes, the importance of 'dumping' it is absolutely so valuable."*

There are important references to the critical involvement of supervision in the support of the counsellors concerned under other headings.

Counsellor Preparation

Basic training in counselling to diploma level was described as thorough and comprehensive. Further specialised and intensive training was needed and received by all participants in the early stages of their working with survivors, and continued intermittently. Sally remembered that she had had *"certainly over the first two years, very intense training. We looked at a variety of models, at the impact on the individual, particularly influences around dissociated processes."* Sally was influenced by the Kepner (1995) and his Healing Tasks Model, which she has adopted and amended to her own way of working.

Carol was an experienced Registered Mental Nurse (RMN) before she qualified as a counsellor. She recalled vividly her first disclosure from an adult survivor in her third year of counselling, and *"the feeling of being completely out of my depth, not being able to know what I was doing, or what to say. The client had such faith in me because I was a mental health nurse who had visited her.* When she attempted to remedy this on her university

course and to obtain training about childhood sexual abuse, Carol found that her *"tutors at that particular time hadn't come across adult survivors."* She commented that *"five years down the line they were teaching it on part of that same course."* Carol went on to obtain her M.Sc. She emphasised that *"the biggest part of my training comes from my patients. That is a learning experience on a daily basis. Patients' stories, moving on, and how they found ways of moving away from it."*

All the interviewees had been trained in the person-centred approach, and all had found that there were times when something more was needed. Carol gave an example when she said *"If I've got somebody who is trying to convince me that the person who has abused her is OK to be interested in her children, then that's obviously something I need to be challenging."*

Each of the interviewees acknowledged the crucial importance of building a trusting and safe relationship with their clients., and the significant part that empathy played in this. Joan said *"I think the person-centred approach forms the basis of our work, a very strong basis, but I don't think it's always enough. Sometimes clients come to us and say I don't want someone who just sits and listens to me, I want them to say something, I want feedback."* She went on to describe the feelings of isolation of women who have experienced sexual violence and abuse. *"They want information... that's not person-centred counselling... this is a big part of our work... as an example, what will happen if I go to the police? We are very clear that we don't give advice, but people can't make choices unless they have the information in front of them"*. Joan went on to say that "*sometimes counsellors will use other skills, rarely things like gestalt or cognitive behaviour, but occasionally those if the client wants to use those particular ways of working and the counsellor is skilled in their use."*

Mary in describing her agency training as very good, endorsed their emphasis on the use of language. She put the need of it as *"recognising a wide range of terminology and the ability to deal with that, and to make sure that we understood fully what was being presented to us*

in whatever shape or form it came. We needed to have the ability to work with the person using the language they were comfortable with... Other people on the course who came from extremely person-centred training courses found this very difficult." Her training also included *"an awful lot of role-play, and finding other ways of showing my empathy. I had to be willing to show it in real terms, on my face... and I let the tears well up in my eyes. I needed to be stopped and forced to think about how I would humble myself with somebody who had gone through the worst possible experience a child can go through, and carry the weight of that so often in complete silence for all those years."*

Bess expressed the feelings of all the interviewees when she said that a deeper understanding of transference and counter transference was essential. She said *"its very important to be aware of what belongs to me, what belongs to the client, what could be a transference, it's a minefield."* She had always found it to be important to be very grounded in this *"because the client can be off on a multitude of emotions."*

Sally recalled an experience involving her in *"huge counter transference. I had a huge response to my client and felt overwhelmed and completely disorientated. The client had a list of really traumatic issues that she was dealing with, many of which were in her very recent past, and others which were in the distant past. I found it very difficult to actually handle that. It was difficult to hang on to me, and very easy for me to be experiencing guilty feelings which were resonating with the depth of her despair and pain."*

Two interviewees disclosed that they had had personal experience of childhood sexual abuse. Bess commented *"the way children perceive things and the way adults do can be very different."* What she perceived as a child as love and affection, as an adult she came to realise *"that the adult was actually sexually abusing me. It was a shock to me to realise that."* She went on to describe her feelings later when working with survivors, *"It gave me a great insight from a personal perspective. This is what I've experienced all these years and*

now I'm experiencing this person. Being aware of my history enabled me to work more effectively because I was aware of what was going on and I was getting that support."

Having had what she described as a *"minor experience of being abused, and having had to deal with my family."* Mary learned that her younger sister had been abused by her brother. She felt that she had been able to find positives from very negative situations. She said *"I had been able to see how you could survive this absolutely catastrophic mess."* Mary only disclosed that she had been abused if her client asked her. She *"never went into detail. If they asked how I'd done, I would simply say that I had received counselling, found it very helpful, that I had managed to come through to the other side, and I believed it was possible for them to do so. They need somebody to tell them that that's possible."*

Outcome Propositions

These propositions are grounded in the data and have emerged through a process of inductive reasoning. The deriving of these concepts, their properties and dimensions has come from an intensive analysis of the data. This process enabled me to deduce tentative and coherent concepts and examine the relationships between them.

Reference has been made to the timing of my literature study in relation to the formulation of the following propositions. In each case I was able to study what the counsellors were saying; the context of their experiencing and the impact that occurred; and was able to draw out what seemed to me to be the lessons that I needed to learn. I accept that my intensive study of the literature immediately following the interviewing process helped me understand at a deeper level what was being said, and will to some extent have influenced my conclusions.

Taylor and Bogdon (1984, p.134) define a proposition as *"a general statement of fact grounded in the data"*, which I understand to mean a statement that represents the meanings grounded in the data. From my study of the data there have emerged five propositions. In the case of the first, fourth, and fifth propositions brief notes have been added drawing attention

to specific aspects of interest.

FIRST PROPOSITION

- **Counsellors working empathically with survivors of childhood sexual abuse experienced in varying degrees the intensity of that trauma.**

  a) The core conditions formed a crucial foundation with survivors in building a trusting and confidential relationship. There were situations when the person-centred approach was found to be insufficient and more cognitive and/or directive techniques were used.

  b) Counsellors found that using empathy was essential to their understanding of the clients' experiencing. When engaged in long term relationships at a deep level with severely damaged clients it could at times produce disturbing effects on the counsellor.

  c) Counsellors, at times, became overwhelmed with their clients' pain and found it helpful to both parties to acknowledge their distress.

SECOND PROPOSITION

- **The impact on counsellors engaged in long term empathic relationships with survivors of childhood sexual abuse often resulted in important changes in both their feelings about themselves at work, and in their attitudes and concerns in their domestic and social situations.**

THIRD PROPOSITION

- **When circumstances arose where the intensity of individual case loads was over-whelming, and appropriate support was either insufficient or not available, limits of physical and psychological endurance were breached and conditions of burn-out and vicarious traumatisation ensued. The impact on the counsellor led**

to an inability to face coming to work and was followed by periods of sick leave and rehabilitation.

FOURTH PROPOSITION

- **The experience of regular, sustained, empathic, and intensely emotional sessions with survivors requires the sensitive management of case loads, appropriate supervision and other forms of support.**

a) All of the counsellors acknowledged their need at times, following particularly stressful sessions, to engage in what they termed 'dumping.' This facility of being able to talk briefly about their feelings with a supervisor or other experienced and trusted colleague helped to release tensions and anxieties built up during the session. The positive encouragement of a supportive culture amongst counselling teams was also found very helpful.

b) Regular supervision with a supervisor experienced in working with survivors of childhood sexual abuse was regarded as an essential form of support by all the participants.

c) Lack of understanding of therapist emotional and physical exhaustion by line management, themselves under pressure from waiting lists, was sometimes a factor which restrained counsellors with full case loads from refusing to take on additional clients.

FIFTH PROPOSITION

- **In preparing to help clients who have suffered the trauma of childhood sexual abuse, counsellors needed and benefited from specific and intensive training.**

a) Training to diploma level provides a basic grounding in important aspects of counselling, but counsellors needed more specialised training to help survivors of

childhood sexual trauma. Counsellors continuously learned from their clients.

b) A deeper understanding of transference and counter transference issues was often found to be necessary when dealing with survivors' trauma.

c) Two counsellors who had themselves been sexually abused as children were convinced that these experiences had no negative effects on their work, but had helped their empathic understanding of their client's distress. Both found that limited disclosure of their own experience had encouraged clients to believe it was possible that they too could come through.

Chapter Five

ANALYSIS AND DISCUSSION ABOUT THE IMPLICATIONS OF THE OUTCOMES

The paucity of literature that examines the role and needs of the trauma therapist working with survivors of childhood sexual abuse is mentioned by Pearlman and Saakvitne (1995, p.1) who comment:

> *"to date only a handful of authors have written specifically about the counter transference issues faced by psychotherapists working with adult survivors of childhood sexual abuse and even fewer about the cumulative effects of such work upon the self of the therapist that we call vicarious traumatisation."*

This small qualitative study has examined the experiences of five counsellors, and has attempted to draw some conclusions from that research.

Proposition One

- **Counsellors working empathically with survivors of childhood sexual abuse experienced in varying degrees the intensity of that trauma.**

Rogers (1980, p.142) in defining empathy as a process, describes this facility as occurring when *"the therapist senses accurately the feelings and personal meanings that the client is experiencing and communicates this understanding to the client."* (1990, p. 136). In the context of this study the impact on the therapist of empathically 'sensing the feelings and personal meanings' of survivors of traumatic abuse, who are seriously emotionally damaged by their horrific and almost unspeakable experiences, was found to have had at times disturbing effects. In spite of these all the participants stressed the crucial need for the use of empathy as the foundation in building a trusting, understanding and confidential relationship in which the survivor felt safe to disclose their experiences and their suffering. It was also felt that at times empathetic understanding might be at such a deep level that the therapist was what Herman (2001, p.140) described as *"In the role of witness to atrocity,"* and while experiencing to a lesser degree the same terror, rage , and despair as the survivor, could at times be emotionally overwhelmed. Sally reached a stage of being terrified and in fear for her

life.

In discussing traumatic abuse Pearlman and Saakvitne (1995, p.296-7) suggest that empathy varies along two dimensions, one focusing on the cognitive understanding of how and what happened, the narrative account, and associated matters such as the aftermath. The second type of empathy is affective. The therapist feels some of the client's pain, her fear, rage and grief, together with a range of intense emotions arising from her experience. They argue that in addition the therapist will experience two time frames, past and present. The impact on the therapist is most likely to be deepest by the affective empathy of the abuse trauma in the client's childhood.

During the course of the research interviews I was privileged to hear details of some horrific client experiences as heard and narrated by the participants. All victims of childhood sexual, physical or psychological abuse experience in varying degrees intense feelings of helplessness, terror, shame, rage and despair. Each of the counsellors participating in the research was able to describe the impact on them when listening empathically to almost unspeakable cruelties narrated by their clients. These were situations in which as children the clients were horribly abused and shamefully exploited. At times it was overwhelming and needed all their experience, training, and the support of high quality supervision experienced in working with survivors of child abuse.

Proposition Two

- **The impact on counsellors engaged in long term empathetic relationships with survivors of childhood sexual abuse often resulted in important changes in both their feelings about themselves at work, and in their attitudes and concerns in their domestic and social situations.**

The study has revealed much about the impact on the therapist's attitudes to work, their feelings towards the safety of their children and their personal safety, and in a wider sense

their assumptions and reflections on both identity, view of the world and of matters spiritual.

Saakvitne and Pearlman (1996, p.26) state that *"Trauma always involves loss; after a trauma nothing is ever again the same."* They argue that trauma workers confront this reality every day. *"Trauma work assaults our self-protective beliefs about safety, control, predictability and protection."* Carol described her concerns about the safety of her children, and how these had grown over time. This instinctive worrying persists even though her daughter is now over eighteen years old. She made the interesting comment that when they were younger her children often laughed at her efforts to protect them. Now they accept the need for sensible measures for their security. Her experiences in counselling survivors have made her very aware of the risks to her own personal safety. Mary was unable to leave her daughter unattended in the presence of her father. Sally had found herself in situations where she felt terrified and feared for her life. Joan raised important matters relating to the impact on a therapist's sexuality. Their personal sexual relationships can be affected and concerns for their children raised. Coppenhall (1995, p.32) comments on how one counsellor whose *"listening to descriptions of sexually abusive experiences suffered by clients caused considerable stress upon the counsellor's sexuality generally, more specifically sexual expression within their own intimate adult consenting relationships. Appropriate acts of normal sexual behaviour became contaminated by the client's story."*

I listened to powerful statements about good and evil in the world. Each counsellor in different ways made it clear that working with survivors of child abuse had forced them to accept the existence of both men and women capable of extraordinary depths of cruelty and depravity. At the same time it was forcefully argued that there was plenty of evidence of the presence of people who were kind, caring, and willing to go to great lengths to help and show compassion to those in need. The reality of their worst experiences seemed to be more than offset by their beliefs in human goodness.

Time did not permit a lengthy discussion on spiritual matters. Joan said that she didn't have strong religious beliefs. Her thoughts were more about the individual responsibility we have for choices we all have to make as adults. Sally felt that her experiences had strengthened who she was as a person. She had touched the depths herself and in doing so it had made her feel that she had no right to judge anyone under any circumstances. Bess felt she was quite a spiritual person. She has developed her work expressively using music and objects creatively. She reflected on the importance to her of nurturing herself and sees this as part of her development as a person. If she feels spiritually well, then she is able to work more effectively.

Proposition Three

- **When circumstances arose where the intensity of individual case loads was overwhelming, and appropriate support was either insufficient or not available, limits of physical and psychological endurance were breached and conditions of burn-out and vicarious traumatisation ensued. The impact on the counsellor led to an inability to face coming to work and was followed by periods of sick leave and rehabilitation.**

Perhaps the most important lesson to emerge from this study is the need for even the most experienced and best prepared therapists to be constantly aware of the risks to their health of engagement in long term empathic relationships with survivors of childhood sexual abuse.

It has emerged from the study that the participants, who were very experienced and qualified, who regarded their training and support as good, and who were very aware of the need for self-care, that two of them became affected by vicarious traumatisation, and two by burn-out. Everett and Gallop (2001, p.294) argue that *"an urgent dimension to the issue of personal and professional self-care elevates it to an ethical responsibility."* They comment that trauma

professionals are exposed to specific dangers such as secondary trauma and vicarious traumatisation. Herman (2001, p.140) in her landmark study of trauma, states that:

> *"Trauma is contagious. In the role of witness to... atrocity, the therapist at times is emotionally overwhelmed. She experiences to a lesser degree, the same terror, rage, and despair as the patient. This phenomenon is known as 'traumatic counter-transference' or 'vicarious traumatisation'."*

Pearlman and Saakvitne (1995, p.295) have concluded that *"vicarious traumatisation is ineluctable for trauma therapists."* They state that therapists cannot do this work without experiencing assaults to their usual ways of viewing themselves, the world and other people.

Sally, describing her experiences with a long term client who had been *"horrifically abused as a child"*, was taken to the limits of her psychological endurance and reached a point where she felt there was no alternative but to temporarily stop the therapeutic process. There were many warning signs. Sally, a very experienced trauma counsellor, acknowledged that her supervisor went to extreme lengths in her support. She recognised the symptoms of her condition and was able to address them to the benefit of her client and herself. Pearlman and Saakvitne (1995, p.383) suggest that the recognition of vicarious traumatisation is an essential first step to self-protection. They add that understanding the contributing factors enables us better to address and minimise its negative effects, individually and organisationally.

The condition known as burnout is defined by Everett and Gallop (2001, p.306) as *"accumulated dissatisfaction with one's work and work environment. Burnout can occur in any job situation and is usually solved by a vacation or finding a new employer."* They argue that the main cause of burnout is stress as a result of too much work, work of the wrong sort, uncooperative colleagues, a poor work environment and authoritarian or rigid management. Carol suffered from the stress of her heavy case-load which culminated in burnout when she was pressurised to take on one extra client whose circumstances were desperate and when she was physically and emotionally exhausted.

Research has shown a correlation between a perceived lack of control over one's work and levels of burnout (Ackerley et al.,1988). Pearlman and MacIan (1994) found in a study of trauma therapists, that those working in clinic and hospital settings showed higher levels of distress than those in independent practice or multiple settings. The resulting frustrations feed into vicarious traumatisation.

It has also emerged that the 'duty of care', that all organisations and managements legally owe to those working for them in situations potentially dangerous to their health, is a matter for serious research. The House of Lords ruling in the case of *Barber v Somerset County Council* together with the judgement by the Court of Appeal in *Hatton v Sutherland,* suggest that there could be important implications both for employers, and those therapists engaged in long term engagements with trauma survivors. This matter is beyond the terms of the study but in my opinion is important enough to mention here.

Could the situations described above which led to 'burn-out' and vicarious traumatisation have been avoided? The therapists and those supporting them had an understanding of the risks to welfare and health, and of the contagious nature of trauma therapy. It seems clear that the intensity of a traumatised client's detailed presentations over a lengthy period may cause the building up of emotional fatigue in the therapist as damaging as casework overload. Awareness of the need to self-care is part of counsellor training. Constant awareness of the dangers to trauma therapists, and their vulnerability in circumstances which at times can be overwhelming may require the help of supervision that is very experienced in long term empathic work with survivors. This question suggests that further research could be helpful in determining the degree and quality of the support needed.

Proposition Four

- **The experience of regular, sustained, empathic, and intensely emotional sessions with survivors requires the sensitive management of case loads, appropriate**

supervision and other forms of support.

The issues that are brought to counselling cover an enormous range of emotional distress, intensity and disturbance dwelling in the minds and affecting the behaviours of our clients. It would seem, both from the literature and the results of this modest research, that working empathically and often continuously over long periods of time with abuse survivors, therapists need to be aware of the potential impact this can have, and ensure that they protect themselves.

All the participants referred to their needs to be properly supported, and particularly stressed the importance of having a supervisor experienced in working with survivors of child abuse. It was clear from the examples of the cases that were described that on many occasions the quality of this support was a crucial factor in maintaining the focus of the therapy. In addition to their regular supervision sessions all the participants benefited considerably from the ability to "dump". This aspect has been outlined above. The supportive culture encouraged by several organisations in a very pro-active way was also found to be of enormous help. At the finish of a particularly stressful session with a client a few minutes with an understanding colleague can help to ease away the tensions and assist in the grounding process for the next person. Sanderson (1995, p.243) argues in favour of counsellors having *"their own support network that they can turn to discuss and evaluate their counselling."* She also advocates having a supervisor who has some experience of working with child sexual abuse and its effects.

There are many difficulties in the allocation of case loads. Sensible advice is given by Briere (1989) who suggests that the counsellor should arrange the case load in such a way as not to consist exclusively of survivors, but to intersperse them with non-abused clients. He also argues for taking regular physical and mental breaks away from the counselling environment. It is unavoidably the therapist's responsibility to safeguard their safety and health. Levels of personal stress should be honestly assessed and taken to supervision, and if

necessary to management. This aspect of the study provides a painful example of the result of failure to do this, and links with the content of Proposition Three.

Proposition Five

- **In preparing to help clients who have suffered the trauma of childhood sexual abuse, counsellors needed and benefited from specific and intensive training.**

It is clear from the contributions of the interviewees that therapists working with trauma survivors, and particularly childhood sexual abuse, need comprehensive training and extensive preparation to be able to do this work. Saakvitne and Pearlman (1996, pp.17/8) refer to *"the personal cost of the work we do."* They go on to say *"The truth is that we all are profoundly changed by the work we do with survivors of trauma."*

The experiences described by the participants of this study reflect their reliance on the training received to diploma level. All emphasised the extent that this fell short of what was needed to accomplish the task of meeting the needs of clients seriously damaged by traumatic events. Specialised and intensive training varied from one agency to another and relied largely on the knowledge, experience and expertise of the counselling manager. The evidence given was that this training was very good, and together with the valuable learning gained in interactions with clients, formed the basis of the service given. It seems important that practitioners considering working with trauma abuse clients should have had a more broadly based experience of counselling, perhaps several years post diploma, before beginning the specialist training and preparation needed to do this arduous work. Carol, in her third year of counselling, admitted that when faced with her first client abuse disclosure that she felt completely out of her depth.

All participants reported persistent pressure in the demands from increasing numbers of adult survivors for help. Mary acknowledged that at times her organisation did not have enough counsellors. More trained therapists were needed to provide help. Therapists introduced to this

experience need intensive training and support, and their specialised needs and preparation for this difficult and emotionally demanding work should be highlighted and taken to a deeper and an appropriate level.

The experience of the five counsellors emphasised the importance of the relationship with the client. It was suggested that although the Person-Centred Approach formed the main basis of their working, there were times when directive, cognitive and other techniques were needed. A real engagement with the client was necessary which often included giving feedback and the provision of information. Joan made the important point that a therapist needed the necessary training and skills to enable these alternative techniques to be safely used.

There were various references to the need for a fuller understanding of counter transference. Jacobs (1999, p.133) comments that while some feelings may be triggered off directly from the relationship with a particular client, it is also possible that they may belong more appropriately to another part of the counsellor's life. The therapist's difficulties in entering the world of the client may be increased if there is a lack of awareness of unresolved personal psychological conflicts. This aspect is referred to by Clarkson (1995, p.92) who states:

> *"Since few of us fully resolve all our personal issues completely and permanently, it is important that we understand ourselves enough to be able to identify and counteract our own pathological patterns, especially counter transferential responses based on unresolved issues from our own past."*

She comments further (1995, p.62) when referring to the *"astonishing variety of contradictions, ambiguities, and connotational disputes."* Clarkson also notes that this is marked by a relative paucity of research. Herman (2001, p. 141) points out the risks to the therapist's own psychological health. She says that: *"Traumatic countertransference includes the entire range of the therapist's emotional reactions to the survivor and to the traumatic event itself."* Corey (1991, p.17) acknowledges that *"it is unrealistic to think that counsellors can completely rid themselves of any traces of counter-transference. But they can deal with these feelings in their*

own therapy and supervision sessions."

Transference and counter-transference issues will be present in varying degrees throughout the counselling relationship and particularly so when it is trauma based. Further instruction and a deeper understanding of these complex matters would seem to be an essential part of the preparation of the trauma therapist. The interviewees all stressed the importance of having the support of supervisors who are themselves experienced in the understanding of this important aspect. It also seems to point in the direction of a more integrated approach.

American research by Briere (1989) has estimated that at least 33 percent of female and 10 to 15 percent of male therapists have sexual abuse histories, and a much larger percentage has been victimised physically and emotionally in childhood. Other research (Pope & Feldman-Summers, 1992; Elliott & Guy, 1993) has suggested percentages close to these results.

It is not surprising perhaps that two out of my five interviewees were themselves survivors. Pearlman and Saakvitne (1995, p.175) comment that *"many survivors of childhood sexual abuse have developed heightened capacities to be attentive to the needs of others."* They add that such personal histories can make survivors well-suited to the role of therapist. They may have an acute sensitivity to the affects, needs, and unspoken defences of another survivor, and a highly developed capacity for empathy as well as a special appreciation of the arduous healing journey their clients have to face. Sanderson (1995, p.240) while stating similar very positive conclusions argues that there are some pitfalls, one is *"that abused counsellors may project their own unresolved issues and internalised fears on to the client."* A warning that there are also disadvantages which should be considered is given by Dolan (1991) who argues that survivor therapists may become trapped by the belief that they have to demonstrate at all times and to everyone that they are "over it". Hiding recurring symptoms, having flashbacks that are difficult to control, and just having bad days might lead to becoming guilt–ridden.

Mary and Bess showed a deep understanding of these aspects, and demonstrated this in their professional approach to their work. In our discourse I was aware that both were to some extent re-stimulated by painful memories. They were convinced that their own experiences considerably helped their empathic understanding of their client's issues, stressing that even limited disclosure of their own journey, when appropriate, provided a living proof of coming through that experience and this could give hope and belief to their clients. This view is supported by the comments of Gestalt counsellor Elizabeth Ross (2004, p.12) who says *"there's something powerful about seeing someone in front of you who has been through this. It's a living proof that there is a way out."* Her view is that the therapist can offer a sense of being understood that goes beyond empathy.

In the introduction I questioned the nature of the long term relationships with survivors. The study has revealed the considerable range of abuse that five experienced counsellors have been engaged with. Adult survivors, both male and female, have brought deeply distressing and painful accounts of assaults by perpetrators of both sexes. Many of these are almost unspeakable in their horror. Their complexity extends from a single traumatic sexual assault, to repeated abuse over a lengthy period of time; it encompasses the extreme pain of females abused in childhood by their mothers; the victimisation of boys who in addition to their struggle to find healing are *"confronted by accusations of latent homosexuality"* (Grubman-Black. 1990, p.7); and the hideous, brutal outrage suffered by survivors of organised child abuse. Most common is abuse by the father, mother or other close relative. From whatever cause the counsellor engages in forming a relationship with deeply distressed and damaged persons.

Chapter Six

SUMMARY AND CONCLUSIONS

What are the implications emerging from this research? Therapists working with adult survivors of childhood sexual abuse enter a relationship with persons who have suffered severe distress of a physical, emotional and spiritual nature. The therapist becomes involved at a deep empathic level with the havoc that such experiences leave behind. Horrendous stories, narrated by clients, of unimaginable cruelty cause changes to the counsellor's perception of humanity.

Although to me the spiritual dimensions of life are very important I found very little in the literature about spirituality. There was no space in this study to examine the value to a trauma therapist of such a discussion. In my experience sometimes severely distressed clients express a wish to talk about spiritual matters. This has often made an important contribution to their healing process. For the trauma therapist meditation and pursuits such as the enjoyment of nature, music, art and literature can be seen as examples of spirituality which can help to provide a balance of things peaceful and beautiful to offset the emotionally draining effects of continually hearing about the horrific and the unspeakable. This would seem to be a subject for future research. I have made reference to the need for research in other parts of this dissertation.

The answer to the question posed by the title of this research, would seem to be that the nature and complexity of the work involved will have an inevitable impact on the counsellor. Each counsellor is a unique being, and will bring their own personal strengths and weaknesses to their work. Some will have experienced abuse in childhood, and many will need to work through their own counter transference issues. The individual cases that are heard will differ in complexity and detail, but all will contain the pain and horror of the trauma that the client has

experienced. The impact will vary depending on the personality, experience and training of the therapist. The evidence from this, and the results of other research, from the literature, and my own experience, suggests that the impact on the counsellor of the sheer awfulness and intensity of the clients experience, particularly in long term empathic engagements, will result in changes in beliefs, attitudes, and behaviours both at work and in their domestic and social lives.

Saakvitne and Pearlman (1996, p.17) describe this in the introduction to their workbook on vicarious traumatisation as *"The truth is that we all are profoundly changed by the work we do with survivors of trauma"*. Evidence from the counsellors interviewed indicated changes in attitudes to the process and practice of counselling; the awareness of their experiences and the effects this had on self-care; a heightened awareness of the need for personal and family safety; and the realisation that the need for experienced supervision and support was crucially important. Throughout the study there has been a heavy emphasis on thorough preparation and training. Both in the literature and from the evidence of the interviewees it is clear that experienced support must be made available to the therapist, and that workloads should be sensibly controlled.

From the evidence of the participants relating to the focus of this study my conclusions are:

- That the counsellor must be made fully aware of the potential risks inherent in long term empathic involvement in hearing stories of horrific cruelty, emotional devastation, and betrayal of trust, and the impact this may have on their beliefs, social, spiritual and domestic life.

- That there is a serious need to ensure that work-loads are carefully and sensitively managed.

- That the therapist is fully supported by supervision that is experienced and aware of the

stresses and difficulties of this much needed but extremely difficult area of therapeutic work.

- That the counsellor should be specifically and intensively trained in the theory and practice of working with survivors of traumatic abuse, and properly prepared in understanding the need for self care including learning the techniques to protect mental health.

There are well understood ways of safeguarding trauma therapist's health and well-being. Awareness of the risks associated with empathy, which Figley (1995) suggests linked to emotional contagion are amongst the components that contribute to compassion fatigue, will be needed throughout all trauma counselling. Research by Pearlman and Saakvitne (1995, p.385-393), indicates the importance of recognising vicarious traumatisation as a *"sort of occupational hazard"* as an essential first step. They provide detailed suggestions focused on dealing with the problems of self-protection. This theme and a vital need to maintain awareness has been emphasised repeatedly and underpins the evidence given by the counsellors in this study.

I have been greatly encouraged by the openness and honesty of all those who have participated in what I believe to be my search for truth. It has been a huge privilege to get to know and to work with them, and I acknowledge my indebtedness and gratitude. They have taught me so much. Although the research experience included many painful moments there were many valued aspects which are now part of my practice, and which are being used in my work as a supervisor. I have also become increasingly aware of how much more there is to learn about myself, counselling in general, especially in the area of mental health, and working with survivors of childhood abuse in particular.

Everett and Gallop (2001, p.295) sum up my feelings accurately when they say *"Our job, as*

professional helpers, is to apply our knowledge and skills so that we can understand, as best we can, each client's unique situation and assist him or her to make changes".

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Appendix A

Diagnostic criteria for 309.81 Posttraumatic Stress Disorder

(American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* 1994, pp 427-429)

A. The person has been exposed to a traumatic event in which both of the following were

(1) the person experienced, witnessed, or was confronted with an event or events that involved avtual or threatened death or serious injury, or a threat to the physical integrity of self or others
(2) the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganised or agitated behaviour

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
(2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognisable content.
(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific re-enactment may occur.
(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
(2) efforts to avoid activities, places, or people that arouse recollections of the trauma
(3) inability to recall an important aspect of the trauma
(4) markedly diminished interest or participation in significant activities
(5) feeling of detachment or estrangement from others
(6) restricted range of affect (e.g., unable to have loving feelings)
(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilence
(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

Appendix B

Proposed diagnostic criteria for the syndrome that follows upon prolonged, repeated trauma. (Herman. 2001, p.119-121).

Complex Post-Traumatic Stress Disorder.

1. A history of subjection to totalitarian control over a prolonged period (months to years). Examples include hostages, prisoners of war, concentration-camp survivors, and survivors of some religious cults. Examples also include those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organised sexual exploitation.

2. Alterations in affect regulation, including
   - persistent dysphoria
   - chronic suicidal preoccupation
   - self-injury
   - explosive or extremely inhibited anger (may alternate)
   - compulsive or extremely inhibited sexuality (may alternate)

3. Alterations in consciousness, including
   - amnesia or hypermnesia for traumatic events
   - transient dissociative episodes
   - depersonalization/derealization
   - reliving experiences, either in the form of intrusive post-traumatic stress disorder or in the form of ruminative preoccupation

4. Alterations in self-perception, including
   - sense of helplessness or paralysis of initiative
   - shame, guilt, and self-blame
   - sense of defilement or stigma
   - sense of complete difference from others (may include sense of specialness, utter aloneness, belief no other person can understand, or nonhuman identity)

5. Alterations in perception of perpetrator, including
   - preoccupation with relationship with perpetrator (includes preoccupation with revenge)
   - unrealistic attribution of total power to perpetrator (caution: victim's assessment of power realities may be more realistic than clinician's)
   - idealization or paradoxical gratitude
   - sense of special or supernatural relationship
   - acceptance of belief system or rationalization of perpetrator

6. Alterations in relations with others, including
   - isolation and withdrawal
   - disruption in intimate relationships
   - repeated search for rescuer (may alternate with isolation and withdrawal)
   - persistent distrust
   - repeated failures of self-protection

7. Alterations in systems of meaning
    - loss of sustaining faith
    - sense of hopelessness and despair

Herman (2001, p.120) comments that *"As the concept of a complex traumatic syndrome has gained a wider recognition, it has been given several additional names. The working group for the diagnostic manual of the American Psychiatric Association has chosen the designation 'disorder of extreme stress not otherwise specified.' The International Classification of Diseases is considering a similar entity under the name 'personality change from catastrophic experience."*

Appendix C

Outline Audit Trail

1. Topic: The concept for this research arose directly from module HCM521 'Working with abuse'. It was also extremely relevant in connection with my professional work with the charity MIND.

2. Title: The title was discussed and agreed with my research supervisor, and confirmed by Dr Mintz, Programme Leader.

3. An important decision was taken at an early stage to make progress with the research interviews before attempting to develop and complete the literature review. This would ensure that the collection of the raw data and data analysis was not influenced unduly by the latter. (McLeod, 2001, p.72).

4. Research design and methodology: An analysis of the quantitative and qualitative paradigms indicated that the latter was the most appropriate to meet the purposes of of this study. The Constant Comparative Method of data analysis described by Strauss and Corbin (1990) and developed by Maykut & Morehouse (1994) was used.

5. Research sample: Purposive sampling was chosen as most likely to provide variability suitable for the focus, size and content of the study.

6, Access: The specialised nature of the study suggested a direct approach to a number of organisations employing counsellors whose work-load was mainly with trauma abuse survivors. I wrote requesting expressions of interest from suitably qualified and experienced counsellors in both public sector and established charities. It seemed sensible having regard to my available resources to restrict the search to adjacent counties.

7. Data collection: Beginning with a pilot interview the study moved to contacting five suitable counsellors and discussing convenient arrangements for recorded interviews. I wrote to each counsellor setting out in more detail the objects of the research, and enclosing a brief questionnaire requesting basic information on qualifications, context and setting of work, and experience of working with child abuse. I also asked about willingness to participate in a recorded interview. (See attached typical letters, form of consent, semi-structured interview guide, and questionnaire).

8. Data analysis: The *Constant Comparative Method* was used as being well suited to the requirements of the research. This included a methodical way of separating out and coding units of meaning so that constant comparison is possible leading to the emergence of different categories and patterns. The text describes the detailed use of this approach.

9. At that point when the emergent categories were becoming apparent and before the deductive stage leading to the presentation of the data and the outcome propositions, I decided to press ahead with my intensive reading of the literature. My reason for this was that in widening my learning as much as possible this would be beneficial in the

deepening of my understanding of the lessons resulting from the study and would help to underpin the outcomes.

10. On the completion of my literature research I attempted to thoroughly read through the dissertation at the stage reached as if it were a 'new document'. My purpose was to identify afresh the lessons I hoped to learn from a now deeper understanding of what the participants had been telling me. In this part of my process I found that those aspects which had hitherto been implicit could now be made explicit and resulted in the outcome propositions. Chapter six summarises the main arguments in support.

11. Validity and trustworthiness: See text.

12. Ethical considerations: The study had full regard to the requirements of The British Association for Counselling and Psychotherapy. Particular attention was given to informed consent, confidentiality, and avoidance of harm to those participating. (See attached details).

By following the details set out in this outline and perhaps setting up a similar study I would expect the results to be generally comparable. It should be understood however that whatever the context of their work, each counsellor brings an individual experience and personality to such a study at a particular point in time. It will also perhaps be of some assistance that this audit trail follows my research process and important aspects of my philosophy.

I accept the argument put forward by Strauss and Corbin (1998, p. 136/7) that in conceptualising the data there is a form of deduction. It follows that in attempting to understand what the participants were saying about and beyond their experiencing there will be some interplay between the data and my personal life and counselling experiences. I found that the constant comparisons between different pieces of data helped me to avoid possible distortions. By keeping my focus on what they were telling me I feel I was able to learn some important lessons about an extremely difficult area of therapy and the impact this has on the professionals attempting to provide help.

Appendix D

RESEARCH TITLE

A QUALITATIVE STUDY OF THE IMPACT ON THE COUNSELLOR OF ENGAGEMENT IN LONG TERM EMPATHIC COUNSELLING RELATIONSHIPS WITH SURVIVORS OF CHILDHOOD SEXUAL ABUSE.

Key words: **IMPACT ON THE COUNSELLOR**

LONG TERM

EMPATHIC RELATIONSHIPS

SURVIVORS

CHILDHOOD SEXUAL ABUSE

Appendix E

20th June 2003

Addressed to various agencies/organisations who may be prepared to approach possible interviewees known to have experience in this type of counselling work.

Dear

Re: Research for MA in Counselling Studies, at University College, Chester.

Title: **A qualitative study of the impact on the counsellor of engagement in long term empathic counselling relationships with survivors of childhood sexual abuse.**

I would appreciate very much a few moments of your time to read this brief description about the subject of my research into the effect their work has on counsellors who have regular and prolonged involvement in working with clients who are survivors of childhood sexual abuse. During my studies for an assignment entitled 'Working with Abuse' I found an extensive literature dealing with the many forms of abuse and describing the distress that survivors bring to counselling. In my counselling practice a high proportion of my clients at some stage disclose having been abused. Despite a diligent search I found a paucity, both in the literature and research, concerning the impact that prolonged and regular working with survivors has on the therapist. The subject for my research emerged from this.

My research will have full regard to the Ethical Framework for Good Practice in Counselling and Psychotherapy published by BACP (2002).

My research proposal is based on the use of a purposive sample to identify four or possibly five counsellors experienced in this work. In order to select for inclusion from the widest variability, I will send to any counsellor expressing an interest a brief questionnaire covering matters such as qualifications, length of time in practice, an indication of the degree of involvement in counselling survivors of childhood sexual abuse, and asking if he/she is willing to participate in a recorded interview. A covering letter will give details of the recording, confirmation of the accuracy of the transcription, confidentiality, the use of the recording as data, and final disposal of the tape. It will also refer to informed consent and Chester College's consent form.

I should be most grateful if you would pass this information to any counsellor likely to have had such experience. In case it may be of help I have designed and enclose a copy of a small poster which contains the substance of the above.

Yours sincerely

Howard Watkin

Encl: Small poster.

Appendix F

RESEARCH

RESEARCH FOR MA IN COUNSELLING STUDIES AT UNIVERSITY COLLEGE CHESTER

Title: A qualitative study of the impact on the counsellor of engagement in long term empathic counselling relationships with survivors of childhood sexual abuse.

An expression of interest to participate would be most welcome from any counsellor who has had regular and prolonged involvement in working with clients who are survivors of childhood sexual abuse. My research will have full regard to the Ethical Framework for Good Practice in Counselling and Psychotherapy published by BACP (2002).

My research proposal is based on the use of a purposive sample to identify four or possibly five counsellors experienced in this work. In order to select for inclusion from the widest variability, I will send to any counsellor expressing an interest a brief questionnaire covering such matters as qualifications, length of time in practice, an indication of the degree of involvement in counselling survivors of childhood sexual abuse, and asking if she/he is willing to participate in a recorded interview. A covering letter will give details of the recording, confirmation of the accuracy of the transcription, confidentiality, the use of the recording as data, and the final disposal of the tape. It will also refer to informed consent and the use of Chester College consent form.

In the first instance would you be kind enough to telephone me on
write to me at

Thank you

Howard Watkin

Appendix G

Date

Dear

Re: Research for MA in Counselling Studies, at University College, Chester.

Title: A qualitative study of the impact on the counsellor of engagement in long term empathic counselling relationships with survivors of childhood sexual abuse.

Thank you for expressing an interest in participating in my research into the effect their work has on counsellors who have regular and prolonged involvement in working with clients who are survivors of childhood sexual abuse. My research will have full regard to the Ethical Framework for Good Practice in Counselling and Psychotherapy published by British Association for Counselling and Psychotherapy (2002).

I would appreciate your completion of the enclosed brief questionnaire which will provide me with basic information from which to approach four, possibly five, counsellors experienced in this work. A summary of data from questionnaires may be included in my dissertation, a copy of which will be retained and deposited for safe keeping in the Chester College Library. Data collected at each stage will be confidential.

The final question on the brief questionnaire enquires if you would be willing to participate in an interview. I will need to record the interview, lasting approximately 45-60 minutes, on audio tape. As soon as I have completed transcribing the tape I will send a copy of the transcription for your confirmation that it accurately reflects our discussion. It will then form part of the data to be analysed by me with other recorded interviews. The tape will be heard only by me or my research supervisor, and on completion of the formalities of the degree will be destroyed. It is a requirement of Chester College that your 'informed consent' has been given before we can proceed and I will bring copies of their consent form with me to the interview.

Yours sincerely,

HOWARD WATKIN

Encl., SAE.

Appendix H

BRIEF QUESTIONNAIRE

NAME Age M/F
Contact Address Telephone number

1. What are your qualifications? Year

2. Please indicate membership of professional associations

3. Are you currently in practice as a counsellor? Yes/No

4. How long have you been in practice?

5. Please briefly describe the context and setting of your counselling work

6. What is your theoretical orientation?

7. Do you have regular and ongoing counselling supervision? Yes/No

8. Do you have access to personal counselling support? Yes/No

9. Are you involved regularly with clients who are survivors of childhood sexual abuse?

10. What proportion of your caseload would this averagely represent?

11. Would you be willing to participate in an interview? Yes/No

Thank you for completing and returning this questionnaire.

Howard Watkin.

Appendix I

RESEARCH

INFORMED CONSENT

The study will be carried out by Howard Ernest Watkin.
Contact address and telephone number:

The study will be supervised by Anne Le'Surf, MA, University College, Chester.

Title: A qualitative study of the impact on the counsellor of engagement in long term empathic counselling relationships with survivors of childhood sexual abuse.

Aims of study: During my studies I reached the conclusion that the paucity of relevant literature and research in this sensitive and distressing area of therapist involvement might provide me with an opportunity to focus on a matter of personal concern, and one which could be of interest to others. My aim would be to develop a deeper insight into the experiencing of the phenomenon known as "traumatic countertransference" or "vicarious traumatization" (McCann and Pearlmen, 1990) by counsellors working with survivors of childhood sexual abuse with the objective of gaining a clear understanding of their coping mechanisms.

Participents will have had long term empathic counselling relationships in this sphere of work with regular professional supervision and access to personal counselling when needed.

The research will have full regard to the Ethical Framework for Good Practice in Counselling and Psychotherapy published by British Association for Counselling And Psychotherapy (2002). Participation in the form of an interview will provide data which will be analysed by me. Data and the contents of the audio tape will be seen and/or heard only by me or my research supervisor and will be confidential at all stages. A transcript of the tape will be sent to you for your verification of its accuracy and will be destroyed when the formalities of the degree are complete.

You have the right to withdraw from the study at any time.

Signature
Date

Signature
Date

Appendix 'J'

9th July 2003

SEMI-STRUCTURED INTERVIEW - GUIDE

Establishing a trusting and warm relationship in which sensitive, distressing and confidential matters can be discussed is of prime importance. I envisage the interview in two sections. Before the recorded part begins I need to explain the purpose, scope and limitations of the research. Although this will have been discussed in our prior contacts, I feel that working through the concept will enable the interviewee to ask questions and clear any misconceptions or ethical concerns in advance of the recording.

Part one.

The first stage will begin with a concise statement explaining the aims of the research, and clarify any aspects raised by the interviewee. It would continue including the following:

- A brief description of the proceedings using a semi-structured approach, would include mention of the need to maintain emotional safety and ensure support is available if needed.

- Informed consent about permission to audio tape the interview. To be explained and the necessary Chester College forms signed.

- Limits of confidentiality and agreement of same, including disposal of the tape and methods of using data. Agreement that a copy of the transcript will be sent for interviewee's confirmation of accuracy and content.

- Explain the right to withdraw from the study at any time.

Part two.

The second stage will consist of the audio taped recording and will use the following general guide:

- **BRIEF STATEMENT SETTING OUT AIMS OF STUDY**
- **CONFIRM INFORMED CONSENT DISCUSSED AND FORMS SIGNED**
- **EXTENT OF INVOLVEMENT WITH SURVIVORS OF CHILDHOOD SEXUAL ABUSE. FOR HOW LONG, FREQUENCY, % OF CASE LOAD, NUMBERS, DURATION OF TREATMENTS, PRACTICE SETTING etc ?**
- **REFER TO QUESTIONNAIRE, ANY COMMENT ON HOW YOU CAME TO DO THIS KIND OF WORK, HOW WOULD YOU DESCRIBE YOUR APPROACH? WHAT SORT OF RELATIONSHIP? EXTENT OF USE OF EMPATHY?**
- **HAVE YOU HAD ANY ADVANCED TRAINING OR TRAINING SPECIFIC TO WORKING WIT SURVIVORS OF CHILDHOOD SEXUAL ABUSE? HAVE YOU DEVELOPED A THEORETICAL/PRACTICAL FRAMEWORK TO GUIDE YOU?**
- **COULD YOU COMMENT ON ANY POSITIVE AND/OR NEGATIVE ASPECTS THAT MAY HAVE AFFECTED YOU RESULTING FROM ENGAGEMENT IN LONG TERM EMPATHIC RELATIONSHIPS WITH SURVIVORS? HAS THIS CHANGED YOU IN ANY WAY?**
- **COULD YOU DESCRIBE ANY COPING/SELF CARE STRATEGIES YOU HAVE USED TO HELP YOU MANAGE YOUR WORK?**
- **CAN YOU SHARE YOUR VIEWS ABOUT SUPERVISION?**
- **DITTO PERSONAL COUNSELLING?**
- **IS THERE ANY WAY IN WHICH YOU MAKE SENSE OR FIND MEANING IN THIS WORK? IF SO COULD YOU SAY WHAT?**
- **IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD TO OUR DISCUSSION?**

I WOULD LIKE TO THANK YOU MOST SINCERELY FOR PARTICIPATING WITH ME IN THIS RESEARCH.