The Journey of Listening to Someone: Therapists' Meaning-Making of the Impact of Working with Sexual Abuse Survivor Groups

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Thesis Abstract

Introduction The topic of study is concerned with the impact that working with sexual abuse survivor groups has on therapists. The existing literature primarily utilises quantitative methodologies and is, on the whole, concerned with the negative impact of trauma work. Previous studies have suggested that qualitative research exploring the experiences of therapists working in this field would provide a richer understanding of the potential impacts. The methodological limitations and shortcomings of the existing research base are addressed, specifically the lack of research on group therapists.

Objectives This study aimed to provide a qualitative, phenomenological exploration of the impact that therapists state, working with sexual abuse survivor groups, has had on them.

Design Interpretative Phenomenological Analysis (IPA) was used to conduct an in-depth study of a small sample of group therapists.

Methods Multi-site ethics approval was gained to conduct the study within two local NHS trusts and an independent sector service. Therapists were selected using purposive sampling from these services. Semi-structured interviews were conducted with five therapists who ran groups for adult survivors of sexual abuse. Verbatim transcripts were analysed using IPA.

Results Two concurrent theme groups were described. Themes concerned with the impact that the work has on the therapists, were discussed under the headings 'Sense of Responsibility', 'Impact', 'Protecting and Maintaining Sense of Self', 'Contradictions in Narratives' and 'Evolving Impact'. Furthermore, findings related to the aspects of working within a group setting, were titled 'Unique Aspects of the Group Setting' and 'Group Milieu'.

Discussion Therapists did not ascribe to having 'positive' or 'negative' impacts, but seemed to simultaneously experience both, having created meaning for the impact of the work. Furthermore, in contradiction to previous literature, the therapists felt that working in a group setting had less potential to traumatise the facilitators. Implications for clinical practice and future research are discussed.

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Research Paper

The Journey of Listening to Someone: Therapists' Meaning-Making of the Impact of Working with Sexual Abuse Survivor Groups

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Abstract

Objectives Researchers, to date, have primarily used quantitative methodologies to explore the effects on therapists of working with sexual abuse survivors. This study aimed to provide a qualitative, phenomenological exploration of the experiences of group therapists working with sexual abuse survivors and the meaning they ascribe to these experiences.

Design Interpretative Phenomenological Analysis (IPA) was used to conduct an in-depth study of a small sample of group therapists.

Methods Semi-structured interviews were conducted with five therapists who ran groups for adult sexual abuse survivors. Verbatim transcriptions were analysed using IPA.

Results The four super-ordinate themes discussed are described under the headings 'Sense of Responsibility', 'Impact', 'Protecting and Maintaining Sense of Self' and 'Contradictions in Narratives'.

Conclusions The therapists in this study seemed to describe many impacts as a result of working with sexual abuse survivors. However, these impacts were not necessarily construed as negative. This has implications for the construct of vicarious traumatisation; to think about the meaning the individual creates for their experience of listening to trauma stories.

Introduction

Research has suggested that childhood sexual abuse can disrupt a person's beliefs about the world, and the meaning he or she ascribes to life (Pearlman & Saakvitne, 1995a). As a therapist, one has to offer to clients, a coherent sense of hope and faith in overcoming such experiences (Jenmorri, 2006). However, being faced with frequent stories of mankind's inflicted trauma, may well disturb our own sense of meaning. How do we, as therapists, maintain a sense of hope amidst such powerful stories of

despair? Literature suggests that therapists are, indeed, changed by this work. Pearlman (1999) described this process:

> Those who voluntarily engage empathically with survivors to help them restore the aftermath of psychological trauma open themselves to a deep personal transformation. This transformation includes personal growth, a deeper connection with both individuals and human experiences, and a greater awareness of all aspects of life. The darker side of the transformation includes changes in the self that parallel those experienced by [direct trauma] survivors themselves. (p. 51-52.)

Terms to describe this 'darker side' of transformation include 'burnout', 'secondary traumatic stress', 'compassion fatigue' 'traumatic countertransference' and 'vicarious trauma'. Pearlman and Mac Ian's (1990) term 'vicarious traumatisation' (VT) seems to best encapsulate these impacts, defined as "the cumulative transformative effect…It is a process through which the therapist's inner experience is negatively transformed through empathic engagement with clients' trauma material." (Pearlman & Saakvitne, 1995a, p.31). McCann and Pearlman's (1992) Constructivist Self-Development Theory suggests that vicarious trauma involves changes in a therapist's world view, spirituality, identity, and ability to maintain connection with others, as well as their fundamental psychological needs including trust, intimacy, control, esteem and safety.

'Symptoms' of VT can include changes in self and professional identity, beliefs about self and others, avoidance and persistent arousal, anger, sadness, rage, confusion, nightmares, sleeplessness, agitation and drowsiness (Pearlman & Saakvitne, 1995a; Carlier, Lamberts & Gerson,

2000; Sexton, 1999; O'Halloran & Linton, 2000). Steed and Downing (1998) also found that it is possible for a non-victim, through the process of listening to an explicit account, to develop an internal picture in their memory of the event discussed, and subsequently re-experience the event.

Quantitative research has also suggested that a therapist suffering from VT is more prone to anxiety, depression, physical ill health and an increased use of drugs or alcohol (Stamm, Varra, Pearlman & Giller, 2002). With regard to the implication for services, therapists experiencing VT are at a higher risk of making poor professional judgements than those not affected (Munroe, 1999; Pearlman & Saakvitne, 1995; Williams & Sommer, 1995).

However, as Pearlman's quote describes, therapists who expose themselves to clients' traumas can also undergo positive transformation, characterized by growth, deeper connection with others and increased awareness. Researchers have found evidence for the concept of 'posttraumatic growth', defined as "the experience of significant positive change arising from the struggle with a major life crisis" (Calhoun, Cann, Tedeschi & McMillan, 2000, p.521). Arnold, Calhoun, Tedeschi and Cann (2005) argued that similar psychological growth can occur following 'vicarious brushes with trauma'. Aspects of such growth for therapists have been found to include "increased appreciation for the resilience of the human spirit, the satisfaction of observing clients' growth and being a part of a healing process, personal growth, and spiritual well being" (Arnold, Calhoun, Tedeschi & Cann, 2005, p. 243).

Given these paradoxical reactions to exposure to clients' trauma, researchers have become interested in exploring the journey of therapists to, either the 'lighter', or 'darker', side of this personal transformation.

The existing research that has contributed to the discussions has been, in the majority, quantitative, utilising standardised psychometric

measures. To use such assessment tools, to measure the experiences of a therapist, limits the reporting of both positive and negative changes in that individual, to the predetermined categories recognised in the psychometric. Pearlman and Saakvitne (1995b) acknowledge that the existing psychometric measures of VT are limited and state "as yet the strongest assessment tool is our own ability to reflect on our experience." (p.165). Sabin-Farrell and Turpin (2003) argue that more qualitative research is needed to understand the actual experiences of therapists, rather than those prescribed by predefined categories.

This study employed an Interpretative Phenomenological Analysis approach (IPA); based in phenomenology or a 'contextual constructivist' epistemology (Madill et al., 2000). IPA is primarily concerned with how the participant experiences the world, rather than the truth of the reality. The objective of the analysis is to, through their account, obtain an insight into another person's thoughts and beliefs about a phenomenon. However, the IPA methodology takes the position that such experience is never directly accessible to the researcher. As a result the phenomenological analysis is always an *interpretation* of the participant's experience (Willig, 2008, p.57).

Utilising the IPA methodology, the paper aims to report the quality and texture of the experiences of these therapists working with sexual abuse survivor groups, and transparently demonstrate the interpreted meanings that the therapists ascribe to those experiences. . *(For further background see Extended Introduction).*

Method

Participants

Participants were identified from all the services in the local area, providing group support for sexual abuse survivors, including NHS trusts and a

charitable organisation. Five participants were purposively selected from a population of therapists who worked for these services.

The sample was all female therapists, four psychotherapists and one clinical psychologist, who ranged in age between 40 and 58 years. Their years of experience of working with clients with sexual abuse histories ranged from 14 to 25 years. All therapists had worked with both groups and individuals with sexual abuse histories. All names have been changed and identifying information removed, to safeguard confidentiality.

Multi-site ethics approval was gained from Cambridgeshire 1 Research Ethics Committee and the Institute of Work, Health and Organisations University Ethics Committee *(see Appendices A & B).*

Procedure

Managers of the identified services were contacted and informed of the purpose of the study. They were then asked to approach members of their staff for permission to be contacted by the researchers. From preliminary investigations it became clear that there was only one male therapist working with this client group, in the region. Therefore it was decided that in order to maintain participant confidentiality only female therapists would be asked to take part. A participant information sheet was sent to potential participants, with the relevant local details for staff support, should they find the interview at all distressing *(see Appendix D)*.

Those therapists that provided consent completed a demographic information sheet, and were interviewed using a semi-structured interview schedule *(see Appendices F & G)*. Interviews were all less than an hour in length, and were recorded using a digital audio recording device. A typist, not part of the research team, who had signed a confidentiality agreement, transcribed each interview, which were then checked for errors, and amended where necessary.

Interview Schedule

The focus of the interview was determined by the areas lacking in the current research base, specifically the therapist's experience of working with sexual abuse survivors in a group setting. An open question about the impact on the therapist was asked so as to flexibly allow the interviewee to bring to the interview the most pertinent issues for them. Questions broadly relating to issues of vicarious traumatisation, intrusive imagery, and vicarious posttraumatic growth were included. A question specifically aimed at considering the unique aspects of the group setting was asked, in case this had not been covered earlier in the interview. Prompter questions were developed in advance to provide direction if the interviewee could not provide sufficiently detailed answers.

The interview schedule was constructed with consideration of the existing literature, and in consultation with several members of the research team. The final questions were piloted on a therapist who had experience of working with sexual abuse survivors.

Analysis

An Interpretative Phenomenological Analysis (IPA) method was used to analyse the data (Smith & Osborn, 2003). IPA involves, in the first instance, reading and re-reading one transcribed interview. The left hand margin was used to note down any interesting, or significant amplifications, and contradictions in the narrative. Summaries, associations and other preliminary notes were also recorded. Once this was completed for an entire transcript, themes were noted in the right hand margin. These themes served to grasp the concept and essential quality of what was in the text. This was completed for each transcript, after which, the themes were listed and clustered with other similar themes, before being given appropriate super-ordinate conceptual headings. *(See Appendix H).*

Quality Issues

In accordance with Madill, Jordan and Shirley's (2000) argument that the criteria for evaluating qualitative research must be consistent with the specific and ontological assumptions of the methodology, the study has endeavoured to meet the criteria set out by Elliott, Fischer and Rennie (1999), who locate themselves within the phenomenological-hermeneutic tradition. In summary these criteria state that researchers should be explicit about their assumptions, be grounded in the data and provide examples of analysis, check credibility by referring to others' interpretations of the data, and present the material in a transparent way that serves to resonate with the reader.

In order to meet the quality standards there was a process of triangulation with two additional members of the research team. Once the initial readings and annotations of each transcript had been made, the themes and corresponding data were discussed and debated at both stages of clustering themes and grouping them into named super-ordinate headings.

As the primary researcher the ontological assumptions I brought to the analysis were consistent with qualitative research; that reality is subjective with multiple versions of reality existing (Cresswell, 2007). The assumptions I had prior to the research were that participants would be able to provide an account, which would reflect their experience and that participants would likely experience both 'positive' and 'negative' impacts from working with this client group. My assumptions were shaped both my personal experiences of working as a therapist with sexual abuse survivors and discussions with other therapist, prior to, and during, the process of conducting the research. Furthermore, I would propose that I engaged with a social constructionist epistemological stance; assuming that human experience is mediated socially, culturally and linguistically. *(For further*

details on methodology see Extended Methodology, and examples of analysis Appendix H).

Results

Themes were grouped into seven super-ordinate headings, which were: Sense of responsibility, Impact, Protecting and maintaining sense of self, Contradictions in narratives, Evolving impact, Group milieu and Unique aspects of a group setting. Strauss and Corbin (1990) suggest analysis should focus on reporting fewer themes in rich detail, rather than attempting to summarize all aspects of the data. Therefore, this paper focuses on the first four themes listed above; these themes represent the therapists' narratives about the impact of the work and the meaning they ascribed to these experiences, whereas the latter three address how the impact changes over time and the specifics of working with sexual abuse survivors in the group setting. *(See Extended Results and summary table).*

Sense of Responsibility

The therapists described a strong sense of responsibility towards the clients they worked with, which are described here in the three sub-ordinate themes; maintaining connection, putting client's needs first and therapist as container.

Maintaining connection

An expression of this sense of responsibility was the acknowledgement, and prevention, of the desensitisation that occurs when one repeatedly hears accounts of abuse, as well as the pull to assign hierarchy to clients' experiences:

> *Dee*. If you hear stuff over and over again, that actually you know, this doesn't seem as bad as this…what I want to be concerned about as a psychotherapist is this individual that's in front of me. So I think there's a consciousness around not wanting that to happen but feeling that that's a pull really.

Dee's account demonstrates the conflict she has between her desire to stay connected, and conscious, for each and every client she sees, with a state of becoming desensitised and rehearsed in hearing accounts of abuse. Despite this, her narrative demonstrates her perseverance in preserving a one-to-one connection.

Putting clients' needs first

The therapists also described various approaches to their work that were aimed at ensuring the clients' needs were met, even if that was to the detriment of their own well being. Sarah's statement below is a reply to being asked about whether she experienced intrusive images:

> *Sarah*. If you're going to talk about with …people on those memories, you either are or you're not [going to experience intrusive images]…And if you're not, then you probably should be doing something else.

An interpretation of Sarah's narrative is that she holds a belief system based on the necessity to feel the 'impact' in order to be a 'good therapist'. She suggests, by saying *"you should probably be doing something else"* that if you're not able to empathise to the degree that it affects you, you are not providing an adequate service for that individual. This extract

seems to depict a meaning for those 'intrusive' images for Sarah, and how they contribute to her sense of identity as a capable clinician.

Therapist as container

This theme was only spoken about by one therapist, and yet it provided an interesting perspective about her identity as a therapist. Caroline described being moved by her role as 'container', hearing collective trauma stories, and preventing their onward passage into the world:

> *Caroline*. We're trying to help people contain and that 'it ends here' kind of stuff...Because there is that belief that if you hear it and help contain it and help people say it, it isn't just going to go on you know, having effect and causing damage. So I find that quite moving.

An interpretation of this role as 'container' is that, for Caroline, hearing and retaining the stories of trauma holds a sense of higher meaning; she is helping to protect others from trauma's capacity to cause harm.

These themes, together, provide an informative insight into the role of, and identities, held by the therapists.

Impact

There were subordinate-themes, grouped under the super-ordinate theme title *'Impact'*. These included *'Anger'* and '*Feeling different*' to others who are not exposed to frequent accounts of trauma. Therapists also described '*Creating internal pictures*' of events described to them, '*Owned trauma and distress'* (i.e. absorbing the distress into their own sense of self), '*Changed world view'* (i.e. being acutely aware of the common occurrence

of abuse, and yet conversely, also being confronted with the strength and resilience of victims). Furthermore, therapists referred to how this awareness of abuse translated to their own perception of safety – *'Awareness of and defences against abusability'*. '*Dissonance between what you hear and what you do'* refers to the conflict of absorbing the message that the world is an unsafe place, and yet going about daily life. However, alongside, what could be argued are 'negative' impacts, therapists spoke of how these have secondary positive gains. For example, within the sub-theme '*Changed world view'* therapists spoke of their exposure to the absolute extremes of humanity:

> *Dee*. The amount of violence and degradation and you know humiliation and neglect you know, I feel like…whether I have or not, but I feel like I've heard it all.

Following this, Dee comments on a positive aspect that she has been able to retrieve from that experience:

> *Dee.* I feel like it's widened my perspectives hugely…The picture is far too complex for any generalisation. And I think that is a really good thing because I think that means that in life I don't really [generalise].

Similarly, the theme *'Awareness of and defences against abusability'* captures the sense that therapists acquire a heightened attention to risk and vulnerability of being abused. Emma describes her worries for her niece:

> *Emma*. I wouldn't want her going to toilets in public places on her own and things like that really. Just because of the stories you know … I mean it might not happen but the stories we hear …

Emma has also however, developed a positive meaning for this heightened awareness:

> *Emma*. I'd say it's positive that I'm aware that these things happen in society…that I do think about the children's that I'm in involved in safety… I suppose it makes you aware of your own personal safety as well, so I'd say that's a positive.

These extracts demonstrate that, what would initially appear to be an impact, has not been a wholly negative experience for these therapists. Instead there are aspects for which they are grateful, contributing to a sense of positive self-transformation.

The sense of constructing meaning around these experiences also relates to the theme of *'Broader meaning making'*. Several of the therapists seemed to engage in sense-making discourses, which addressed a wider view of the reasons things occur and how these are assimilated into their view of the world. Caroline's narrative demonstrates how she has created a context around the perpetration of abuse, which is concerned with compassion and understanding of the perpetrators' "lostness". She also speaks of her need to create a broader framework for conceptualizing her view of the world:

> *Caroline*. Over the years of being a therapist, I've become more and more involved in Buddhism and I think there has been a real need to have some sort of big picture to help manage it, you know, I've needed sort of … so maybe that's one of the impacts, is that in the face of all this you know, a need for meaning…maybe that really is one of the impacts, is that real need to find frameworks that can go on giving me meaning. Because if I thought this was just this horrible mess of meaningless kind of abuse and violence and I couldn't find any other sort of meaning…

This extract demonstrates the absolute necessity for Caroline to refer to a larger frame of reference, in order not to be destroyed by *"a horrible mess of meaningless abuse and violence"*. Other therapists, too, refer to a *"faith in human nature"* and the *"nature of nature".*

Protecting and maintaining sense of self

No specific questions were asked of participants about how they maintained their sense of self amidst trauma work, and yet this was an area discussed by all therapists. Therapists spoke about '*Compartmentalising*'; maintaining psychological and physical boundaries between work and home life. They also reflected on their use of '*Introspection and self-care'*, for example being aware of their own state of mind and attending to emergent emotions in supervision.

Further to these, therapists employed '*Normalising*' narratives, demonstrated in the following extracts:

Interviewer. I was wondering whether the experience of working with sexual abuse survivors, affects how you feel about relationships outside of work?

Sarah. I think it has to, I don't think you can pretend it doesn't…anyone who works with any kind of traumas…

Sarah. But you can't not have imagery, I don't think you can not have that.

Emma. But I don't know I would have thought people that do our sort of work would have that view really.

Emma. I could feel tears in my eyes but that didn't…it didn't bother me too much, you know…but I thought that's about being human isn't it really?

These extracts seem to have an element of justification, or self-reassurance. One hypothesis for this might be that in order to cope with the impact, the therapists go through a process of normalising the effects. *"Anyone who works with any kind of traumas"* implies that this is a normal, adaptive, response to being exposed to that kind of work. Emma's term *"our sort of work"* supports this idea; here it is not clear who she is referring to as *"our"* but could represent identification with a wider membership of trauma therapists. Her reference to *"being human"* suggests an invested belief that to be emotionally affected makes you, in some way, more 'real', more 'normal'.

Another theme identified was *'Maintaining a sense of hope'*; which seemed to reflect a need to witness the positive transformation of the clients, as well as hearing about the trauma:

> *Dee*. Because actually what I hear alongside the trauma is I see every time I work with a group, I see the shifts and the changes and I see the empowerment…

Dee also speaks of how different her experience is when, during assessments, she is not permitted to be a witness to that transformation:

> *Dee*. It would literally be one trauma story after another, with nowhere to go with it. So we'd just have a story and we'd have nothing happen about that, there'd be no transformation because we wouldn't see them again for three months… that used to leave me … I just felt kind of wrung out like I didn't want to hear or see or talk or …

Dee's account includes the term *"wrung out",* occurring if she is only presented with the trauma. It appears that the recovery and improvement of the women is paramount to the preservation of the therapists' sense of self.

Another therapist describes how she is *"often the one that just has a kind of faith in somebody's core humanness and their ability to survive."* This too reflects a need to believe that people can come through and survive the most horrific of events; perhaps allowing the therapist the continued optimism and hope required to remain therapeutic.

Contradictions in narratives

In response to the question whether they thought the work had an impact on them, more than one therapist said they didn't think so; *"But I mean personally, I don't think it had a particularly exceptional impact on me."* When asked whether she experienced what she would describe as intrusive images Dee said *"I think I'd say generally no".* However, she continued:

> *Dee.* There is always someone's story that kind of….gets under my radar…But I feel that I'm not overwhelmed by kind of loads and loads of unwanted thoughts or images, but I think I'm probably carrying someone all the time…if someone is talking in a graphic way, about being the age that (son) is and I transpose him into that situation, that I find unbearable.

This extract demonstrates an interesting dilemma in analysis. Initially stating that she does not experience intrusive images, and is not 'overwhelmed by thoughts', Dee however, later uses the word *"unbearable"* to describe the experience of transposing her son into abusive situations.

During the interviews, it seemed that the majority of therapists would initially state they didn't experience any impact or intrusive images, but later seemingly contradict this by describing , as a result of their work, changed world views, heightened awareness of abusability and distressing memories, among others. An example of a contradictory narrative is from Emma; in answer to the question "do you think it has any impact on you, hearing those stories?" she states *"not now I wouldn't say, no",* but then says *"I think it does have an impact…"* These will be further examined in the discussion. *(For further results see Extended Results).*

Discussion

The social constructionist approach facilitates discussion of the themes. This epistemology proposes that the self is not an independent entity that can be commented upon in isolation. Instead we generate meaning through creating stories and narratives about our experiences, which in turn influence the way in which we interpret these experiences, and therefore how they impact upon us (Gergen, 1999).

As mentioned earlier, being exposed to clients' stories of trauma and human cruelty will "force therapists to question their own sense of meaning and hope" (Brady, Guy, Poelstra & Fletcher Brokaw, 1999, p. 387). Crossley (2000) states that narratives can be "used to restore a sense of order and connection, and thus to re-establish a semblance of meaning in the life of the individual." (p. 542). The themes identified in the data seem to support this argument; despite the exposure to trauma, the therapists have been able to produce alternative narratives that incorporate these experiences into their sense of self. For example, the 'Sense of Responsibility' described by the therapists represents a collective narrative about their role as therapist. There is reference to the idea that as a therapist one *should* stay empathic to each and every client, and to be emotionally engaged is to provide an adequate service to that individual. An interpretation of this is that their experience of images or impact may be defined as acceptable, or tolerable, because it is inextricably linked with their identity as a 'good' therapist. This is echoed in the discussions about therapists' role as container.

Furthermore, alongside the impacts the therapists described, they were able to construct a positive function for these experiences; therapists felt that they were glad of an increased awareness of risk, as this enabled them to more effectively protect themselves and their loved ones. Interestingly, Caroline's discussion about her increased spirituality reflects

the literature. Brady et al. (1999) comment: "Confronted with clients' issues of meaning, hope, and spiritual understanding, female psychotherapists' own faith may emerge stronger and more resilient" (p.392).

The mechanisms described in the theme 'Protecting and Maintaining Sense of Self' represent the therapists' process of assimilating these changes or impacts into their view of themselves. To construct a meaning of these changes, as a normal and adaptive response, serves to minimise the impact. In contrast, if they became preoccupied and distressed about the changes to their view of the world, as a result of being exposed to trauma, it would disrupt their sense of order and homeostasis, and be experienced as traumatising. The 'Maintaining of Hope' that the therapists seek out through the witnessing of client transformation reflects the importance of holding onto a degree of hope. Gergen (1999) argues that "the therapeutic relationship is one of conjoint meaning making" (p.170). Therefore, to bear witness to positive transformation in some clients allows the therapist to maintain a belief in survivability, which in turn aids their resilience and their ability to provide hope to other clients in a state of despair.

Finally, in regards to theme 'Contradictions in narratives' concerning the therapists' tendency to state they did not experience any impact or intrusive images. One interpretation could be that this was because, despite experiencing what one could interpret as negative impacts, their construction of these experiences was not that they were traumatising. The therapists had been able to construct an overarching narrative that did not interpret their exposure to trauma as being wholly distressing. Jenmorri (2006) states "researchers suggest that practitioners' experiences of despair are related to vicarious traumatisation" (p.49). If the narratives that the therapists create are, however, not full of despair, where does this

leave the concept of vicarious traumatisation? It would be reasonable to assume that if, simultaneously, the therapists in this study had been asked to complete a standardised VT psychometric they may have scored highly enough to indicate the presence of VT. The term vicarious traumatisation, by the nature of the words, implies that if someone experiences the associated symptoms they have been 'vicariously traumatised'. However, this does not take into account whether the individual views it as an undesirable impact.

This study might suggest that despite exposure to trauma, if therapists are able to construct a positive narrative about their work with trauma, it may be protective against the negative impact of VT described in the literature. This has implications for the role taken on by supervisors; to help therapists integrate these changed views into their sense of self and the world, and create positive, coherent narratives about the impact that the work has on them.

Due to the double hermeneutic nature of IPA, these conclusions are based on "the researcher trying to make sense of the participants trying to make sense of their world." (Smith & Osborn, 2003, p. 51). However, a process of triangulation and supervision occurred in order to reflect on the generation of themes, and ensure the quality of the research.

An IPA study is not designed to produce findings generalizable to a broader population. The study therefore cannot conclude that all therapists would construct meanings of their experiences in a similar way to the therapists in this study. Furthermore, it does not suggest that those therapists that do experience their exposure to trauma as distressing should be invalidated. However, further qualitative studies investigating therapists' meaning-making of these 'negative' symptoms of VT could inform the research further. *(See Extended Discussion).*

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Extended Introduction

Terms and Definitions

The terms used to describe the potentially negative impact, on therapists, of trauma work include, 'burnout', 'secondary traumatic stress', 'compassion fatigue', 'countertransference', and 'vicarious traumatisation'. Each of these terms describes aspects of the stressful nature of working with clients who have trauma histories, but they differ in their theoretical basis and focus. According to Pines and Aronson (1988) burnout is "a state of physical, emotional and mental exhaustion caused by long-term involvement in emotionally demanding situations" (p.9). Burnout is the psychological result of working with difficult clients, and can, therefore, apply to any profession. The literature on burnout is symptom focussed; Kahill (1988) identified five categories including physical symptoms (e.g. fatigue, specific somatic problems and general physical depletion), emotional symptoms (e.g. irritability, anxiety depression, guilt, sense of hopelessness), behavioural symptoms (e.g. aggression, pessimism, defensiveness, cynicism, substance abuse) work-related symptoms (e.g. quitting the job, poor work performance, absenteeism) and interpersonal symptoms (e.g. withdrawal from clients and co-workers.)

The term 'secondary traumatic stress', used interchangeably with compassion fatigue, is also symptom based. Figley (1995) defined it as "the natural consequent behaviours and emotions resulting from knowledge about a traumatizing event experience by a significant other. It is the stress resulting from helping, or wanting to help, a traumatized or suffering person." (p.4). Figley (1995) specifically related secondary traumatic stress to the Diagnostic and Statistical Manual of Mental Disorders 4th edition (DSM-IV, American Psychiatric Association, 2000) definition of post traumatic stress disorder (PTSD). Included in the criteria

for PTSD is "the development of characteristic symptoms following…learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate." (DSM–IV, APA, 2000 p.425). This recognition by the DSM-IV that trauma does not necessarily have to be experienced first hand, has influenced the development of the construct of secondary traumatic stress.

Thirdly, the process of countertransference, which is defined as "(1) the affective, ideational and physical responses a therapist has to her client, his clinical material, transference, and re-enactments, and (2) the therapist's conscious and unconscious defences against the affects, intrapsychic conflicts and associations aroused by the former." (Pearlman & Saakvitne, 1995, p.23). The literature on countertransference describes how therapists can experience parallel states of affects, such as helplessness, as a result of the therapist's own past experiences and psychological defences (Neumann & Gamble, 1995).

Finally 'vicarious traumatisation' (VT) can result in changes to a therapist's cognitive schemas and belief systems, (Laidig Brady & Guy, 1999), as well as identity, world view, spirituality, affect tolerance, and interpersonal relationships. While vicarious traumatisation and countertransference are distinct constructs and experiences, they affect one another, and are theoretically linked within the literature. Countertransference is present in all therapies, whereas VT is specific to trauma therapy. The effects of VT are thought to reach beyond the therapeutic relationship to the therapist's wider professional and personal life. Whereas countertransference is "temporally or temporarily linked to a particular period, event, or issue in the therapy or in the therapist's inner or external life as it interacts with the therapy." (Pearlman & Saakvitne, 1995a p.33.) Blair and Ramones (1996), Pearlman and Saakvitne (1995a) and Wilson and Lindy (1994) provide a discussion on the complex interplay

between the experiences connected with countertransference and VT. They argue that unacknowledged countertransference reactions can make the therapist vulnerable to experiencing VT. Conversely, VT creates changes to the self of the therapist, and as all countertransference reactions are determined by the self, VT thus invariably shapes countertransference.

Stamm (1997) concluded that there is no consistently used term regarding the impact on a therapist of being exposed to traumatic material. This can create difficulty in comparing, and critiquing, the empirical evidence, and determining which construct, hence set of experiences, are being referred to, because the research can not be directly compared.

Theoretical Explanations and Symptoms of Vicarious Traumatisation

In order to understand the mechanisms by which vicarious traumatisation causes such changes in therapists McCann and Pearlman's (1992) model is considered. Constructivist self-development theory (CSDT) de-constructs the psychological, interpersonal and transpersonal impact of traumatic life events upon the adult survivor. Furthermore, it provides a framework from which to understand the impact of trauma work on the therapist. CSDT assumes that the therapist's vicarious reactions are normal and adaptive strategies for affect management. The premise of this theory is that "individuals construct their realities through the development of cognitive schemas or perceptions, which facilitate their understanding of surrounding life experiences" (Trippany, White Kress & Wilcoxon, 2004 p.32). Constructivist self development theory proposes that each person's meaning, and experience, of a traumatic event are affected by a complex interplay between the individual, the event, and the wider context (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995b). As a therapist is exposed to client-presented traumatic material they develop new

perceptions. These changes are "pervasive (i.e. have the potential to affect every part area of the counsellor's life) and cumulative (i.e. potentially permanent because each traumatized client the counsellor encounters reinforces these changes in cognitive schemas" (Trippany, White Kress & Wilcoxon, 2004 p.32).

CSDT proposes that there are five aspects of an individual impacted by exposure to trauma: (1) frame of reference (2) self-capacities (3) ego resources (4) psychological needs and (5) cognitive schemas, memory and perception (Pearlman & Saakvitne, 1995a). Frame of reference refers to an individual's framework for viewing and understanding themselves and the world, and incorporates world view, identity and spirituality (Pearlman & Saakvitne, 1995a). Changes to a therapist's frame of reference can be distressing, and can have an impact on the developing therapeutic relationship.

Self-capacities are "inner capabilities that allow the individual to maintain a consistent, coherent sense of identity, connection and positive self-esteem." (Pearlman & Saakvitne, 1995a, p.64.) These refer to an individual's ability to tolerate and integrate emotions, maintain positive self-esteem, and relate to others.

Ego-resources refer to an individual's ability to interpersonally connect with others, and meet their psychological needs. Necessary resources include introspection, personal growth, empathy, ability to establish mature relationships, and establish boundaries.

Finally psychological needs and cognitive schemas relate to an individual's safety needs, trust needs, intimacy needs, and control needs. A therapist experiencing VT, who doubts that their safety needs will be met may fear for their safety, and the safety of their family, and may be hypervigilant to cues of threat. Changes to a therapist's basic trust can have wide-reaching effects, from doubting their own intuition and abilities

in therapy, to developing trust issues in personal relationships. If a therapist's esteem is affected they may feel inadequate and unable to help their trauma client. Pearlman and Saakvitne (1995a) described the consequences of disrupted intimacy needs as avoidance or withdrawal, or over-dependency on significant others. Finally, disrupted control needs might result in the therapist feeling helpless, or tempted to over control their professional, and personal, life. Whilst this is only a brief summary of the mechanisms by which CSDT postulates the way negative changes occur in trauma therapists, it highlights how pervasive the changes can be.

Symptoms, additional to those described in the paper, may include sensory disruptions, including imagery intrusions, and their experience of their body and the physical world (Pearlman & Saakvitne, 1995a).

Further to the symptoms explained within the CSDT model, Figley's (1995) description of secondary traumatic stress symptoms resemble those of PTSD; including re-experiencing the event of the traumatised person, avoidance and persistent arousal (O'Halloran & Linton, 2000). In support of this, Brady, Guy, Poelstra and Brokaw (1999) found the experiences of secondary trauma are similar to those of direct trauma victims.

Implications of Vicarious Traumatisation for Therapists and Clients

The extensive list of symptoms highlights the importance of studying VT in therapists. Posttraumatic symptoms, as described above, are risk factors for the development of subsequent mental health problems, including depression and anxiety disorders (Steed & Downing, 1998). Vicarious traumatisation has also been associated with greater use of sick leave, lower morale, and lower productivity (Stamm, Varra, Pearlman & Giller, 2002). Another potential personal consequence for therapists is suffering overwhelming grief, which can create a sense of alienation from others (Herman, 1992). For these reasons early detection, and

intervention, with VT is vital for the welfare of the therapist. However, Motta, Joseph, Rose, Suozzi and Liederman (1997) highlight how VT can occur at a significantly lower intensity than direct trauma, which might result in chronic, milder distress. As a result vicarious traumatisation can go undetected because the individual is still able to function relatively well (Lerias & Byrne, 2003). This can, in turn, result in ethical issues regarding the quality of treatment a client might receive (Saakvitne & Pearlman, 1996).

Research suggests that therapists experiencing vicarious traumatisation are at a higher risk of making poor professional judgements than those not affected (Munroe, 1999; Pearlman & Saakvitne, 1995; Williams & Sommer, 1995). Examples of poor judgement include mis-diagnosis, clinical error, and poor treatment planning, including the over-medication and inappropriate hospitalization of patients (Hesse, 2002).

Disruptions in cognitive schemas might result in the compromising of therapeutic boundaries (e.g. forgotten appointments, abandonment and unreturned phone calls). In its most extreme form a therapist might seek intimacy within the therapeutic relationship (Hesse, 2002). Hesse (2002) states the most harmful situation is if a therapist blames the client for their own experience of traumatisation, and views them as manipulative. Therapists may also doubt their skills, and lose sight of the client's strengths and progress (Herman, 1992). In addition they may collude with the client to avoid traumatic material, or be intrusive when exploring traumatic memories (Munroe, 1999), impeding the client's progress.

Predictor Variables

In an attempt to detect early signs of vicarious traumatisation it is vital to understand the predictor factors associated with experiencing VT. These have been divided into two categories; those associated with the

nature of the work, and those particular to the individual. Considering those factors, which have been found in previous research, to be predictive of vicarious trauma symptoms will also inform selection of participants and the information collected, from those participants, for the current study. The nature of trauma work is predictive of the likelihood of experiencing negative symptoms. Trauma can be defined as "an exposure to a situation in which a person is confronted with an event that involves actual or threatened death or serious injury, or a threat to self or others' physical well-being", (APA, 2000, p.425). Client traumas can include sexual abuse, physical violence, or naturally occurring disasters such as earthquakes (James & Gilliand, 2001). However, Johnson and Hunter (1997) found that sexual assault counsellors scored higher on emotional exhaustion (as measured by the Maslach Burnout Inventory) than counsellors working in other areas. This would suggest that the nature of working with sexual assault victims is particularly stressful to the therapist. Cunningham (1999) highlighted how, when the trauma is inflicted by another human being, as is inherent in sexual abuse, it is much more devastating (McCann & Pearlman, 1990a; Janoff-Bulman, 1992; Herman, 1992; Courtois, 1988). In support of this Cunningham (1996) found that clinicians working with sexual abuse survivors were more negatively affected than those working with a natural trauma, such as cancer. This could also be due to the specific presentation of sexual abuse clients. Mas (1992) found that patients with a history of childhood sexual abuse had qualitatively different psychological presentations from those with histories of physical abuse, or no trauma history.

Another predictor variable associated with vicarious traumatisation is the number of trauma clients in a therapist's caseload. Schauben and Frazier (1995) assessed female psychologists and female rape crisis counsellors. They found that those therapists that had a greater number of

survivor clients in their caseload were correlated with, more disruptions in beliefs and schemas, with PTSD symptoms, and with the likelihood of experiencing vicarious traumatisation. In support of this therapists, who work primarily with trauma clients, experience more VT than those counsellors with only a few trauma survivor clients (Brady, Guy, Poelstra & Brokaw, 1997; Chrestman, 1999; Cunningham, 1999; Kassam-Adams, 1995; Pearlman & Mac Ian, 1993). In contrast, Follette, Polusny and Milbeck (1994) and Coyne, (2003) found that the proportion of trauma cases in a therapist's caseload was not predictive of trauma symptoms. Whereas, Lind (2000) found that the number of trauma patients in a caseload was predictive of symptoms of secondary traumatic stress disorder, but only in male psychologists. These discrepancies can be explained in terms of the different operationalisations of exposure. Depending on how the researchers have defined exposure to trauma-based material e.g. hours per week, number of clients, or cumulative amount of time therapist has been involved in trauma work, will affect the results (Steed & Bickell, 2001).

Finally, the quantity and quality of supervision has also found to be associated with vicarious traumatisation (Sabin-Farrell & Turpin, 2003). Neumann and Gamble (1995) suggested that particularly inexperienced therapists are vulnerable to VT if supervision is not provided. McCann and Pearlman (1990) proposed that therapists need to engage in a process of integrating, and transforming, the traumatic experience, in the same way a client does during therapy (Dunkley & Whelan, 2006). This is an important factor to consider, particularly considering Pearlman and Mac Ian's (1995) findings that only 64% of trauma therapists reported receiving adequate supervision.

Pearlman and Mac Ian (1995) also acknowledge the part played by work factors not specific to trauma, including the work setting, the social-cultural context and the wider organizational climate.

Characteristics of the therapist are also predictors of VT. These include gender, age, experience, qualifications and own personal trauma history as well as the social support and coping strategies employed by the person. There are many studies which have found gender effects in the experience of vicarious trauma. The majority of the research suggests that being female is a predictor of vicarious traumatisation (Brady et al., 1999; Brewin et al., 2000; Resick, 2000). Kassam-Adams (1995) stated that whilst female therapists reported more PTSD symptoms, it shouldn't be assumed that secondary trauma is of primary concern only for females. It is possible that male and female therapists simply experience different changes as a result of vicarious trauma. Jackson found that women had more disruptions in their beliefs about their safety, whereas male clinicians reported more changes to their self-esteem. In contrast, Moosman (2002) found that male therapists were found to experience greater disruptions, generally, to their cognitive schemas. Again the discrepancies in the research make it difficult to make conclusions about the role of gender in predicting vicarious trauma. These discrepancies could again be caused by the different measures and definitions, of vicarious trauma, used. The lack of consistency makes it difficult to directly compare the studies, and critically evaluate the findings.

In summary, the research also suggests that the younger, and less experienced, a therapist is, the more likely they will experience vicarious traumatisation and other negative consequences of working with trauma clients (Ackerley, Burnell, Holder & Kurdek, 1988; Pearlman & MacIan, 1995). However, Rudolph, Stamm and Stamm (1997) found that there is a "U" shaped relationship between qualification and compassion fatigue.

Hence, bachelor, and PhD level, therapists experienced fewer symptoms than masters level therapists.

An area which has been studied extensively is that of a therapist's own trauma history. Figley (1993) warns that mental health professionals with personal trauma histories are at risk of developing trauma symptoms, when working with survivors. In support of this, many studies have found trauma history increases symptoms of VT, secondary traumatic stress disorder, and generally greater disruptions to cognitive schemas (Wrenn, 2005; Trippany, Wilcoxon, Allen & Satcher, 2003; Pearlman & Mac Ian, 1995, Kassam-Adams, 1995; Battley, 1996). Lerias and Byrne (2003) argued that "people with a trauma history may find it difficult to adjust to a recent critical incident if they are having recurrent, distressing memories of past traumatic events." (p. 132). However, the research findings are contradictory. Follette, Polusny and Milbeck (1994) found that a professional's personal sexual abuse history was not significantly predictive of vicarious trauma symptoms. Similarly, Lucca and Allen (1996), Schauben and Frazier (1995), Simonds (1996) and Vandeusen and Ineke (2006) found no relationship between history of child sexual abuse and vicarious trauma effects. Benatar (2000) posited a reason for the contradictory findings as the failure to differentiate between the new therapist and the experienced practitioner, and also that only Simonds (1996) and Schauben and Frazier's (1995) studies limited their inquiry to sexual trauma in both therapist and client. Despite these inconsistent empirical findings, it is an important area to consider, given that Elliott and Guy (1993) found that 43% of the female mental health professionals in their sample had experienced sexual abuse.

Social support is thought to mediate the effects of stressors (De Jong, Sonderen & Emmelkamp, 1999), and those with more perceived social support tend to have greater resilience to secondary traumatic stress

disorder (Lucero, 2002). Finally, negative coping strategies such as increased alcohol intake, risk-taking behaviours, and withdrawing from family and friends, are also associated with higher levels of negative symptoms (Follette, Polusny & Milbeck, 1994).

Positive Changes as a Result of Trauma Work

There is acknowledgement within the research of the positive processes which therapists can undergo when working with trauma clients, but these are, in the majority, mentioned secondarily to the negative consequences. Arnold, Calhoun, Tedeschi and Cann (2005) coined the term 'vicarious posttraumatic growth' to describe the process of psychological growth following vicarious exposure to trauma. Another term used to describe these positive changes is 'positive self-transformation', which has been defined as "experiences of enduring change in the self and identity attributed to working with child sexual abuse survivors over a period of time, and is a concept corresponding to VT but with a positive valence." (Benatar, 2000, p. 12). Calhoun and Tedeschi (1999) describe the inspiration that follows hearing a client's struggle and survival through horrible circumstances; "the client's courage and determination may inspire us to press forward in our own continuing personal growth." (Pearlman & Saakvitne, 1995, p. 404).

Arnold, Calhoun, Tedeschi and Cann (2005) found that therapists, working with sexual abuse survivors, reported experiencing a "deeper, more nuanced understanding of the entire spectrum of human behaviour…their faith had grown deeper as a result of trauma work and…this change in self-perception had made life seem more precious and inspired them to live fuller, richer lives." (p. 257-258). These results prompted them to conclude that "the rewards of working with trauma survivors may have been vastly underestimated." (p. 259).

These positive, reported symptoms are conceptualised within the posttraumatic growth (PTG) research. Posttraumatic growth refers to positive changes following trauma, and it has been found that between 30% and 90% of survivors report at least some positive changes, (Tedeschi & Calhoun, 1995), including survivors of childhood sexual abuse (McMillen, Zuravin & Rideout, 1995). It is suggested that there are three areas which can be changed, as a result of experiencing trauma; changes in self-perception, interpersonal relationships, and philosophy of life (Calhoun & Tedeschi, 1999). Anecdotally the effects of vicarious posttraumatic growth can mirror these changes (Arnold et al., 2005). Currently the research is not conclusive about why, or how, the process of posttraumatic growth is achieved. However, it is acknowledged in the literature that some degree of distress and rumination are necessary for growth to take place. Linley and Joseph (2002) suggest that exploring the following, positive qualities, with the client may act as a foundation, working toward posttraumatic growth:

(a) help the client make sense of, and find meaning in what has happened;
(b) indicate to the client any insights they may have gained into themselves;
(c) use these positive gains to repair self-schemas damaged by the trauma, or challenge negative self-schemas that have arisen as a result of the trauma;
(d) provide hope that the trauma can be overcome, and that there may even be the potential for positive gains arising from it.

If these help to develop positive changes in direct trauma victims, the principles may well apply to therapists experiencing vicarious trauma.

Saakvitne, Tennen and Affleck (1998) argue that the Constructionist Self-Development Theory can also predict positive transformative, changes as a result of exposure to trauma. CSDT posits 'frame of reference' as the main cause of traumatic change. Trauma acts to disrupt a person's identity, worldview, and spirituality. They argue these changes map onto the five arenas of posttraumatic growth described by Tedeschi and Calhoun (1996): new possibilities (identity, worldview, spirituality), relating to others (worldview), personal strength (identity), spiritual change (spirituality), and appreciation of life (spirituality). According to CSDT, posttraumatic growth occurs if an individual is able to understand a current, traumatic event and incorporate the feelings, perceptions, beliefs and distress into their experience of past events. The individual needs to make an event understandable, in order to create a meaningful narrative, which emphasises personal choice and power. CSDT guided therapy, therefore, aims to create meaning following traumatic loss and help the client to develop insight, mindfulness and self-knowledge. If the processes by which vicarious posttraumatic growth occur i.e. disruptions in one's frame of reference, this theory could also help to develop positive transformation in therapists.

Recently, the term 'vicarious resilience' (VR) has also been discussed; Engstrom, Hernandez and Gangsei (2008) have found that "through a process of introspection, clinicians apply lessons of client resilience to their own lives, which allows them to reframe and better cope with personal difficulties and troubles." (p.19). Vicarious resilience is concerned with therapists who work in extremely traumatic social contexts, specifically survivors of kidnappings, or political trauma. However, they argue that this "inevitably confronts therapists with the impact of human evil" (p. 14), which one could argue is a defining feature of therapists working with sexual abuse survivors. Using a qualitative study, the

researchers interviewed clinicians. From these accounts they found that the main themes relating to vicarious resilience were; being positively affected by the resilience of clients, alteration of perspectives on the therapist's own life, and valuing the therapeutic work performed. Empathy seems to be a necessary element in the development of vicarious resilience (Hernandez, Gangsei & Engstrom, 2007). Engstrom et al. (2008) also discuss the difference between vicarious resilience and posttraumatic growth. They state that VR is concerned with "the process whereby therapists are positively affected by resilience. Therefore vicarious resilience does not assume that a higher posttrauma level of functioning is necessary." (p. 20).

Arnold et al. (2005) conducted the first investigation, which focussed equally on the positive, and negative, experiences of therapists working with trauma survivors. This study used semi-structured interviews and phenomenological qualitative methodology. They found that a large majority of the therapists questioned spontaneously reported positive consequences of this work. The researchers argued that "adopting a more inclusive, less pathologizing conceptualization of trauma work…might help clinicians to view themselves, their clients, and their work in new and empowering ways." (Arnold et al., 2005, p. 260.)

Methodological Issues

Within the vicarious trauma research some methodological issues stand out; of particular note, the constructs, the measures used, and the differing methodologies. Kadambi and Ennis (2004) concluded that research in this area, to date, has been plagued by a lack of baseline data, disparate results, and methodological limitations. As described, many of the studies utilise different definitions of the negative effects of trauma. This results in a different theoretical basis, and focus, of the research. This,

in turn, influences the choice of measure the researcher employs. There are many psychometrics used by the studies discussed, including the Traumatic Stress Institute Belief Scale (Pearlman et al., 2002), which measures disruption in beliefs. The Compassion Fatigue Self-Test for Practitioners (Figley, 1995a) has two subscales measuring compassion fatigue and burnout. There are also The Impact of Event Scale (Horowitz et al., 1979) and Trauma Symptoms Checklist-40 (Elliott & Briere, 1992) which measure PTSD symptoms. Pearlman and Saakvitne (1995b) acknowledge that measures of VT are limited, thus a phenomenological approach, which allows flexibility and openness to an individual's meaning of their experience, will alleviate the limitation of not being able to directly compare one study with another.

A further criticism of the methodologies employed is the use of survey methodology. It is difficult to determine how representative the samples are. The majority of populations are self-selected, and therefore, there might be important differences between those who choose to volunteer, and those who don't (Benatar, 2000). This may be confounded by the necessity of asking therapists to disclose any history of childhood sexual abuse. This is a difficult limitation to overcome, but perhaps being cognisant of the limitation relieves the pressure to apply to broader populations. An approach, which strives only to achieve a greater understanding of the phenomenon being studied at present, with the aim of informing and shaping further research, might be more appropriate. This too might answer Kadambi and Ennis' (2004) call for a re-evaluation of the construct of vicarious traumatisation.

Methodological limitations also exist within the research addressing the 'positive' transformation of therapists. Furthermore, there are again, different terms used to describe different aspects of the positive gains. It is a much newer area of research, and therefore, concepts such as

posttraumatic growth, let alone vicarious growth are still barely understood and cannot be placed conclusively within a theoretical framework. Zoellner and Maercker (2006) point out that, models of PTG assume that posttraumatic growth is a positive and adaptive phenomenon, yet this has not been demonstrated convincingly. Therefore, more longitudinal and process-orientated research should be conducted. In addition, posttraumatic growth research uses individual's introspective statements as an indicator of positive gains. However, these are taken at face value and are not supported by measures of behavioural change (Zoellner and Maercker, 2006).

The area of vicarious resilience is newer still; Engstrom et al. (2008) have stated that further research would benefit from a more diverse sample group. It would also necessary to discover whether the findings of vicarious resilience in political trauma can be applied to other areas of trauma work.

Shortcomings of the Research Base

A further shortcoming of the research is the focus on quantitative methodology. Qualitative methods additionally increase the understanding of how working with trauma clients is actually experienced by therapists, and might work towards understanding what would help to prevent or intervene. Steed and Downing (1998) conducted a phenomenological study examining VT amongst psychologists and professional counsellors, working with sexual assault and abuse. This study significantly contributed to the research, by identifying the experiences of VT by the therapists, and detailing them. Steed and Downing (1998) reported the negative effects to include anger, pain, frustration, sadness, shock, horror and distress. The qualitative methodology enabled the researchers to gain rich information from therapists, such as the acknowledgement that their responses varied,

according to the abuse, the age of the client and the impact on the client's life, none of which have been discussed in the literature. They also identified positive effects from working with this client group including "positive alterations in their sense of meaning/spirituality, re-evaluation of previously held beliefs, increased self-awareness and the acquisition of new perspectives." (p.8). These results concur with the results from quantitative studies, but provide a richness of data not possible with quantitative methodologies. However, a criticism of the Steed and Downing study is the lack of information given about the participants. Trauma histories, experience, and qualifications are not stated, nor is the method of sampling the population. The reporting of results is not comprehensive, which reduces the ability to compare results with quantitative studies.

A further shortcoming of the research in this area is discussed by Dunkley and Whelan (2006). They highlighted how most of the research, to date, has been restricted to face-to-face counsellors, most of which have conducted therapy on a one to one basis. There has been little research on the effects of therapists working within a group setting (Ziegler & McEvoy, 2000). Given the different dynamics involved in group work, compared to individual therapy, there may be additional stresses. Ziegler and McEvoy (2000) summarised the differences between individual and group therapy in the excerpt below;

"In individual psychotherapy with trauma survivors, the privacy of the office creates a contained environment for rebuilding safety and trust. The therapist concentrates her energy on one person, tailoring interventions to fit the client's uniqueness, and taking the time required to work safely through the client's transference reactions. The trauma group therapist has to build safety and trust in an exposed environment in which she often has little information about each person's history, traumatic

exposure, or response to trauma. She observes at first hand the difficulties in building connection, yet cannot respond to each individual." (p.120)

Group therapy is recommended, particularly for adult survivors of sexual abuse (Briere, 1989; Carver, Stalker, Stewart & Abraham, 1989) in order to decrease the survivor's shame, and isolation, and also to increase assertiveness and trust in others. Courtois (2001) noted that group treatment provides a supportive environment, in which survivors can develop a more positive perspective about their lives. The group atmosphere can also encourage self-disclosure (Weinberg, Nuttman-Shwartz & Gilmore, 2005). The fragility of trauma survivors means that group relationships can be slower to develop than non-trauma groups (Ziegler & McEvoy, 2000). Therefore, an added challenge is for the therapist to make appropriate reflections and interpretations which would highlight areas of conflict, without threatening the group's homogeneity or identity. The group needs to experience the co-ordinator as empathic, which the therapist must achieve amidst tolerating negative projections (Hannah, 1984), painful affects and disturbed schemata (Ziegler & McEvoy, 2000). They must also have a deep understanding of the group dynamics to cope with the inevitable re-enactments of various roles, including victim, victimizer, or the passive role of indifferent bystander. Trauma groups inevitably create anger and hostility in its members, the therapist must strive to validate all emotions, whilst maintaining strict boundaries to ensure the safety of all its members. Furthermore, Yalom (1995) argued that research has failed to deliver on the issue of selection of clients for group treatment. While managing all of these competing priorities there may also be a serious potential for vicarious traumatisation as a result of the cumulative nature of hearing lots of trauma stories in one setting. Herman (1992) noted that survivors, who had not yet established methods

to ensure their safety, could become highly disorganised by exploring traumatic experiences in a group setting. Palmer, Stalker, Harper and Gadbois (2007) found that 20% of group members reported experiencing vicarious traumatisation as a result of hearing other members' trauma. Therefore the therapists must be mindful of their own vulnerability to vicarious trauma, as well as the other members of the group.

Despite the unique pressures of running sexual abuse survivor groups described above, there has been very little research conducted on the effect on the therapist. One paper, that has considered these issues, discusses transference and countertransference issues, unique to long-term group psychotherapy of adult women abused as children (Abney, Anderson Yang and Paulson, 1992). These researchers also discuss the difficulties of coping with transference between members and that projected toward the therapist. They describe 'splitting' as common; each therapist alternately seen as the "good" and "bad" parent by the group. The authors describe experiences of vicarious traumatisation, including intrusive recollections of abuse experiences and increased sensitivity, following accusations of being a perpetrator of abuse. Further countertransference reactions were initiated when group members tended to 'band' together in support of one another's 'acting out'. Despite all the difficulties described Abney et al. also acknowledge positive experiences from running survivor groups, including satisfaction and inspiration. They describe witnessing the courage and strength of women to facing their pain as provoking a sense of hopefulness, and stimulating healing of one's own issues. This study provides an insight into the author's experiences, but lacks formal design, or recording of information. Further studies need to be carried out to understand the complexities of working with a trauma group, and what positive and negative effects that therapists can encounter.

Aims and Purpose of Investigation

The current study aimed to investigate the lived experiences of female therapists running female sexual abuse survivor groups, without a bias towards the 'positive' or 'negative' aspects of transformation. The study's purpose was to add to, and address the shortcomings of the current research base, providing a more comprehensive understanding of the experiences of therapists working with sexual abuse survivor groups. The study proposed to utilise the strengths of the research conducted by Steed and Downing (1998) and Arnold et al. (2005) by employing an interpretative phenomenological analysis methodology.

Interpretative phenomenological analysis shares the aims of other, more descriptive, phenomenological approaches to data analysis in that it wishes to capture the quality and texture of individual experience. IPA's aim "is to explore and detail how participants are making sense of their personal and social world… and the meanings particular experiences, events, states hold for participants." (Smith & Osborn, 2003 p.51). IPA makes the assumption that people's accounts tell us about their private thoughts and feelings. Hence, to some degree holds a realist stance in relation to knowledge, but also acknowledges that the researcher's understanding will, too, be influenced by their own thoughts and assumptions. Therefore, the knowledge produced is reflexive, in so far that it is dependent on the researcher's positioning. Furthermore, due to the interpretative nature, IPA acknowledges how the researcher is necessarily implicated in the analysis. Therefore, the method requires that the researcher is reflexive and transparent in their reporting of the data.

IPA employs an idiographic level of analysis, concerned with making statements about specific individuals, rather than the nomothetic approach of making probabilistic claims about groups (Smith, Harre & Van Langenhove, 1995b). Therefore the purpose of the study was to comment

on these therapists' experiences, rather than make conclusions about a broader population.

Given the controversy within the literature regarding gender, and the concerns regarding maintaining participant confidentiality, given only one male worker in region, the participants were all female therapists. It is acknowledged the term 'therapists' is broad, but given that the interest of phenomenology lies in exploring the meaning an individual gives to their experience, no exclusion criteria were applied to profession. In an attempt to address the lack of research regarding group settings, the trauma clients that the therapists worked with were sexual abuse survivors, who were attending a trauma group.

Extended Methodology

Research Design

This study was a qualitative research design using Interpretative Phenomenological Analysis (IPA). Similar qualitative methodologies e.g. Lincoln and Guba's (1985) constant-comparison qualitative method, (Arnold, Calhoun, Tedeschi & Cann, 2005), and thematic content analysis, (Steed & Downing, 1998) have been used in papers investigating both vicarious traumatisation and vicarious posttraumatic growth, and have added to the research base, producing informative results.

Participant Recruitment

The process of recruitment, in the first instance, involved contacting the managers of the potential participants. The managers were informed of the purpose of the study, the phenomenon being studied, what would happen during, and after, the interview, and the amount of time that would be required of the therapist. Managers were asked to identify therapists

that met the criteria (as discussed later), and request their permission to be contacted by the researcher. Those therapists that agreed to be contacted were sent the information sheet and consent form, by post, along with a pre-paid envelope to return the signed consent form *(see Appendices D & E)*. They also received a covering letter explaining the position of the researcher, and giving relevant contact details. Subsequently, the participants had the opportunity to get in contact and ask any additional questions prior to agreeing to take part. Those therapists that provided consent were sent a sheet on which to record demographic information (*see Appendix F),* which was collected on the day of the interview. The participants were contacted to arrange an appropriate time to conduct the interview. Of the four services identified there was a possible recruitment total of twelve therapists. Each of the twelve therapists were invited to take part. Smith and Osborn (2003) suggest that five or six participants are sufficient for an IPA study, particularly given the lengthy process of analysis of data. Whilst there is no data available regarding the qualitative studies, quantitative studies in this area suggest response rates vary between 32% (Pearlman & MacIan, 1995) and 57% (Cornille & Meyers, 1999).

Participant Inclusion and Exclusion Criteria

The inclusion criteria specified that all participants would be female therapists, with any qualification or experience, who were currently, or had been in the past, involved in running a group for female sexual abuse survivors, and not just involved in the initial stages of assessment. All participants had to be able to give full informed consent, and have a good understanding of English. Of the twelve participants five completed the consent form and were willing to take part in the interview. Each of these

participants met the inclusion criteria, having each been involved with the running of a sexual abuse survivor group, hence none were excluded.

Information Recorded about Participants

As described earlier, following the receipt of informed consent, the participants were sent a sheet on which to record demographic and clinical information (*see Appendix F*). As evidenced by previous research, there are demographic factors that influence the positive and negative impact on therapists from working with sexual abuse survivors. Hence, the following information was recorded; age, qualification and profession. Further clinical information, which has been identified as pertinent in previous research, was also included. This includes the therapist's years of experience of working with patients with trauma histories, years of experience working within group therapy work and other psychological trauma work conducted outside of this realm within their current vocation. It was debated whether to include a question asking about the therapists' own experience of sexual abuse. However, it was decided not to include this so as to uphold the ethical responsibility to the therapists. It was felt that due to the small number of participants, it would be very difficult to maintain confidentiality.

Sample Characteristics

The five female participants who provided consent came from one NHS trust and from one service in the independent sector. The four participants who were psychotherapists came from varying theoretical backgrounds including psychodynamic psychotherapy, and integrative psychotherapy. The therapists had all received post-graduate qualifications, including Masters and Diplomas. Two therapists were still currently engaged in running groups, while the other three therapists had not been actively involved for some time. The years of working with

groups for clients with sexual abuse histories, ranged from 4 or 5 years to 19 years. Four of the therapists undertook work, outside of the position of employment in which the researcher met them, that involved working with clients with trauma histories. These roles included additional NHS work and private practice.

Semi-structured Interview

As concordant with the IPA methodology, a semi-structured interview was devised *(see Appendix G)*. This allowed the interview to be guided by the schedule, and yet be flexible enough to follow interesting issues that arose, which had not been initially identified as significant. As suggested by Smith and Osborn (2003) the interview began with a general question asking the therapist to reflect on their first experience of running a sexual abuse survivor group in order to allow the participant to habituate to the interview process, and to set up a reflective process.

In regards to the vicarious traumatisation literature, it was thought that self and professional identity, beliefs about self and others, spirituality, safety, and intimacy were issues that might warrant consideration. In addition, the literature discusses the similarities between direct and vicarious traumatisation, and therefore a specific question about intrusive thoughts or images was included. For consideration of vicarious post-traumatic growth, issues of increased relationship skills, appreciation of human resilience, increased self-awareness, and satisfaction of observing clients' growth, were thought to be important, and were therefore included in prompter questions.

The questions were also specifically designed to focus on running groups, so as to think about which experiences specific to working with groups, rather than individuals, might add to the changes that the therapists had identified.

Each interview was carried out at the interviewee's place of work, and lasted approximately one hour. The interviews were recorded using an Olympus DS-30 audio-recording device. Following the interview all participants were again directed to the contact details of the local NHS counselling service, should they feel they might want to discuss anything that had emerged during the interview. All data was kept secure and transported to a locked filing cabinet.

Procedure

Initially, a member of the research team was aware of various services that ran sexual abuse survivor groups. It was then endeavoured to find out who the managers for these services were, and approximately how many participants were available who might meet the inclusion criteria. These managers were contacted via letter stating the position of the researcher, the aim of the study and the possible applications of the results *(see Appendix C)*. The managers were asked to approach any members of their staff that met the inclusion criteria. The anticipated commitment that would be required of the participants was detailed, and there was an opportunity to seek further information. This was attached with a letter addressed to the participants, explaining their manager had been approached and they had been identified as a potential participant for a doctorate research paper. A participant information sheet was also enclosed, which detailed the purpose of the study, information about what would happen if they agreed to take part, issues concerning confidentiality and should they wish to withdraw *(see Appendix D)*. For each service a different participant information sheet was sent out, with the relevant local details for staff support, should they find the interview at all distressing. Enclosed was a consent form, asking for contact details and a pre-paid envelope *(see Appendix E)*.

For those services where no participants returned a consent form to the researcher a reminder letter was sent to the same managers approximately three months after the initial letter. This letter reminded the managers of the study and explained additional participants were still required. Another copy of the consent form was attached.

Those participants who returned the signed consent form were then contacted via telephone or email to arrange an appropriate time to conduct the interview. Once this had been arranged, approximately one week prior to the interview, the demographic and clinical information sheet was sent to them to complete and be returned on the day of the interview.

On the day of the interview the researcher attended the interviewee's place of work at the arranged time. Introductions were made, and the process of using the recording device was explained. Each participant was asked, again, whether they were happy to have the interview recorded. The equipment used was an Olympus DS-30 audio recording device. The participants were then interviewed using the semi-structured interview schedule (*see Appendix G*). Each interview varied in length depending on the detail of the answers given. However, they were all less than an hour in length. Participants were thanked for their involvement and reminded of the local staff support should they want to discuss anything. The researcher's contact details were reiterated should they require any further information. The participants were informed that they would receive a copy of the research, once written up. Each interview was then transcribed, either by an identified typist or the researcher. Transcriptions were checked for errors, and amended where necessary. Each transcription was then analysed using an interpretative phenomenological approach.

Ethics

Ethical approval was sought initially from the Cambridgeshire 1 Research Ethics Committee in October 2007 *(see Appendix A)*. Minor amendments were suggested, which were adhered to. Final ethical approval was granted in December 2007. Subsequently Research Management and Governance approval was sought from two NHS Trusts. In order to receive research approval, in the area outside of the researcher's employment, it was also necessary to apply for an honorary contract for the duration of the research study.

Initially there were two questions on the demographic information sheet sent out to participants asking about their own trauma histories, including experiences of sexual abuse. Whilst these questions had been constructed with consideration and sensitivity, one of the Research Management and Governance departments highlighted these questions as a concern. After consideration these questions were omitted in order to uphold our ethical responsibility to the participants to maintain confidentiality.

The other site was not an NHS facility and therefore required additional ethical approval from the university. The Institute of Work, Health and Organisations Ethics Committee granted ethical approval in December 2007 *(see Appendix B)*.

Analysis

A typist carried out verbatim transcription of the interviews. The identified typist was asked to sign a confidentiality agreement, regarding the content of the interviews, and was provided with an honorary contract for the NHS Trust. These transcriptions were then checked for errors, and amended as necessary. The transcriptions were anonymised using

participant numbers in replacement of names, and all other identifiable information e.g. place of work, was omitted.

An interpretative phenomenological approach was used to analyse the data (Smith and Osborn, 2003) *(for example see Appendix H)*. The process of analysis initially meant making annotations on the left hand side of the interview transcripts pulling out interesting words or concepts. Following which, the transcript was re-read and, on the right hand side, amplifications, possible themes, nuances or repeated concepts, were noted. Following this process for every transcript a comprehensive list was created of all the concepts noted in the data. These were then pulled together into more succinct lists. At this stage the interview transcripts were revisited to see whether the initial stage of clustering still represented the data accurately. Once this was verified the list of concepts was drawn into a large map. At this stage two additional members of the research team were consulted to discuss the development of the super- and sub-ordinate themes- a process of triangulation. This process involved being asked to justify why some concepts should be placed under one subordinate theme over another, with reference to the transcripts, and discussing alternative ways to interpret the data. This process occurred a number of times until the final theme titles were agreed upon, following which, a table summarising the theme and providing example quotes in the data was created (for a summarised version of table see Extended Results).

Throughout the process of analysis I also received additional supervision in order to discuss my reactions to the data, and to discuss how my assumptions may impact the analysis of the data.

Memos were kept throughout the analysis phase, which aided the construction of themes and highlighted any interesting thoughts or observations during analysis *(see Appendix I).*

Quality Issues

Madill, Jordan and Shirley (2000) argue that the criteria for evaluating qualitative research need to fit the specific epistemological and ontological framework of the methodology, as they each have different assumptions about the nature of knowledge and role of the researcher. Elliott, Fischer and Rennie (1999) locate themselves within a phenomenological-hermeneutic tradition, and have proposed specific considerations for the evaluation of qualitative research. They suggest that researchers should:

1. *Disclose their own values and assumptions*
2. *Describe the participants in some detail to allow some understanding of applicability*
3. *Provide examples of the data to demonstrate analytic procedures*
4. *Check credibility by referring to others' interpretations of the data*
5. *Present analyses with coherence and integration*
6. *Be clear about their task in respect of general understanding of phenomena versus a specific case*
7. *Present material in a way that resonates with the reader.*

The study endeavoured to meet the criteria set out to ensure good quality research by stating the position of the researcher (as set out below) and providing details about the characteristics of the sample as far as is possible whilst still maintaining confidentiality. Furthermore, details of the process of analysis and triangulation are set out above, and included in Extended Results and Appendix H. Finally, the write up has endeavoured to be transparent and reflective of the therapists' accounts, and create a narrative that is both coherent, but also inclusive of nuances in the data.

Position of the Researcher

IPA acknowledges that engaging with the participants' meanings and experiences requires a degree of interpretation (double hermeneutic).

Therefore the researcher's existing knowledge, and inherent pre-conceptions, inevitably becomes a part of that process. To orientate you to the principal researcher; I am a trainee clinical psychologist, with experience working with survivors of sexual abuse. I have considered what impact such work has on my own sense of self, but, at such an early point on my journey as a clinical psychologist, I have not yet developed a formed conclusion about the ways in which trauma work impacts on me. My personal experiences have, however, led me to develop certain axiological assumptions, including, that working with trauma clients does have an impact on your view of yourself, others and the world. I also came to the research with the assumption that the impacts that therapists might describe could be both 'positive' and 'negative'.

My epistemological stance (my view on what can be known and how) is consistent with a social constructionist approach. This stance emphasises experience as being embedded within culture, language and a social world, and therefore all experiences must be understood within these environmental conditions. Working alongside this epistemology my ontological assumptions are of a phenomenological perspective, in between realist and relativist positioning; that experience is always a product of interpretation and therefore constructed, but nevertheless 'real' to the person (Willig, 2008, p.13).

The assumptions I held were monitored throughout the project through the process of supervision and keeping a research diary. Interestingly, my assumptions regarding the 'positive' and 'negative' impacts experienced by therapists were challenged, in regards to the meanings they had constructed for these experiences. These challenges to my assumptions were discussed during the process of triangulation with the research team.

Appendix A

Copy of Ethics Approval Letter

Cambridgeshire 1 Research Ethics Committee
Victoria House
Capital Park
Fulbourn
Cambridge
CB21 5XB

Telephone: 01223 597653
Facsimile: 01223 597645

03 December 2007

Miss Alexandra Toombes
Trainee Clinical Psychologist
University of Nottingham
Trent Doctoral Programme of Clinical Psychology, I-WHO
5 William Lee Buildings, Science and Technology Park
University Boulevard
Nottingham
NG7 2RQ

Dear Miss Toombes

Full title of study:	**A phenomenon logical Study of Female Therapists' Experiences of Working with Female Sexual Abuse Survivor Groups**
REC reference number:	**07/H0304/101**

Thank you for your letter of 14 November 2007, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the REC Manager, acting under delegated authority from the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for local Research Ethics

Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*	
Application (Lock code: AB/106626/1)		06 September 2007	
Investigator CV: Miss Elizabeth Toombes		28 August 2007	
Protocol	1	15 August 2007	
Covering Letter (Re: Initial application)			
Letter from Sponsor: Paul Cartledge		16 August 2007	
Peer Review: Letter from Dr Shirley Thomas			
Interview Schedules/Topic Guides	1	15 August 2007	
Letter of invitation to participant	1	04 November 2007	
Participant Information Sheet	2	01 November 2007	
Participant Consent Form	2	04 November 2007	
Response to Request for Further Information		14 November 2007	
Demographic Information Sheet	1	15 August 2007	
Co-researcher's CV: Dr Rachel Sabin-Farrell		14 August 2007	
Supervisor's CV: Dr Shirley Thomas		16 August 2007	
Applicant's checklist		06 September 2007	

R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.

Guidance on applying for R&D approval is available from http://www.rdforum.nhs.uk/rdform.htm.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

Here you will find links to the following:

a) Providing feedback. You are invited to give your view of the service that you have received from the National Research Ethics Service on the application procedure. If you wish to make your views known please use the feedback form available on the website.
b) Progress Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
c) Safety Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
d) Amendments. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
e) End of Study/Project. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nationalres.org.uk.

07/H0304/101	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Dr Daryl Rees
Chair

Appendix B

University Ethics Approval

Institute of Work, Health & Organisations
http://www.i-who.org

The University of Nottingham

Institute of Work, Health & Organisations
University of Nottingham
William Lee Buildings 8
Science & Technology Park
University Boulevard
Nottingham
NG7 2RQ UK

T: +44 115 84666 26
F: +44 115 84666 25
E: i-who@nottingham.ac.uk

Director
Professor Tom Cox CBE AcSS FBPsS
Hon FFOM (Dublin) Hon FErgS FRSH FRSA

2007

Dear

I-WHO Ethics Committee Review

Thank you for submitting your proposal on "A phenomenological study of female therapists' experiences of working with female sexual abuse survivor groups". This proposal has now been reviewed by I-WHO's Ethics Committee to the extent that it is described in your submission.

I am happy to tell you that the Committee has found no problems with your proposal and is able to give approval. It is the policy of the Committee that a study that has obtained ethical clearance via the NHS will receive clearance assuming that the procedures are no different to that described in the submission to the NHS ethical committee.

If there are any significant changes or developments in the methods, treatment of data or debriefing of participants, then you are obliged to seek further ethical approval for these changes.

We would remind all researchers of their ethical responsibilities to research participants. The Codes of Practice setting out these responsibilities have been published by the British Psychological Society. If you have any concerns whatsoever during the conduct of your research then you should consult those Codes of Practice and contact the Ethics Committee.

Independently of the Ethics Committee procedures, supervisors also have responsibilities for staff and student safety during projects. Some information can be found in the Safety Office pages of the University web site. Particularly relevant may be:

Sections 6.9, 6.10, 6.11, 6.14 of the *Safety Handbook*, which deal with working away from the University.
http://www.nottingham.ac.uk/safety/
Safety circulars:
Fieldwork P5/99A on http://www.nottingham.ac.uk/safety/publications/circulars/fieldwk.html
Overseas travel/work P4/97A on http://www.nottingham.ac.uk/safety/publications/circulars/overseas.html
Risk assessment on http://www.nottingham.ac.uk/safety/publications/circulars/risk-assessment.html

Responsibility for compliance with the University Data Protection Policy and Guidance also lies with the project supervisor.

Ethics Committee approval does not alter, replace or remove those responsibilities, nor does it certify that they have been met.

We would remind all researchers of their responsibilities:

- to provide feedback to participants and participant organisations whenever appropriate, and
- to publish research for which ethical approval is given in appropriate academic and professional journals.

Sincerely

Nigel Hunt PhD CPsychol AFBPsS
Chair, I-WHO Ethics Committee

A World Health Organization Collaborating Centre in Occupational Health
Member of the European Agency for Safety and Health at Work Topic Centre GPSP

I-WHO Institute of Work, Health & Organisations

Appendix C

Letter to Managers

Trent Doctoral Training Programme
in Clinical Psychology
I-WHO, University of Nottingham
5-8 William Lee Buildings
Science and Technology Park
University Boulevard
Nottingham
NG7 2RQ

01158466646

Dear

I am writing to you in regards to research I am conducting as part of my doctoral training in clinical psychology. I am a second year Trainee Clinical Psychologist, based at the University of Nottingham, supervised by Dr. Rachel Sabin-Farrell, Clinical Psychologist.

As part of the course I am conducting research on the experiences of female therapists who run female sexual abuse survivor groups. The aim of the study is to flexibly explore individuals' experience of the positive and negative effects that they attribute to the running of these groups. The study utilises a qualitative research design using Interpretative Phenomenological Analysis (IPA) – a research method which aims to look at the data and analyse the recurring themes which emerge. The study's purpose is to add to, and address the shortcomings, of the current research base. I would hope the findings of the study will provide a more comprehensive understanding of the processes involved for therapists working with trauma clients, which could in turn inform interventions to reduce any negative impact on staff.

From preliminary enquiries I understand that you manage a service which has female therapists who have experience in this area. I would like to ask whether you would consider approaching members of your staff to see if they would be interested in taking part in this study. Participants would need to be female therapists, of any qualification or experiences, who are currently or have been in the past, involved in running a group for female sexual abuse survivors. My research is particularly focussed on a therapist's experiences of the additional complexities caused by group dynamics, therefore I would exclude anyone who has only been involved in the assessment stage of developing a group.

I have attached copies of the covering letter, participant information sheet, consent forms and pre-paid envelopes, as well as extra copies for any additional therapists you can identify who might be interested. Those therapists that return the signed consent form will subsequently receive a

demographic sheet to complete, after which I will contact them to arrange an appropriate time to conduct an interview.

The total duration of time expected of the participants would be, that required to complete the consent and demographic forms, and approximately one hour to complete a semi-structured interview. I would arrange the interview to take place at the most convenient venue for participants, to avoid the need for them to travel. Once the interviews and analysis are complete I will provide feedback to both participants and managers of the findings of the study. I would anticipate this to be before the end of 2008.

I have also enclosed a copy of the approval letter from the Cambridgeshire Ethics Committee which provides ethical approval for multi-site studies. If you require any further information please do not hesitate to get in contact with me, or my supervisor Dr. Rachel Sabin-Farrell, at the address at the top of this letter or by email (rachel.sabin-farrell@nottingham.ac.uk).

Many thanks for your time,

Alex Toombes
Trainee Clinical Psychologist

Appendix D

Participant Information Sheet

Study Title: A Phenomenological Study of Female Therapists' Experiences of Working with Female Sexual Abuse Survivor Groups

We would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish.

Part 1 of this information sheet tells you the purpose of the study and what will happen to you if you take part.

Part 2 gives you more detailed information about the conduct of the study.

Please get in touch if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Part 1

What is the purpose of the study?

The study aims to investigate, both the positive and negative, experiences of female therapists running female sexual abuse survivor groups. The study's purpose is to add to, and address the shortcomings, of the current research base, and provide a more comprehensive understanding of the processes involved for therapists working with trauma clients, given the added complexities of group dynamics.

Why have I been invited?

You will have been asked by your manager if you were happy to be contacted by researchers. You have been identified as a female therapist working with female sexual abuse survivor groups. There are 8 other therapists who have been identified from services within the Trent area.

Do I have to take part?

It is up to you to decide. After you have read the information sheet, if you wish to take part you should complete the consent form and return it in the pre-paid envelope. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?

If you decide to take part, and you return the consent form you will then receive a sheet asking you to record some demographic and clinical information on the form and return it to the researcher. We will then contact you to arrange a suitable time to conduct a semi-structured interview. This interview will take place at your place of work, if appropriate and possible, and be conducted by the primary researcher. The interview should last approximately 1 hour, during which you will be asked to explain your experience of working with sexual abuse survivor groups. The interview will be recorded using an audio-recording device. The tapes will be transported to a locked cabinet. The tapes will then be transcribed by the researcher and typist, who will have signed a confidentiality agreement. Following transcription of the tapes all data will be coded to ensure anonymity.

What are the possible disadvantages to taking part?

We acknowledge that some of the issues under discussion are sensitive, although you will not be obligated to discuss anything which you are not comfortable to, and you are able to stop the interview at any time if you wish.

What are the potential benefits to taking part?

We cannot promise the study will help you but you will be given the opportunity to discuss and reflect upon your experiences of working with trauma clients. Future benefits of the research may include a better understanding of the positive and negative impact for therapists working with sexual abuse survivors. Awareness of these issues could inform prevention or interventions to reduce the harmful effects of working with trauma clients.

What happens if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed, in the first instance it is best to contact the primary investigator, Alex Toombes at the University of Nottingham. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part2 before many any decision.

Part 2

What will happen if I don't carry on with the study?

If you withdraw from the study, we will destroy all your identifiable data, and you will not be included in the final write up.

What if there is a problem?

If you have any concerns about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions (0115846646). If you remain unhappy and wish to complain formally, you can so this through the NHS Complaints Procedure or through the Trent Doctoral Programme of Clinical Psychology, University of Nottingham. Details can be obtained from the main NHS switchboard or the University of Nottingham.

In the event that you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Nottingham, but you may have to pay for your legal costs. The normal NHS complaints mechanisms will still be available to you.

Will my taking part in this study be kept confidential?

Your data will be collected during the semi-structured interview and recorded using an audio-recording device. Following interview the tapes will be transported to a locked cabinet. These tapes will be transcribed by both the researcher and typist, who will be asked to sign a confidentiality agreement. The transcribed data will then be coded, ensuring anonymity. The data will only be used for this study. Authorised persons such as supervisors of this research, regulatory authorities and R&D audit may

have access to the raw data. The data will be kept for seven years in a secure facility, and then disposed of securely.

What will happen to the results of the research study?

It is intended to publish the results of the study, but individuals will not be identifiable in any report/publication. All participants will be sent a copy of the final report of the results. If individuals would like to see the results of their individual interview you can request a copy, and this will be sent to you.

Who is organising and funding the research?

The University of Nottingham is the sponsoring organisation of this study. There will be no exchange of funds for this study.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by Nottinghamshire Research Ethics Committee.

Further information and contact details

If you require any further information about the study please do not hesitate to get in touch.

Researcher:	Miss Alex Toombes
Address for correspondence:	Trent Doctoral Programme
	I-WHO, University of Nottingham
	5-8 William Lee Buildings
	Science and Technology Park
	University Boulevard

Nottingham

NG7 2RQ

Phone number: 01158 466646

Due to the sensitive nature of the topics that will be discussed we have included the contact details of your local NHS staff counselling service should you wish to discuss with them any distress you have experienced following interview.

***

***

***

If you would like to receive this information sheet in larger print please contact researcher.

Appendix E

Consent form

Patient Identification Number:

CONSENT FORM

Title of Project: A Phenomenological Study of Female Therapists' Experiences of Working with Female Sexual Abuse Survivor Groups

Please initial box

1. I confirm I have read and understand the information sheet provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected. ☐

3. I understand that relevant sections of my data collected during the study, may be looked at by individuals from Trent Doctoral Programme of Clinical Psychology, University of Nottingham, from regulatory authorities or from the NHS Trust, where it is relevant to ☐

my taking part in this research. I give permission for these individuals to have access to my data.

4. I understand that my data will be recorded using an audio-recording device, and that anonymised use of my data may be used for verbatim quotation in the write up of this study. I consent to my interviews being recorded, and verbatim quotation used. ☐

5. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature

_____	_____	_____
Name of Person taking consent	Date	Signature

Please provide a contact number, which we can contact you on……

Appendix F

Demographic and Clinical Information Sheet

Demographic and Clinical Information Sheet

Participant identification number:

1. Age:……

2. Date of birth:……..

3. Qualifications:……

4. Profession:……

5. Years of experience working with clients with sexual abuse trauma histories:

……

6. Years of experience working with groups for clients with sexual abuse trauma histories:

……

7. Do you undertake any work outside of this position which involves clients with trauma histories? If so, please give details:

……

Appendix G

Interview Schedule

1) Can you think back to the first sexual abuse survivor group you helped run, and tell me what that was like for you?

2) Thinking now about all of those groups who have worked with, do you think that working with groups of clients who have experienced abuse trauma has impacted on you?

Prompt

I imagined that hearing clients' stories might be difficult and wondered if that had changed your views at all?

Prompt

I was also wondering whether it might have influenced how you feel about…

- others (and relationships)
- self
- world
- spirituality

3) Would you say you have ever experienced what you would describe as intrusive images or thoughts, that on reflection, you would attribute to working with sexual abuse survivor groups?

4) Would you say that there are positive differences in the way you experience the world because of having worked with sexual abuse survivor groups?

Prompt

I was wondering whether seeing changes in group members might have changed how you experience things in your life?

5) How do you think working with sexual abuse survivor groups has changed the way that you live?

Prompt

What do you do differently?

How do you see things differently to how you might have without those experiences of sexual abuse survivor groups?

6) What do you think it is about working with sexual abuse survivors in a group setting specifically that has contributed to those changes in your life you've described?

Appendix H

Example of Analysis and Commentary

33.		I So thinking now about all of the groups that you've worked with over that sort of *** years. Do you think that working with groups of clients who've experienced abuse trauma has impacted on you?	
34.		F Yeah, I would say so, yeah.	*Impact*
35.	*Hard to separate group/ survivors*	I'm trying to separate what the impact of working with groups and the impact of working with survivors … because I think they've both had an impact.	
36.	*Live dynamic* *Lots of people to attend to*	I think if I start with working with groups actually, that you know, I think kind of working in such a live dynamic, where there are lots of people that I have to attend to and you know, I facilitate the way that they interact.	*Live dynamics*
37.	*Layers upon layers of analysing*	I have kind of thoughts and interventions about what's happening, all of that kind of … layers upon layers of analysing what's kind of going on, I think has had a huge impact on me.	*Mass of people – layers and layers*

38.	*Way think about world*	I think adding the bit about trauma; I don't know, I think in a big way, I think it affects the way that you think about the world.	*World view*
39.	*Freedom / autonomy important*	I think I'm quite safe here in the *** in that you know, it's a women only ***, I'm under no pressure to do anything other than what I do and I have the freedom and autonomy to start new things, to you know, think about developing services.	*Safety* *Organisational context*
40.		I have all of that freedom, which is a really … you know, I think is an amazing position to be in.	
41.		I Mm, yes.	
42.		F But I think in terms of how it's impacted me … gosh, that's a big question.	
43.		I It is. I mean one of the things I was thinking about is just the process of hearing the client's stories and if that's changed your …I guess what you were saying about the world really, if it's changed your views on it?	

44.	*Anger at news*	F Well I get angry when I hear the news (laughs).	*Anger*
45.		I Okay.	
46.		F I think what it's done is kind of … it does go back to this desensitisation bit as well.	
47.	*Nothing haven't heard* *Odd position*	I mean I don't feel like there is anything I could hear that I haven't heard before, which you know, is kind of an odd position to be in I think.	*Different to others*
48.		You know, the amount of violence and degradation and you know, humiliation and neglect and you know, I feel like … whether I have or not, but I feel like I've heard it all, you know.	*Extreme negative stories* *Heard them all*
49.	*Not becoming desensitised*	And so, I think one of the things that I am really conscious of when I'm meeting new assessments is that I've heard it all and I haven't heard you.	*Desire not to lump together* *Responsibility of therapist*
50.		Do you know what I mean?	
51.		I Yes.	
52.	*Heard every act but not*	F It's like you know, I don't think there's an act that I haven't heard about, an act of	*Maintaining individualised*

	every story	abuse that I haven't heard about, but I haven't heard this particular woman's kind of story around that act.	*approach*
53.		Do you know what I mean?	
54.		I Yeah.	
55.		F So I think there is a real consciousness about not getting into the position of 'oh right, it's just that', or somehow kind of putting a hierarchy in.	*Mindful*
56.		Which I kind of feel you know, could happen and I think you know, I'm conscious that I don't want that to happen.	*Responsibility to client?*
57.	*Not wanting a hierarchy*	And I can see through you know, if you hear stuff over and over again, that actually you know, this doesn't seem as bad as this.	*Over and over*
58.	*Maintain quality for individual*	And actually you know, what we're concerned about and what I want to be concerned about as a psychotherapist is this individual that's in front of me.	*Reflective* *Want to be….for the client*
59.	*'Pull'*	So I think there's a consciousness around not wanting that to happen but feeling that that's a pull really.	*conflict*

60.		I think sometimes it feels like you know, if I'm with friends who aren't in this kind of work, I feel like I … you know, in conversations that will happen, I'm kind of amazed that people don't have the same kind of thinking as me.	*Different to others. Changed thinking*
61.		And they don't, because they've not heard or you know, seen the impact of that degree of trauma.	
62.	*Open a door* *Alone?*	And I can sometimes think that you know, I've opened a door into you know, a whole other world that actually I think everybody else knows about and actually they don't.	*Opened a door into another world. Who inhabits?*
63.	*Hold a lot*	And so it kind of … I think there is a tendency of you know, I feel like I hold a lot and it's not anything that I talk about really with other people.	*A container*
64.		I don't talk to my partner about the work I do really.	
65.	*Supervision*	I have supervision for that.	
66.	*Feels like I'm different*	But it kind of feels like I'm different and I think that is definitely a response to hearing the level of trauma that I have heard over *** years you know, I do feel like that's been an impact.	*I'm different*
67.	*It's ok*	And that fits fine with my personality, it's not like I want to be any different or be in a positioned anywhere differently with my friends.	*But ok with that…?*

68.	*Shocked?*	But it does feel like it's blimey, you don't actually know about that.	
69.		You know, if I hear them say 'God, did you hear something on the news?', I think I hear that every … (laughs)	
70.		I Yeah.	
71.	*Set apart*	F Do you know what I mean, it's that kind of stuff. So it feels like I feel set apart sometimes.	*Different*
72.		I And do you feel that that being set apart is something that other people acknowledge or is it something that you see? Because like you were saying they don't hear the things that you hear?	
73.	*Colleagues understand Comradery*	F I don't think they know or acknowledge it but I do think my colleagues do.	*Comradery with colleagues*
74.		I feel like I could say this to them and they'd say 'oh God, yeah you know, I understand	*A communal understanding*

		that'.	*but set apart from other world*
75.	*Parallels to victims*	So it's almost like you know, the parallels I think with abuse are really interesting because this is the kind of stuff that women will come and talk to me about.	*Parallels with abuse* *Identification with victims*
76.	*Being abused sets you apart*	Somehow the experience of being sexually abused makes them feel set apart or somehow you know, away from the rest of the world.	
77.	*World oblivious stigmatised*	The rest of the world is kind of oblivious to these traumas and they sit with the stigmatisation of it.	*Stigma of sexual abuse*
78.		And I think somehow the parallel process occurs.	
79.	*Journey of listening to someone*	You know, I'm telling you that I feel set apart; this isn't about personal experiences of abuse, this is about the experience of being with … you know, the journey of listening to someone.	*Not about own experience…but journey of listening to someone*
80.		Do you know what I mean?	
81.		I Yeah.	
82.		F So I think there's very definitely a parallel process that goes on.	

83.		I That's really interesting. I hadn't thought about it so directly as that, but yeah, absolutely. And you were saying before something about that you feel quite angry when you hear those sort of things like on the news and …?	
84.	*Anger*	F Yeah, I get angry when I hear things like the public outcry of you know, one … generalising but you know, one man not known to a family who abuses a child and how horrendously terrible this is and he's got you know, five years.	*Anger*
85.	*Women I work with…*	And then I think but actually, the women I work with you know, it's their father or it's their step-father or … who is abusing them on a daily basis.	*Injustice*
86.	*Abnormal / vilified*	You know, somehow this kind of desire for society to you know, make perpetrators into this kind of thing that is abnormal and vilified and you know, how terrible.	*Acceptability in society*
87.		And actually it's in your next-door neighbour's house you know, I get angry about the need to kind of vilify one person rather than for us all to accept that this is happening kind of you know, in houses that you don't expect it to be happening in.	*Ignorance.* *Denial.* *Lack of knowledge*
88.	*Angry?*	And it's happening to children who you don't think it should be happening to, do you know	

		what I mean?	
89.		I Yeah.	
90.	*Compartmentalisation*	F In a kind of weird sort of compartmentalisations and … do you know what I mean?	*Compartmentalising*
91.		I Yes.	
92.	*Anger*	F It's that kind of stuff I get angry about.	*Anger*
93.		I An inability to incorporate it into what is general to society?	
94.		F Yeah, yeah.	
95.	*Invisibilises* *Women I listen to*	And so that makes me mad because I think it just invisibilises so much of you know, the women's experiences that I listen to, where it where it wasn't you know, a paedophile who wasn't known to the family, who you know, suddenly came in and then went out again.	*Taking on survivor's cause*

96.	*Hierarchy* *No escape*	This is kind of constant ongoing you know, where the child has no escape because it's happening in the house.	*Empathy*
97.	*Mother's role* *Father abusive*	Mother is either passively neglectful or you know, actively neglectful and you know, father is sexually abusing them.	*Parental betrayal*
98.	*Horror* *Not hierarchical*	That is the horror story you know, but again it's not about making hierarchy that one is worse than the other, but it something about one is more appropriate to be reported than the other I think.	
99.	*Society*	You know, it's fine if we can say 'oh there's this horrible man with a horrible beard over there' but actually we don't want it to be the bank manager, so we won't talk about that.	
100.		I Yeah.	
101.		F You know, that's what I get angry about I think.	*Anger*
102.		I And would you argue that the work with sexually abused survivors has impacts on your views generally of people?	

103.	*Having male child* *Gender*	F Well that's an interesting question because I've got a little boy and I think before I had ***, I think I was much more of the stance of you know, this is an issue that affects women as victims and is perpetrated by men.	*Can no longer categorise.* *Changed - mother*
104.	*Women victims*	Now I still think that women are the majority and girl children are the majority victims and survivors of sexual abuse.	*Holding on to that for her clients?*
105.	*Men perpetrators*	And I still think that men are the majority of perpetrators of sexual abuse.	
106.		And I think there's a whole kind of continuum within that, that isn't gender specific.	
107.	*Having child changed view*	But I think since I've had ***, I think I'm really … you know, I don't feel like I come from that real sort of you know, men are bastards and they're the perpetrators, do you know what I mean?	*Can no longer categorise*
108.		I Yeah.	
109.	*Proud of male energy*	F And I think that is partly having a boy child you know, that I really want him to grow up and be you know, proud of his manliness and you know, his male energy.	*Must find exceptions*

110.		And it is very different.	
111.	*Narrow view – abused women*	So I kind of think I don't want to, I think the possibility is because I work only with women and every woman I see will have suffered abuse.	*Possibility of skewed view of the world*
112.		And I can say in the *** years that I've worked with women you know, a tiny percentage have talked to me about being sexually abused by women.	
113.	*Bigger story*	But what I hear constantly, time and time again, is actually the acts of sexual abuse perpetrated on them by men is only part of the story and only part of their traumatic responses.	
114.		And I think that's another thing that I've learnt over the *** years you know, we can do work around you know, acts of sexual abuse and you know, how sexual abuse has impacts in terms of relationship stuff and all of that kind of stuff, we can do all of that.	
115.	*Mothers- care/nurture*	But actually, what women are talking to me about are more in terms of their trauma response, is the impact of their mothers more than anything and the absolute desire for mothers to be caring and nurturing and protecting.	*Not a simple story – complexities.* *Views of others/world*
116.	*Passively non-protective*	And even if they weren't … even if mothers weren't collusive in the sexual abuse, what we're hearing about is they were passively non-protecting.	

117.		So they didn't ask, they didn't see, they didn't kind of care or put themselves forward enough to … so it's that relationship that we're talking more and more with women about.	
118.		Rather than 'this is what happened to me and now I struggle in relationships with partners'.	
119.	*Complex picture*	We're hearing much more about the relationships with mothers, which makes for a much more complex picture, where you can't say you know, men are the perpetrators and women aren't.	*Can't hold categorical view*
120.		I Yeah.	
121.	*God, where are the mothers?*	F You know, we might not be able to say in equal measures that women sexually abuse children in the way that men do but we are hearing more and more and my picture of the world I think is much more about you know, God where are the mothers, do you know what I mean?	
122.		I Mm.	

123.	*Conflict*	F Which kind of … it's an odd position, because it then … you know, I also don't want to get into the whole situation of you know, invisibilising men's perpetrating of sexual abuse, do you know what I mean.	
124.	*Blame / Responsibility*	And it's their responsibility, da-da-da-da-da, and it's a very complex picture about where trauma originates and where blame and responsibility lies.	*Meaning making*
125.		So I think women have to be in the picture, mothers have to be in the picture in that. I've kind of gone off the …	
126.		I No, but I was thinking I should imagine that … well I was wondering whether that complex picture has become more complex for you since you became a mother as well?	
127.		F Yeah, I think so, absolutely, yeah. I think it's … yeah, without a doubt it has.	
128.		I Yeah. It's that interesting thing about are women talking about it more or were you more open to hearing that because of … it's an interesting …	

129.		F Yeah, yeah.	
130.		I … kind of dynamic.	
131.		F Yeah, I think so, I think so.	
132.		But certainly if I think back to the first groups that we ran and the groups that we run now, the more complex picture that we're working with is women's relationship with their mothers, alongside kind of the effects of sexual abuse.	
133.		It's kind of like they are completely entwined.	
134.		And I think to work with one without the other doesn't feel like it kind of gets to the lap of things really.	
135.		I Mm. I think that's … I guess I was also wondering … I'm not sure whether this is kind of already kind of part of what we've spoken about, but how you would argue all of those complexities and all of the ways that you have to work with people, sexual abuse survivors, whether that affects your relationships? Any relationships really, not sort of	

		specifics?	
136.		F Yeah. You see, I want to say yes it does and as I'm kind of thinking about that, I'm thinking yeah, but be specific you know, in what ways.	
137.	*Trying to tease apart roles* *Mother role*	You see, I don't know whether it's working with survivors or working as a psychotherapist generally, that you become more aware of you know, the impact of what … so I'm thinking about being a mother.	*Being a mother*
138.	*Who I am* *Awareness and reflection*	You know, I'm hugely aware of the impact of what I do, how I am, who I am to my little boy. Do you know what I mean?	*Awareness. Self reflection*
139.		And I don't know whether that's because I've worked with survivors in groups or whether that's because I'm a psychotherapist and it would happen whether I worked with you know, anybody.	
140.		I I recognise that you can't always tease apart what …	
141.	*Because of your work*	F Yeah. But erm … yeah, my partner will often say to me … you know, I can't even	

		give you specific examples, but I can hear her say that 'yeah, but that's because of the work you do'.	
142.		That seems to be something that is quite often said to me, 'that's because of the work you do', or 'you're seeing that' or 'you're worried about that because of the work you do'.	*Unknown impact, noticed by others*
143.		So I think because that's being said to me you know, it has to be.	
144.	*Not aware of impact*	And I guess I'm not you know, massively conscious of the ways in which it impacts me, do you know what I mean?	*Not always conscious of impact*
145.		I Yeah.	
146.	*Assumptions?* *World must be a terrible place*	F I don't think there's any … you know, I don't feel … when you said you wanted to do this, I think the kind of first response would be oh there would be burnout or there would be you know, just like the world must be a terrible place if you listen to that.	
147.	*Don't feel like that Environmental*	And I don't feel like that, I don't feel like the world is a terrible place, apart from you know, the fact that we're destroying the world and it's probably going to end very soon.	*Don't feel like world is terrible place despite her assumption*

			I would assume.
148.	*Not as a result of hearing trauma*	But apart from that (laughs) you know, I don't think that's as a result of hearing the trauma that I've heard.	
149.	*Empowerment* *Shaking off shame*	Because actually what I hear alongside the trauma is I see every time I work with a group, I see the shifts and the changes and I see the empowerment and I see women kind of shaking off this thing of shame that I think is utterly debilitating.	*Alongside trauma admiration of survivors. Witness transformation.- protective?*
150.	*Inspirational*	And that is … you know, it sounds a bit of a cliché but it is inspirational you know, when you see someone has just been shamed to almost paralysis in their lives, they can't do anything or won't do anything because of … or talk to anyone because of the utter shame they feel about their past.	*inspiring*
151.	*Witnessing shift*	And for that person then to move into 'actually it wasn't my fault, I'm not carrying this anymore' you know, blimey, do you know what I mean?	*Powerful. witnessing*
152.		I Mm.	
153.	*Assessment process*	F So it's not … I think if I was … I notice a difference actually between when I'm	*Assessment is stark –*

		working in assessments and when I'm working in a group.	*language change*
154.		And the difference is stark.	
155.		I think I changed the assessment system because of this on the ***.	
156.		We used to run blocks of assessments.	
157.		So we wouldn't see anyone until just before a group, right, we run groups three times a year.	
158.		I Yeah.	
159.	*Full-on*	F And so before each group, we'd have three weeks of assessments, full-on assessments. So we'd see … in three weeks, we'd see up to 21 women.	
160.		I Gosh.	
161.		F And that is a lot.	*Too many?*
162.	*Consideration for group*	And it would literally be … because we'd want to see everyone who was possibly going to	*Putting their needs first*

	members	come into a group, we'd want to see them just before the group started, so they didn't have a long wait between assessment and coming to the group.	
163.		I Yeah.	
164.		F So that's why we did it and there was kind of …	
165.		I There was a thought process?	
166.		F There was a thought process behind it.	
167.	*Back-to-back*	But what it meant was for three weeks, I would be sat here, right, and it would literally be back-to-back, maybe three or four women for hour and a half assessments.	*Back-to-back*
168.		And all you have time for in an assessment is you know, we need to check out what is their ability to be able to you know, connect with their past.	
169.	*Must talk about abuse*	We have to talk about sexual abuse, to be able to have some kind of psychological mindedness around you know, the effects of what's happened and the link between what	

		happened and how they are now.	
170.		I Mm.	
171.		F So there's some things that we need to check out about that.	
172.	*Basics* *Hear everything.* *Awfulness?*	But the basis of those assessments was someone would come in, we'd start talking, eventually we'd get to talking about their history and we'd hear about you know, what happened to them, who did it you know, what life was like growing up.	*Feels abusive to them and to you/*
173.	*Awfulness* *Responsibility of decision*	And it literally was just an hour and a quarter of the awfulness of my life condensed in an hour and a quarter and then you know, we'd say yes you can come or no you can't come to the group.	*Power. Decision*
174.	*What it felt like*	I mean that is a terrible generalisation about it, but that was what it felt like to me.	*Disconnection. What it felt like – abusive.*
175.		I Yeah.	

176.	*One trauma story after another*	F That it would literally be one trauma story after another, with nowhere to go with it.	*Accumulative*
177.		You know, and quite often we would meet with women and it wasn't going to be appropriate for them to come to the group or it wasn't appropriate for them to come to the group right now.	
178.	*Wouldn't witness transformation*	So we'd just have a story and we'd have nothing happen about that, there'd be no transformation because we wouldn't see them again for three months or you know, whatever.	*No transformation – seems very important. Guilt?*
179.	*Wrung out*	And so that had an impact and that used to leave me … I just felt kind of wrung out you know, like I didn't want to hear or see or talk or … do you know what I mean?	*Wrung out*
180.		I Mm.	
181.	*Hear worst of humanity and no transformation*	F It was like they were really unpleasant weeks because you'd hear the absolute worst of humanity, without any of the possibilities for transformation that I believe therapy offers.	*Only see worst of humanity, need counter view?*

182.		I Yeah.	
183.	*Awful*	F So that I think was awful.	
184.		And we've changed that system now, so we don't do that anymore.	
185.	*Good for client*	But we did that for possibly like *** years, in that kind of structure and we kind of kept it because it felt like it was good for the clients.	*Putting their needs first*
186.	*No good for us*	But it was not good for us.	
187.		I No.	
188.	*Put themselves second?*	F But the way that we kind of rationalised it was it's three weeks every three months you know, you can get through it.	
189.	*Steel yourself*	And you'd kind of steel yourself before the assessment process, right okay, we've got three weeks of this and I'd book nothing else in my diary for three weeks apart from assessments you know, because there'd be a huge amount of admin that would kind of come up as a	

		result of it.	
190.	*Traumatising*	But yeah, that was … I felt that was traumatising you know, because it really was you know, just hearing one awful thing after another and you know.	*Traumatising*
191.		I Yeah, it's a lot to take in, in one go isn't it?	
192.		F Yeah, yeah.	
193.		I And I guess on the traumatising thing, would you say that you've experienced what you would kind of describe as intrusive thoughts or images as a result of that?	
194.	*"no"*	F I think I'd say generally no.	*No images?* *Contradiction*
195.	*Always*	And then there is always someone, someone's story that kind of … I call it kind of getting	*Failed protective*

	Becomes personal	under my radar you know, and it will get in there.	*mechanism*
196.	*No specific stories,* *But always one.* *Use of supervision*	And I don't really understand why that particular story kind of gets in there because you know, I've talked a lot about this in supervision and with my colleague and there doesn't seem to be like a common thread around what stories kind of get in there and what stories don't.	*Lack of understanding.* *Can't stop it – no control*
197.	*Not overwhelmed but "always someone"*	But I feel that I'm not overwhelmed by kind of loads and loads of unwanted thoughts or you know, images but I think I'm probably carrying someone all the time, who is someone … some story or someone who has kind of got under there.	*Not overwhelmed – Minimising?* *Protective mechanism?*
198.	*Mainly images*	And so it's not everybody but there will be something and it's mostly images actually.	*Images*
199.	*Stories about children son's age*	And I do wonder again about where this fits in with … because my son's *** and I do wonder whether one of the common threads in all of this is hearing stories about children his age.	*Connecting life and work*
200.	*Transpose him – to empathise. Unbearable*	And I think if I connect, if someone is talking in a very graphic way, very descriptively about being the age that *** is and I transpose him into that situation, that I find unbearable, you know.	*Creating imagery – "unbearable"*
201.	*It's alright but it*	And you know, I kind of feel like I have ways of dealing with it you know, and it's alright but	*Minimising –*

	happens!	it happens.	*Normalising?*
202.	*Something unique about this job*	And you know, I think if you spoke to a bank manager, they wouldn't say (laughs) you know, 'I have problems with customers and …'	
203.	*I say it's odd BUT… conflict, what's ok – what you say?*	So in a way it's odd because I say 'oh it's fine you know, it's just part of my work and I know how to deal with it and it doesn't really have any great impact', but I think it's another level of actually 'God, that does happen'.	*Reflection on impact – How great is the impact?*
204.	*Not active thinking. No Control. Assessments Bad. "He's there"*	You know, I think sometimes it will just happen … it's not me thinking, I don't make myself think about him in those situations but sometimes someone will say something and it's particularly in assessments actually, someone will say something and it's like he's there.	*Out of control, creating Images. Assessments worse*
205.	*Responsibility ? Empathise-putting needs first*	You know, in order to kind of think what that was like for them, I guess he kinds of creeps in and that is awful.	*So as to empathise. Impact on self*
206.	*Not about acts Sense of isolation*	And it's not … generally it's not about you know, acts of abuse, generally it's stuff around the utter isolation that that child felt.	*About the sense of child*
207.	*No protective adult Because a parent?*	Or you know, just the … I don't know, just the awfulness of not having any protective adult around them and having to cope with the world, it's that kind of stuff.	*Feelings?*

208.		I That vulnerability?	
209.	*Sense of protection of Child, struggling to Come to terms with Loss of childhood*	F Yes, it's that. And when you know, I think of my little boy having to do … and I'm not talking about active abuse, I'm talking about kind of having to live in circumstances where you know, he'd have to get up and get his own breakfast and you know,… it's a lot.	*Thinking about own child Transposing on to own life*
210.	*Matter of fact Skewed reality?*	You know, and these women will talk about you know, the most awful circumstances in quite matter of fact ways sometimes and you know, I think fucking hell, you know.	*Shock Maintaining perspective*
211.	*Not in control of images?*	So I think there are … and that's when the images kind of come.	*Images*
212.		I Because you were saying that you feel like you've got ways to deal with that; what sorts of things … how do you manage that?	
213.	*Self protection*	F I feel like I've got kind of alarm bells that ring, that let me know that actually something's not okay.	*Protective mechanism Awareness, reflection*

214.	*Home and work* *Stop and realise!*	So if I'm at home and I'm thinking about someone, then I kind of think 'hang on you know, why that person and not the other woman that I've seen that week.'	*Stop and reflect*
215.	*Informative* *Reflection*	And so I kind of log it as you know, there's something there, some information there and then I'll come back and I'll talk with the woman that I run … ***, who I run the groups with, or I'll take it to supervision.	*Coping with impact.* *Supervision and colleagues*
216.	*Use your reactions*	So it's about kind of … if something kind of happens you know, whether it's a thought that doesn't carry any kind of traumatic reference or if it's an image or you know, I kind of have the thinking that everything is information.	*Everything is information* *At cost to self?*
217.	*Information* *Empathy*	And so if it's coming … if I'm getting something, then it's information about something and either something that I'm not attending to or something that you know, whatever I'm feeling might be something of what the client's feeling.	*Thinking about client*
218.		You know, I kind of want to explore it.	
219.	*Don't ignore*	So I think it's about talking about it rather than pushing it away.	
220.		And in a sense kind of going back to parallels, that's what we kind of advocate with the groups really, is that the groups are a space to invite you know, the stuff that you push away, the group is a space to invite it in really.	*Parallels with victims*

221.		So we're not about pushing stuff away or you know, managing by forgetting.	*Coping*
222.	*Everything is survivable*	You know, this is about managing and believing that everything is survivable.	*Belief* *Everything is survivable*
223.		I think that's the other kind of ethos really.	
224.	*Parallels / Modelling*	So I think the parallel is that I do that too and I have supervision and my colleague to do that with.	
225.		I On a more positive note, would you say there are any positive differences in the way that you experience the world as a result of working with sexual abuse survivor groups? So you talked before about the strong inspiration of some of the women …	
226.	*See breadth* *Extremes of humanity*	F Mm. I feel like I … it's like I see the breadth of possibilities in the world, I see the kind of awfulness and the kind of degradation that humanity can do to itself.	*Changed view of others* *Awareness of spectrum* *Of humanity*
227.	*Inspiration / hope*	And then I also see the real kind of inspiration and hope.	*Hope*
228.	*Broader*	So I feel like I've got a whole range in which I can kind of experience all the bits in	*Widened perspective*

	spectrum	between.	
229.		So I feel like it's widened my perspectives hugely.	
230.	*Can't have categorical view* *Too complex*	And I think it stops me from generalising because you can't you know, you can't come from a place of you know, these definitive … you know, all men are perpetrators or you know, women are never perpetrators.	
231.		The picture is far too complex for any generalisation.	
232.	*Positive - glad*	And I think that is a really good thing because I think that means that in life I don't really.	*Secondary gain?* *Journey of self development*
233.		So yeah, I think that's kind of given me a much wider perspective.	

Interview commentary

Line 33 & 43

Initially asked question, relating to question two of interview structure, but therapist seemed to feel overwhelmed by question, hence prompter was used to explore further what she had stated about the way it changed her view on the world, in adherence to planned prompts.

Line 72

Enquiring whether the concept of being 'set apart' was an internal experience, as a result of the work she did, or whether she felt this was something that was 'done to her' i.e. others created distance between them and her.

Line 83

Reflection; had not previously considered parallel processes that occur between therapists and clients in regards to the stigmatisation of sexual abuse. Prompter question used to explore further the issue of anger that she had raised previously.

Line 102

Therapist had been describing society's view of sexual abuse, and so I wondered whether that linked to her views of others generally on a more individual basis.

Line 126

Prompter question used to explore further the role she felt being a mother contributed to her views, having discussed this in relation to her perception of men.

Line135

Interested in how she felt the work had impacted on her relationships, having talked about the relationships in families of those sexually abused and how she views others now as being set apart.

Line 140

Interjection; due to many therapists describing it difficult to tease apart their work with sexual abuse survivors in group settings versus other work they carried out in their role as psychotherapist.

Line 191

Interjection; serving to validate and reflect on her experience of feeling traumatised as a result of 'hearing one awful thing after another'.

Line 193

Question; following on from her use of the word traumatising, wondering whether she experienced intrusive thoughts (as question 3 of interview schedule) associated with PTSD.

Line 212

In line 203 therapist had referred to having ways to deal with thoughts, so asked prompter question to explore how she coped with these.

Line 225

In accordance with question 4 of interview schedule asked specifically about the positive differences she experienced. At this time during the interview it felt like there was a change in the tone of the therapist from discussing difficult experiences to talking about 'believing

everything is survivable', hence like a time to move to the more explicit 'positive' experiences. And referred her to the inspiration of women she had previously discussed in line 150 to explore further.

Appendix I

Example of Memo to Self

Note to self during analysis phase:

Transcript No. 3 feels different to the others

Why? More vulnerable due to organisational context – she feels unsupported, could that lead to more sense of traumatisation? She mentions a desire for structure within the group, does this serve to protect her and keep boundaries so that she does not have to cope with the uncertainty and unruliness of disclosure on top of the other pressures she is experiencing?

What impact does the organisational context have??

Note to self during analysis / write up:

Concept 'vicarious traumatisation' : what does it mean? If symptom based these therapists are 'suffering' from VT …? If they have a changed world view but they have incorporated that into self view are they traumatised? Is experiencing the symptoms of VT by its very nature 'traumatising' or is it just 'an' experience that 'we' as the objective outsider are deciding is a negative experience?? Are we projecting negative assumptions and labels on to someone else's experience? Or as objective outsiders should we take the position that they should not continue to contain this information to the 'detriment' of themselves? Other factors…?

Extended Results

Super-ordinate themes	Sub-ordinate themes	Description	Quotations
Sense of Responsibility	Putting clients' needs first	Engaging in things in the clients' best interest, to the detriment of the therapist	Transcript 2 Lines 184-185
	Maintaining connection	Not allowing desensitisation to the material or assigning hierarchy.	Transcript 2 Lines 49-59
	Therapist as container	Maintaining genuine empathic connection	
		Upholding client confidentiality, and containing sexual abuse information	Transcript 4 Lines 219-222

Impact	Anger	Emotional response to different aspects of the work	Transcript 2 Lines 84-88
	Feeling different	The experience of hearing about sexual abuse sets you apart.	Transcript 1 Lines 285-286
	Creating internal pictures	Creating images as a result of hearing trauma stories	Transcript 4 Lines 111-114
	Owned trauma and distress	Internalised sense of trauma or distress	Transcript 5 Lines 45-53
	Changed world view	Acute awareness of extremes of humanity, both atrocities and resilience	Transcript 1 Lines 75-76
	Awareness of and defences against 'abusability'	Being aware of your own potential to be	Transcript 1 Lines 138-141

	Dissonance between what you hear and what you do Broader meaning making Secondary self transformation	abused. Conflict how to live with knowledge of risk and yet not feel unsafe. Broader understanding of the world. Issues of meaning and spirituality Secondary gains from being exposed to 'negative' effects of trauma	Transcript 4 Lines 52-63 Transcript 4 Lines 84-104 Transcript 3 Lines 189-189

Protecting and maintaining sense of self	Normalising	Framing impact as normal, given exposure to trauma. Identification with other trauma therapists	Transcript 1 Lines 123-124
	Compartmentalising	Boundaries between work and home	Transcript 3 Lines 203-207
	Maintaining hope	The need to witness client's transformation to offset trauma. Need to hold belief everything is survivable	Transcript 2 Lines 150-179
	Introspection and self-care	Self-awareness and reflection	Transcript 3 Lines 134
Evolving Impact		How the impact changes over time – issues of accumulation or inoculation	Transcript 5 Lines 146-157

Unique aspects of the group setting	Power of shared membership The value of a co-facilitator Potential destructiveness of the collective trauma	Power of bringing survivors together and protection for therapist of being member of the group Vital support of co-facilitator Sense that anything can happen. Fear over compounding trauma for members. Having to cope with live dynamics	Transcript 2 Lines 313-324 Transcript 4 Lines 317-333 Transcript 5 Lines 162-167
Group Milieu		The organisation, structure and wider context to the group impacting on the therapists' experiences	Transcript 3 Lines 66-67

Table 1. Super-ordinate and sub-ordinate theme titles, with descriptions and sample quotation references

The table depicts the super-ordinate and sub-ordinate themes, including those not discussed in the paper. Whilst the descriptions are not comprehensive they provide an overview of the general content of the theme titles. The referenced quotations are also not comprehensive, but point to relevant sections of the data.

Worth considering, when reading the results, is that the therapists all noted how they could not decipher between the effects that working in a group had had on them, versus any other individual work they undertook with sexual abuse survivors.

Sense of Responsibility

Those results not discussed in the paper will be considered here, these include the three themes: Evolving Impact, Unique Aspects of the Group Setting, and Group Milieu. Further discussions on the other results will also be presented.

Putting clients' needs first

One therapist described how the assessment protocol was structured in order to ensure that clients were not left too long without being seen, the result being for the therapists that they were exposed to long periods of seeing one client after another. Dee described it as "*it literally was… the awfulness of my life condensed in an hour and a quarter and then you know, we'd say yes you can come or no you can't come to the group. I mean that is a terrible generalisation about it, but that was what it felt like to me."* Dee goes on to describe how, despite the draining impact on them, they continued to keep this structure for the benefit of the clients:

> *Dee*. We kind of kept it because it felt like it was good for the clients. But it was not good for us.

Therapist as Container

Caroline's narrative about confidentiality echoed this sense of containment:

> *Caroline*. So I used to feel really wiped by those particularly…it's that usual thing about confidentiality. I mean in supervision you can say things about it but you know, you come home from a day where people have … you know, three women, one after the other you know, who are just in a real state and who've got pretty horrific…So it used to be very hard coming back, you say to your friend or whoever you meet, 'it's been a hard day, we had assessments', 'oh what does that mean?' And you can't kind of say very much about it.

In this extract Caroline reveals times when she is feeling *"wiped out",* but supervision is not available, leading to a conflict about her need to offload, and her responsibility to preserve confidentiality. The tone of the extract does seem to reflect a degree of internalised trauma or distress.

Impact

Anger

Interestingly, throughout the therapists' narratives there are few references to the emotional impact that trauma work has on them. However, several therapists mentioned anger, albeit in different contexts. This is mentioned in relation to society's views of perpetrators:

> *Dee.* I get angry about the need to kind of vilify one person rather than for us all to accept that this is

> happening kind of you know, in houses that you don't expect it to be happening in…? …and so that makes me mad because I think it just invisiblises so much you know, the women's experiences that I listen to.

Here Dee's anger is in response to the injustice of society and the treatment of sexual abuse survivors, conveying an idea that it is only tolerable to discuss abuse that occurs outside of the family context. That which also comes across is a picture of a bond, or union, between therapist and client *"…it just invisibilises the women's experiences that I listen to"*; she acknowledges that it's not her experience and yet she is privy to hearing these stories and therefore identifies with them.

Another therapist speaks of her anger at people undervaluing therapists:

> *Caroline*. And occasionally I get upset actually, occasionally if I hear people criticising therapists or you know, saying 'oh you know …', I get angry.

Feeling 'different'

A theme was constructed concerning the therapists being set apart from others, and that this was as a direct result of working with sexual abuse survivors. Dee describes below her realisation that others around her have not been privy to the information she has heard and, therefore, do not share her altered view of the world:

> *Dee*. I'm kind of amazed that people don't have the same kind of thinking as me. And they don't, because they've not heard or you know, seen the impact of that

> degree of trauma… I've opened a door into you know, a whole other world that actually I think everybody else knows about and actually they don't.

"I've opened a door into…a whole other world" seems, to the interviewer, that Dee is saying that once the awareness of trauma is acquired it can never be lost. Dee later describes how this has contributed to her feeling different:

> *Dee*. But it kind of feels like I'm different and I think that is definitely a response to hearing the level of trauma that I have heard over *** years you know, I do feel like that's been an impact. And that fits fine with my personality, it's not like I want to be any different or be in a positioned anywhere differently with my friends. But it does feel like it's blimey, you don't actually know about that… So it feels like I feel set apart sometimes… I feel like I could say this to (my colleagues) and they'd say 'oh God, yeah you know, I understand that'. So it's almost like you know, the parallels I think with abuse are really interesting… Somehow the experience of being sexually abused makes them feel set apart or somehow you know, away from the rest of the world. The rest of the world is kind of oblivious to these traumas and they sit with the stigmatisation of it. And I think somehow the parallel process occurs. I'm telling you that I feel set apart; this isn't about personal experiences of abuse, this is about

> the experience of being with … the journey of listening to someone.

As an interviewer this extract encapsulates the complexities of the impact on therapists. Dee describes her feeling of being different to others, and how she is shocked to realise others around her are oblivious to aspects of life she is exposed to daily *"blimey, you don't actually know about that".* Conversely she says she's fine, and doesn't want to be positioned anywhere else. This conflict leaves her in a position where she feels *"set apart".* However, in what appears to be a reaction to this isolation, she then aligns herself with her colleagues, in what could be self-reassurance that they would also understand this sense of 'being different', *"I feel like I could say this to them and they'd say 'oh God, yeah, I understand that."*. Dee's observation that her experience mirrors that of the stigmatisation that survivors experience, is an interesting one. Dee's account suggests that one impact of working with sexual abuse survivors is that, despite not being a direct victim of the abuse itself, *"the journey of listening to someone"* in itself makes you a part of that world and has its own consequences for the therapist.

Creating internal pictures

Participants were asked whether they experienced what they would describe as intrusive images or thoughts, which could be attributed to working with sexual abuse survivor groups. All therapists thought that on some occasion they had created, in their own mind, visual images of events that had been described to them:

> *Caroline*. I suddenly get a visual image of it or something. And that seems to stay longer.

> *Dee*. And I think if I connect, if someone is talking in a very graphic way, very descriptively about being the age that (my son) is and I transpose him into that situation, that I find unbearable, you know.

Both of these quotations echo how visual images occur, and seem to have a powerful impact. Dee describes the experience of imagining her own son in those situations as "*unbearable"*. She later states that *"it's not me thinking, I don't make myself think about him in those situations but sometimes… someone will say something and it's like he's there."* This illustrates a lack of control over the creation of these images, contributing to the possibility of them becoming intrusive and traumatising.
Sarah describes her reluctance to create certain images:

> *Sarah.* I think … there's a need to not want to image the actual act of abuse because that's just too … that is too invasive I think. It's more of a not allowing that to happen I think.

Sarah, here, talks about her need to refrain from imagining the acts of abuse, and acknowledges that this is *"too intrusive"* for her. Despite this, she was able to create a coherent narrative of her client's experience, and has internalised that story sufficiently to bring it to mind again.

Owned trauma and distress

All of the participants related how, as a consequence of being privy to trauma stories, they had experienced a sense of internalised trauma; that no longer belonged to the client, but was now owned and felt by them:

> *Caroline*. My energy, my being was really disturbed there.

This could be the result of 'one story that stayed', a graphic visual image, or a breakdown of their usual protective boundaries.

Jackie described a particularly graphic image, which had stayed with her for a very long time:

> *Jackie*. It was … that's what's stayed with me, this session. It was like a shock really, we kind of … for me, it was an experience of shock, sort of her talking and the conversation going where I wasn't … hadn't anticipated or expected it to go. And it was current you know, this had just happened…it was a violent … quite a violent image really, that she described. It's that that stays with me, just …and the way it was expressed and you were kind of there in the room you know, strongly identifying…and I think that was more traumatic really and shocking and unexpected.

Jackie's account refers to it as 'traumatic', confounded by this unexpected disclosure; she refers to the fact that she had not anticipated the conversation going that direction, inferring that she was, in some way, not equipped to protect herself against the traumatic material. Jackie later describes this event as *"that feeling of being dumped on".*

Interestingly, a few of the therapists described stories that stayed with them, and articulated this in very similar ways:

> *Dee.* And then there is always someone, someone's story that kind of … I call it kind of getting under my radar you know, and it will get in there …I think I'm probably carrying someone all the time, who is someone … some story or someone who has kind of got under there.
>
> *Caroline*. You know, and occasionally one of us will come in and say 'oh that woman stayed with me all evening' you know, and somehow it was in my dreams or something you know.
>
> *Sarah.* But that stayed with me.

There is something about the term 'stayed with me' that seems to describe the feeling that the therapist has, almost of carrying that person onwards with them.

Emma makes clear her feeling about the accumulative effects on therapists:

> *Emma.* The job at times can be draining, sometimes I might think oh I wish I'd have done something else or I don't think you can do this job full-time day in, day out long-term.

Changed world view

When asked to describe the impact that working with sexual abuse survivors has had on them, the therapists identified a change in their broader understanding, and view of the world. There was a common view

that the therapists have heard the absolute extremes of human inflicted abuse:

> *Dee*. You know, the amount of violence and degradation and you know humiliation and neglect you know, I feel like…whether I have or not, but I feel like I've heard it all.

Emma states *"there's no getting away from that, I think that does colour your views on things."* This exposure to trauma leads to a polarized view of the world and the people contained within it:

> *Sarah.* I believe that people can be profoundly dreadful and cruel and yes, abusive to the point of almost evil. And there are some people that can be on the opposite end of the scale, breathtakingly courageous and brave and available to others…So it's both; it's an awareness of the appallingness of human nature but also of its strengths and wonderful bits in it.

Sarah's account seems to capture a depth of awareness of the two extremes of humanity. This knowledge, of the capabilities of humans to cause harm, may explain the attentiveness to possible cues of danger. Caroline described her automatic thoughts when seeing a young man out with his children:

> *Caroline*. If I see men with children … I was in a café today, earlier, and there was a family and there was a

> young guy and there were two small daughters, one was a baby and one was about 4… You know and then you think well I wonder if that's happening. So it always there you know, there is … it's just there as part of your consciousness.

Caroline's emphasis that 'it's there as part of your consciousness' suggests that, as Emma's statement earlier indicates, there is no getting away from it; once you are aware you cannot close that door. However, held alongside this consciousness of abuse and trauma, is the admiration for the strength and resilience of the survivors of sexual abuse. Many of the therapists refer to this:

> *Sarah.* I think you know, some abuse survivors I've worked with, I have nothing but admiration for their capacity to build their life following it. … I think that's amazing.

> *Caroline*. I mean one of the things that's always very, very moving is the extent to which women often work so hard to give their children a different experience from themselves. You know, and it's often very, very moving when you hear about you know, women who've had completely shit childhoods you know, doing so much to make sure that they know their children can talk to them about what's going on. So yeah, I mean I've got a lot of respect for lots of the women that we work with.

One interpretation of these extracts, is that they point towards a sense that it is important for the therapists to hold both possibilities in their minds; that while human atrocities do occur, it is also possible to survive and overcome the effects of abuse.

Awareness of and defences against 'abusability'

There were references in the transcripts to how having this awareness of abuse translates to your own perception of the safety of yourself and loved ones. One therapist in particular, portrayed a sense of meaning-making about those who do and do not get abused:

> *Sarah.* There's unconscious processes that … there's some women that give off you know, messages quite clearly that say 'touch me and I'll have you in four pieces in seconds'. And others are saying 'I'm abusable'. You know, we do give off unconscious communications in that way I think abusers know that, they gravitate towards certain groups of people because the potential to find someone to serve their needs is more … is higher. So I think it's not random in that respect but it is random that we are you know, at the end of the day … we could just bump into the wrong person you know, get the wrong corner of the street at the wrong time.

Sarah's narrative seems to be concerned with an internal struggle about the randomness of abuse. This seems to reflect her need to reduce all of those variables within her control:

> *Sarah.* I think it does affect my relationships generally because again, I do think that if I think someone is engaging with me in anything that's abusive, I am more likely to nip that straight in the bud and say you know 'let's stop this right now because this is what I think is happening'. …And I can remember thinking there's a point where, if you don't do that, you become an abuse survivor.

This extract seems to demonstrate Sarah's concern with ensuring her safety, and addressing her potential 'abusability'. Other therapists echo this issue in relation to their child relatives; an awareness of their vulnerability and a responsibility to protect them:

> *Dee*. I'd say I was kind of protective without hoping that he doesn't feel too kind of you know … too trapped. But it is hard because I think God, I know all of this and actually he doesn't and I want him to have a little bit, so that he knows that the world can be … you know, he needs to be kind of able to discern what feels safe and not safe. But you know, I know all of this …

This extract seems to be concerned with the therapists' dilemma of how to protect children, and equip them with enough knowledge to be safe, yet allow them to live freely, made more pertinent by the wealth of knowledge they, the therapists, possess about risk.

Dissonance between what you hear and what you do

This theme is concerned with how to assimilate the knowledge you own about risk, and abuse, with living a 'normal' life, untainted by fear. The theme is encapsulated by Caroline and Dee's statements:

> *Dee.* You might expect you know, because I've been running these groups for so long and heard so much trauma, that I might be really quite keen on safety…I'm not particularly you know…So I don't kind of transpose trauma that I hear to trauma that I could experience. Do you know what I mean?

> *Caroline*. But I'm not walking around the streets all the time feeling like all these men are … I mean it's all really dangerous and awful. Sometimes I wonder why I'm not because we do hear so, so much about it.

These extracts are interesting and seem to suggest that the therapists' acute awareness of abuse does not translate to their day-to-day sense of their own safety, which is, in some ways, contradictory to previous statements about their own abusability.

Broader meaning making

Several of the therapists engaged in sense-making discourses, which addressed a wider view of the reasons things occur, and how that was assimilated into their view of the world.

The issue of why people perpetrate abuse on others was addressed by several therapists:

> *Sarah*. I don't know if people do get up and decide to be cruel but I think people are born, things happen to them, life happens, history occurs, we are in the wrong place at the wrong time or the right place at the right time and that then sets off a system of events and things therefore sometimes happen that are very wrong, you know. And I don't think there's like good and bad, it's more like you know, it's not possible to actually make that much sense of it, which is probably a good reason not to worry about it too much because you can't … you just have to engage in your life the best you can, with whatever values you choose and hope you get through the day.
>
> *Caroline*. But maybe I feel more about the lostness of human beings because you know, on some level, I feel like people who do this are just really lost. They're kind of out of control and no capacity to manage themselves...it is about just no capacity for reflection, no framework, no ethical kind of framework and probably no mental ability to manage themselves or to be able to kind of even think you know. I think people that commit these things are in pain, they just don't know it or they haven't got a language for thinking about it or something.

This meaning-making is concerned with a compassion, and attempt to understand the position of the perpetrators. Sarah concludes that she is not able to make sense of it, which is a good reason not to trouble herself

with asking the question. This has a sense of helplessness, but, for her, provides comfort and freedom to live her life the way she sees fit. In Caroline's extract she has created a context around perpetration of abuse, which is concerned with compassion and understanding of their own 'lostness'. This, too, seems to serve, for her, a comfort in having created a broader understanding.

Protecting and maintaining sense of self

Compartmentalising

A further protective mechanism for therapists was discussed in different ways, but involved the process of keeping work, and home, separate. Caroline's narrative describes her psychological setting apart of her 'two lives':

> *Caroline.* So there is this … I mean I think all therapists have quite a sort of compartment. I mean it's known as bracketing isn't it, you sort of bracket all this material. So there is this huge chunk of my life but I don't know how much that's sexual abuse and how much it's part of being a therapist. But there is something about there is this horrific material that I somehow keep separate from the rest of my life.
> And I think in some ways that's quite healthy.

Other therapists describe maintaining boundaries in their lives:

> *Sarah.* And often I'm not you know, my boundaries are quite good, I leave work and I'm into Sainsbury's

> mode, what's for dinner and how much ironing is there to get through.

This extract indicates permission giving; a need to continue with the mundane chores of life, and leave at work the trauma stories that she has heard during the day. Another therapist commented that *'if I'm reading for pleasure, I don't really want to read any books about childhood trauma, I do feel like I've had it up to here at work really."* Again, there is an acknowledgement of the need to have time away from stories of trauma, and pain, in one's personal life.

Introspection and self-care

The therapists demonstrated a depth of self-reflection and contemplation, aspects of which were useful for them to cope with working with trauma groups. Therapists described being aware of their own state of mind:

> *Emma*. But I suppose I'm aware of you know, knowing that I've had enough that week.

A further theme was regarding a reflective use of emotions and impact. There was a sense that, examining those times when work was intruding on their personal lives, enabled the therapist to acknowledge the issue, and discuss it in supervision:

> *Dee*. So if I'm at home and I'm thinking about someone, then I kind of think 'hang on you know, why that person and not the other woman that I've seen that week. And so I kind of log it as you know, there's something there, some information there and then I'll

> come back and I'll talk with the woman I run the groups with, or I'll take it to supervision…I kind of have the thinking that everything is information.

An interpretation from this extract is that, in acknowledging the thought, and attending to it, this allows it to be taken to supervision or a colleague where it might inform an understanding of that client. Consequently it's meaning becomes less intrusive, and more helpful, perhaps minimising the negative effect.

Evolving impact

A further issue considered was how the impact on the therapists changes over time, depending on factors such as experience and age. The way in which the impact evolved was different for each individual, but did highlight the sense that impact is not a static phenomenon.

One therapist commented on how, over the years, she had become desensitised, and paid less attention to the effects of the work:

> *Dee.* I think in the beginning, I think I was much more clued in or much more prioritising vicarious traumatisation…. It's like I kind of desensitise myself to some of the impacts, so now there's less of a prioritising of my needs in all of this. And I think part of that is experience … kind of keeping stuff more bounded, that the groups are there and you know, actually I have good supervision and I have good support, so it doesn't kind of leak out. And I think maybe in the beginning it did a bit more, it's like it was a journey, a process around finding out how to be

> … how I could maintain myself in hearing the amount of trauma that I was hearing.

The way Dee describes it as a 'journey' is a very powerful notion; a process by which she has to maintain, and clearly define, her sense of self, amidst the trauma she is hearing. Yet, at the same time, she acknowledges that along the way she has lost the prioritisation of her needs.

In addition, another therapist acknowledged the changes in herself, with the advantage of experience:

> *Jackie*. I used to leave work at work, you know, not risk or want to risk bumping into patients outside of work and things. I suppose now, I'm much more relaxed. It's about feeling more confident in myself and in myself as a therapist…I suppose it's able to face things without as much fear in a general sense… It's the learning through experience really isn't it, it's kind of much more fearful, anxious, aware of risks, aware of the potential to harm, seeing people as much more fragile maybe.
>
> Whereas now, I don't make those assumptions and I think I have a healthier respect really for people's strength and resilience as well. But also their capacity to judge and know you know, what … I don't know, what's appropriate really. I don't carry such a sense of responsibility than I think I did then. I feel kind of freed up.

Jackie's narrative portrays a 'freeing up' over time. She feels less responsibility for her clients, and therefore feels less anxious about her personal and working lives colliding. Jackie makes sense of this change as a result of her growing experience and 'healthier respect for people's strength'.

Emma's discourse also reflects a positive change over time:

> *Emma*. I think initially….I really struggled then. I felt like I had to be busy in my social life or I had to have a good social life. And I didn't really want to be on my own or dwelling on these things. Whereas like now, I think I deal with it better, I don't have to be with people, I don't have to be busy. I don't have to be doing or socialising to cope with stuff…but I think that's probably come with age as well, learning to look after myself better.

Emma attributes this change to a natural process of ageing and developing, as well as her ability to look after herself, and prioritise her needs.

There are contradictions, and differences, in the ways in which the therapists describe how the impact has changed over time, but equally there is an acknowledgment that for better, or worse, they are affected in different ways.

Unique aspects of the group setting

Participants were asked what specific aspects of working within a group setting contributed to the changes in their life, that they had described. All therapists discussed aspects of working with sexual abuse survivors within the group setting, rather than in individual therapy, that qualitatively

changed that experience for them. These discussions should be considered with the acknowledgement that all participants had experienced the role of trauma therapist within individual therapy, and therefore held a comparative view.

Power of shared membership

Many of the therapists related how, as a consequence of bringing survivors together, there was a sense that the members' shared experiences, in some way, contributed to less internalised trauma on the therapist's part.

Dee's account captured a sense, articulated by most of the therapists, that being a part of a group serves to share out the responsibility of responding to very difficult emotions, thus relieving pressure on the therapist. Furthermore, the power of bringing together a group of people, who are able to empathise and truly understand that individual's experience, enables a degree of comfort and normalisation that may well surpass that offered by a therapist:

> *Dee.* I actually think it's less traumatising… in the group because you have someone else who says that they also experience suicidal feelings. And suddenly suicidal feelings aren't something to you know … it's not like this huge thing that everyone's got to be scared about. And in a group, it's held by more people and so even though I'm the therapist, I'm also part of this group… I actually think it's less kind of. So I do feel like there's this … it kind of feels freer really…it wouldn't just be my responsibility to let you know that this is alright or that this is survivable. Actually

> there's someone who's gone through it, who is letting you know that it's survivable or you know. So you know, what I think my interventions are as a therapist, are less important really…the support that they're able to give to each other is … you know, that's the power of group work really. It's not how clever I am as a therapist to be able to kind of give that perfect intervention.

Dee's account seems to emphasise the importance of the group membership, identifying herself as *'part of this group'*. This appears to convey a protective function by giving permission to refrain from holding all the responsibility for the emotions in the group, but instead allows her to 'sit back' and witness a process of mutual support and comfort.

Another aspect, related to the power of bringing survivors together, was discussed in regards to the capacity for speedier improvements:

> *Jackie*. So actually being impressed by the impact of a short number of sessions and the power really of groups really for people to benefit from hearing each other. What you don't get from individual therapy is kind of being struck by the impact of that, the beneficial impact of that and how people can get a lot from you know, relatively few sessions really.

Emma, also, echoed this:

> *Emma.* When I'm working with someone individually…it can be a lot slower, a lot harder work.

These extracts discuss the quicker developments witnessed within group therapy, compared to individual work. These quicker changes offer opportunities for the therapists to be exposed to positive transformation. This, in itself, could serve to indirectly reduce the internalised trauma experienced by the therapist; a majority focus on the recovery of the members, compared to the prolonged discussion of the effects of the trauma in individual therapy.

Alongside this, two of the therapists spoke of the different transference that occurs between therapist and client in a group setting:

> *Caroline.* The counter transference seems to be much more about…it's more parental I think, it's more about adult betrayal, sort of children and…and issues around authority and power, but more parentally than sexually…

It is not purported what effect this has on the therapists, but it could be hypothesised that, to be placed in the position of responsible adult, or protector, may be experienced as less traumatising than being assigned the role of the perpetrator of abuse.

The value of a co-facilitator

All of the therapists mentioned how much they valued having a co-facilitator. This was not an issue brought up by the interviewer; but each therapist reflected on how integral this relationship was in regards to their experience of running survivor groups. There was a theme of the supportive nature of a co-facilitator:

> *Caroline*. I think the burden would be horrendous if one carried it alone, I would feel that…You can feel that one of you has been completely wiped out by something and the other person hasn't…

In this statement Caroline's sense of comradery comes across, again echoing the theme of group membership, and how important it is to feel a part of a team. Conversely, one participant spoke of having a difficult relationship, and how that affected her experience of the group:

> *Jackie*. The fourth one I did was with another co-facilitator and I didn't work so well with her really, so again, that wasn't such a positive experience.

The relationship shared with a co-facilitator seems to have a direct implication for how that group is experienced.

Many of the therapists also reflected on the implications of having a co-facilitator in the context of complex dynamics and splitting. One therapist referred to the "*good cop, bad cop"* phenomenon.

> *Caroline*. The whole thing that happens in groups about the various sorts of splittings and one of us will cop one. And very often we'll split about … that we'll perceive a client, a group member, very differently, you know. And actually we're copying you know, one of us will catch one side as it were. And then it becomes very important to kind of put that together.

Here, Caroline discusses the function of the splitting; by saying *'actually we're copying";* she implies that, as therapists, they are mirroring or playing out the different roles within the abuse dynamic e.g. one might take on the sympathetic protector, while the other becomes the punisher. The value of having a co-facilitator comes when this experience can be objectified, and reflected upon, providing more information about what is occurring within the group. This, too, may serve as a protective feature; enabling negative projections to be discussed explicitly minimises the likelihood of those projections being internalised by the recipient therapist.

Each of these sub-themes highlights aspects that are unique to working with sexual abuse survivors, within the group setting. There was no definitive conclusion about the overall 'positive' or 'negative' effect by therapists, rather an acknowledgement of the differences.

Potential destructiveness of the collective trauma

In contrast to the positive elements of group membership, some of the therapists discussed a sense of being overwhelmed by the enormity, and uncertainty, associated with having more people, and more trauma, with which to contend. Jackie's narrative describes her feelings of anxiety about embarking on group therapy:

> *Jackie.* And I think the first group, there was a sense of the potential destructiveness of the collective trauma of it and the anxiety all the way through was something about the enormity of it.

This quotation seems to represent the anxiety Jackie felt about having to cope with the quantity of trauma addressed in the group, but also acknowledges the possibility that the trauma might compound, and

negatively impact, on those present. Jackie's choice of the word *'potential'* seems to represent the responsibility, felt by her, to ensure that the potential destructiveness was not realised.

Furthermore, the group setting can be a place of uncertainty and unpredictability:

> *Jackie*. I suppose in a group, it feels like the uncertainty is the openness to the unknown, in a way it feels greater. So the anxiety, the sense of more people, you don't know what's going to be said or its impact. In a one to one… a sense of not being so vulnerable to being faced with the unexpected. Of course you will be faced with the unexpected but when it's just one person, somehow whether that feels … I'm not sure if I'm explaining this right.
>
> So in a group there's that sense of anything can happen.

This extract effectively provides an insight into the precariousness experienced by Jackie, and how this created an internalised anxiety and fear. '*Vulnerable to being faced with the unexpected'* holds great symbolic force; she is at risk of being out of control, and caught unawares, by something brought by the 'collective group'.

Further to this, it was related by the therapists that, due to the nature of sexual abuse, the group members were more likely to bring complex dynamics to the group:

> *Caroline*. But you know, the elements, the kind of complexity of the elements when you've got more

> people, then it becomes a whole different thing, you know. It does play out through the dynamics in the group…

The unique complexities associated with sexual abuse means that those relationship dynamics can be echoed in therapy. The role of the therapist is to work with these *"live dynamics"* and be able to attend to each member with equal compassion and understanding, amidst their own emotions about the individual:

> *Sarah.* The dynamics I think that she invoked quite abusive responses from other people because she was so frustrating to work with…

Group milieu

One unanticipated area discussed in the interviews was the importance of the group milieu, in other words, the organisation, structure, and context to the group. In particular, therapists spoke of the wider organisational context of the group. One therapist commented on the positive experience she had in her establishment, and how this contributed to her feeling of safety and confidence:

> *Dee*. I think I'm quite safe here…I'm under no pressure to do anything than what I do, and I have the freedom and autonomy to start new things, to you know, think about developing services. I have all of that freedom, which is a really…you know, I think is an amazing position to be in.

Whereas, other therapists reported that a stressful, and unsupportive, environment led to more negative experiences:

> *Emma*. I have had some difficulties resulting from that work and that was more to do with staff…yeah my main stress wasn't the clients.

Furthermore, Jackie commented on her need to feel safe and confident, in order to deliver a safe therapeutic experience for the clients, which was hampered by external pressures and resentment about the way in which the group had come about:

> *Jackie*. And there was an element of feeling pressured into doing it because it was kind of life it stemmed from an initiative that a more senior colleague in the department had kind of set up and got going. And we kind of felt it had generated an expectation in a way and we felt obliged to meet it. So there was an element of it being quite a scary prospect, maybe some kind of resentment about how it had all come about as well…It felt quite precarious…You've got to feel safe, you've got to feel contained in order to help the patients to feel safe and contained and to have a therapeutic experience.

This emphasis on feeling safe was echoed by other therapists in reference to the structure of the group:

> *Emma.* We deliberately ran the group really, really structured, to make sure that there was less chance of a lot of transference reactions between people in the group.
>
> *Jackie*. So how to kind of offer an experience where people can share and…but not hopefully traumatise each other or you know, compound the trauma in some way. So the next three groups were very structured ones.

What comes across from these extracts is a sense of needing to maintain structure, to ensure control over the group in order to reduce the chances of any potentially traumatising material emerging. Jackie states that this structure "*allowed for a very gentle pacing of disclosure",* but later goes on to add that *"structure isn't necessary to make it safe"* but *'being tasked with providing time-limited groups…unstructured with time pressure contributed to it feeling unsafe."*

This wider context to the group was not one that was directly referred to in interviews, but emerged as an important consideration, both to ensure that the therapists felt safe, and to maximise their ability to provide a helpful and therapeutic experience for the group members.

Extended Discussion

In this section the additional themes will be discussed. Interestingly, there seemed to be two categories of themes; the themes concerning the impact on the therapists and their construction of what those impacts meant to them as individuals, and the findings relating to the specific aspects of

working with sexual abuse survivors in groups. These will be discussed in turn, and also considered in how they influence each other.

The three sub-themes, within the super-ordinate theme, 'Sense of Responsibility' could be considered within the framework of Finkelhor's (1985) four traumagenic dynamics. He argues that there are four core areas of psychological injury as the result of childhood sexual abuse, including traumatic sexualisation, stigmatisation, betrayal, and powerlessness. These dynamics alter an individual's emotional and cognitive orientation to the world. Of particular relevance here, stigmatization, which is reported to distort the person's sense of their own value and worth; many sexual abuse victims experience guilt, and shame, as a result of the abuse (Anderson, Bach and Griffith, 1981). This guilt, and shame, may also be as a result of other people's reactions to their disclosure of sexual abuse. The dynamic of betrayal refers to the realisation by a child that a trusted person has caused them harm. Furthermore, a family member who was not abusive, but was inactive in protecting them, or dismissive to their disclosure, will contribute to a greater sense of betrayal. Finally, the dynamic of powerlessness distorts a person's sense of their ability to control their own life. An adult abused as a child may suffer subsequent victimisation because they feel powerless to thwart others who are trying to harm them (Finkelhor & Browne, 1985).

These traumagenic dynamics are relevant to the therapeutic relationship between client and trauma therapist. Hill and Alexander (1993) note that "the working alliance seems to be particularly important for treating adult survivors because their experience of betrayal of trust by someone in a position of authority is so germane to their abuse" (p.420). One explanation for this sense of responsibility, to which the therapists refer, may be a natural reaction to these traumagenic dynamics; a sense that they have to compensate for these individuals' previous abusive

experiences at the hands of a trusted person. Therefore, they put the client's needs first, even if this is to the detriment of themselves, and contain this information, in order to uphold the client's confidentiality. Indeed, literature suggests that therapists with a higher trauma caseload talk less to family and friends about their work, (Chrestman, 1999).

Finkehor's model can also be used to explain the sub-theme of 'Anger'; Dee's anger represents an alliance with her clients, she describes how society's inability to awaken to the realisation of the common occurrence of sexual abuse "invisibilises" her clients' experiences. Again, the therapist may be reacting to the traumagenic dynamics of powerlessness and stigmatisation. The therapists react to their clients' powerlessness by compensating; experiencing their anger, and fighting against the stigmatisation that is so common in society. Indeed, anger has been repeatedly reported in the literature as an identified impact of working with trauma clients (Pearlman & Saakvitne, 1995a). Therefore, a further exploration of the application of Finkelhor's model to the area of vicarious traumatisation could inform how best to alleviate 'negative' symptoms.

A second model to refer to is the Constructivist Self-Development Theory (CSDT) (McCann & Pearlman, 1992). This model has been used to explain various impacts on therapists, and could also explain the themes described in this study, under the super-ordinate theme title 'Impact'. Disruptions to the five core areas of the self; frame of reference, self capacities, ego resources, psychological needs and cognitive schemas, correspond to some of the areas of impact described by the therapists. For example, the therapists described 'feeling different' to others around them. The CSDT model proposes that, as a result of their trauma work, the therapists have differing worldviews to others, which in itself would set them apart from friends and family. Pearlman (1999) speaks of the "sense

of isolation" (p. 60-61) that comes from trauma work, and having to work under the constraints of confidentiality, which disallows one to share one's altered worldview with others.

Furthermore, the sub-themes, 'changed world view' and 'broader meaning making' would also be evidence for this sense of disrupted frame of reference. The therapists spoke of how, as a result of their trauma work, they had come to be acutely aware of the extreme capability of mankind to commit atrocities. This awareness had changed their life philosophy; Sarah's statement "*it's not possible to make sense of it…you have to engage in your life the best you can, with whatever values you choose"* depicts a real sense of her ideas about causality and moral principles, as described by Pearlman (1999). Furthermore, the aspects of spirituality were directly addressed by Caroline's connection with Buddhism and her compassion for perpetrators. These findings are concordant with other studies; Arnold et al. (2005) found that therapists had come to view perpetrators of abuse as "wounded rather than evil, with more compassion" (p.258). Other studies have also found that increased exposure to trauma survivors is linked with higher levels of spiritual well-being (Brady et al., 1999).

In addition, the discussions in the data regarding 'Awareness of and defences against abusability', are consistent with the CSDT's cognitive schemas of safety and control; the disruption of which, results in hypervigilance to cues of threat as well as either feeling helpless or attempting to excessively control aspects of their life. Indeed, Jackie describes 'nipping straight in the bud' any effort she perceived to be an attempt to engage her in abusive dynamics because, as she comments "*there's a point where, if you don't do that, you become an abuse survivor*". Chrestman (1999) describes how therapists experiencing secondary exposure were more likely to report increased efforts to protect

themselves, and their families, from harm. However, in contrast other therapists in this study spoke of how their awareness of risk did not impact on their own perception of their safety; Dee commented "*I don't transpose trauma I hear to trauma that I could experience*". CSDT does not comprehensively provide an explanation as to why some therapists do, or do not, experience these disruptions.

A hallmark of vicarious traumatisation is said to be the experience of intrusive imagery (van der Kolk, 1989). In accordance with previous literature, e.g. Steed and Downing (1998), the therapists described creating internal images of clients' experiences. Caroline described recalling a client's experience of sexual assault, which occurred in the underground, whenever she had to use that particular mode of transport. However, the therapists reported not necessarily experiencing such images as intrusive. Some felt that they were able to use these images to maintain empathy with the client, or reflect on those images to gain information. Again, there is no literature that addresses the issue of what constitutes 'intrusive' – is it the presence of uninvited images, or the meaning that the individual ascribes to those images?

In support of the existing literature on vicarious traumatisation, the therapists reported a degree of internalised distress, including having one client's story that stayed with them, that they took on into their lives. Jackie also described feeling *"dumped on"* by a particular client, which could give cause for concern; Hesse (2002) stated that a disruption of cognitive schemas might result in the therapist blaming the client for their own experience of traumatisation.

In summary, many of the findings in this study are concordant with the previous literature on vicarious traumatisation (or secondary traumatic stress). However, due to the qualitative nature of the study, there is exploration of the meaning that the therapists have ascribed to their

experience, which does not seem to be covered in the VT literature. For example, the secondary positive self-transformation described by the therapists; despite the negative side of exposure to trauma, they were grateful for the additional positive aspects that exposure had brought to their lives. They described being able to better care for themselves, and their children, as a result of being equipped with the knowledge about risk and sexual abuse. They were more able to identify abusive dynamics within groups, and subsequently address them, and they felt a sense of honour at being witness to their clients' stories.

One could conceptualise these positive changes within the three aspects of posttraumatic growth described by Tedeschi and Calhoun (1995) – positive changes in self perception, interpersonal relationships, and philosophy of life. The therapists described not only being aware of the atrocities committed by mankind, but also the amazing capacity of their clients to overcome such adversity, resulting in a deeper appreciation for human resilience. These findings are comparable to those found by Arnold et al. (2005) who coined the term 'vicarious posttraumatic growth'. However, several shortcomings of the existing research are highlighted by this study's findings. Firstly, the literature does not comprehensively describe how these 'positive' changes emerge as a result of exposure to trauma (possibly with the exception of Saakvitne et al., (1998) application of CSDT to posttraumatic growth). Secondly, the literature is categorical in nature; one is either experiencing vicarious traumatisation, measured by the presence of various undesirable symptoms, or posttraumatic growth, demonstrated by desirable changes to view of self and the world.

This, however, yields a further discussion about the ethical implications of the experience of VT. There may be alternative explanations as to why the therapists say they do not experience these symptoms negatively. Whilst Pearlman and Saakvitne (1995a) argue that VT does not

signify immaturity, countertransferential reactions or bad practice, there could be wider societal, or professional, reasons for not divulging experiences of VT. As Munroe (1999) argues, if the profession is not willing and able to accept these effects there may be victim blaming; "those who begin to show signs of being affected will be identified as poorly trained, unable to do the job, or personally flawed" (p.216). Is there a preferred narrative within the profession, that hearing repeated trauma does not impact on therapists? Stadler (1990) found that denial of burnout was common, and attributed this to the myth that professional training offers immunity from emotional problems. This has implications for the need to make more knowledge, and training, widely available to therapists, supervisors and employers. To emphasise the narrative that suffering from VT symptoms is not a reflection of one's skills, or capabilities, as a therapist, but is an inevitable result, might encourage therapists to openly discuss their experiences of VT.

An alternative argument, as to why the therapists say they do not experience these symptoms as negative, is because they are engaged in denial. Munroe (1999) argues "it is entirely possible that when a therapist is being secondarily traumatised, denial becomes a way to cope" (p. 222). The ethical dilemma comes, as a supervisor or colleague, over when to intervene. Is it appropriate to argue that it depends on the meaning that one makes of their experiences, i.e. if a therapist recognises they experience symptoms associated with VT, but they do not construe these as traumatising or distressing, does this mean they are not susceptible to providing a compromised service? Or, as objective witness, should one intervene as soon as someone indicates they experience any impact from doing trauma work? As Munroe (1999) suggests, perhaps individual therapy should only be conducted when a clear support team, who are trained on the issues of secondary traumatisation, are involved. This

argument seems to be extreme, and does not offer any locus of control to the therapist, to decipher and reflect on their own experiences. Instead, if the profession was willing to conceive of the possibilities of VT and its implications, this would allow therapists the arena to openly discuss the effects of trauma work and create a positive narrative about these changes.

A further, super-ordinate, theme is concerned with 'Protecting and Maintaining Sense of Self', this relates to those protective mechanisms, which the therapists engaged in, to minimise the impact of the work. The four sub-themes of 'normalising', 'compartmentalising', 'maintaining sense of hope' and 'introspection and self-care', each appear to reflect the advice given to therapists. Pearlman (1999) published some helpful strategies for self-care. These included balancing one's caseload; balancing one's day to intersperse therapy, supervision, meetings etc; and balancing one's clinical and non-clinical work, as well as providing time for self-care (exercise, chatting to friends etc.). It could be argued that, indeed, the therapists are already engaging in all the protective processes suggested, hence are not experiencing the work as wholly negative.

Finally, the super-ordinate theme of 'Evolving Impact' is concerned with comments the therapists made about how the effects had changed over time. There was no consensus about whether the impact had decreased or increased. One therapist described her *"developing cynicism"*, whereas another described her increased confidence and feeling of being *"freer".* This seems to reflect the inconsistent findings in the literature, Chrestman (1994) found years of experience was associated with fewer effects, and yet Munroe (1991) found that neither age, nor experience, buffered the effects of secondary trauma. Hence, the question of accumulative or inoculation effects of secondary trauma exposure remains unanswered. Further research in this field would, without doubt, add to this

area, but it is also important to keep in mind that no therapist would be immune to the effects and therefore, awareness should be brought to therapists of all ages and experiences.

The second theme group addressed the question relating to whether working with sexual abuse survivors in a group setting mediated, in any way, the impact of the work. Interestingly, the therapists, overall, reported that they felt that working in a group setting reduced the effects of secondary traumatic stress. This is in contrast to the majority of the literature. Previous studies have emphasised the complex dynamics and exposed environment of the group setting, suggesting group therapists may be at more risk. However, the therapists in this study reported that, as a result of being a group therapist, but also a group member, relieved them of the pressure of providing perfect interventions. The therapists reflected on the unique power of bringing survivors together, and its potential for healing. The literature suggests that the fragility of trauma survivors means that developments in the group can take longer to occur than for non-trauma groups, (Ziegler and McEvoy, 2000). However, emphasised in the therapists' narratives was their astonishment at how quickly the changes in the members could occur. As mentioned in the results section, these rapid developments mean that the therapist is not exposed to the same prolonged discussion of the negative consequences of sexual abuse, but is, instead, able to focus on the positive transformations accomplished by the group's members. Secondly, all of the therapists commented on the absolute imperative importance of the co-facilitator. One therapist commented that *"the burden would be horrendous if one carried it alone".* It could therefore, be argued that the reason the groups are experienced as less traumatising is because of the additional support available for the therapists. A direct application to clinical practice could be the use of more peer support for trauma therapists; for those involved in

individual therapy regular meetings could be arranged for therapists to come together and share their experiences. They could discuss issues of countertransference and experiences of VT with other therapists. Alternatively, it could be argued that trauma therapists, who currently undertake solely individual therapy, should engage in more group work, so they have the opportunity to work with another therapist.

Before concluding that group therapy is more protective for the therapists, a further sub-theme, titled the 'potential destructiveness of the collective trauma', was also constructed. This confirmed earlier findings that the sheer quantity of the collective trauma could be overwhelming, and anxiety, provoking for therapists. The unique aspects of sexual abuse survivors did indeed produce 'splittings' between the facilitators (Abney et al. 1992), although the therapists felt that, with the help of their co-facilitator, these served to be informative in the group process. Jackie also described the *"potential destructiveness of the collective trauma"* and feeling a responsibility to ensure that the collective trauma did not negatively affect other members of the group. This concern of Jackie's is reflected in the finding that 20% of group members reported experiencing VT (Palmer et al., 2007). Given that group therapy is often recommended for sexual abuse survivors, further research would inform our understanding of the long term effects of this VT on other group members.

The final super-ordinate theme 'Group Milieu', was unanticipated. The therapists referred to the wider context of the group, in particular the organisational setting of the group. Those therapists that felt they had both autonomy, and support, seemed to experience the groups they ran more positively, whereas those who felt pressured, and inexperienced, described a sense of 'precariousness' and 'vulnerability'. This has implications at the service level; therapists who are expected to engage in group therapy should be supported throughout the process, and should not be pressured

into running a group that they feel is beyond their capability or experience. Furthermore, therapists described maintaining rigid structure to some groups, in order to reduce the chances of transference reactions. This could reflect findings that therapists experiencing VT will avoid discussion of trauma to protect him or herself, (Munroe, 1999). Again, these results emphasise the need for therapists to feel equipped to cope with disclosure, to enable the provision of an effective service to the clients.

Overall, the findings, relating to the unique setting of group therapy with sexual abuse survivors are particularly interesting; especially given how little research has been conducted, to date.

In summary, the findings would seem to suggest that the therapists in this sample did not necessarily experience the work's effect on themselves as traumatising. Furthermore, there was a general consensus that, overall, being one facilitator in a group setting had less traumatising effects, than being a clinician in individual therapy. It could be argued, therefore, that because the therapists in this sample had worked in groups with another co-facilitator, they were not constructing their experiences as negatively as therapists who only ever worked in individual therapy might. However, in defence of this argument, as mentioned before, some of the therapists had not been involved in running groups recently, and had since been involved in individual therapy. Nevertheless, as argued earlier, being involved in both group and individual therapy may minimise harm to therapists, and therefore, this could be an argument worth considering in future research. This could also however, be considered a weakness of this study; that therapists were not able to distinguish between the impact of working with sexual abuse survivors, or other trauma clients, and working with groups for sexual abuse survivors.

A further limitation of the study relates to the limited information gathered about the types of groups the therapists ran. Some mentioned, in

their interviews, the psychoeducational or therapeutic remit of the groups, but this information was not explicitly collected on the demographic and clinical information sheet. It could be argued that certain types of groups, for instance those that encourage disclosure, could have a different impact on the therapist. In addition, the nature of purposive sampling denotes that therapists are self-selected, which may inadvertently skew the sample. Of particular note in this study, whilst two NHS trusts were contacted, no participants volunteered to take part from one trust. This could be for many reasons, for example the managers of the therapists could have been less inclined to pass on the information, or the structure of the service could have meant that they had less opportunity to take part in non-clinical work. Without speculating as to the reasons, it did inevitably have an impact upon the sample of therapists that was used in the study.

Furthermore, whilst IPA was an appropriate use of qualitative methodology, there are facets of the data that IPA does not tell you about. For example, the quotations used to demonstrate the resulting themes are representative of what the therapists said, but they do not present the intonation, pauses or other characteristics of speech, which inform interpretation. The main researcher conducted all of the interviews and completed the analysis, and so was witness to the therapists' vocalizations, but these cannot be represented in quotations. Other methodologies such as conversation analysis may have provided different information, enabling alternative interpretations.

Despite these limitations, the study has its strengths. Few studies have been carried out on group therapists, and therefore these results could inform both future research and practice. In contradiction to the existing literature, the therapists in this sample stated that the group experience was potentially less traumatising than individual therapy. This could have important applications for practice, and be a consideration for

services, when deciding what therapy to offer clients. In addition, whilst there is a good deal of research on the issue of vicarious traumatisation, there has been less on the positive aspects of transformation and also very few qualitative studies. The findings of this study highlight the need for considering the concept of VT in more depth, and regarding the meanings that the therapists ascribe to their experiences of trauma work, rather than relying on a symptom checklist type approach.

Future work that would further inform these areas include an analysis of how Finkelhor's model of traumagenic dynamics influences therapists, and whether more knowledge and understanding of this process could add to the therapists' ability to reflect on their reactions to the client. Furthermore, a qualitative study designed to ask therapists whether they feel there is a narrative within the profession that it is unacceptable to admit to negative effects from trauma work, would aid our understanding of the wider context within which these experiences occur.

Finally, this study was conducted on all female therapists. The literature does suggest that females report more VT symptoms (Brady et al., 1999). However, it could be that male therapists are insufficiently represented in the current research, therefore more studies looking at gender issues and male therapists, specifically, would add significant information.

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